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the state of play report

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BAOMS
British Association of Oral and Maxillofacial Surgeons

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group

THE FUTURE OF OMFS

Executive Summary

Report Purpose

The specialty of oral and maxillofacial surgery (OMFS) faces a significant recruitment crisis[1–3]. This report investigates the systemic barriers, inefficiencies, and cultural issues that hinder trainee progression. It outlines actionable recommendations targeting key stakeholders, including BAOMS, educational boards including NHS England, and regulatory bodies, aiming to foster a sustainable future for OMFS.

Methodology

The report employed a modified Delphi method, integrating perspectives from junior trainees through surveys, roundtable discussions, and meetings. This process ensured comprehensive data collection, thematic analysis, and trainee led prioritisation of recommendations.

Summary of Key Themes

1. Trainees have suffered a loss of agency
   Trainees face diminished autonomy due to changes to recruitment and geographic inflexibility. Recommendations include prioritising geographic stability, reforming national recruitment processes, and enhancing flexibility in training pathways.
2. The training pathway must be improved
   Current pathways are disjointed, overly lengthy with unnecessary repetition and do not maximise quality. Key reforms include implementing nationally available run-through training incorporating a fully funded “second degree” and creating tailored foundation and dental core training programs which deliver outcomes appropriate for OMFS.
3. The financial situation is unsustainable
   The second degree must be funded. The loss of pay-protection, which disproportionately affects OMFS trainees must be reversed. Institutions offering second degree courses should offer concurrent OMFS posts which are both financially rewarding and incorporate documented high-quality training.
4. Trainees leave OMFS due to burnout
   High workloads, redundant competency requirements, and bureaucratic burdens exacerbate burnout. Recommendations emphasize reducing duplicative training elements, streamlining recruitment, and harmonising CPD requirements between medical and dental regulators.
5. Challenging and reforming the culture of surgery
   Themes identified by the wider surgical community, such as bullying, harassment, undermining, racism and misogyny are a deterrent. The report advocates for zero tolerance of sexual misconduct, development of a national reporting mechanism, and inclusive policies supporting work-life balance, parental responsibilities, and LTFT training.

The report's purpose

The specialty of oral and maxillofacial surgery (OMFS) is facing a recruitment crisis[1–3]. Despite unprecedented interest at the student and junior trainee levels[4], the specialty consistently struggles to fill ST3 training posts[1–3], with a current fill rate of approximately 50%[5,6]. This alarming statistic highlights a significant disconnect between early enthusiasm for the specialty and the progression to higher training.

Trainees are frequently asked to share their perspectives on why this gap exists[7,8]. Common themes include systemic barriers, inefficiencies within training pathways, financial challenges[9,10], and burnout. These issues collectively deter capable individuals from committing to a long-term career in OMFS, threatening the future workforce of the specialty.

The purpose of this report is to assess the current "state of play" in junior maxillofacial training, identify examples of good practice, and highlight the barriers faced by trainees at a national level. Drawing on feedback from junior trainees, this review outlines actionable recommendations aimed at addressing these challenges.

These recommendations are directed toward key stakeholders including the British Association of Oral and Maxillofacial Surgeons (BAOMS), Joint Committee on Surgical Training (JCST), the OMFS Specialty Advisory committee (SAC), NHS England (NHSE), Health Education and Improvement Wales (HEIW), NHS Education for Scotland, Northern Ireland Medical and Dental Training Agency (NIMDA), the General Medical Council (GMC), the General Dental Council (GDC), Dental Schools Council, Medical Schools Council, and university medical and dental schools. Many of the proposed solutions require interdisciplinary collaboration between these bodies to ensure meaningful reform and long-term sustainability of OMFS training.

