Review Article

An overview of the initiation, development, performance, and current status of UK interspecialty collaboration in training in head & neck surgery: "The UK Head & Neck Training Interface Fellowships—concept and reality …"

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Abstract: Responding to the need for consistency and universal surgical training in the field of head & neck surgical oncology, the United Kingdom surgical education bodies (the Royal Colleges of Surgeons) established, through the Joint Committee for Surgical Training (JCST) a series of Training Interface Groups at the turn of the century. The Head & Neck Surgical Oncology Training Interface Group (TIG) established in 1999/2000 had the remit to create specialist training fellowships across specialties active within the field of head and neck surgery (H&N), with free access to all training opportunities & clinical activity in H&N, giving a trainee originating from ear, nose and throat (ENT), oral & maxillofacial surgery (OMFS) or plastic surgery (PS) open license to all clinical settings of all the three parent disciplines, for a period of one year. The first 5 posts commenced in phases during 2004–2005. Recruitment is national and based on merit & performance in validated and standardized national selection processes. Ninety-nine percent successfully completed their fellowships. Many progressed to take full involvement in National Health Service (NHS) Head and Neck Cancer service provision. The fellowships were rated highly by those completing, when sampled. Research productivity was good, and most Fellows continued to provide H&N in a multidisciplinary setting. Take-up of Fellowships by candidates from the 3 parent specialties varied over time. Units hosting a fellowship are quality managed and the trend in participation has fluctuated over the duration of the fellowships. A recent overhaul of the H&N TIG Fellowship curriculum is in progress to encompass the developments, clinical and technical in head and neck oncological practice since the Fellowships were instituted.

Keywords: Subspecialty training; surgical education; head and neck cancer; fellowship

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Introduction

Training in surgery is predicated on the transfer of knowledge, understanding, practical skill sets and insight into surgical principles, along with accumulated experience and sound judgement, from those in possession to those preparing to take up responsible roles in that area of surgical practice. The expectation is that they will go on to further develop, expand and extend their subspecialty practice in their own time.

As the expertise of a training surgeon builds, and he/she gravitates to more complex or rarified clinical remit, inevitable pressures concentrate and centralize the fewer more demanding cases into bigger, higher resourced and generally more capable care centres. A trainee intending to progress and further refine their skills needs to gain access to those centres or units where such advanced work is available—or their education remains essentially incomplete and development to the ultimate "expert" level is frustrated.

Most nations have established processes for the education and training of surgeons; in the United Kingdom the relevant surgical Royal Colleges collaborate through the Joint Committee on Surgical Training (JCST) which supervises and drives surgical education (1), overseen by the UK General Medical Council which holds the specialist lists and oversees registration as a specialist (2).

UK GMC Specialist Registration exists today for plastic surgery (PS), ear, nose and throat (ENT), and oral & maxillofacial surgery (OMFS); there is no specific specialty listed as head and neck. Apart from informal interactions at local level between the 3 specialties, the only collaborative formalized surgical training in head and neck oncological surgery open to trainees in these specialties are the United Kingdom Training Interface Group Fellowships (TIGFs) in head & neck surgical oncology.

Up to the point at which a surgical trainee considers which area of specialization to move to, the overall principles of training from graduation, through foundation years (FY) and core training (CT) in surgery bring the doctor up to a required standard based on achieving set competencies, and most recently by fulfilling specified capabilities in practice and 'entrustable' activities e.g., performing an operating list unsupervised, or managing an outpatient clinical session 'independently', as laid down by the General Medical Council (3), specified in published curricula for each surgical specialty and recorded in a universally applied central system open to all surgical trainees—the electronic Intercollegiate Surgical Curriculum Programme (ISCP) (4). Recently, a review of medical training by Greenaway (5) threw doubt on the traditional route of specialization by calling for earlier consultant status "*in the generality of their Training area*" and further proposed that "*Subspecialty skills will be acquired … by a process of credentialing*". This has yet to be fully implemented and may push fellowships in surgical subspecialties beyond the point of completion of standard surgical training in the parent discipline, i.e., after the grant of a certificate of completion of training (CCT).

