The first week as a maxillofacial surgery senior house officer (SHO), as the majority of past and present SHOs will tell you (and the ones that don’t are lying!) is a scary business. The learning curve at first seems impossibly steep and suddenly being required to function in a hospital environment is an overwhelming and daunting prospect. It doesn’t matter how much you prepare beforehand, there is no substitute for getting in there and experiencing the job first-hand.

I can vividly remember feeling completely shell-shocked, crawling into bed fully clothed and curling up into a ball after my first day on-call. My legs hurt. My brain hurt. I wondered just what I’d got myself into. Eleven months on and looking back, it’s incredible to see how far my colleagues and I have come compared to the startled rabbits we were in August 2009 when we started!

Of course, we by no means know it all and it would be ignorant of us to think that, but gaining an understanding of how a maxillofacial department works, enables us to follow the right pathways and ask the right people to manage most situations.

An important skill

Working as part of the maxillofacial team is probably the most important skill to master early on. “Teamwork” always seems to be a buzzword thrown around a lot in the workplace environment, but within the hospital setting I’ve seen first-hand how essential it is. Everyone in the department – SHOs, middle grades, consultants, receptionists, secretaries, nursing staff, theatre staff, technicians, etc, all work together to provide continued care to the patient. As soon as one part of the team fails to carry out their role, the system begins to break down and places additional strain on the others.

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The duties of an SHO vary hugely depending on the unit...
you work within, though typically, this will involve working on consultant clinics, pre-assessing patients for theatre, conducting your own minor oral surgery lists, ward duties and of course, being the dreaded SHO ‘on-call’ for the department, which tends to be the most demanding, exhausting and exciting part of the job – you never get the same day twice! Knowing when you are out of your depth is vital.

There’s no shame in calling your registrar if you’re stuck, and all the team members (nurses in particular) have a broad knowledge and can be an invaluable source of information – remember they have seen years of SHOs come through the department, making the same mistakes; filling out X-ray forms incorrectly, struggling with cannulas, fainting in theatre...

First point of contact
Being the on-call SHO means being the first point of contact for the department. Receiving referrals from other hospitals, A and E departments, walk-in centres, GPs and GP surgeries across your region, one of the most important skills to masterearly on is to assess the urgency and appropriateness of the referral to assess whether a patient is fit for transfer. The nature of referrals varies widely and often depends on the department you work in. From my experience from working in a busy city centre hospital in the North East of England, a significant volume of referrals tend to be for facial trauma (frequently including facial lacerations, zygoma, mandible and infra-orbital fractures to the more severe complex poly trauma cases).

Adrenaline rush
It’s a unique chance as a dentist to truly work on the medical ‘frontline’ and there’s never a dull day when a potential neck stabbing, road traffic accident, shooting, or airway compromising swelling could be coming your way the next time the phone rings. The dreaded ring tone will be etched in your brain and it’s an amusing phenomenon watching a room full of SHOs jump in unison as soon as it rings! Though you can’t beat the sudden burst of adrenaline (and panic!) when you hear the words from a tense sounding A and E registrar “Fias in resus, we need you here now!”

There will be times when you feel exhausted and tempted to dropkick the on-call phone across an overflowing A and E department at 4am on a Saturday night as the revellers begin to roll in, and you sometimes will be on shifts where you feel totally overwhelmed.

For me, the major stresses came not so much from the nature of the work, but the sheer volume. You have to constantly reassess the tasks that need to be done and more importantly prioritise who must be treated first – something which can be really tricky when A and E staff start breathing down your neck about patients who are close to ‘breaching’, but you’ve got to put your patients interests first rather than work to targets.

Learning curve
There are times when it’ll feel like the worst job in the world, but equally there are times when your shift ends and looking back you can’t believe what you’ve managed to achieve and what you’ve learnt. Nothing beats the job for hands-on surgical experience. You’ll pick up some fantastic skills in examining patients, facial suturing, dento-alveolar surgery and so on, as well as other, slightly more bizarre skills, like the ability to go from fast asleep to running down the corridor in 10 seconds flat and being able to present a ward round of patients coherently to a room full of consultants after being awake all night closing lacerations. I’m just concerned I’ll find going back to dentistry a little dull in comparison...!

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About the author
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