Method

To engage as many junior trainees as possible and ensure comprehensive representation, the "State of Play" report was developed using a modified Delphi method. This iterative, collaborative approach allowed for systematic data collection, synthesis of input from our diverse membership, and the prioritisation of key themes and recommendations. The process involved multiple phases of consultation and analysis:

1. Junior Trainee Group (JTG) Committee Meeting and Report Conceptualisation (September 2023)
   The process began with the JTG Committee convening in September 2023 to conceptualise the "State of Play" report. This meeting established the objectives and scope of the review.
2. Anonymous Padlet Contributions (September 2023 – January 2024)
   To facilitate broad and anonymous participation, an interactive padlet wall was hosted on *jtgonline.org*. Junior trainees were invited to share perceived barriers to pursuing a career in OMFS and highlight good practices that could be replicated.
   - Over 300 interactions were recorded, encompassing written comments, "likes," and "upvotes."
   - All submissions were anonymous and stored in a secure database for subsequent analysis.
     This platform ensured inclusivity by allowing trainees to contribute anonymously at their convenience, whilst interacting with the anonymous contributions of others.
3. Online Roundtable Meeting (October 2023)
   Key themes from the padlet contributions were identified and discussed in an online roundtable meeting held in October 2023. This session, open to all JTG members of BAOMS was widely advertised via social media and email campaigns.
   - Minutes from the meeting were anonymised and integrated into the existing collection of padlet submissions.
4. Initial Thematic Analysis
   Initial themes were developed by inductive thematic analysis was conducted on all qualitative data from the padlet submissions and following the online roundtable meeting. No predetermined codebook was used, instead, themes emerged organically. These themes were then presented for feedback and refinement in the JTG Annual general meeting.
5. JTG Annual General Meeting (November 2023)
   During the JTG Annual General Meeting (AGM), a dedicated session focused on discussing the preliminary findings and refining the themes identified from prior consultations. Attendees provided feedback, suggested additional

themes and ideas and contributed to the development of actionable recommendations.

6. Further Thematic Analysis and Data Synthesis (2024)
    - Themes were distilled into concise, easily understandable headline titles, which are further elaborated upon in the report.
7. Member Voting and Recommendations (December 2023 – March 2024)
   Post-AGM, JTG members were invited to vote on the prioritisation of the identified key themes.
    - Alongside voting, members were asked to submit detailed specific actionable recommendations to address these themes.
    - All responses were anonymised.
8. Presentation and Final Consolidation (June 2024)
   Initial findings, themes, and draft recommendations were presented at the BAOMS Annual Scientific Meeting in Oxford (June 2024). Feedback from this session was carefully documented and incorporated into the final synthesis of the report, further enriching its recommendations and ensuring alignment with general trainee perspectives.

Anonymisation

To protect participant confidentiality, all contributions at each stage were anonymised prior to inclusion in the analysis.

Conclusion

This rigorous, multi-phase process ensured that the "State of Play" report was grounded in comprehensive trainee input and reflected the collective insights and priorities of the JTG community. The iterative nature of the modified Delphi method allowed for continual refinement and consensus-building, culminating in a report designed to drive meaningful change.

Headline Themes

The themes identified are listed in order of priority as defined by the votes submitted by JTG members following the 2023 JTG annual general meeting.

Headline Theme 1 - Trainees have suffered a loss of agency

Headline Theme 2 - The training pathway must be improved

Headline Theme 3 - The financial situation is unsustainable

Headline Theme 4 - Trainees leave OMFS due to burnout

Headline Theme 5 - Challenging and reforming the culture of surgery

Theme 1 – Trainees have suffered a loss of agency

A key theme identified in this report is the significant loss of agency experienced by surgical trainees. One prominent example is the increasing shift toward national recruitment processes, which has significantly reduced the control trainees have over their training location. This lack of geographic flexibility is frequently cited as a major barrier to pursuing a career in oral and maxillofacial surgery (OMFS)[8]. While this concern resonates across various medical and surgical specialties[11], it is particularly acute for OMFS trainees, who, on average, are older and often face additional personal, economic, and professional obligations that necessitate staying within a specific region[12].

Trainees highly value autonomy and geographic stability, including the ability to **choose where they work** and to **maintain flexible working** arrangements. These factors are essential for ensuring a sustainable work-life balance, particularly for OMFS trainees, who often require support networks to manage family, housing, or other life commitments.