Once a trainee approaches the final stages of training in their parent specialty, on the current trajectory the choices open for niche or super specialist activity, and head and neck oncological surgical practice represents one such area. Traditionally, a surgeon about to complete their overall training in the broad remit of ENT, OMFS or PS would need to gain additional or focused exposure, teaching and practical tuition in the techniques applied to head and neck. The product would be a clinician about to start as a consultant in one or other specialty "with an interest in" the narrower field of H&N, implying the new specialist would be active in that specialty's "corner" of the whole concept.

Is this enough? Some consider the superspecialised procedures and diagnostic, staging, treatment principles and pathways in Head and Neck Cancer demand a type of surgeon committed to and focused purely on head and neck. The UK National Health Service (NHS) evaluated and adopted the principles of multidisciplinary team (MDT) management of head & neck and other cancer types based on the UK standing and relative performance when compared to other countries—and improvement was clearly necessary (6,7).

Given the contribution from differing specialties each contributing to the new MDT structures, some of the old rivalry and competition was seen to be counterproductive. New common treatment principles and patient pathways brought a need for congruence in surgical training for those who would staff and develop the surgical side of a cancer service.

The concept of the Training Interface Group on its establishment was to condense the best features of specialist training in surgery provided by the various specialties where overlap in remit and interests occurred.

The motivation was firstly to maximise the positives on offer through a new and integrated programme of surgical training, and secondly to defuse or eliminate "turf wars" or unproductive competition between those specialties competing for supremacy in each niche discipline.

Table 1 Original list of training interface group fellowships specialisations [2005]

Cleft lip & palate
Hand surgery
Head & neck surgical oncology
Oncoplastic breast surgery
Cosmetic surgery*

*, later redesignated reconstructive and aesthetic surgery.

The JCST a sub-group of all of the UK Royal Colleges overseeing surgical training, was the founding agency, and a number of areas were identified where more than one parent specialty was active in service provision & training of future surgeons looking to pursue clinical practice in that area. The intention was to select late period trainees, well on their way to completion of parent specialty training, and give them a supervised fellowship year in an environment with free access across all the contributing Specialties and their work, to gain knowledge and skills outside their own curriculum, equipping them to be a more rounded and accomplished expert in the given field.

The initial TIG Fellowships were established as shown (*Table 1*).

Head & neck

UK H&N had no real national coordination prior to this development: the 3 specialties of ENT, PS and OMFS competed in open for the clinical work available and team influence in the diagnostic, treatment planning and delivery side of head and neck oncological care.

Due to this, the overall flavour within individual units varied widely, by evolution, with some dominated by one or other specialty, and most having a workable, if sometimes uneasy collaboration.

There were "interest groups" formed for discussion and education, but it took the establishment of a more inclusive way of working in oncology, modelled on the tumour boards seen in other countries, for the head and neck specialties to collect in the same room for the purposes of consistency in pathways, staging and treatment planning. This was triggered by the "Improving Outcomes" initiative adopted by the NHS, later followed by the "Long Term Plan" in 2019 (7). Hand in hand with this went a reduction in the numbers of hospitals and surgeons permitted to provide surgical oncological procedures within a given region.

So called "Network Site Specific Groups" covered most of the important cancer diagnoses and included head and neck (with thyroid incorporated). Specifications on minimum catchment area and numbers of cases, resulted in a reduction in the numbers of centres providing head and neck oncological care, and the gravitational pull caused centralization of training in the surgery involved. Large centres attracted more of the workload, and less busy (district general) hospitals became non-viable as providers within this framework (*Table 2*).

Subsequent refinement of the concept to MDTs—and the application of tighter national "Standards" or "Measures", under a system of national peer review (quality service framework) to assure facilitation and compliance, brought real consistency—and for the first time the core surgical contributors to head and neck were defined, named and recognised.

