Women in specialty training: Challenges, decisions, or opportunities?

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Introduction

Imagine a student dentist who has successfully finished dental school. They're a long way from home, but they've settled down and are in an established relationship. They're looking to further their career in oral and maxillofacial surgery (OMFS) and become a surgeon, but children follow quickly, and they take time off work to look after the new-born. They return to work part time while their partner continues to work full time. Childcare becomes a central pillar of their life and so their career goes on hold until the child at least starts primary school, by which time they've missed out on more hours of CPD than hours sleep. It becomes difficult to resume their career, and while they end up working in dentistry, it isn't the career they envisaged when they left dental school.

And now imagine that person is a man. Difficult, isn't it?

Much of the above is unimaginable for a man in large part due to the way society functions. You may think dentistry and career progression is immune from such societal influences, but you may be surprised. The most recent GDC registration report of February showed there are roughly the same amount of male and female dentists on the register (1,006 more females than males),¹ but when you look at those on the specialty

register, that changes. That register shows there are 25% fewer women than men.¹

What is it about specialty training that dissuades women from taking it up? What hurdles are there to overcome? Does being female even factor into the discussion? Should it even factor into the discussion?

Take the discussion about training issues in OMFS, for example. Issues partly relate to the length of training, the challenges it presents in financial terms and lack of flexibility for women who enter the specialty and who want to have children, and are openly being discussed by the British Association of Oral and Maxillofacial Surgeons (BAOMS) to assess how to improve inclusion. Some of the smaller OMFS units face difficulties in recruiting, while others say there is no recruitment problem and deny there is an issue anywhere although there are reported recruitment problems across surgical specialities.

A problem or a non-starter?

So, is there an issue relating to women in specialty training? I asked Kanwalraj Moar, Cleft Oral Maxillofacial Surgeon and Divisional Director for Women's and Children's Services at Addenbrookes Hospital, and BAOMS Diversity Lead. 'If we're being honest, the answer is yes and no', she said. 'It depends on where you get your training place, which really shouldn't be the case.'

'Many of the problems aren't specialty specific, nor are they profession specific either. Societal expectations have a huge

Key points

- Female uptake of surgical specialty low – why?
- Do women face more hurdles completing specialty training than men?
- Diversity needed to improve pathways

role to play. I remember my father being concerned that by going into OMFS I would delay having a family. His point was that I'd spend my time focusing on my career, and while it's true for some consultants, there are many who have gone through their training and come out of the other side having a family en-route. But the number of female consultants varies from region to region, with maybe only one as a role model.'

'In my mind it's the responsibility of the workplace to mitigate for such societal expectations. You only need to look at how COVID-19 has affected families across the country in all walks of professional life. It has been shown that a man with three children hasn't been as badly affected in his career as a woman with three children. Research suggests your gender, relationship and family status plays a huge role in how successful you are in completing exams. Previously the pass rate for the American Board Surgery Exams was highest in single women with no children but less for married women with children.² For men, the pass rate was highest in those who were partnered with the other groups not far behind. Is this related to support rooted in societal expectations? Possibly,

so we should support our trainees in their totality, not just their workplace interactions, to enable them to function at their best.

‘That means you really have to look at training pathways, and I believe training has changed for the better. The way trainees are assessed has changed. It’s not necessarily about putting in hour upon hour to build up a quantitative picture, but about the quality of the work achieved. We can support less than full time training, and for example mothers who want to breast feed or express on return to work. It is approaches like this that facilitate diversity in the workforce which have to become the norm rather than the exception.’

Which poses the question, why is the problem region-related? Is that fair, or is it a true reflection of the overall issues dentistry has recruiting specialists?

‘Some regions are huge, and the density of the workforce is thinner. That will impact where and how much training you need to do’, Kanwalraj suggested. ‘Don’t forget, traditionally those who wish to pursue a career in maxfax are very focused – they have to be to complete two degrees – and they will choose their training carefully, largely by reputation and geography’.