For "dental-first" OMFS trainees, there are numerous options for pursuing their second medical degree[13], with many regions offering shortened medical courses. However, "medical-first" trainees face a disparity in opportunities, as there are fewer options for pursuing a shortened dental degree[13]. This inequity further exacerbates the challenges faced by aspiring OMFS surgeons, particularly in navigating training pathways.

Recent changes to the UK Foundation Programme (UKFPO) recruitment process have further compounded this issue[14]. The introduction of "preference-informed allocation" has replaced traditional methods of ranking trainees based on their portfolio, academic performance, or interviews. Instead, trainees now submit regional preferences and are subsequently assigned a "computer-generated ranking" (as per UKFPO guidelines)[15], leading to allocation. Trainees have no right to appeal this ranking and are effectively obliged to take up post, as FY1 is a mandatory requirement for GMC registration. While this approach may offer administrative efficiency it significantly undermines the autonomy of trainees. For OMFS trainees, in particular, this process is perceived as a form of random allocation, which is both demotivating and unacceptable. It makes retaining links with OMFS during foundation training difficult or impossible.

The certificate of readiness to enter higher surgical training (CREHST) form[16] provides an alternative route to specialty training, where trainees can be accredited as “ready to progress” having met the equivalent competencies to core surgical training. This pathway should be advertised, and BAOMS fellows supported to utilise it to support trainees locally as an alternative pathway to core surgical[17] or run-through ST1 posts. It may be appropriate to develop a specialty specific form which mandates specific ST3 appropriate competencies in preference to the more generic core surgical framework currently available.

The prospect of being "moved around" without consideration for personal circumstances is a considerable deterrent for dual-qualified OMFS trainees. Greater geographic stability is essential to maintaining a stable personal life, including housing, family commitments, and support networks. Addressing these concerns will be critical to mitigating barriers to entering and sustaining a career in OMFS.

Theme 1 Recommendations:

1.1
Trainee autonomy, and flexibility should be central to discussions around the future of OMFS training. Flexibility in training should be enhanced, and this flexibility equitable to both dental and medical first trainees.

1.2
Less than full time training (LTFT) must be available equitably and across the whole training pathway. Long term workforce planning will need to model for and account for an increasingly LTFT workforce which may need more training places and more consultant posts.

1.3
The Certificate of Readiness to Enter Higher Surgical Training (CREHST) form should be advertised, and all hospitals with OMFS units supported create posts to support trainees as an alternative pathway to core surgical or run-through ST1 posts. A focus of these posts should be acquisition of knowledge and skills to ensure successful completion of the MRCS examination and development of surgical skills and logbook to thrive in the early years of higher training (ST3 and beyond).

1.4
The process of recruitment should be overhauled, with the opportunity to apply for locally appointed training posts with national benchmarking to ensure trainees are at an adequate standard to enter training.

1.5
Inter-deanery transfer must be supported and facilitated. Trainees drop out due to concerns over loss of geographic autonomy.

1.6
Lobby UKFPO to include “dual degree OMFS trainee” as eligible for special circumstances pre-allocation to mitigate the random allocation of foundation trainees, in addition to formally opposing random allocation of foundation doctors in any circumstances.

1.7
Stakeholders must engage with dental schools, the Dental Schools Council and the dental regulator to increase the opportunities for nationally available shortened dental training for medical first trainees. A disproportionate reliance on shortened dental training available only in London is not sustainable and disadvantages those trainees not willing or able to relocate to the capital.

Theme 2 – The training pathway must be improved

The current training pathway for oral and maxillofacial surgery (OMFS) requires urgent reform to enhance its appeal to prospective trainees. In the 2008 report by the Postgraduate Medical Education and Training Board (PMETB)[18], a key recommendation was that the second year of foundation training (F2) is not essential for OMFS training.
For the first two years of national selection to OMFS training posts trainees with their MRCS were appointed directly from FY1 to OMFS ST3 posts. This process was supported by Modernising Medical Careers[19], and is in the spirit of the Shape of Training review[20], but the GMC stopped it whilst allowing trainees whose training was accelerated to retain their ST posts[21]. All of these trainees successfully completed training, providing an evidence base for the PMETB recommendation.