Following this a national cancer patient experience survey (8) showed improved performance in the specified areas required for good cancer management—and training in these areas is integral to maintaining the constant improvement.

Over recent years the group of fellowship types have altered. Additional areas have been added, and some have been controversial and unproductive for various reasons.

Added have been major trauma [2018], spinal surgery [2019] and shorter laser surgery [2012] and Mohs Surgery [2020] TIG Fellowships (*Table 3*). Laser training, which could be useful in the H&N sphere, formed one part of the Reconstructive and Aesthetic Fellowships [2009]. These were effectively suspended recently due to major issues arising over cosmetic and aesthetic practice in the independent sector outside the UK NHS, where it seemed any clinician with little (or sometimes no) specialist training could set up an aesthetic or cosmetic practice—and with some disastrous results. The General Medical Council, as the competent authority for all UK medical practice, was keen to eliminate bad or untrained practice and the area was under review and threat of change for an extended period.

The TIGFs have, over the period of their existence, provided numerous trainees with specific and specialist training. Within the head and neck fellowships, this resulted in 99% of fellows satisfactorily completing their fellowships and receiving certification. Only 1 failed to complete or not achieve certification. This is granted when formal assessment of the Fellow's year (some other fellowships have shorter periods of training) shows acceptable performance against published requirements, monitored using the UK

Table 2 UK head & neck cancer related background

Current UK population approx. 67.5 million (UN figures)
Based on figures to 2017.
Head & neck cancer new diagnoses—approx. 12,500 pa (approx. 20% increase since the 1990s)
Male approx. 8,500, female approx. 4,000
One fifth in patients aged 75 or older. Head & neck cancer rates are significantly higher in areas of social deprivation
Approx. 4,000 head & neck cancer deaths pa (2% of all cancer deaths)
Wide variation in survival exists across subsites in head & neck cancer in the UK

Source: Cancer Research UK (https://www.cancerresearchuk.org/about-cancer/mouth-cancer). pa, per annum.

Table 3 List of current specialisation Training Interface Group Fellowships

Cleft lip & palate
Hand surgery
Head & neck surgical oncology
Oncoplastic breast surgery
Major trauma
Mohs surgery (6 months)
Spinal surgery

standard tool for assessment of surgical trainees' progress—the ISCP (4) forming the day-to-day electronic record of progress.

Other evidence considered includes Fellowship Trainers' Reports, logbook records and a summative assessment held by the training deanery supervising their original specialty training programme. The chair of the TIGF (head and neck) then attests to satisfactory completion of the required components by certification—or otherwise.

Since its inception, some new H&N units have joined the group providing head and neck fellowships.

Selection of training units

A hospital or unit can apply to host a H&N TIG Fellowship by supplying information which assures the resources, activity and material support are present to support fellowship level training in this area; by assuring there is no impact on the training of ordinary trainees at the same venue; that the administration of the unit supports the bid; and that the local senior clinicians are prepared to contribute of their time, interest and commitment.

The original list of 5 head and neck centres included Liverpool, Manchester (Central), Oxford, Birmingham and Newcastle.

Over the years Hull, East Grinsted, Guys Hospital (London), Manchester (Pennine), Sheffield, Norwich, Leeds, Glasgow and Middlesbrough centres joined the concept.

The contributions of Liverpool, Birmingham, Glasgow are now historic and these units no longer offer training (see below). This leaves 11 units out of 14 still active.

The designation of cancer centre will usually infer a population coverage of from 1.7 to 3 million, commonly around the 2 million mark, with a minimum throughput of new head and neck cancer cases and an approved and monitored MDT structure and pathways—this should be a fruitful setting for a fellow to gain the exposure and depth of experience necessary to complete.

