How Do Current Senior Registrar Job Profiles Relate to Proposed Specialist Registrar FTTA Posts?

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Abstract *The proposed United Kingdom training pathway for Orthodontic Specialist Registrars is now accepted to be of 3 years duration. In the final year, Specialist Registrars will take the Membership in Orthodontics, with the end point of training marked by the award of the Certificate of Completion on Specialist Training (CCST).*

There will be a predetermined number of fixed term training appointments (FTTAs), available through competitive entry, which will provide 2 years of additional training and lead to eligibility to apply for a Consultant appointment. The end point of the Specialist Registrar (FTTA) will be marked by the Intercollegiate Specialty Examination (ISE).

The current 3-year Senior Registrar orthodontic training will be reduced to 2 years as the transition to the Specialist Registrar FTTA grade occurs. In the light of these changes, a survey of full time NHS Senior Registrar posts was carried out to examine current job profiles with particular reference to their suitability for assimilation into the Specialist Registrar (FTTA) grade and preparation for the ISE.

Index words: Specialist Orthodontic Training, Sp. R, FTTA.

Introduction

The proposed training pathway for orthodontic Specialist Registrars in the United Kingdom is now accepted to be of 3 years duration. Towards the end of this period, Specialist Registrars will take the Membership in Orthodontics, with the end point of training marked by the award of the Certificate of Completion of Specialist Training (CCST).

A number of fixed term training appointments (FTTAs) of 2 years duration will be available by competitive entry (Department of Health, 1998), to provide additional hospital training, leading to eligibility to apply for a hospital Consultant appointment. The number and location of FTTA posts will be determined by the SAC in Orthodontics and Paediatric dentistry following manpower planning advice from the Specialist Workforce Advisory Group (SWAG), and it may be necessary for a trainee to move from one region to another in order to complete their training. The end point of the FTTA will be marked by the Intercollegiate Specialty Examination (ISE) with the award of the F.D.S. (Orth.) by one of the Royal Colleges to successful candidates. This additional 2-year training aims to prepare the future Consultant in the provision of:

1. Orthodontic advice and, where appropriate, treatment plans or second opinions for referring primary and secondary care providers in the general dental services, community dental services, and occasionally to medical practitioners.
2. Supervision and support for general dental practitioners or community dental officers carrying out orthodontics within the primary care sector.
3. Advice and liaison with specialist orthodontic practitioners, community orthodontists, and hospital clinicians, including consultants in oral and maxillofacial surgery, restorative dentistry, paediatric dentistry, plastic, and ENT surgery.
4. Treatment for complex, severe cases with a high treatment need.
5. Treatment for cases with particular management difficulties.
6. Co-ordinated inter-disciplinary treatments requiring input from consultant oral and maxillofacial surgeons, plastic surgeons, paediatricians, paediatric surgeons, and restorative specialists. Such cases would include patients with cleft lip and palate and other craniofacial anomalies.
7. Clinical training for career junior staff, future specialists, and trainee academics
8. Continued professional education, in association with postgraduate deans, for general dental practitioners and community dental officers.
9. Education and training of dental and medical undergraduates.
10. Liaison with consultants in dental public health, in order to determine the needs and demands of the resident population, with respect to orthodontic care, and to ensure equity of access to orthodontic treatment by planning developments and strategies to meet demand.
11. Advice to employing trusts on the specification and contracts drawn up by purchasers
12. Advice to trusts in negotiating with purchasers.
13. Advice and participation in national and local NHS-based committees and, where appropriate, in other areas such as examinations and conferences.
14. The future consultant will also be involved in

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personal research and, where appropriate, in national and international collaborative research programmes, and will lead or play an active role in sub-regional and departmental audit (CCHDS, 1997).

The Grade Commissioning Date for Specialist Registrars in Orthodontics and Paediatric dentistry was 1st July 1998, and the current minimum 3-year training for a Senior Registrar in orthodontics will reduce to 2 years as a FTTA. In the light of these proposed changes, a survey was carried out to examine the job profiles of all current full time Senior Registrars with particular reference to their suitability for assimilation into the SpR (FTTA) grade and preparation for the ISE.