The current requirement must be **urgently revisited**, particularly for dual-qualified trainees, as it prolongs their already lengthy training pathway, and many feel it does not contribute to their educational development.
While the duration of training is a significant concern, trainees consistently emphasize that the quality of training remains their foremost priority. If the quality of foundation training can be demonstrated as robust, such as by satisfying the recommendations of Improving surgical training[22] and by providing themed rotations relevant to OMFS—F2 could be effectively integrated into a run-through training model.

The current OMFS ST3 person specification[23] mandates a minimum of 36 months full time clinical practice post medical qualification, 24 months FY1-2, and 12 months of CT1/ST1 equivalent. If this requirement was changed from time based to competency based many trainees who complete full MRCS and satisfy the other criteria in the person specification in less than the mandatory 36 months could proceed to ST3.

Run-through Training Implementation

Run-through training must be available in every training deanery nationally. Additionally, fully integrated dual degree OMFS Specialty training (FIDDOST) should be developed on a national basis, with “the second degree” funded and integrated into the training pathway.

The **second degree must be funded**, and this should be aligned with the financial support provided by NHSE to fund the training of our Advanced Clinical Practitioners (ACP) colleagues[24], ensuring financial barriers do not deter aspiring OMFS trainees. (See recommendation 3.1).

The recent changes to the UK Foundation Programme (UKFPO) allocation system present an impending challenge for OMFS recruitment and retention (see theme 1). Trainees currently have minimal agency over their training location, a factor repeatedly identified as a significant deterrent to pursuing OMFS training. We call on all key stakeholders to urgently address this issue.

Proposed OMFS-Specific Foundation Programme

An OMFS-specific foundation programme should be developed to better support both medical-first and dental-first trainees. This programme would:

- Be open to competitive application from singly and dually qualified doctors.
- Provide each trainee with an OMFS consultant educational supervisor.
- Include a dedicated study budget and head and neck-themed rotations.
- Offer support for MRCS Part A (for example, a tailored teaching programme)

For medical-first trainees, this pathway would provide an excellent foundation for applying to dental school. For dual-qualified trainees, it would prepare them for entry to specialty training (ST1).

Rotational Training Improvements

Rotational training must be critically examined to ensure its value. Early rotations that provide meaningful exposure to subspecialties, such as cleft or craniofacial surgery, should be prioritised. However, short placements lasting less than a year should be avoided as they fail to provide adequate training continuity. Trainees should be employed by a central regional employer to reduce onboarding challenges and minimise the administrative burden associated with rotation. Training programmes should consider the fewest placements that are compatible with delivery of the full curriculum.

Facilitating early exposure to sub-specialisms such as cleft, craniofacial is essential if OMFS is to maintain a foothold within these specialties, and to support trainees to be successful should they apply for interface training fellowships later in their career.

Ensuring the Core Element of OMFS ST1-2 posts are the highest quality

In some regions, run-through training does not include any OMFS exposure during ST1 or ST2, with trainees instead placed in generic core surgical training posts that offer limited relevance or benefit. This disproportionately impacts medical-first trainees, who would greatly benefit from OMFS exposure before progressing to ST3. All OMFS ST1-2 posts should be of the highest quality and exceed the standards outlined in Improving Surgical training. Once trainees complete their MRCS, they should be able to progress to ST3. This process should be nationally equitable, as at present, some trainees are unable to advance due to variation in local policy.

Including OMFS placements in every core training deanery
In addition to nationally available run-through OMFS training, core surgical trainees (CSTs) should have access to OMFS training. OMFS is one of the 10 surgical specialties, but core surgical jobs are not available in the majority of deaneries. Placements in OMFS would be of high educational value to CSTs and would improve recruitment to the specialty.