List of currently approved centres

- Queen Victoria Hospital NHS Foundation Trust—South England;
- Hull and East Yorkshire Hospitals NHS Trust—North East England;
- Leeds Teaching Hospitals NHS Trust—North England;
- Guy's & St Thomas' NHS Foundation Trust—London;
- Manchester University NHS Foundation Trust—North West England;
- Pennine Acute Hospitals NHS Trust—North West England;
- South Tees Hospitals NHS Foundation Trust—North East England;
- Newcastle Upon Tyne Hospitals NHS Foundation

Trust—North East England;
- ❖ Norfolk and Norwich University Hospitals NHS Foundation Trust—East England;
- ❖ Oxford University Hospitals NHS Foundation Trust—Central England;
- ❖ Sheffield Teaching Hospitals NHS Foundation Trust—North England.

Selection of fellows

The UK has practiced national selection of all surgical specialty Trainees since 2005—the process is well established and organized, with a lead Deanery for each specialty—this formula is followed for the TIG Fellowships selection.

Person specifications require 4 years satisfactory progress in home specialty training up to appointment (3 in OMFS), completion of the relevant specialty "Exit" examination, i.e., FRCS (specialty), a minimum of 12 months cumulative head and neck experience within their own programme, and, at writing of this paper, must be prior to grant of final certification (see above re-specialist registration). Their portfolio should demonstrate appropriate knowledge, interest, skills, competencies suitable to H&N practice, and a logbook showing 120 operations related to H&N practice from a specified list of index recognised procedures, with 50% being as first surgeon.

At interview, areas for exploration include candidates' surgical Training progress and achievements to date; set standards of performance and surgical logbook achievement and other aspects such as the published curriculum; clinical governance, and ability in critical analysis and priority setting. This is assessed using consistently applied interview questions and marking schemes, and for complete "fairness" across the process, each station of the H&N TIG selection panels has a panel member from each of the three parent specialties.

Marking the individual candidates' performance at selection follows the same pattern as that used for standard specialty trainee recruitment and all is overseen by deanery and lay representatives for educational validity, correct process, and probity. All panelists must have current training in equality & diversity as per UK regulations.

Questions from interviewers largely cluster around knowledge of and views about:
- ❖ The curriculum;
- ❖ Research principles and critical appraisal of scientific papers;
- ❖ Exercise of judgement in difficult or escalating circumstances;
- ❖ Knowledge of governance principles and good practice/probity;
- ❖ With a review of the individual's personal portfolio & achievements as indicators of suitability.

A merit table of candidates' overall performances forms the basis for selection—and an individual who performs well will have a greater likelihood of having their choice of preferred TIGF host Unit from their submitted preference list—a proven, validated matching process allocates the successful candidates to the fellowships available, until either all unit placements are filled—or all fellows placed. Geography, family, and distance will sometimes influence the willingness of a successful candidate to take up a particular placement on offer. As a general principle, application to units away from the home centre are encouraged for reasons of wider exposure and fresh experiences - but this cannot be enforced.

Recruitment fluctuations across specialties have arisen and although the ENT representation has been consistent, the numbers of PS and OMFS have fluctuated significantly over the period of the fellowships.

Original curriculum

The approved curriculum in force [2015] concentrates on the commonest and most important parts of surgical practice in head and neck oncology; chiefly security of the airway, resective surgery and reconstruction. Fellows are expected to complete specified areas of the syllabus in a list of key topics covering what was essential for safe surgery—and permitted a choice of additional areas of activity or advanced topics—2 to be chosen, agreed with the educational supervisor and completed within the year.

2015 syllabus

Key topics

(I) Airway management;
(II) Swallowing and speech;
(III) Surgical skills;
(IV) Wound care;
(V) Decision making and management skills for head and neck cancer;
(VI) Management of the neck.

