Dual Degree Training: Balancing Clinical Aptitude and Medical Licensure Requirements

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Nearly 50 years ago, the first dual degree-general surgery-oral-maxillofacial surgery residency program set a precedent for the specialty and all of its trainees aspiring to obtain a medical education, become integrated into the general surgery service, and be granted medical licensure.1 According to Guralnick et al., the oral and maxillofacial surgeon should possess the same basic surgical skillset as trainees in other surgical subspecialties, most of which also incorporate time on a general surgery service.1 The main accrediting body for dental specialty training programs, including oral-maxillofacial surgery, is the Commission on Dental Accreditation (CODA), while graduate medical programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). Rotations on oral-maxillofacial surgery are inconsistently recognized for ACGME credit by surgical training programs. There is a national trend toward increasing medical licensure requirements set by state licensing boards from 1 to 3 years of postgraduate ACGME training. While off-service rotations are essential to meet medical licensure requirements, there is a concern that increasing off-service rotations at the expense of oral-maxillofacial surgery rotations within a constrained 6-year curriculum is detrimental to dual-degree oral-maxillofacial surgery trainees.

The increasing requirements for postgraduate training for medical licensure eligibility are certainly not foreign to our specialty. Although the period of time spent on other surgical services is variable between residencies, the program director is tasked with the responsibility of incorporating sufficient off-service rotations to attain ACGME credit while ensuring that their residents receive quality oral-maxillofacial surgery training. Most dual-degree oral-maxillofacial surgery programs incorporate at least 1 year of general surgery into the curriculum, usually completed at the PGY-1 or PGY-2 level. For the single degree resident, the general surgery rotation is variable in length, often less than 6 months, and gives the trainee exposure to intensive care unit and complex perioperative patient management. While the core purpose of this off-service time is the same for dual degree residents, additional time is allocated to meet the minimum postgraduate surgical experience defined by the ACGME for licensure eligibility, which was historically 1 year. Upon review of state licensure requirements and CODA accredited oral-maxillofacial surgery residency program websites, nearly 40% of states now require 2 years or more of postgraduate surgical training to obtain medical licensure, and some are requiring 3 years (Fig 1). However, only 12% of dual degree programs reported general surgery length of 24 months, 55% reported general surgery length of 12 months, 5% reported general surgery length of 8 months, 2% reported general surgery length of 7 months, and 26% did not report the length of general surgery training (Fig 2).

Our surgical colleagues in plastic and reconstructive surgery (PRS) and otorhinolaryngology (ENT) with whom oral-maxillofacial surgery shares significant overlap in clinical scope meet their postgraduate

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surgical training requirement within the natural length of the residency program without sacrificing their specialty training. The trend within ACGME-accredited surgical subspecialties is to decrease the amount of time spent on general surgery and increase the time spent on the subspecialty training. For example, PRS was historically completed as a fellowship after completion of a surgical residency, most often in general surgery. The residency program structure then shifted to the “3-3” model of 3 years of general surgery and 3 years of specialty training. Many programs have decreased the time spent on general surgery to as little as 5 months. Today, ACGME accredited integrated PRS residency programs require only a “basic experience in clinical general surgery” with no specific required time on a general surgery service but instead receive guidance on the specific type of experiences their residents should hope to obtain through the course of their residency. Similarly, ACGME accredited ENT residency programs require only 6 months of structured education on non-otolaryngology rotations designed to foster proficiency in airway management, core surgical, perioperative, and interdisciplinary skills. With new technology and an increasing complexity and case-load required to master the growing scope of subspecialty surgical care, the trend among these ACGME surgical subspecialties is to favor decreased time on general surgery rotations to allow for more dedicated time for their subspecialty training.

In the era of increasing sub specialization and medicolegal considerations, the question arises as to whether medical licensure for dual trained oral-maxillofacial surgery will be at risk in light of increasing requirements for licensure, and the appropriate response by our specialty. Increasing the time of off-service surgical rotations in dual degree programs to meet licensure requirements would threaten the core 120 weeks of oral-maxillofacial surgery required for CODA accreditation and would be deleterious to oral-maxillofacial surgery training. Despite the educational challenge that changes to the oral-maxillofacial surgery curriculum exhibits, the specialty is undeniably confronted by the licensure conundrum. If the dual degree oral-maxillofacial surgery program is to remain a viable option for our specialty, appropriate steps...
need to be taken to put residents in a position to be fully prepared to obtain medical licensure without extending training past completion of the oral-maxillofacial surgery residency or lengthening the oral-maxillofacial surgery residency. Two potential means of addressing this problem are the following: (1) lobbying state boards to accept American Board of Oral and Maxillofacial Surgery (ABOMS) certification and allow for CODA-accredited training time to count toward medical licensure requirements and (2) pushing for joint accreditation between ACGME and CODA. If time spent on oral-maxillofacial surgery rotations was recognized as ACGME-accredited training, a program model similar to that of PRS and ENT could be adopted in which time spent on OMS would count towards postgraduate training for medical licensure.

The undergoing transformation by the state medical boards nationwide warrants immediate adaptability to best serve the educational interests of the next generation of surgeons. With the American College of Surgeons accepting ABOMS certification as equivalent to ACGME-accredited board certification, the lobbying of state boards to accept ABOMS certification could prove beneficial. CODA-accredited training time may additionally be allocated toward the mandated postgraduate surgical training. Significant efforts have been made in several states to alleviate the burden of appeasing their respective requirement of 3 years of postgraduate surgical training for licensure; however, a coordinated effort on a national level will be needed to avoid leaving geographic voids in oral-maxillofacial surgery medical licensure.

In July 2013 the ACGME implemented the Next Accreditation System, designed to focus on educational milestones rather than a process-based accreditation system, for 7 of the 26 ACGME-accredited core specialties. Furthermore, as of February 2014, the ACGME, the American Osteopathic Association, and the American Association of Colleges of Osteopathic Medicine, the osteopathic residency accrediting body, announced their agreement to form a single GME accreditation system which allows allopathic and osteopathic medical residents to complete residency under a single accrediting body, the ACGME. The development of Next Accreditation System and formation of a common residency accreditation body may pose an opportunity for oral-maxillofacial surgery as a specialty to consider dual accreditation with adoption of a less burdensome accreditation reporting system in the setting of these ongoing changes to the ACGME. Ignoring these ongoing changes to the ACGME and consolidation of medical residency accreditation may introduce additional challenges to the oral-maxillofacial surgery dual degree program.

The challenges of pursuing ACGME accreditation have been heavily discussed among academic oral-maxillofacial surgery with substantial barriers including increased administrative burden and resident work-hour limitations. However, there are many oral-maxillofacial surgery programs that have found it feasible to meet work-hour limitations that are often mandated at a hospital level.

Dual degree oral-maxillofacial surgery graduates have achieved great heights in acquiring a medical education and completing their training with competency. Modern changes to accreditation requirements add significant burden to the graduating resident hoping to obtain licensure. While off-service rotations tremendously add to the resident’s skillset in patient management and perioperative care, sufficient core oral-maxillofacial surgery training should not be traded in order to appease more stringent licensure requirements. Despite potential barriers and challenges to actualizing dual accreditation in oral-maxillofacial surgery, this model may strengthen the resident’s operative volume, skill, and experience in subspecialty oral-maxillofacial surgery training while allowing for conformity to the practices of other surgical disciplines of the ACGME and ever-changing medical licensure requirements.

References