Reforming Dental Core Training

Dental core training in its current form is does not meet its potential for aspirant OMFS trainees. DCTs with an interest in OMFS should have access to OMFS focused programmes with specific learning outcomes and curriculum. Stakeholders should develop an OMFS-specific dental core training curriculum with transferable competencies aligned with higher surgical training requirements. Trainees should be supported to use ISCP from DCT onwards[25]. In competency-based training models, skills assessed during early years should contribute directly to evaluations in advanced stages of training.

Encouraging Academic Opportunities

OMFS trainees should be supported in pursuing academic opportunities alongside clinical work[26]. Flexible pathways must be available for trainees to temporarily exit and re-enter training to undertake academic experiences, such as PhDs or MDs. These opportunities are vital for developing future leaders and innovators in the field of OMFS.

Theme 2 – Recommendations

2.1
In line with the recommendations of the 2008 Postgraduate Medical Education and Training Board (PMETB) report[18] – the requirement for two years at foundation level for dual qualified trainees must be removed.

2.2
Change the requirement for 36 months of full-time clinical training following qualification in medicine (in particular, for dental first OMFS trainees) to be competency rather than time based. Trainees who complete full MRCS, demonstrate foundation and core competencies would be appointable to ST3.

2.3
Although the length of training is a concern for trainees, the quality of this training is their foremost concern. If this training can be demonstrated to be high quality, (for instance by exceeding the standards of Improving Surgical Training) then F2 could be embedded into run-through training. This would move career and geographic certainty earlier into the career path.

2.4
Run-through training must be available in every training deanery.

2.5
Changes to the UKFPO allocation system for foundation programme present an impending disaster for OMFS. All stakeholders must work urgently to address this. Currently trainees exert little to no agency over their training location and this review highlights this as a **major deterrent from entering medical training**.

2.6
An OMFS foundation programme should be created. This would be open to competitive application for both medicine-first and dental-first FY doctors. Trainees should be allocated an OMFS consultant educational supervisor, a dedicated study budget, head and neck themed rotations, and support for MRCS part A. For medical first trainees this would provide excellent basis to apply to dental school. For dual qualified trainees this would be a basis to apply for ST1.

2.7
Develop run-through training at entry to second degree, and embed the second degree into formal training (FIDDOST). **The second degree must be funded** (as it is for ACPs).

2.8
Rotational training must be examined. Rotational training programmes should consider the best combination of placements to deliver training across the whole curriculum whilst reducing the travelling required. Where rotation is demonstrably beneficial for training, it should be implemented, such as to experience sub-speciality work e.g. cleft/craniofacial. Short placements under 1 year should be avoided. Trainees should be employed by a central regional employer to mitigate issues with "on-boarding" and minimise the bureaucracy and stress associated with rotation.

2.9
Run-through training must be evaluated. In some regions there is no OMFS component at all in ST1 or ST2, with trainees placed in core surgical training posts which are unrelated to head and neck and of dubious training benefit. This disproportionately disadvantages medic-first trainees who would benefit from OMFS exposure prior to commencing ST3.

2.9.1
Dental core training (DCT) does not fulfil its potential and is not currently fit for purpose. Stakeholders should develop an OMFS specific DCT curriculum designed with transferable competencies to higher training. In competency-based training, skills acquired and assessed in early years training should contribute to competency assessment in higher training.

2.9.2

Opportunity for trainees to undertake academic work alongside clinical work should be supported and further developed. Trainees must be able to flexibly exit and re-enter training to pursue out of programme academic experience such as PhD or MD.

Theme 3 – The financial situation is unsustainable

Financial barriers remain a significant challenge for trainees pursuing oral and maxillofacial surgery (OMFS), particularly given the requirement for dual qualification in medicine and dentistry. The JTG recognises that dual qualification is essential to practicing maxillofacial surgery, and therefore, **the second degree must be fully funded**. Comparable funding arrangements, such as those available to Advanced Clinical Practitioners (ACP)[24], should serve as a model for supporting OMFS trainees.