Table 4 Proposed new syllabus [2021]

Key topics (all to be completed)
Management principles, decision making & multidisciplinary working
Airway management
Surgical skills
Management of regional (neck) nodes
Wound care
Swallowing, speech, nutrition, rehabilitation
Understanding non-surgical treatment (radio/chemo/immunotherapy)
Palliative principles/end of life
Communicating with the cancer patient
Advanced topics (3 topics to be chosen and completed)
Tumours of the lip, oral cavity
Tumours of the oro- and hypo-pharynx
Tumours of the nose and paranasal sinuses
Tumours of the larynx
Tumours of the skin of the head and neck
Salivary gland disease
Thyroid disease
Reconstruction in head and neck oncology
Management of the facial nerve/reanimation techniques
Skull base involvement by tumours
Sentinel node biopsy technique
Trans oral robotic surgery
Laser surgical technique

Advanced topics

(I) Tumours of the larynx;
(II) Tumours of the oro- and hypo-pharynx;
(III) Tumours of the oral cavity including access procedures;
(IV) Tumours of the skin of the head and neck;
(V) Reconstruction in head and neck oncology;
(VI) Thyroid disease;
(VII) Salivary gland disease;
(VIII) Tumours of the nose and paranasal sinuses;
(IX) Management of the facial nerve.

There were few concessions to recent developments in H&N practice, holistic principles of care and those non-technical surgical skills (NOTSS) (9) now recognized as essential for humane and effective patient management, so an update was indicated.

New curriculum (*Table 4*)

A new curriculum based on an expanded and developed syllabus is shown. This considers scientific and technical advances, new developments, alterations in practice, and aims to provide for the widest exposure for a fellow regardless of parent specialty, subject to that area being available in the hosting unit.

The rewritten curriculum is now complete, includes specific aims, objectives and learning points for each of the key topics and tailored achievements for the chosen advanced areas. It is awaiting sanction by the JCST and General Medical Council before implementation. It expanded to cover many new areas.

These included those generic essential skills in

- Holistic management of head and neck cancer patients;
- Good communications;
- An understanding of the important and widening non-surgical oncology treatment options in head and neck cancer [systemic anti-cancer therapies (SACTs)];
- A more anatomically based division of sites using International Classification of Diseases (ICD) indices;
- Specific modules covering the recent developments in sentinel node principles, laser surgery, and transoral robotic surgery, longer term rehabilitation and skull base tumours;
- As thyroid cancer was initially bundled with head and neck in the UK there is a specific module allowing a trainee to take up this area and provide succession in staffing for the specific thyroid cancer MDT structures in the UK.

The flexibility of the new proposed syllabus permits a trainee from any parent specialty to explore new areas whilst developing skills essential for collaborative working in a MDT. The eventual product should be a clinician with a very broad grasp and understanding of clinical practice in the H&N sphere and "expert" level skills and knowledge in whichever area is of most appeal or best suited. This suits the declared future direction laid out in "The future of Surgery" (9).

Performance of the programme

As part of the quality assurance process a regular review of the achievement of fellows completing and moving on to clinical practice is pursued:

Gavin Watters, in his quality assurance role ran a review of the outcomes and ongoing performance of all previous H&N TIG Fellows, sampled in the 2018–2019 period (10), and found that:

Trainee verbal and written feedback was generally positive, with favourable aspects quoted in a 2018 feedback exercise being:

- "Joining up skills" across specialties;
- Flexibility in taking up training opportunities;
- Good supervisor support;
- Bespoke timetables;
- Plenty of operating time;
- Pay opportunities by providing (non-mandatory) paid acute on call cover.

Invited suggestions for improvement included:

- Increased access to some specified procedures, including thyroid surgery/robotic surgery;
- Avoidance of competition with other standard trainees;
- Elimination or minimizing of non-specialist clinics and work;
- More independent operating.

