

Editorial

There are no average otologists . . .

(JACK HOUGH)

Conservative or reconstructive microsurgery of the middle ear has developed during the lifetime of today's practising otologists. The discovery of antibiotics and the design and production of the operating microscope, micro instruments and prostheses allowed the innovative minds of the early modern era otologists the necessary scope to put into practice the principles which govern most of present day middle ear surgery.

Over the last 35 years the field of otology has witnessed a remarkable outpouring of surgical and scientific talent which has only been matched by the personalities responsible for some of these innovations.

Many of the earlier participants in this new specialty have now retired and some are no longer with us. Sadly however, in the last 12 months the specialty has prematurely lost three of its brightest stars, Jean Marquet, Ted McGee and Gordon Smyth.

This may be a good time to take stock and consider what lessons can be learned from their example. To achieve the high levels of attainment which are possible, a very high level of personal commitment is required, not only in the diagnostic and surgical fields but also in meticulous and long term post surgical review. There is no substitute for painstaking, honest, personal audit for without this it is not possible to offer patients accurate expectations upon which true informed consent can be based. It has been pointed out several times recently, especially by Gordon Smyth, that it is all too easy to offer unrealistic claims for success. Nevertheless there is every reason to be optimistic if one's audit results justify it.

There would seem to be a number of factors which influence the likely outcome of any surgical procedure, and in otology these are particularly critical. They are the surgical environment, surgical skill, the anaesthetic field, nursing competence, the working space and surgical equipment.

The development of surgical skills depends only partly on the competence of those who teach. The trainee otologist has two great advantages over other surgical specialists. Firstly, temporal bone dissection allows almost unlimited, safe surgical practice. There can be no excuse for performing any surgical procedure on a patient without gaining mastery of the anatomical and manipulative details in advance. Secondly, otology lends itself well to learning by observation. Optical viewing systems and television monitoring are now almost universal and experience has shown that otologists throughout the world are more than willing to share their techniques and tricks of the trade. The vast majority are also most hospitable. Visiting colleagues is an enjoyable way of travelling the world and making good friends. It is sad that at the last Politzer meeting, David Austin commented that nowadays there seem to be fewer visiting doctors.

The role of the anaesthetist in providing a good operative field cannot be over-emphasised. Whether hypotension is considered appropriate or not, there must be a good working relationship between surgeon and anaesthetist who should understand the complexities of the procedures.

In an ideal world, the otologist should work with a dedicated nursing team. Such suggestions are not always well received but it seems reasonable that if the surgeon can take the trouble to specialise, the nursing staff might be expected to do likewise. Overseas travel to centres of otological excellence provides numerous examples of the enormous benefit to both patient and surgeon of such well trained nursing teams.

The operating room should also ideally be dedicated to the work in hand. A large space is not necessary but a quiet space where interruptions are unlikely seems a reasonable request. Surgical equipment of a high standard is of paramount importance. This is clearly a personal matter but there is no place for penny pinching and there must be duplication of the more essential items of equipment in case of failure. The use of television monitoring should no longer be looked upon as a luxury. It is necessary for the anaesthetist and scrub nurse to be in touch with the procedure constantly, apart from any teaching role which such equipment might play.

A somewhat more contentious issue is who should carry out otological procedures. There is a case for some degree of streaming in the training programme, as applies in the U.S.A., as not every potential E.N.T. surgeon has the aptitude or interest to develop the necessary skills. There seems little to be gained by demanding that all trainees undergo a full otological experience if it is not appropriate. The potential risk to patients and the demoralising effect on the surgeon must be considered. Similar arguments can be made for some degree of centralisation. As otology becomes more specialised and certain types of pathology become less common, the necessary opportunity to remain practised in the required skills poses a problem. Under these circumstances tertiary referral must be a reasonable consideration. This of course assumes a degree of professional courage on the part of the referrer and the existence of an appropriate point of reference.

All this may seem Utopian in a clinical political climate which equates quality with quantity and discourages tertiary referral and the pursuit of excellence. The present trend would seem to be towards mediocrity and to quote Dr. Cezard from Beziers, 'l'otologie ne tolère pas la médiocrité'.

Looking on the positive side, it is reasonable to say that modern otology at its best has developed an adequate surgical response to perforation of the tympanic membrane, deafness due to otosclerosis, cholesteatoma and the majority of wet ears. There remain two obvious challenges which should be capable of resolution: the main-

tenance of hearing in chronic ear disease where the chain remains intact and reliable reconstruction of the middle ear transformer mechanism where it has been damaged. The surgical laser, bone anchored and implantable hearing aids, developments in autograft and prosthetic repair and the application of more accurate micro engineering techniques to our surgical methods, all come to mind as areas for consideration.

To complete Jack Hough's quotation '*There are no average otologists—only good ones and bad ones*'.

The challenge is clear and our predecessors have shown the way. The only question that remains is whether the new entrepreneurial health service has a place for a specialty where real quality is of paramount importance.

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