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Editorial

Should we consider devolution of "head and neck" surgery from the specialties of oral and maxillofacial surgery; ear, nose, and throat surgery; and plastic surgery?☆

Background

In the United Kingdom the practice of vascular surgery has now become recognised as the tenth independent surgical specialty by the Royal College of Surgeons of England and the General Medical Council (GMC). Traditionally, surgical trainees developed their subspecialty vascular interest within the parameters of obtaining a certificate of completion of training (CCT) in General Surgery. The process of devolution of areas of subspecialty may also apply to other surgical specialties.

At present head and neck surgical practice is covered by three recognised surgical specialties: oral and maxillofacial surgery (OMFS), otorhinolaryngology (ENT), and plastic surgery. The curriculum for each includes overlapping set of competencies in head and neck surgery, acknowledging the contribution of endocrine surgeons to thyroid and parathyroid surgery.

Currently, in the UK the specialty of OMFS could reasonably be considered a major player in head and neck surgical practice in that it provides the most comprehensive range of services, as well as performing a significantly higher proportion of primary oncological procedures. The development of a new specialty to bring together surgeons who operate on the head and neck under one umbrella raises a number of interesting topics for discussion. I would particularly like to consider the respective influences of interspecialty surgical fellowships and the trend towards subspecialisation as major factors in the evolution of head and neck surgery, together with the potential implications of any such devolution for care of patients, regulation, and national audit.

In recent years the development of the interspecialty surgical fellowship has provided specialty registrars in surgical disciplines with the opportunity to develop and expand their training in overlapping areas of surgical practice. Through this breaking down of the boundaries between traditional specialties, surgeons seek to improve their ability to provide the best quality of care for their patients. A number of fellowships in head and neck surgery have been created that are open to trainees from OMFS, ENT, and plastic surgery, and the selection of candidates is highly competitive for the limited number of available training opportunities.

Surgical trainees who complete such fellowships may view their consultant remits differently from their contemporaries who have completed more traditional training programmes. It could be argued that the evolution of the "head and neck" interface training model suggests that the process of creating a new specialty of "head and neck" is already under way. This group of surgeons may actively seek to differentiate themselves to reflect their individual competencies and clinical practice, rather than be restricted to conventional areas of the specialty. For this reason, a separate specialty of "head and neck" may particularly appeal to fellows or to those who have chosen a head-and-neck-biased remit in their consultant practice.

An additional effect of the "head and neck" fellowship may perhaps be to increase the trend towards subspecialisation.

It should be borne in mind that, at the time of writing, the total numbers of such fellows from all affiliated disciplines are small, and no data are currently available either to confirm or refute the hypothesis that these fellowships result in more subspecialised clinical practice.

A number of defined subspecialty areas have evolved within the nine traditional surgical specialties in the UK. Surgeons are encouraged to develop subspecialty interests that often have a major bearing on their individual caseloads. The expansion of surgical knowledge, in conjunction with ongoing innovation of new technology, makes it increasingly challenging for individual surgeons to stay up-to-date within their specialty as a whole. This has consequently driven and promoted the process of subspecialisation in surgery.

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A devolved specialty of "head and neck" could therefore be viewed as a natural endpoint within the disciplines of OMFS, ENT, and plastic surgery.

Recent research published in the *British Journal of Oral and Maxillofacial Surgery* reported that about a quarter of the OMFS consultants surveyed use a title in their clinical correspondence that reflects a subspecialty interest.[1] Interestingly, 10% of OMFS consultants surveyed specifically included the term "head and neck" to describe their specialty of affiliation. The research also showed that a minority of practising OMFS consultants used the title "head and neck surgeon" alone. This suggests that among OMFS consultants, being identifiable as having a subspecialty interest in the head and neck is important to them in their correspondence with patients and colleagues.

The case for devolution

There are a number of arguments that favour devolution of "head and neck" into a separate specialty. As a major subspecialty branch of OMFS and ENT, in particular, a large number of surgeons already consider themselves to be practising head and neck surgeons. This is already reflected in the widespread use of the terminology.

Surgeons who operate on the head and neck have already collaborated by forming organisations such as the British Association of Head and Neck Oncologists (BAHNO), and (more recently) the International Academy of Oral Oncologists (IAOO), to increase wider representation and development of the subspecialty. It is conceivable that some clinicians may feel a stronger affinity to such cross-specialty groups than to their own parent-specialty associations. In recognition of increased subspecialisation within OMFS the British Association of Oral and Maxillofacial Surgeons (BAOMS) has recently created a number of designated specialist interest groups (SSIG) to better integrate their members. Finally, the National Cancer Research Institute (NCRI) and the National Institute of Health Research (NIHR) already consider head and neck as a single specialty in the UK.

In other developed countries (such as Australia and the United States) the specialty of "head and neck" is already well-established with a surgical remit that reflects an individual surgeon's skills as much as their nominal specialty of affiliation. If it is established as a recognised specialty in the UK, therefore, it brings us into line with such nations.

Perhaps the most persuasive argument is that in bringing together individual surgeons in "head and neck", the development of a designated specialist service is facilitated. A devolved specialty would allow for an increase in the focus of surgical activity, with an associated impact on related clinical research. This may also prove advantageous from a training perspective, as across disciplines it is already accepted that specialist-led surgical services improve standards of care.

Patients with cancer already have their diagnostic and therapeutic management routinely conducted by a "head and neck Multidisciplinary Team (MDT)", which includes surgeons from different specialties. It is thought that the benefits of the MDT include improvements in communication between health professionals, coordination and continuity of care, and better clinical outcomes, and it is therefore a potent driver towards devolution.

It is imperative that referring doctors select the most appropriate specialty to evaluate a patient's clinical problem further. The creation of a devolved specialty of "head and neck" may help improve this process as it would alleviate any referral dilemmas in providing a single specialty for head and neck oncological cases for primary care and hospital doctors. An important issue for patients is the ability to readily identify their attending surgeon and specialty. In simple terms our patients may find that "head and neck surgeon" is easier to understand than perhaps "maxillofacial" or "otolaryngology" consultant, for example.

The case against devolution

There are arguments against the establishment of head and neck as a specialty in its own right in the UK. The current provision for the management of head and neck conditions is already comprehensively covered by the specialties of OMFS and ENT, and the natural tendency to conservatism within these groups could potentially lead to resistance to a major change in the provision of head and neck surgical services being realised. There is currently no evidence that the British system is any less effective than that in those countries with an active separate "head and neck" specialty.

It is arguable that creating a devolved "head and neck" specialty will prove disruptive in terms of planning the workforce, and will prove expensive. There is published work that has highlighted greater costs of providing health-care in countries with specialism-orientated systems.[2,3]

A potential barrier to devolution is the possible impact it would have on an individual surgeon's private practice. Would a reduced scope of core operations within a devolved "head and neck" specialty lead to similar reductions in private operating? A considerable proportion of practicing surgeons operate in the private sector, so it seems likely that any devolution that results in a disruption in this aspect of their practice would be viewed unfavourably.

The question of specialism over generalism remains a subject of debate, with many surgeons providing excellent head and neck oncological services as well as continuing to contribute to a wide range of other specialty-based activities such as maxillofacial trauma. This observation would equally apply to the other surgical specialties. It would seem undesirable to curtail highly-competent generalists in a drive towards specialism for specialism's sake.

Generalism potentially provides for a healthier group of surgical specialists, with the wide variety within each specialty likely to be beneficial. Published studies have shown that head and neck oncological surgeons experience more