Societies' Proceedings

The Education of an Otolaryngologist

By T. G. Wilson*

Medical education, including postgraduate education, is very much in the news today. During the last couple of weeks alone two important articles on the subject have appeared in the medical press.

One of these is the report of a conference on the training of specialists which was held at the Royal College of Physicians on 31 October and 1 November (*Brit. Med. J.* 1966). This meeting was sponsored by the Royal Colleges, and the 92 invited participants included six representatives of hospital junior staff. A representation of 6 among 92 would not appear to be too many, for amongst these young men are the future leaders of our profession. Many of them are in the middle thirties and married with a family. Professor Charles Wells (*Ann. R.C.S. Eng.* 1966) says that they are "realistically, if not overgenerously, remunerated". Whether this is true or not is a matter of opinion: they are certainly about as well paid as a bus-conductor, if not as well as the average dock labourer.

Nothing very much came out of this conference. Dr. Yellowless of the Ministry of Health said that "present conditions (of postgraduate education) were not ideal". Dr. J. R. Bennett said the present system of postgraduate education was "a non-system". Finally, Sir Robert Aitken spoke of a conference of the medical subcommittee of the Committee of Vice-Chancellors and Principals with the deans and postgraduate deans of medical schools held in July 1966, which had recommended the formation of a small central committee for the organization of postgraduate study.

The second article is a conspectus on *Surgical Education and Training* from the International Federation of Surgical Colleges, published in the November issue of the *Annals of the Royal College of Surgeons of England*. This is a comprehensive review of medical education from late school-days onwards. Part 2, section 3, is headed *Post-graduate surgical education and the major specialities*. In it neurosurgery, ophthalmology, gynaecology with obstetrics, orthopaedic surgery, plastic surgery, thoracic surgery, vascular surgery, and urology are all spoken of, but there is no mention whatever of otolaryngology.

This is strange: very strange when one reflects that in the United Kingdom there are about 850 "general surgeons" and 1,000 specialist surgeons, of whom 300 are otolaryngologists. Is it the case that otolaryngologists are not to be regarded as surgeons, as urologists, for instance, are?

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My own particular interest in this matter goes back about ten years to the time when I was first appointed one of the two representatives of the Royal College of Surgeons in Ireland to what was then called The Reciprocity Committee. This was a small committee consisting of two representatives from each of the Royal Colleges in these islands. Its function was to co-ordinate the Primary Fellowship examination. The Royal Colleges of England, Scotland and Ireland had agreed to allow any candidate who had passed the Primary Fellowship of any one College to take the Final Fellowship of any or all of the other Colleges; and it was obviously necessary to ensure that the standard of all three Primaries was the same. To this end the Reciprocity Committee was established.

The worth of the Reciprocity Committee was soon very evident, and its scope was soon extended to all matters jointly concerning the welfare of the Royal College in general. Its name was therefore changed a couple of years ago and it is now called The Joint Conference of the Royal Surgical Colleges.

This Conference takes place annually at the headquarters of one of the Royal Colleges in these islands. They are four in number—England, Ireland, Edinburgh and Glasgow. Australia, Canada and South Africa also join in our deliberations.

At the meeting last May a Memorandum concerning postgraduate training in the surgical specialties was discussed. This was defined as the training a registered medical graduate requires in order that he should be recognized as suitable for consultant status in the National Health Service.

This Memorandum was sent from a committee representing the British Orthopaedic Association, the British Association of Plastic Surgeons, the Society of British Neurological Surgeons, the Society of Thoracic Surgeons of Great Britain and Ireland, the British Association of Urological Surgeons and the British Association of Paediatric Surgeons. It will be noticed that again otolaryngology is not included.

This Committee of the Specialist Associations made a number of recommendations. Briefly, they are:

(1) That before embarking on training in any specialty the postgraduate should have a sound knowledge in a wide field of general surgery.

(2) That the Fellowship of one of the Royal Colleges, being "an indication that a satisfactory understanding of surgery has been achieved" is "an essential prerequisite for higher specialist training". The Associations hoped that "the present general nature" of the F.R.C.S. Diploma should be maintained. In other words while recognizing the great importance of the Fellowship they specifically do not wish to establish specialist Fellowship examinations.