Pay Protection

Pay protection must be ensured to address the substantial financial disadvantages associated with OMFS training. Currently, dentists who return to study to become doctors can expect to approximately halve their take home salary on graduating medical school. This is unsustainable. Stakeholders, including NHS England (NHSE) and the British Medical Association (BMA), must collaborate to ensure that the terms of pay protection explicitly support maxillofacial surgeons in training, defining the second degree as a component of a continuing training programme.

Support for Early Training Costs

Once dual qualified, OMFS trainees should have access to a dedicated study budget to support the mandatory additional training required during the early years of their career. All trainees regardless of primary qualification should be supported to complete relevant courses at a stage appropriate for their training. This includes essential courses and examinations such as:

- Membership of the Royal Colleges of Surgeons (MRCS).
- Basic Surgical Skills (BSS).
- Advanced Trauma Life Support (ATLS).
- Care of the Critically Ill Surgical Patient (CCrISP).

Currently, foundation trainees would be required to self-fund these courses as they fall outside the foundation curriculum, not considering trainees' personal development goals.

Bursaries and Funding Opportunities

Where funding streams, such as BAOMS bursaries, are available, the application process must be equitable and accessible. Deadlines for these bursaries should align with the academic year, be open to students at all stages of their second degree and avoid falling during examination periods. Such measures will ensure that financial support is both practical and effective in supporting OMFS trainees.

Theme 3 – Recommendations

3.1
The JTG recognise that dual qualification in medicine and dentistry is required to practice oral and maxillofacial surgery. **The second degree must be funded**.

3.2
Pay protection must be facilitated to mitigate the significant financial disadvantage to undertaking maxillofacial training. Stakeholders must engage with NHSE and the BMA to ensure that the terms of pay protection enshrine support for maxillofacial surgeons in training.

3.3
Institutions offering shortened degrees should develop roles to support trainees enrolled in these programmes, not only providing a source of income, but facilitating their professional development with educational supervision and surgical training in line with their level of clinical experience.

3.4
Once dual qualified, OMFS trainees should have a dedicated study budget to facilitate mandatory "extra-curricular" training in early years training (MRCS / BSS / ATLS / CCrISP)

3.5
The cost-effectiveness of postgraduate examinations must be examined.

3.6
Where funding streams are made available, (such as BAOMS bursaries) – deadlines to apply must reflect the academic year, be available for students in all years of 2nd degree study, and deadlines must not fall during examination periods.

Theme 4 – Trainees leave due to burnout

Burnout is a significant factor driving trainees to leave the specialty of oral and maxillofacial surgery (OMFS). High workload, redundant competencies, bureaucratic barriers, and financial strain exacerbate the challenges faced by trainees. Addressing these issues is crucial to improving retention and ensuring the sustainability of the specialty.

Efforts must be made to identify and eliminate redundant competency requirements in dual-degree OMFS training. While dual qualification remains essential, unnecessary duplication of skills should be avoided. Both dental-entry medicine and medical-entry dental courses should be streamlined to focus on relevant and transferable skills, reducing the training burden without compromising quality.

As outlined in Recommendation 2.1, the requirement for an FY2 year for dental-first trainees must be reconsidered. This additional year adds unnecessary time and cost to training and does not provide clear benefits specific to OMFS.

The national recruitment process for OMFS must undergo reform. Current national recruitment processes frustrate trainees who perceive a focus on "hoop jumping" at the expense of recognising real clinical experience. This feeling of hoop jumping and constantly needing to prove oneself contributes to burnout. Streamlining recruitment will reduce administrative burdens and improve the overall trainee experience.

The requirement to sit the multi-specialty recruitment assessment (MSRA)[27] should be removed from all stages of OMFS training. There is no evidence to support its effectiveness in selecting surgical trainees, and it adds to the already substantial assessment burden placed on OMFS trainees. Eliminating this requirement will reduce unnecessary stress and improve recruitment efficiency.

