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Editorial

# Privileges

This editorial is about privileges. Lest it be misunderstood, it is not questioning the right to perform procedures, but an attempt to see if an overall improvement in training can be achieved, thus improving the quality of care and results.

This editorial was stimulated by some very interesting observations by Dr. Satish Bhat from Mangalore, and he has assisted me in putting our thoughts together.

In response to an RTI query, the Dental Council of India, issued a reply dated December 15, 2015,[1] that 'As per revised MDS regulations 2007 notification, a qualified oral maxillofacial surgeon is eligible to harvest rafts(sic) and free flaps from the distant sides(sic) such as fibula, ilium and radial forearm. A copy of the relevant pages (59–62) of Revised MDS Course Regulations 2007 is enclosed herewith'.

While the inclusion of these topics in the curriculum[2] would certainly offer a measure of protection in the eyes of the law, one wonders if this is not a case of putting the cart before the horse.

A detailed look at training in oral and maxillofacial surgery (OMFS) in Western countries has revealed some very interesting facts. There was a paper published in the J Oral Maxillofac Surgery[3] some years ago, analysing the pattern of training for OMFS programme, and offered some fascinating insights. They apparently take the OMFS training very seriously, and it is very extensive.

The gist is as follows. In most disciplines of post-graduation in a Dental Speciality, the standard 3 years is adequate. However, in OMFS, it is markedly different. This change, initiated by the Harvard Programme in1971, at present involves a training lasting 6 years.[4] In view of the widening scope of the Speciality, with a spectrum of the harvest of various distant tissues, and surgery involving potentially long periods of time and possible fluid and electrolyte shifts, they have zeroed in on what seems to be an acceptable programme. The paper can be referred to of course, but the gist is reproduced.

Goals of revised OMFS training programme:

- The expanded biomedical and clinical curriculum would enhance the overall education of OMFS trainees
- With the revised training, OMFS residents would now be educationally qualified and licensed to serve as residents on a general surgery service. OMFS surgeons should have the same basic training as other surgical specialists. Hence, the programme philosophy contends that a core (12–24) months of general surgery training is a valuable foundation
- With this training, graduates of combined programmes would become part of the 'mainstream' of surgeons and surgical specialities. Turf battles among surgical specialities have always existed and will continue to exist. However, the playing field will be levelled to a great extent. Differences are easier to negotiate, and more rational solutions might be developed when all parties have a similar triad of credentials: Education, training and experience.

Components:

- OMFS intern: 12 months
- Medical school: 12 months in year 3 (principal clinical year)
- Medical school: 12 months in year 4 (final clinical year)
- General surgery residency: 18 months
- OMFS resident: 18 months.

Total 6 years.

Merely increasing the curriculum in the training syllabus of a certain subject is not enough. This has to be matched by an appropriate increase in the training duration, to do justice to these augmented subjects. Looking at the Western world,[3,5] in nearly all places, there is a dual qualification, both medical and dental, to complete the training in OMFS. This does not exist in India.

In fact, for the first time, a senior Professor and Department Head of OMFS in India, has written about the training schedule, and has suggested modifications.[6,7]


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He concluded that the MDS course need sufficient number of years to train in basic medical subjects which were not included in the basic BDS course, combined of course with advanced training in maxillofacial surgery. We do not intend this editorial to read like a witch-hunt, or point idle fingers at any sections of practitioners. This should serve as positive suggestions to our colleagues, performing many procedures, to augment their existing training, responsibilities and awareness, so that,

- Overall better standard of care and quality is achieved
- Better integration into mainstream is achieved.

While it is true that introduction of topics into the curriculum does offer a measure of safety vis-a-vis lawsuits, there is also the other aspect to be considered… Is there someone more qualified on paper and better trained, to perform the same procedure? With the firm establishment of the concept of specialities in Modern Medical Practice, and the legalities and dangers of Cross Speciality practice, an unambiguous and all-encompassing augmented training programme will go a long way in negating any and all of these litigations. Especially if it is obvious that these programme are parallel to their counterparts in the Western world.

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