(3) They welcome the new Fellowship requirements of the English College because these regulations ensure that all Final Fellowship candidates will have some experience of general surgery, of accident and emergency surgery, and of one specialist subject.

They consider that the four year period after qualification leading up to the Final F.R.C.S. should be organized as follows:

(*a*) The pre-registration year (prescribed by the G.M.C. and administered by the Universities).

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(*b*) A rotating appointment of two successive years within one hospital group. This will comprise:

Two periods of 6 months general surgery.
One period of 6 months accident and emergency surgery.
One other period of 6 months in one other specialty.

(*c*) A year in any post in the British Isles recognized as suitable by the Royal Surgical Colleges.

At the end of this time the trainee has got his Final F.R.C.S. and he is now ready to start training as a specialist. The Committee of surgical specialists whose Memorandum I am quoting consider that this post-Fellowship training should take "3 or 4 years" and that it should be the concern of the Councils of the Royal Surgical Colleges. These 3 or 4 years should be kept elastic so that considerable variation would be possible; for instance the trainee should be able to devote 12 months or so to foreign travel or to the study of research methods.

Such organized post-Fellowship training would, it is claimed, save time when compared to what has been called the present "lack of system". Training could be completed in 7 or 8 years following qualification and the young surgeon would be ready to compete for consultant appointments by the age of 32 or 33.

Opinions are divided as to whether or not at this stage it would be a good thing to give the young surgeon "a certificate of completion of training" which would have the same purpose as but would differ in form from the Diploma of the American Boards. The Associations do not suggest that he should submit to a formal examination at the end of his period of apprenticeship.

That is a summary of the Memorandum of the Committee representing the surgical specialties. I should like now to make some brief comments on it. These are my own views, not necessarily those of my College.

(1) To begin with, there is no mention of the M.Ch. degree. The reason is that this degree is the concern of the universities, not of the Royal Colleges. The requirements of the various universities vary enormously. In Dublin University, it is an examination in general surgery of equal standing to the Final Fellowship, *plus* a thesis. In other universities it is an examination only, and in others again it is what I personally think it should be, an examination by thesis alone. I should like to think that it would be possible to persuade the Universities and the Colleges to co-operate to the extent of allowing those who have passed the F.R.C.S. to take the M.Ch. by thesis only.

(2) Secondly it brings up the question of the specialist Final Fellowship in Otolaryngology.

The Memorandum I have been discussing was drawn up by a Committee formed by the six specialist Associations named in it to consider surgical training in all the specialties *except* otolaryngology and ophthalmology. The general surgeons have I understand now also applied to be represented on this committee, which confirms the view many of us hold that there are now no general surgeons. Otolaryngology is now also represented through the prompt action of the British Association of Otolaryngologists under the chairmanship of Mr. Myles Formby.

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Our specialty which is, of course, the oldest of all specialties, was presumably at first excluded because we have our own Final Fellowship examination. This fact seems to have resulted in our being regarded as something outside the main stream of surgery. No doubt many of you were present, as I was, at a dinner of the British Association of Otolaryngologists when it was publicly implied by the then President of the Royal College of Surgeons of England that our E.N.T. Fellowship was of lower standing than the ordinary Fellowship in general surgery. What he said was that we might in time regret that we "did not take the full Fellowship".

No doubt many of you were also present at the dinner of the British Association of Otolaryngologists last month when the distinguished new President of the Royal College of Surgeons of England suggested that we otolaryngologists should institute our own Primary Fellowship examination, citing as an example the fact that the Australasian College of Surgeons had done so in ophthalmology, and apparently regretting that British ophthalmologists, after considering the idea, should have decided not to follow suit. The British ophthalmologists were very wise: what Mr. Atkins had forgotten was that if they had indeed established their own Primary Fellowship they would have foregone the valuable privilege of reciprocity, as the Australians have done. Professor Wells makes a somewhat similar mistake in the article (*Ann. Roy. Coll. Surg. Eng.* 1966) already referred to. He says, supporting the Australian action, that "in the Royal Colleges anaesthesia has established its own Primary". This is, of course, misleading. What the anaesthetists have done is to establish a Primary examination for the Fellowship of the Faculty of Anaesthetists, not a Primary for the F.R.C.S.