Continuing Professional Development (CPD) requirements must be harmonised between the General Medical Council (GMC) and General Dental Council (GDC). Redundant requirements, such as completing Basic Life Support (BLS) for GDC requirements when Advanced Life Support (ALS) has already been achieved, must be eliminated. BAOMS should actively engage with medical and dental regulators to consolidate CPD standards and ensure that professional development requirements are relevant, transferable, and minimally burdensome, with an emphasis on quality education and a move away from box ticking.

Burnout is often intertwined with financial pressures. Many trainees report working excessive hours or taking on additional work simply to cover the high costs of dual qualification, examinations, and living expenses. Financial strain exacerbates stress and detracts from trainees' ability to focus on their professional development. Addressing financial challenges (see Section 3) is therefore critical to mitigating burnout and retaining talented individuals in OMFS.

Theme 4 – Recommendations

4.1
Identify and where possible eliminate the need to obtain redundant competency. The requirement for dual degree OMFS need not prohibit the removal of redundant competency and streamline both dental-entry medicine and medical-entry dental courses.

4.2
Remove the need for FY2 for dental first trainees (see recommendation 2.1)

4.3
Review the value of FY2 for medical first trainees. Improve the training value of FY2 by developing themed opportunities such as locally appointed academic foundation programmes and OMFS themed posts including rotations in allied specialties.

4.4
An overhaul of national recruitment is necessary. Streamline application processes, paperwork, and minimise hoop jumping.

4.5
Remove the need to sit the MSRA from any component of maxillofacial training. There is no evidence that this assessment selects surgical trainees well and adds to the already high assessment burden on OMFS trainees.

4.6
CPD must be transferable (between GMC and GDC) -> remove / minimise the need for redundant competency (no benefit in doing BLS for GDC if you're an ALS provider). BAOMS must engage both medical and dental regulators to consolidate professional development requirements.

Theme 5 – Challenging and reforming the culture of surgery

Workplace bullying, harassment, and a culture that normalises excessive working hours in the name of "dedication" continue to contribute significantly to burnout among surgical trainees. According to the Royal College of Surgeons (RCS) workforce survey, 24% of respondents identified bullying and harassment as contributors to their burnout[28]. The issues range from criminal acts, including sexual violence[29–31], to a wider culture of undermining, harassment, and the marginalisation of trainees who prioritise family life or work less than full time (LTFT). Such individuals are often unfairly perceived as less dedicated, perpetuating a harmful and exclusionary culture. The important work done by the Working Party on Sexual misconduct in surgery (WPSMIS)[30,31] revealed deeply troubling statistics: 30% of female surgeons have been sexually assaulted, and two-thirds have experienced sexual harassment. Where sexual misconduct takes place, studies show it is not handled adequately[30]. These findings underscore an urgent need for reform. The **JTG unequivocally supports a zero-tolerance approach** to sexual misconduct and calls for robust reforms in reporting and investigation processes within healthcare.

The perception that starting a family poses insurmountable barriers to professional advancement discourages many from pursuing a career in surgery. Addressing these concerns is critical to fostering a supportive and inclusive culture.

By addressing systemic issues in workplace culture, improving reporting and accountability frameworks, and creating an environment that values work-life balance, the specialty of surgery can become more inclusive and supportive. This is critical not only for the wellbeing of current trainees but also for ensuring the sustainability of the future workforce.

Theme 5 – Recommendations

5.1
The JTG calls for a **zero tolerance** for sexual misconduct and supports reform of reporting and investigation processes of sexual misconduct in healthcare.

5.2
A national, independent tool should be developed to allow trainees to report incidences of illegal acts and unacceptable behaviour, including sexual assault, harassment, discrimination and bullying. Where concerns are raised, investigations must be external, independent and fit for purpose. The framework for these investigations and where appropriate, sanctions, must be **transparent, fair, and nationally consistent**.

5.3
Individuals who report serious misconduct should be treated as whistleblowers and afforded protections currently enshrined in whistleblowing law.

5.4
Expand access to less-than-full-time (LTFT) training and working, including undertaking workforce planning modelling which accounts for an increasingly LTFT workforce.