‘There’s also the quality-of-life aspect. If you have a family or built up a life network, you’re less likely to want to uproot and move elsewhere, so you’ll stay close to where you graduated, which most medical and dental trainees tend to do. What I would add is that any junior trainee – male or female – needs to know a career in maxfax is challenging, sometimes without support. But is that really any different to other specialties or dentistry overall? I would argue that it is not, and not

dictated by which part of the country you’re in.’

If the problem is multi-faceted and not necessarily rooted in gender, what does Kanwalraj think?

‘It’s worth remembering life isn’t meant to be painful. Work is meant to be a joy! And I do love my job. So it’s understandable that there are clusters of trainees and specialists in areas where they graduated and completed their training – if you’ve started a life and you’re happy, why would you move?’

‘That creates wider issues for the workforce to address. Take the East of England – the nearest dental school to Norwich is Barts and the London, which is not close. The region struggles to attract orthodontists because so many are based in London. We need to look at region-based training at an undergraduate level to ensure patients have the access they

need to the services they need. Stability in training pathways is also a must – you don't want to encounter high levels of drop-outs simply because the region they're training in doesn't sustain what they want from life.'

A choice, or not really

It makes you wonder what sort of thought process takes place before starting out on an OMFS training pathway. If the person described in the introduction is indeed a woman, and there are concerns about the length of training, the challenges it presents in financial terms and lack of flexibility for women, what considerations does one need to take into account?

Emma Woolley, Director of Medical & Dental Education, Betsi Cadwaladr University Health Board and Consultant Oral and Maxillofacial Surgeon, spent 15 years training, but doesn't recall taking too much time to consider her impending journey. 'I must admit I don't recall thinking too long or too deeply about it, before starting out', she said. 'That's not to downplay the size of the decision medics and dentists in 2021 and beyond have to make – the situation is very different to when I made my decision.'

'Looking back now I can see, that without realising it, that what I did have is access to was great informal support and mentorship. Those are still really important now, whichever way your career takes you. Follow a path that works for your life and aspirations at that time. If those need to change career wise that's fine.'

Aimee Rowe, Junior Trainee and OMFS Clinical Fellow has completed her basic surgical training and graduated her second degree. She faces three to four years of additional training on top of her medical degree, so what did she need to weigh up before starting out?

'I took my medical degree first but as a medic I was less exposed to maxfax than a dental student would be. I had always known that I wanted a career in surgery before I even started med school. I had already completed a Bachelor's degree, and liked working with my hands. I'm an amateur artist and I wanted to somehow combine an aesthetic component into the surgical speciality I entered. I considered plastics and hand surgery, but they didn't seem to satisfy what I had in mind. I took a self-selected module in maxillofacial surgery and realised this is what I had dreamt of. The surgery was varied and important, working on the face, head and neck was an incredible privilege.'

'Before settling on my choice, I thought about what my working life as a junior trainee and consultant would be like. I think you need to look at your career as a whole. Where do you want to be based, what kind of work do you want to do? I knew that I would not be bored by maxillofacial surgery, and that's a massive appeal. It's also a smaller surgical speciality than others and felt more friendly and welcoming.'

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'I had to consider how I would manage doing a second degree in terms of finance and location. I've written about supporting yourself during second degree studies for the BAOMS website. For me, I returned to my family home in London and made use of the NHS bursary and a small re-mortgage on my own house in the Midlands. I continued to work part-time in the East Midlands and East London. I know there are also questions about the length of training, but I realised that I would not be far behind my medic colleagues. I'll be a consultant only a couple of years behind them. But I'm in no rush to finish.'

For Radhika Dua, OMFS Fellow in training representative to Association of Surgeons in Training (ASiT) who's beginning her ST5, the potential problems ahead were no deterrent for her starting out.

'Unlike other specialties, I chose to commit to OMFS long before I would be able to start my specialist training', she said. 'My interest was first sparked at dental school lectures courtesy of consultants like Kathy Fan and Rob Bentley from King's College Hospital. From there I did an SSC special study module in OMFS at Guy's and St Thomas' NHS Foundation Trust, and observed and assisted with some surgery. I also observed OMFS during my elective at the University of Maryland. I knew that I wanted to work in a maxfax unit after VT.'