Methods

Questionnaires were sent out to all 38 full time NHS orthodontic Senior Registrars with prepaid reply envelopes supplied. The questionnaire was designed to address specific areas in the *JCSTD Guidelines for the UK Specialist Programmes with Two Years Additional Training for NHS Consultant and Academic Practice (Version S)* (JCSTD, 1998). The questions were divided into the following categories:

(1) job rotation
(2) clinical sessions
(3) caseload mixture
(4) level of supervision
(5) attendance at multidisciplinary clinics
(6) teaching experience
(7) research and audit activity
(8) study leave
(9) management training
(10) on call duties
(11) facilities.

Assurances were given that all replies would be treated in strict confidence.

Results

Thirty-one questionnaires (81 per cent) were returned after the first mailing. Ten respondents (32 per cent) were in their first year of SR training, seven (23 per cent) in their second year, nine (29 per cent) in their third year, and five (16 per cent) in their 4th year. The responses where complete, are set out below.

Job Rotation and Distribution

Twenty-two posts (70 per cent) were split between two centres, eight (26 per cent) between three centres, and one post between four centres. Twenty posts (64 per cent) involved at least 3 days in a teaching hospital, but one post had no sessions allocated to a dental teaching hospital. Fourteen respondents (46 per cent) had at least one split day between centres and 24 (74 per cent) spent more than 5 hours travelling during the week.

Clinical Sessions

Twenty-seven SR respondents (87 per cent) had at least five personal treatment sessions each week (range 4·5–7 sessions). All Senior Registrars were attending new patient or review clinics with 19 respondents (63 per cent) at one new patient/review clinic each week, and the remaining 11 respondents attending two new patient/review clinics. Twenty respondents (64 per cent) were seeing eight or more new patients at each clinic, although this ranged from 3 to 20 patients.

Caseload and Case Mix

Seven respondents (23 per cent), mainly in their first year as Senior Registrar, had a caseload of 150 or less. Five Senior Registrar respondents (17 per cent) had a caseload of 151–200, nine respondents (30 per cent) had 201–250 patients and a further nine (30 per cent) carried a total patient caseload greater than 251 (range 50–465; see Figure 1). However, the caseload was not directly related to the time spent in the post, as one first-year Senior Registrar had a caseload of 200 and one third-year Senior Registrar had a caseload of 150.

When analysed, the number of cases under treatment divided by the number of clinical sessions, ranged from 7·7 to 78.

The number of transfer cases ranged from 0–173, which, when expressed as a percentage of the total number of treatment cases, gave a range from 0 to 49 per cent.

The number of orthognathic cases ranged from 11 to 60, with seven respondents (24 per cent) treating up to 20 cases, nine (31 per cent) treating up to 30 cases, four (14 per cent) treating up to 40 cases, and nine (31 per cent) treating more than 40 orthognathic cases (see Figure 2).

The number of restorative cases ranged from 2 to 52 with 12 respondents (35 per cent) treating 10 or fewer cases, and three (9 per cent) respondents treating over 41 cases (see Figure 3).

The number of cleft lip and palate/craniofacial cases treated ranged from 2 to 41. Thirteen Senior Registrars (45 per cent) saw less than 10 CLAP patients, while 15 respondents (52 per cent) saw between 11 and 30 CLAP cases (see Figure 4).

Twenty-four (78 per cent) respondents reported that some or all of their cases had been pre-selected and 30 respondents (97 per cent) were keeping a computerised patient databases.

Supervision

The number of Consultants directly involved in training programmes ranged from 2 to 8, the majority of 19 (61 per cent) having three or four involved. The Consultant was almost always available to assist or advise in the clinics.

Multidisciplinary Clinic Attendance

Although all Senior Registrar respondents attended orthognathic clinics, two (7 per cent) did not attend a CLAP clinic,