5.5
Develop innovative job-sharing and rota solutions to accommodate parental and caring responsibilities in addition to those trainees who choose to work LTFT for other reasons.

5.6
Ensure parental leave policies, including shared parental leave, are equitable, visible, and easy to navigate.

5.7
Advocate for geographic stability in training rotations for parents. Develop robust mechanisms to co-locate parents where both parties are in medical or surgical training to reduce strain.

5.8
Build networks for parents in surgery (pan-specialty) to share experiences and access peer support.

5.9
Develop and distribute toolkits for managers to better support parents within surgical teams.

Conclusions

The specialty of OMFS stands at a critical crossroads. This report has identified systemic barriers, financial challenges, significant inefficiencies in the training pathway, and cultural challenges which dissuade capable trainees from pursuing a career in OMFS. This report is the first of its kind to deliver clear actionable recommendations to address these challenges. By implementing these targeted, evidence-based recommendations, stakeholders can not only reverse the current recruitment crisis but also create a thriving, sustainable training ecosystem that attracts and retains the brightest talent. It is time to act decisively to safeguard the future of OMFS.

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Contributors

Mohammed Adam
Priyanka Adatia
Kyrillos Adesina-Georgiadis
Julian Ahluwalia
Ahmed Hesham Abuelwafa
Mohamed Ahmed
Cindiya John Alex
Ishtiaq Ali
Ibrahim Amin
Jenna Angle
Aditya Anshu
Eleanor Arnull
Adam Auckland
Imran Aziz
Rosalind Baker
Maria-Alexandra Barbu
Julie Bell
Robert Bosley
Holly Boyes
Jasdeep Brar
Danielle Britton
Kate Bullen
Iona Carter
Amarpreet Kaur Chohan
Taimur Choudhry
Hana Cocker
Katie Crawley
Anna Davies
Katrina Denholm
Devang Deshpande
Benjamin Dunphy
Kai Ewers
Sarah Fischer
Charlotte Fleming
Charlotte Frazer-Cox
Ruby Fussell
Anna Ghosh
Michael Goodfellow
Morgan Gregg
Jonathan Hanna
Clarissa Hjalmarsson
Alex Hodgson
Christopher Houlton
Samantha Houlton
Ryan Howells
Kate Howford
Declan Hughes
Hannah Huguet
Rutangi Hundia
Joanna Ismail
Peter James
Oliver Jacob
Evan Johnson
Matthew Johnston
Tanweer Kamaly
Alex Kawalec
Mairead Kelly
Niall Kent
Pippasha Khan
Rhydian King
Eleanor Kissane
Deepshikha Kumar
Dinesh Kumar Alandur Baskar
Rahail Kumar
Jaspreet Singh Lagha
Rafia A Lahooti
Hannah Lawler
Trudy Ledger
Lino Locurcio
Lily Long
Joshua Lopez
Jie Luo
Alison Mace
Rory Maciver
Lee Mackie
Keira Madden
Divinegrace Maduka
Samuel Maskell
Caitlin McEvoy
Hari McGrath
Jane Murray
Toheed Nasir
Caoimhin O'Higgins
Rebecca O'Sullivan
Aarondeep Pamma
Nutan Roshni Patel
Alexander Rae
Jai Parkash Ramchandani
Martyn David Ritchie
Joshua Rooney
Joanne Rowe
Francesca Saleh
Mohsin Shafiq
Adam Shathur
Albert Shaw
Sarah Shaw
Faheema Ismail Sidat
Rajeevan Sritharan
Krisna Surendran
Jessye Sutton
Jill Sweeney
Milad Tavakoli
Richard Taylor
Eilidh Carys Thomas
Natalie Turton
Jeevan Ubhi
Benjamin Veale
Meena Venkatasami
Victoria Vincent
Kieran Walker
William Walters
Jonathan Wareing
James Wege
Luke Western
Lynsey Whiteside
Harjeet Singh Wilkhu
Millie Windram
Alice Barnes Yallowley