Reverting once more to the Memorandum of the Associations of Specialist Surgeons, it will be realized that to some extent much of the suggested programme of training is directed towards the training of overseas postgraduates in the various specialties. This question has been discussed at length, not only at the Joint Conference, but also at the Advisory Panel on the Training of Surgeons set up by the Royal College of Surgeons of England. On this body the interests of otolaryngology are very ably looked after by Mr. F. C. W. Capps. The Panel has established a valuable "pilot scheme" for surgical tutors in the Regions.

Both these bodies are very conscious of the fact that not long ago a number of overseas postgraduates used to come to these islands, spend 2 or 3 years studying for the F.R.C.S. while doing no clinical work; and then, having passed the Fellowship, go back to their native land and take up the practice of surgery having had little or no practical training. This obviously undesirable state of affairs has now been partly remedied. The Final Fellowship has to some extent come to be regarded as more a theoretical than a practical examination, its function being to ensure that the candidate has the necessary academic attributes required by a surgeon; and it is now considered that his practical training should take place subsequently. Having passed the Final F.R.C.S., say 4 years after qualifying, embryo surgeons should have a further period of 3 or 4 more years of clinical training. It had been suggested that in future the F.R.C.S. may not be fully granted until after the satisfactory conclusion of this period.

These two bodies, the Joint Conference and the Advisory Panel, therefore

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arrived independently at much the same conclusion as the *ad hoc* Committee of the Specialist Associations.

Another matter for consideration is that Great Britain and Ireland will almost certainly be members of the Common Market in 5 or 6 years, possibly sooner. Graduates from all member countries may then, perhaps—or perhaps not—be eligible to practise in any one of them. If this surmise is correct, uniformity of training in these islands in all branches of surgery would be desirable, and obviously it would also be desirable that our methods of training surgeons should be similar to those practised on the Continent. For this reason I have invited our distinguished colleague, Professor Rüedi of Zurich, to come and speak at this meeting. American methods of training are also obviously of extreme importance, if only because so many of our young men are going there, and Professor George Shambaugh, Jr., of Chicago, the famous son of a famous father, has also honoured us by coming here today to tell us about them.

To sum up, therefore, my views are:

(1) That the fact that we have our own Final Fellowship examination seems to have resulted in our being regarded as something outside the main stream of surgery.

(2) To remedy this situation our young men should, in common with the trainees of other specialties, complete their preliminary training by taking the F.R.C.S. in *general* surgery within the first 4 years after qualification. In saying this I wish to emphasize that I intend no criticism of our special Final Fellowship as it is now administered, merely to suggest that its existence is not in the best interests of our specialty.

After this he should normally undergo another 3 or 4 years training in otolaryngology. Whether or not he should be granted the full Diploma of F.R.C.S. before the end of this period is a matter for discussion.

(3) If it is desired to take the M.Ch. degree, this should be done during this period. The M.Ch. is controlled by the universities; unlike the Diploma of F.R.C.S. there is no correlation of requirements for this degree and it is desirable that some uniformity should be established. In my opinion the M.Ch. examination should be by thesis only for candidates who have passed the F.R.C.S. Those who have not passed the F.R.C.S. might be required to pass a formal examination similar to the Fellowship: in other words those who have passed the F.R.C.S. should only be required to present a thesis, but this thesis should be of the highest standard.

(4) It seems to be as certain as anything can be that Great Britain and Ireland will be in the Common Market within 5 or 6 years or less. That some sort of uniformity of training should be instituted not only between otolaryngology and other specialties in these islands, but also with Europe and America would seem to be not merely desirable but ordinary common sense.

(5) Finally, in my view, Sir Robert Aitken's plan (*B.M.J.* 1966) is an excellent one. This is that a small committee should be formed, composed of, say, six representatives from the universities and six from the Colleges, whose function would be "to keep itself fully informed of regional events, give advice when necessary, and negotiate with the two sources of finance—the University Grants Committee and the Ministry of Health".

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