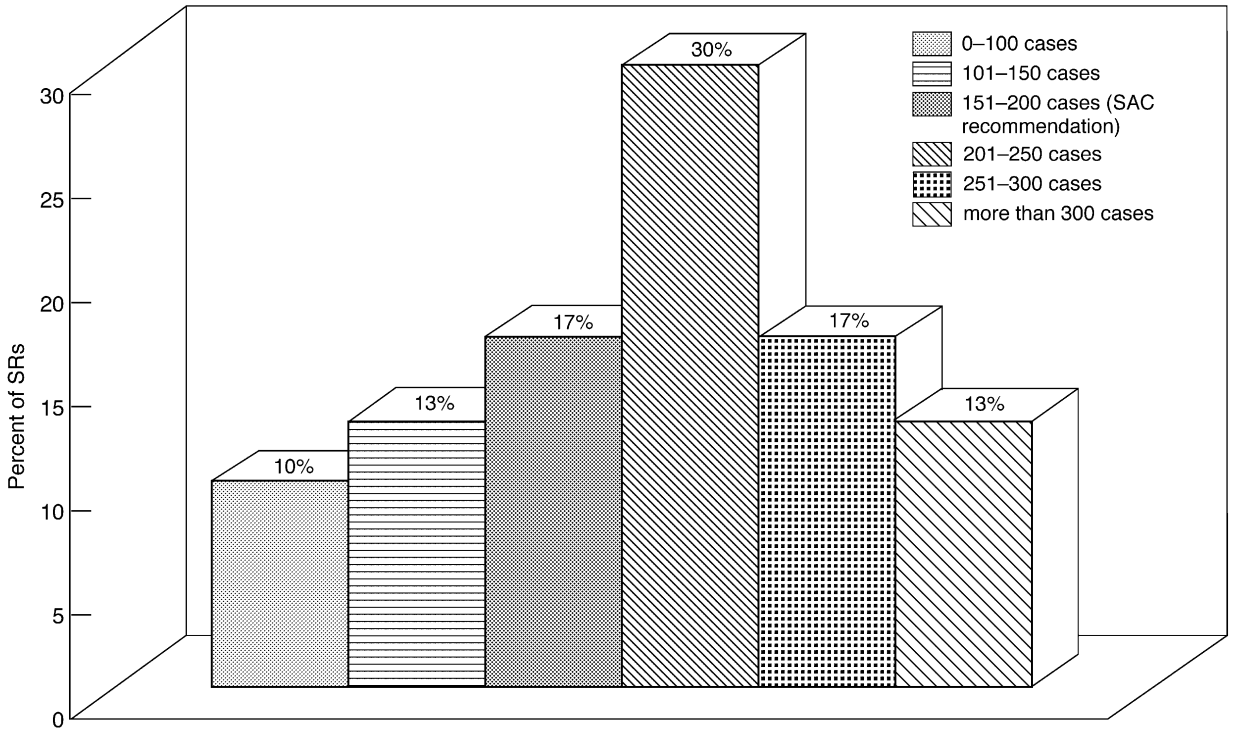

FIG. 1 Number of cases under treatment.