'By the time I had worked as an OMFS SHO at King's College Hospital and at Queen Victoria Hospital in East Grinstead to

ensure I had seen as much of the spectrum of the specialty as possible, I had to consider whether it was worth leaving a perfectly good job in dentistry for OMFS.'

'It was a big commitment to do a second degree – managing my work, finances, a social life and my study seemed like a lot, and it was. Both units I worked at were very supportive and ensured I could work with them.'

'While at university I did night shifts at King's during the week, worked through my holidays at Queen Victoria Hospital by doing clinics, oral surgery sessions and some operating lists. I also worked as an emergency dentist on Sundays. All this while attending lectures and my clinical placements, which could go on till very late. Working while studying was good for me. I had the motivation to do so, which in retrospect I suppose confirmed I had made the right choice for my future career. That doesn't mean I wasn't aware of what was available – I kept an open mind in my foundation and core surgical training years regarding alternative specialties. This one just worked for me.'

'Of course, having a work-study-life balance was also important, and many of my friends from school and university had significant birthdays and weddings. I did my best to attend, so I had to ensure I was working for more than just my daily bread! This is where you need support, and my family could not have been more supportive of my career choice. They have always taken an interest in my work and helped in any way they could. My husband and family have all assisted with exam preparation by quizzing me and willingly allowed me to practice physical examinations on them, and you need that support.'

Money talks

Perhaps the points Aimee and Radhika alluded to regarding finance is a major reason some – regardless of whether they want to or not – do not pursue a second degree in a surgical specialty. After length of training (51%), research has highlighted how financial constraints (31%) were potentially a barrier for students, foundation and core trainees in both medicine and dentistry pursuing a second degree.³ But, is it right that financial challenges present – particularly to women considering starting a family?

Aimee said: 'Sometimes there might be a perception that the lifestyle is incompatible with motherhood or family life. I had hoped to have children earlier in my medical

training, but I became pregnant when I started my dental degree. The university was very helpful in supporting me when I had my son. I was able to breastfeed as long as I needed to and I completed my degree in three years. I was pregnant with my second child during my finals. There were other mothers in my year group at university too – we had a mini-support group!

‘My husband stopped work to provide childcare and now works from home part-time. Today many surgical trainees are dads and child rearing is a joint effort. It’s not a hidden issue anymore, and ST doesn’t preclude you from having children. Times have changed. There’s flexibility in how people care for their families, and flexibility in surgical career development. You can work less than full-time and take time out if that’s what you need to do.’

Emma took a more forthright view.

‘It may be an overly simplistic statement, but most people want to have children and childcare is an issue that OMFS trainees need to think about. But from my roles in medical and dental education, mirrored in society more widely, it is evident more and more trainees of both genders share the responsibility of childcare’, she explained. ‘It’s not always the woman. That’s the reality today. I find myself giving advice to trainees of both genders on how to combine a successful home life and career. I recall a conversation with a male trainee who told me his wife said if he didn’t pass his exam that was it for him, it was his last attempt. If you start training, have children and realise you want to do that full time rather than commit to training, does it really matter? It’s our job to support the individual along their own decision-making process and help make training possible.’

Kanwalraj added: ‘The simple answer is no, but this is where it’s important for Trusts to assess and consider what they do within their training structures to mitigate those challenges. Why is the onus on the woman to return to work one year after maternity leave? Or be the one to take the entirety of parental leave? Why should single parents have to face that choice? If you’re a higher orthodontic trainee, unless you have completed 18 months of continuous training, you have to start again. Is that right? Absolutely not. ‘Some trainees who go into maxfax are driven and would expect to achieve it all. Yet it is difficult to have a high-end surgical career with a private practice working a minimum of 12 hours a day, and maintain

high quality time with a family. There simply isn’t enough time in the day, and even for the man who apparently has it all there will be a compromise, and this may be the family comes last and is left behind in advance of his career.’

