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Inaugural address

The Master — RONALD MACBETH

I AM calling my address 'Quo Vadis?' because a number in our Specialty and outside it have been wondering where we are going. When the antibacterial drugs became established, persons with axes to grind began to tell us that ours was a dying specialty, and some of us believed it. The take-over bids were already being prepared. Luckily it never came to public execution, or public auction, because on the one hand it became clear that Penicillin would not cure everything, and on the other we developed techniques in our various branches of endeavour which were quite foreign to those who would take us over.

The specialties began to evolve after Pasteur, Lister and Jamie Simpson enabled so many areas of surgery to open up. Then it became impossible for any one man adequately to cover everything. It is no accident that the areas furthest away from the main stream of surgery were the first to become specialties in their own right, and Ophthalmology has the priority in this regard, with ourselves as runners-up. One must become interested in the classification of the specialties as they are evolving before one can express any opinion about our own. When I was a student in the mid-1920s, one of the senior surgeons at King's, who had just missed being dresser to Lister, used to complain that everyone was a specialist and that there was only a small area around the umbilicus left

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to him. He described himself as a Periomphalologist. But King's was in the vanguard among the teaching hospitals in already having departments of Orthopaedics and Urology.

One can classify the specialties into anatomical, systematic, technical, chronological, and permeating, and it is not difficult to give examples of each. For example, under Anatomical one might put Cardiology, Dermatology, Ophthalmology and our own Specialty. Under Systematic one could put Neurology, Orthopaedics, Gynaecology with Obstetrics. The Technical specialties are those which are in a sense secondary and can have no independent clinical life—Pathology, Anaesthetics and Radiology. The Chronological specialties are really specialties of convenience; it is obviously best from an organizational point of view to treat medical illness in children and in the old in wards adapted to the needs of their age-groups. The permeating specialties include Public Health, Social Medicine, and Administration.

The groupings Anatomical and Systematic are, however, far from being hard and fast and the specialties slip easily from one group into the other. Neurology and Gynaecology are obvious examples, and our specialty could find its place partly under Respiratory Diseases and partly under Special Senses. Otology and Laryngology started as medical disciplines, but Rhinology seems always to have been part of surgery. As Otology and Laryngology became more surgical, Rhinology became their obvious meeting ground. If for no other reason, therefore, I like to think of our specialty as being anatomically whole.

In the earlier part of this century, many teaching hospitals in this country had Ear Departments and Throat Departments, but nasal disease was treated in both. It is interesting that the trend has been to unify the two and I believe that the Royal Infirmary, Edinburgh, was unique in having an E.N.T. Department from the start. It is true that at the Royal Society of Medicine we still have Sections of Otology and of Laryngology. Their origins were based on history, and in fact their continuance has many practical advantages. In the 1930s, the Otological Section was less well attended than Laryngology, and indeed it met in the Society's smaller hall, but the Fenestration operation and the advent of micro-surgery have so enlarged the techniques open to Otology that now it is the better attended. There are signs that micro-surgery and electron-microscopy may give a much-needed fillip to Laryngology.

The techniques of Otology and Laryngology are at present so far apart at their extremities as to prompt the question, should they separate? It is true that Otology with its subspecialty Audiology might claim to be as viable as Ophthalmology. Laryngology, on the other hand, would need to engulf neck surgery or be engulfed by those general surgeons interested in the neck. Rhinology could not possibly survive as a viable entity, and it similarly might find itself flirting with Cranial Surgery.

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I think that this might produce mis-shapen offspring, and that Rhinology's natural partner is Laryngology.

If Otology were to go off on its own it is difficult to know how a sensible training programme could be worked out. I assume that the tonsils and adenoids would become the property of laryngo-cervicology (if this word of doubtful ancestry can be pardoned), and every time an otologist felt that these lymphoid masses should be adjusted, he would need to call in an expert in the other field. This is surely a *reductio ad absurdum*.

And if the laryngo-cervicologist were basically a general surgeon his appreciation of the physiology and surgical pathology of the area obviously must be suspect. At operative level he has no peritoneum in the neck to help him, and to cover up his technical shortcomings.

Like every other specialty, ours contracts in some directions and expands in others. We have virtually lost bronchoscopy and oesophagoscopy to the chest surgeons. This is logical and we must not weep about it. But I notice that if a patient comes up at night with a foreign body in the air or food passages, there is a certain reluctance on the part of the chest people to deal with him. On the other hand we have gone out into the neck in order to deal with the consequentials of pathology in the air and food passages. This is logical, too, but the techniques would seem to be a long way from the operating microscope. I think, however, that we must refrain from including the Thyroid gland in our field—even though it is derived from the primitive fore-gut—because the expert in the surgery of the Thyroid must be an expert in the medicine of the Thyroid too. Perhaps the most interesting problems of general medicine and pathology which will affect the laryngologist lie in the struggle to find the basic causation of cancer. We seem to be poised upon the brink of far-reaching discoveries in the related fields of virology and biochemistry. My guess is that before the end of the century our need to operate for malignant disease will contract to vanishing point, and that the Radiotherapists will be out of business altogether.

Although this Conference is academic by definition, I feel that I must digress at this point into a look at the background in which we are allowed to conduct our specialty in this country. At the moment we are a free and unfettered group. We have won our independence because we have insisted that we have something useful to contribute. A very high proportion of our patients are, and have been, children. The Ministry, however, seems to have become obsessed by a sloppy sentimentalism about children, and evidence is not lacking that behind this attitude are certain influential persons whose co-operation we value, but whose domination we must staunchly oppose. It is vital that we do not surrender our children's beds (or indeed any of our beds) to another Department, with the corollary that we wait on its kind permission to do operations

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which we (as the only competent experts) have decided are desirable, and with the further corollary that we surrender the after-care to others.

I believe firmly that all patients being treated for E.N.T. diseases are best cared for in E.N.T. wards, and by doctors and nurses specially trained in this field. Here I would pay tribute to the Midland Institute of Otolaryngology whose Diploma in E.N.T. nursing has done so much in providing a specialist incentive for our nurses, and ensuring that there is a continuing supply of good ones.

The final item at which to look is our higher specialist accreditation. In the English-speaking world we have systems of higher practising diplomas based upon the concept of professional rather than academic proficiency, and issued by professional Colleges and Boards rather than by Universities. In many countries on the Continent of Europe and in countries having a European culture, the hall-mark of a specialist is an academic thesis. I believe ours to be the better system. University recognition by higher degree and by academic title should come in later and for the relatively few. I am quite certain that since the R.C.S. of England has followed the lead of its elder sister in Edinburgh in granting a Fellowship in Otolaryngology, the standard of work in our specialty in the United Kingdom and Commonwealth has improved enormously. The next step must be to persuade the Universities that ours is a scientific area in which there are many academic problems well worth solving, and to give us Chairs devoted to our work. Because so much of our work is far away from the main stream of surgery our academic budget and organization must be totally independent.

So where does all this lead us? I have tried to show that any single head of our Medusoid specialty is too narrow to survive on its own and that all three are inextricably linked. It is logical, therefore, that our training programme and our specialist accreditation should be in the diseases of the Ear, Nose and Throat. Dr. Hall in his Master's Address in 1963 truly said that no man can be an expert in all aspects of our work. I would suggest, however, that at some stage in his training he can logically become competent in most of those aspects, but if one individual within the wider framework becomes an expert on the Oval Window, and another an expert on the Cricoarytenoid articulation, then I would say 'Good Luck' to both of them.

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