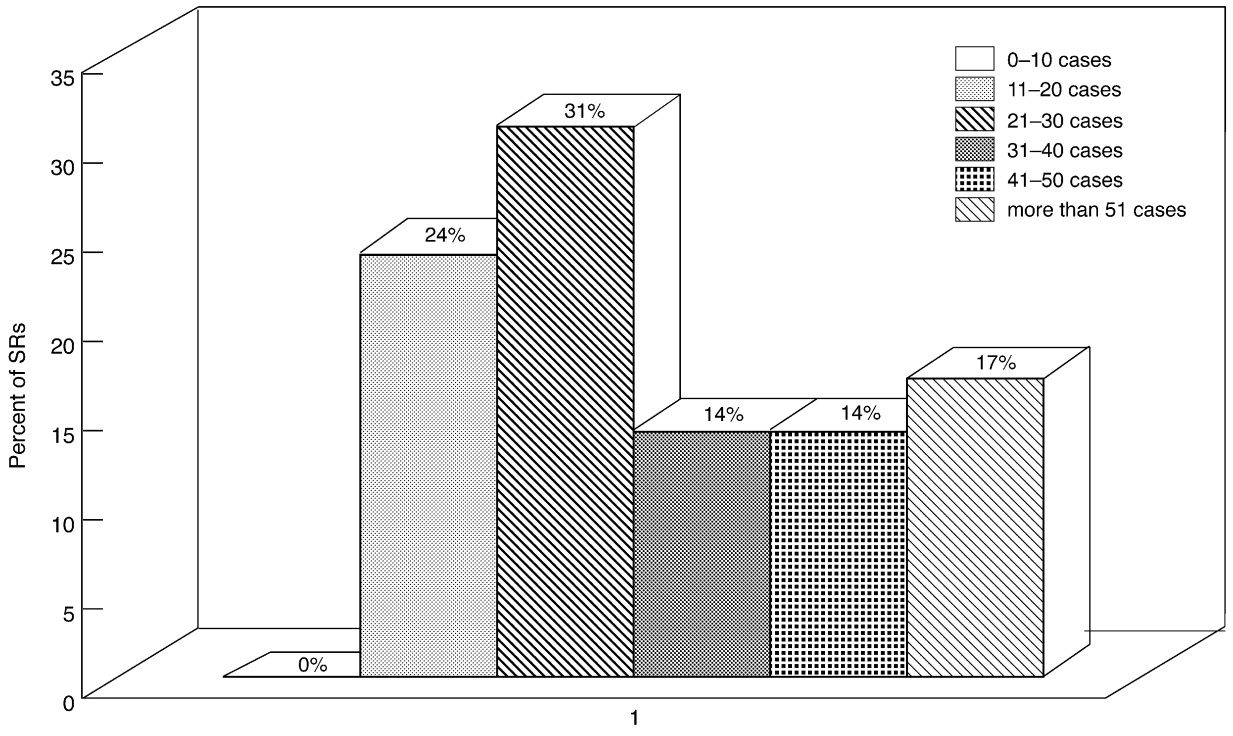

FIG. 2 Number of orthognathic cases under treatment.

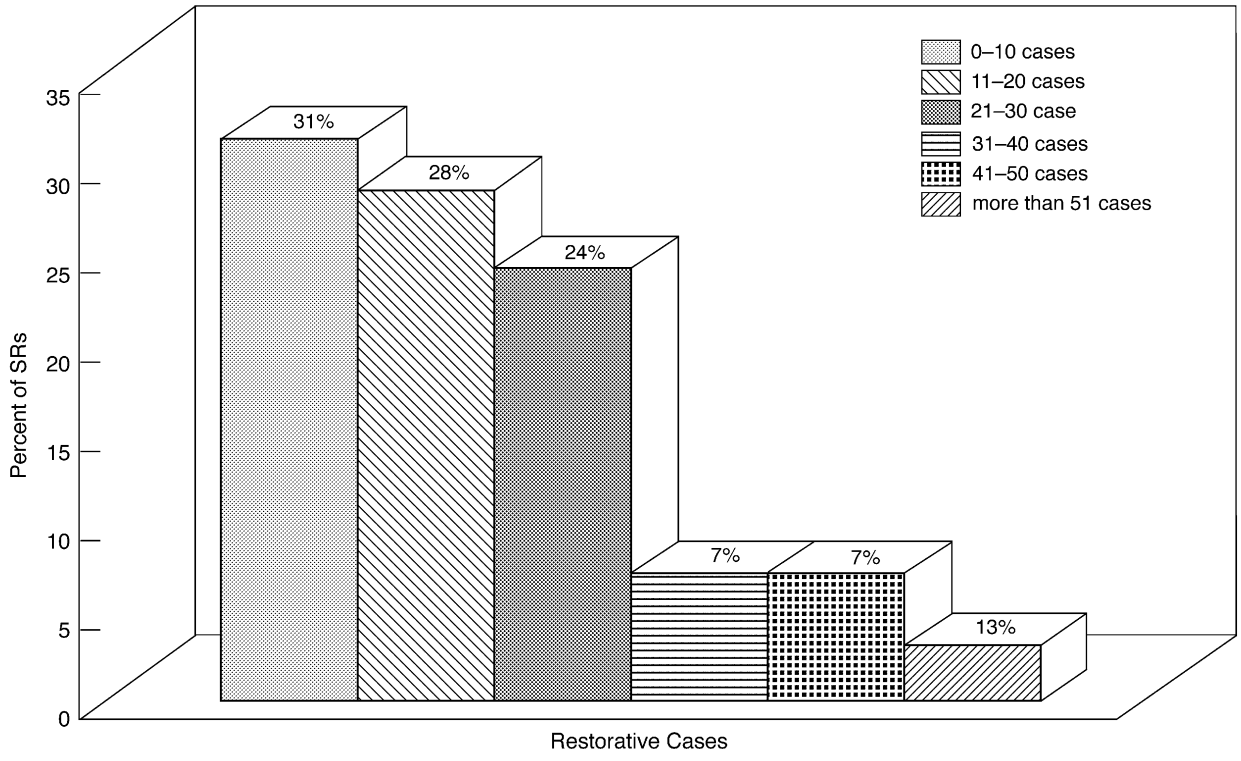

FIG. 3 Number of restorative cases under treatment.