But being a successful oral and maxillofacial is not defined by private practice and the hours worked. That may sound fundamentally sexist, but it is realistic. It’s warming and reassuring to hear that it doesn’t always happen – Aimee and Radhika are clearly examples of what can be achieved with the right allies and the right support. ‘For me, this comes back to how we need to embrace a different culture and approach with maxfax trainees’, Kanwalraj continued. ‘Competency rather than time-based training is one improvement – some will develop quickly, and some will take a little longer. Every trainee flexes their approach to every consultant they meet, which in isolation is wrong. How can there possibly be continuity in that person’s development? Consultants also should flex their approach to trainees to enable a pathway to quicker, more competent development.’

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It is the issue about time again. Qualifications in medicine and dentistry, together with completion of the two-year foundation and attaining core surgical training programmes competence, are currently required for entry into OMFS specialist training. Some have suggested that the dental degree in the pathway could be redundant, and a future exist in the specialty without it. In an editorial, Mannion and Kanatas postured:

‘OMFS has often been described as bridging the professions of dentistry and medicine. While the specialty has advanced beyond recognition from its origins in dentistry, retaining dental qualifications should be regarded in a positive light. The unique identity

afforded by our training allows for an ease of conversation and shared language with both medical and dental colleagues, together with a sense of parity in the clinical relationship. Membership of both professions also grants us a very specific lens through which we view patients and approach care with a particularly broad skill set.

‘Our understanding of, and close affiliation with, dental specialties allows us to treat diseases, injuries, and disorders affecting the head and neck with the knowledge and skill to restore a functional occlusion. Retaining dual qualification and diversity in training, and including a portfolio of skills in dental and general surgery, justifies our identity as experts in this clinical field. This has promoted a close working relationship and respect from those specialties that traditionally treat patients with disorders of the head and neck, while allowing us to provide a more holistic and generalised approach to their care. The undergraduate dental curriculum ensures that OMFS trainees have greater exposure to head, neck, and oral anatomy, as well as orofacial pathology and aspects relating to the temporomandibular joint and occlusion. By contrast, there remains minimal reference to the dentition, oral cavity, and associated specialised anatomy in medical training.

‘Advocates of a ‘bolt-on OMFS’ model of training to a single medical qualification could see this specialist knowledge diluted and ultimately lost.’⁴

Without a fundamental review of whether the two need to co-exist in their current forms, which they later go on to suggest, it is likely that it will only force dental students to choose between pursuing a career in dentistry – one that nearly every dentist and the OMFS surgeons in this article I have spoken to would not change for the world – or committing a sizeable chunk of their adult lives to training. Perhaps this is another reason why a small proportion of maxillofacial consultants in the UK are female – they have to choose between a career or a family. Does this scream diversity? Men aren’t affected, so you’d have to lean towards no, it does not. In fact, in their paper on how diverse OMFS specialists and higher trainees are and have been over time, they commented that ‘to have a future, the specialty must recruit widely and welcome diversity’.⁵

Keeping with the time

And so, in 2021, why are we still discussing inequality? To what extent is society influencing what happens in the workplace?

‘There needs to be a greater understanding of the different ways people ‘are’ and what they bring’, Emma said. ‘I have been taught that recognising diversity of character is important in healthcare. Personally, I dislike being defined by my gender. Whilst no doubt well intended, formal published congratulations for my success in an appointment to a Chair position alluded to my gender when I would argue the more important thing to note was my particular qualification in medical education as a ‘first’.

‘Maybe part of the reason is that it is grounded in society and unconscious bias’. Even for me, if I think of a nurse my brain leads to a female, whereas if you say doctor it takes me to a middle-aged man. Apparently throughout the COVID-19 pandemic PPE mask fit-testing was difficult for many women because the tests were based on male features. Those are the types of stereotypes we need to break along the way if we’re to encourage that diversity of character and individual in specialty training.

‘I didn’t experience any issues throughout my training that were obvious or impacted, but you never know how subtle some could have been. Some would argue I benefitted from being female.’