The specific data from the questionnaire answers (21 responses from 23 contactable past H&N TIG fellows) demonstrated:

- Steady uptake of posts in years 2013–201 7 and increase from 2017;
- 80% of fellows remained as core members of a head and neck cancer MDT;
- Nearly 20% now had a leadership or significant directional role in head and neck cancer MDTs;
- 10% had progressed to national level leadership roles in head and neck cancer and H&N training;
- Over half also participated in other parallel MDT processes for allied cancer types (thyroid, skin cancer teams);
- Over 50% of fellows secured their consultant post before completion of the TIG Fellowship year, with over 80% employed in senior roles within 12 months of Fellowship completion;
- 90% were at the time of survey still in predominantly head and neck clinical practice;
- Almost universally (>90%) those now in head and neck senior practice still contributed to their parent specialty general emergency cover rotas;
- Nearly 20% of fellows had become leads for national head and neck cancer related projects/trials [UK National H&N audits (DAHNO & HANA)/ British Association of Head & Neck Oncologists audits/UK National consent audit];
- Individuals' research activity post–fellowship was variable (bearing in mind the differing periods from completion) with 15 fellows producing a total of 44 peer reviewed articles. Seven of these had published more than 4 papers and one individual wrote 29 publications in the post fellowship period;
- Assessing the overall value of the H&N TIG Fellowship experience in preparation for a future career, 90% of fellows rated it as "Extremely valuable" and 10% "Quite valuable" with no responses in neutral or negative indices.

Threats to the programme

Due to several reasons, some key prominent UK head and neck centres either withdrew from or never participated in the TIG (H&N) Fellowships scheme. The centres in Bristol, Birmingham, Nottingham, Liverpool, Glasgow, Cardiff, Edinburgh and other major city cancer centres to date have either not joined the programme—or withdrawn following initial engagement.

The underlying reasons, elicited by informal enquiry, included:

- Some hosting units were disappointed with the ability/knowledge/surgical skills demonstrated by a commencing fellow deemed apparently suitable by the National Selection process.
- There was some unwillingness to change the format of available training opportunities or balance of power of the main specialties in favour of a strict "one third equal" split of timetables between OMFS, ENT and plastics; this was an essential of the last round of unit applications.
- For some units the demand from overseas applicants making a more lucrative or prestigious prospect of in-house fellowships was more attractive than the TIG Fellowship scheme.

Clearly this causes real concern—as, if some major UK head and neck units with established reputations have

disengaged or remained outside the framework of the TIGF programme, there could be an existential threat to the future of the UK scheme.

If the concept is to produce experts, to man and run the UK national MDT system for management of head and neck cancer, then taking on an overseas fellow is not contributing to this as the product will most likely be exported elsewhere in the world. This might be reputationally desirable by the institution but leaves the UK somewhat the poorer. In very big units it might be possible to host both overseas and UK TIG (head and neck) trainees but interference with "ordinary" Specialist training for PS, ENT and OMFS must be avoided.

The UK General Medical Council is considering the application of the concept of credentialing to specialist practice. One possible eventuality is that a clinician may need to have demonstrated extra specific and specialist training to be granted credentials in each surgical remit.

If successful completion of a UK Training Interface Group Fellowship was to become, he accepted threshold for such credentialling, it would virtually guarantee viability and a future for the programme—but the production of new Fellows completing each year may not be sufficient for replacement of losses of those departing clinical work by retirement and natural wastage. Current factors, including the SARS-CoV-2 pandemic, contractual changes in work patterns, changes in pension arrangements, some clinician burnout, and a progressive re-evaluation of life priorities has seen a depletion of the ranks of senior H&N surgeons as in all areas of clinical practice (11,12).

Most UK MDTs have seen older surgeons elect for early retirement, some admittedly to return on a reduced commitment. Relying on continuous service through to national retirement age is now no longer certain. Replacements only arrive after a prolonged and arduous process. There is no training shortcut or equivalent to "just in time" manufacturing.

Standard surgical training programmes only allow Trainees a 6-month period of grace from achievement of the necessary completion outcome, to remain in training for bolstering clinical experience before their departure to seek or take up consultant appointments. This was to accelerate the throughput of the training continuum and now no "lingering" in training is possible.