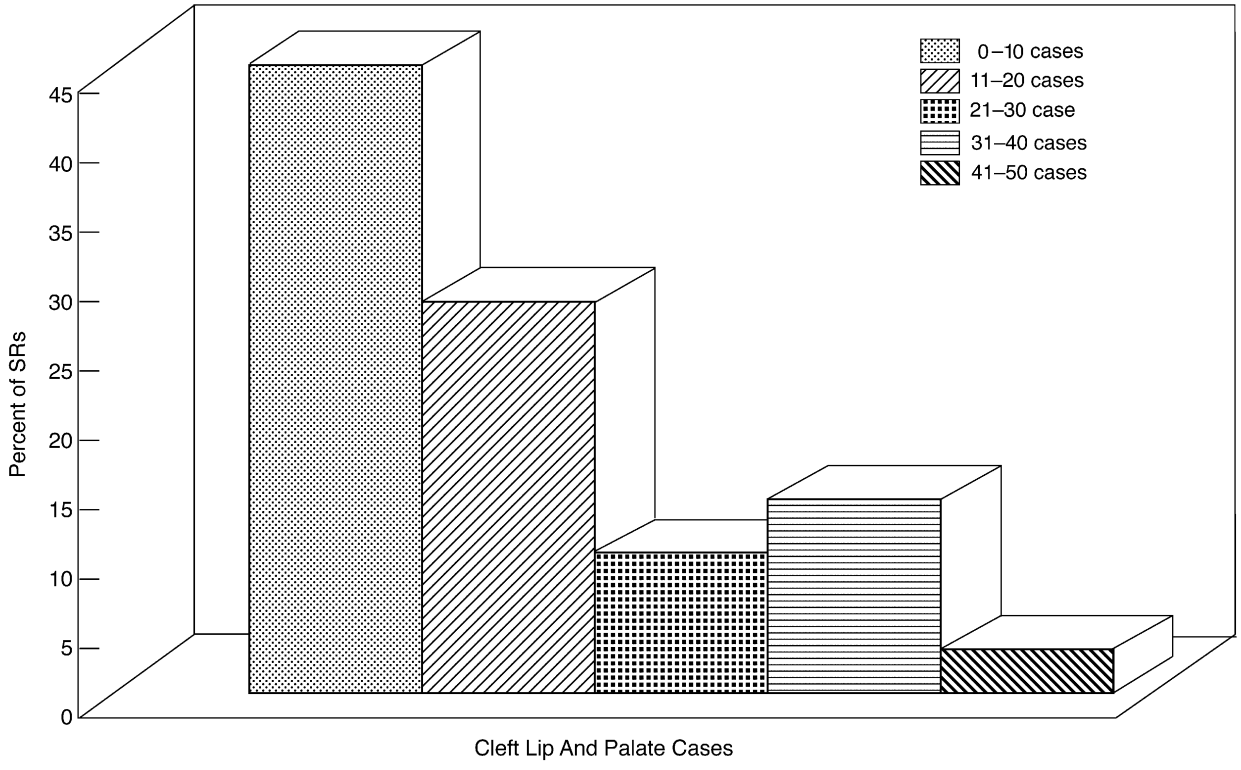

FIG. 4 Number of CLAP cases under treatment.

seven (23 per cent) had no access to a joint restorative clinic, and only two respondents (6 per cent) attended an orthodontic/paediatric dentistry clinic.

Involvement in Teaching

Eighteen Senior Registrars (60 per cent) supervised at least one postgraduate session per week, usually with Consultant cover. Twelve (39 per cent) were involved in the supervision of undergraduates, usually without Consultant cover. More than 50 per cent of respondents were regularly involved in lecture and teaching programmes for postgraduates and GDPs, while 35–48 per cent of respondents reported regular involvement in lecture and teaching programmes for undergraduates, orthodontic study groups, and nursing/technical staff.

Research and audit

Sixteen respondents (52 per cent) reported two protected study/administration sessions per week. Seventeen respondents (55 per cent) had submitted between one and three papers for refereed publication, but nine (29 per cent) had no paper submissions. Facilities for research were regarded as good or excellent by 18 (60 per cent) of respondents, whilst 12 (40 per cent) regarded their facilities as poor or adequate.