Radhika agreed.

‘There is clearly still room for improvement’, she said. ‘As part of ASiT, an independent body that represents and supports all surgical trainees, I can assure you equality and diversity are an ongoing discussion for all surgical specialties. Availability of flexible training is helping. For women who wish to train and have a family, it can help negotiate this. But I would like to see flexible training being used by both genders – and not necessarily for child-rearing. I have several female colleagues who have had kids, either before during or after training, and while I have faced my fair share of ups and downs just like any other trainee, I don’t think I had any issues because of gender.

‘Diversity in surgery also needs addressing. We need to ensure people are coming into dentistry and medicine from different cultural backgrounds and all walks of life.’

Kanwalraj believes challenging the *status quo* is the only way to obtaining equality.

‘We have to continue to challenge the *status quo*. The improvements in equality – and there have been many – allow us to do that from a position of greater strength with more influence. It’s important to have allies, at all levels. People who have not faced the same

hurdles you have, but recognise they exist and work with you to removing them.’

‘In the summer of 2018, we established the Society for Women in Maxillofacial Surgery (SWIMS) where members can openly discuss problems they have faced, share experiences and provide advice on how to move them forward. In reality I’d want the group to be out of business – it isn’t right that in 2021 such a group is necessary because we’re still trying to achieve total equality – but change is happening. Women make up roughly 15-20% of all maxfax surgeons and consultants, and it’s thought the precipice of change happens at 16%. We’re borderline mainstream where it’s accepted in everyday life.

‘There are still units where there are no female consultants, and those regions need a male ally. How can an entire region of female trainees ever have a female role model if their region does not hire one?

‘It’s easy to say these difficult discussions are due to gender, but in reality I believe they start with behaviour. And those behaviours effect all trainees irrespective of gender. That’s why I feel optimistic that there is room for change. We’re becoming more open about confronting issues knowing they won’t be swept under the carpet and dismissed. If you go into specialist training, the protection is there to ensure you’re treated equally. The barriers are coming down, and we have a mandate for change.’

Aimee added: ‘It should be the norm to speak frankly in the workplace about any inequality issues. Progress for women in surgery has been made, but it has historically been a bit of a boys’ club. I was lucky that when I started medical training the boys’ club seemed on the wane. That being said, I have good friends who have had disparaging comments made about their surgical career based on their gender, which has no place in the modern world. We need to be able to address these situations and call out and educate, and empower people in the workplace to speak up.

‘I’ve been fortunate as a student. When I was shadowing in maxfax we had a female surgical trainee, who defied my preconceptions of what a female trainee needs to be. I thought you would have to fight hard as a woman in surgery and as a result not be a very nice person. She showed me that you can be approachable, tough and inspiring, both respected and friendly. It was like being given permission to be a surgical trainee and still be myself. Mentoring is important too, and the Junior Trainees Group

is excellent in providing active support to trainees at all pre-ST levels.’

With the benefit of experience, Emma cast a more thoughtful perspective on where improvements can be made.

‘As Kanwalraj has said, life is supposed to be enjoyable. If you have a bad day or a bad case, that’s OK – that’s why we train for so long. Remember everyone will have these moments but not everyone admits it, so be honest in your own reflection, learn and move on. That’s a healthy way to think, and it’s not gender specific – it’s grounded in the character you are. It doesn’t matter whether you’re male or female, if you have the right character, resilience and you work hard, you’ll go a long way.’

Perhaps Emma is right. Perhaps sometimes we do look too closely at the who rather than the what, be it intentionally or otherwise. And perhaps she is totally wrong – after all lived experiences of inequality matter to those who have indeed experienced them. Whether you believe the ‘borderline mainstream’ threshold Kanwalraj spoke of is a reality or not, there is no escaping your answer to that question is based entirely upon your character. Are you an ally? Can you be an ally? Do you want to be an ally? All questions that aren’t as easy to answer as you may think. What is patently clear to me is that we are some way off imagining that person described in the introduction is a man, and so the journey to the precipice of change continues. ♦

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