If the pressure mounts further to fill H&N specialist posts urgently, it is likely there will be a strong disincentive against yet another stage of training before starting as a productive H&N surgeon. Indeed, recent years have seen some trainees, clearly dedicated, and committed to H&N practice, eschew a TIG Fellowship in favour of securing a consultant appointment immediately on offer, with the intention to "learn whilst in post". There seemed to be no apparent disadvantage in choosing not to pursue a fellowship—and consultant posts were available due to employment market forces. This arguably could lead to a workforce which, over time, would be less developed and/or skilled at the point of appointment to the position of consultant surgeon. The impact of this on workforce productivity, patient treatment pathways and outcomes remain to be evaluated and seen in the coming decade.

The limited numbers emerging from the TIG Fellowships currently may not be adequate to maintain the regional MDTs unless wider recruitment of host Units occurs, and this may face the same resistance as from those eminent units not participating at present.

To attract units to host TIG Fellowships in Head & Neck it may be necessary to be pragmatic—at the last review of the application process it was stated that host Units should demonstrate a definitive 3-way split in the timetable offered, covering all 3 parent specialties equally in terms of exposure, sessional commitment, clinics and operating opportunities.

Given that many units have evolved to what they are now; due to the complex interactions between those contributing, in some locations PS may have a greater influence, in some the ENT axis is dominant; OMFS varies in its relevance from a small part to main provider of H&N from region to region. Fitting to a specified mandatory distribution of timetabling could thus be difficult—or impossible, effectively discounting that unit from hosting a H&N fellowship, however expert, prominent or successful the head and neck cancer service is.

The point is that despite this, some of the units are recognized H&N surgery centres of real prominence, with international reputation—and as such will have good quality evidence-based treatment strategies and principles of care: as the components of a good cancer service in H&N are largely specified and dictated by national policy, it is only the "How" of providing training which is to be settled: provided the curriculum coverage is complete and the outcome assessments are met by a fellow, supported by trainers and educational supervisors, that trainee will be successful—regardless of who taught them and which specialty they represent, ironically one of the prime

reasons why the UK TIG head and neck surgical oncology fellowship programme exists. This may offer hope for the future—most certainly the next couple of years will be decisive as to whether the TIG Fellowships survive or lapse.

Philosophical points

One key question any programme should consider is "What will the outcome be" in terms of the final product.

If TIG Fellowships take a "nearly complete" trainee surgeon, introduce them to areas of H&N practice they have little or no experience of, widen their appreciation and grasp of areas outside their parent Specialty—and the ultimate result is that surgeon simply returning to the original specialty, better educated but with no wider contribution, is it a positive outcome? Does it justify the expense and administrative burden of a formal fellowship programme? These are potentially important 'hidden' added value educational and training experiences for which an objective measure of output does not exist.

If on the other hand, a new breed of early days consultant, able literally to turn their hand to any area falling within the remit of H&N oncology was the result, this might justify a new Specialty altogether, divorced from ENT/OMFS/PS—rather as vascular surgery or bariatric surgery split from surgery in general. Such a group would be small and costly, possibly separate enough to not contribute to the emergency cover of the parent specialties, and might or might not have equitable access to all the traditional resources, space, clinical treatment and equipment each parent specialty enjoys.

Additionally, cover provision for complex cases with high-risk airway or microvascular reconstruction issues would be intense and onerous to the point of being unsustainable unless in a very large centralized unit, with multiple similar super specialized clinicians processing a very large workload—a pattern followed in some Asian countries with great success.

Whether this would be acceptable or sensible in the United Kingdom remains to be seen—the next few years, the uptake and progress or success of the new curriculum, and wider UK medical directions on generalist practice, credentialing and national healthcare resource implications after the impact of the SARS-CoV-2pandemic (13) will probably dictate future specialist head and neck oncology training—and survival or otherwise of the UK TIG Fellowships.

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