Twenty-five Senior Registrar respondents (81 per cent) attend regular audit meetings and in 40 per cent of cases, this occurs more than six times a year. Fifteen (50 per cent) of respondents were involved in audit within the hospital and 11 (35 per cent) involved in national audit.

Study Leave

Twenty-four respondents (83 per cent) were aware of their annual allowance for study leave. In 64 per cent of cases, this was under £750 and in 32 per cent of cases this was between £750 and £1000 per year (range £450 and 'unlimited'). Seven Senior Registrar respondents (24 per cent) reported difficulty in obtaining funded study leave.

Management

Twenty-seven respondents (90 per cent) had attended or would be attending a management course. Ten respondents (34 per cent) had received training in interview skills, four (14 per cent) in equal opportunities awareness, nine (31 per cent) in teaching skills, and five (17 per cent) had received training in counselling skills.

Fourteen respondents (48 per cent) were involved in committee work within their hospital, 13 (45 per cent) in regional committee work, and 15 (52 per cent) in national committee work.

Contract

Only 26 respondents (87 per cent) had signed a contract of employment. Thirteen (45 per cent) were receiving ADHs with 13 (45 per cent) being on-call for cleft lip and palate patients.

Facilities

Facilities, such as fully equipped surgeries, trained DSA support, secretarial support, radiographic facilities, photographic facilities, laboratory support, personal desk space, computer, and library access were generally readily available.

Formal Feedback

Nineteen Senior Registrar respondents (68 per cent) had formal meetings, at least once a year, with their trainer. Seventeen (61 per cent) described these meetings as useful or extremely useful.

Discussion

Job Rotation and Distribution

The SAC recommendation of a two-centre rotation, one of which is a teaching hospital, applies to 70 per cent of the jobs surveyed. For the other 30 per cent, it may be necessary in the future to balance the advantage of exposing a Specialist Registrar to a wide number of Consultant trainers against the disadvantage of the limited input by a trainee who can contribute the department for only 1 day a week.

Unless the two training centres are situated close together, split days are undesirable for effective working practice and are not recommended by the SAC, yet 46 per cent of jobs surveyed had at least 1 day, where the trainee worked at two sites.

Clinical Sessions

The minimum SAC requirement for personal treatment sessions is 5·89 per cent of Senior Registrar respondents had at least five personal treatment sessions each week (range 4·5–7). The remaining 11 per cent of trainees with 4·5 personal treatment sessions, may not have sufficient clinical time or an adequate number of suitable cases, to prepare for the ISE.

Caseload and Case Mix

The total number of cases under treatment, divided by the number of clinical sessions, for each respondent gave a range from 7·7 to 78 cases per clinical session. The SAC guidelines suggest 30 cases under treatment per clinical session. For trainees, who have been in post for longer than 2 or 3 years, the number of cases per session may reflect a larger proportion of completed cases kept under review. However, in posts where current trainees are treating more than double the suggested number of cases per session, it would appear that their service commitment is taking precedence over their training requirements. Consultants

responsible for these posts may find it necessary to be more selective in allocating treatment cases to their trainees, and the SAC should monitor more closely the caseload of trainees.

The number of transfer cases taken on by an incoming Senior Registrar varied greatly in the posts examined, from 0 to 49 per cent of cases under treatment. In the future, as the 3-year Senior Registrar programme is contracted into a 2-year Specialist Registrar FTTA, the proportion of transfer cases is likely to increase and, in particular, those involving complex, multidisciplinary treatment deemed suitable for examination in the ISE will be treated by a succession of post-holders. As a new post-holder enters a FTTA with a large number of transfer cases, it will be difficult to start a significant number of new cases that would show sufficient progress in their treatment after 18 months in order to be presented in the clinical section of the ISE. This difficulty would be most evident in those posts with less than five clinical sessions per week available for treatment. The guidelines currently issued to candidates preparing for the ISE will require alteration to take these potential problems into consideration, if presentation of clinical cases is to remain part of the examination.

The numbers of orthognathic and restorative cases treated by current Senior Registrars varied between units, but all trainees appear to have access to multidisciplinary cases. However, seven Senior Registrars had no access to a joint restorative clinic and only two Senior Registrars attended a joint orthodontic/paediatric dentistry clinic. It would be advantageous for future FTTA posts to include access to these types of clinic to give the trainee greater experience in the diagnosis, as well as the treatment of multidisciplinary cases.

The number of cleft lip and palate (CLAP) patients treated by current Senior Registrars ranged from 2 to 41 and was not related to the year of training. Surprisingly, two post-holders had no access to a CLAP clinic. The CSAG report on cleft lip and/or palate (Sandy *et al*., 1998), surveyed a group of recently appointed Consultant Orthodontists, of whom 60 per cent indicated that their training could have been improved and included a greater opportunity for personal treatment of a wide range of cases, as one area for improvement. In the future, the clinical training in CLAP care for FTTA post-holders may be limited to centres with large cleft lip and palate teams, which would modify the curriculum for many trainees.

Supervision

Most trainees have training input from three or four Consultants, and reported that their trainer was nearly always available for assistance or advice. However, for those post-holders receiving input from up to eight Consultants, the value of a diluted approach is questionable.

Teaching

Current Senior Registrars have a large teaching commitment with 60 per cent regularly supervising postgraduate clinical sessions and 39 per cent supervising undergraduate clinical sessions. This is in addition to regular lecture and teaching programmes for postgraduates, general dental practitioners, undergraduates, and other auxiliary staff (although only 31 per cent of respondents had received formal training in teaching skills). For future FTTA post-holders where 3 years of Senior Registrar experience will have to be gained in 2 years, some reduction of Senior Registrars workload will be necessary. Reduction of teaching commitment may be one area where the Senior Registrar workload can be reduced.

Research and audit

Only 52 per cent of Senior Registrar posts examined have the two protected study/research session per week advised by the SAC. Future FTTA post-holders will be required to prepare and submit research papers in addition to preparing for the ISE, within a 2-year period, rather than the current 3 years and, hence, it will be mandatory that the SAC guidelines are observed for all posts. Opportunities and back-up for research may require improvement in the 12 posts, where Senior Registrars described facilities as being poor or just adequate.

Study Leave

Seven current Senior Registrars (24 per cent) reported difficulty in obtaining funded study leave. In the future, if FTTA post-holders wish to have the same opportunities to gain experience from national and international meetings over a 2-year period, rather than 3 years, the allowance for each trainee's funded study leave will need to be increased. Otherwise, future trainees will either loose the opportunity to learn from these courses or conferences, or self-fund themselves (currently, study expenses are deemed not tax deductible by the Inland Revenue).

Management

Twenty-seven post-holders had been on or would be going on a management course arranged regionally. Attendance on a management course is regarded as essential in order to prepare for the ISE. However, such courses are generally directed at the medical and surgical specialties, and, for future FTTA post-holders, there may be the opportunity to attend courses specifically directed at dental specialties with particular reference to the needs of future Consultant Orthodontists.

Most Senior Registrars surveyed had the opportunity to be involved in committee work either at local hospital, regional, or national level.

Contract

Surprisingly, only 26 respondents (87 per cent) had signed a contract. Those posts currently allocating ADH units for cleft lip and palate on-call duties may well be revised following the regional re-organisation of cleft lip and palate centres, which is occurring as a consequence of the CSAG

report. In the future, FTTA post-holders will be on a lower salary increment as Specialist Registrars compared to current Senior Registrars. This combined with the possible loss of ADHs and greater contribution to study leave expenses will financially disadvantage future trainees.

Feedback

Nineteen current Senior Registrars currently have regular, formal feedback sessions with their trainer(s), which were felt to be useful. For future FTTA post-holders, such feedback should be incorporated in the annual Record of In-training Assessment (RITA) and regular appraisal meetings.

Conclusions

During the transition phase of assimilation to the new 2-year Specialist Registrar grade, FTTA post, it will be necessary to modify and reduce in number, current 3-year Senior Registrar posts. This survey of current Senior Registrar job profiles highlights several areas where current practice does not meet SAC guidelines. The main problem areas identified are

(1) high caseloads of multidisciplinary and transfer cases, which are likely to take in excess of 2 years to treat and may be carried out in limited clinical time
(2) a wide variation in caseload
(3) the high level of teaching commitments undertaken by current Senior Registrars
(4) the limited access of some trainees to multi-disciplinary clinics
(5) the limited potential input to a department by trainees on multi-centre rotations
(6) limited research opportunities and back-up in some posts.

This survey has shown variation in the training of current Senior Registrars and identifies potential problems for incoming Specialist Registrar FTTA post-holders.

Acknowledgements

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