# TIME FOR SUB-SPECIALIST TRAINING OF MANPOWER FOR OTORHINOLARYNGOLOGY PRACTICE IN NIGERIA*

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## ABSTRACT

*The general Otorhinolaryngologist Head and Neck Surgeon is the expert in the art and science of the medicine and surgery of these anatomic regions. He trained to be both a physician and surgeon at same time. Those who pioneered Otorhinolaryngology manpower training locally in Nigeria in the 1980s were products of the British Otorhinolaryngology training of the 20th century.*
*Otorhinolaryngologists have associate professionals such as Otorhinolaryngology Specialist Nurse Practitioners, Speech Therapists, and Audiologists who work most often with them and may have overlapping responsibility of care. Should Nigeria embark on sub-specialty manpower trainings in Otorhinolaryngology (ORL) at this time in our country's level of ORL development?*
*We need to train sub-specialists in ORL practice but NOT to the detriment of General Otorhinolaryngology. We still have many underserved populations. The sub-specialty manpower development for ORL practice must recognize our peculiar setting of multiplicity of training needs including associate professionals. The training of manpower should have an innovative approach that emphasis the patient, teamwork and aware of social determinants of health and the national strategic health plans. The training should be such that the super specialist should still be able to practice general Otorhinolaryngology in addition to the sub-specialty.*

**Key Words**: Manpower training, Otorhinolaryngology, Audiology, speech therapy, Specialist ORL Nurse Practitioner, Nigeria.

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## INTRODUCTION

Let me start from what most of us know or should know. That is by introducing the practitioners of Otorhinolaryngology Head and Neck Surgery and Medicine:
. *'The Otorhinolaryngologist-Head and Neck Surgeon and Physician (hereinafter referred to as Otolaryngologist or Otorhinolaryngologist) is the specialist medical practitioner and surgeon that treats diseases and disorders of the ear (Otology), nose and sinuses (Rhinology), throat (Laryngology), head and neck regions. He/She is the expert in the art and science of the medicine and surgery of these anatomic regions. He trained to be both a physician and surgeon at same time. He is involved in Audiovestibular medical practice, speech disorders, sleep medicine and surgery, endoscopic surgery, allergic disorders and head and neck oncology. He/She is a key valuable member of many multidisciplinary teams.*
*'These are the clinical services work we are doing as an Otolaryngologist. We attend to all persons of every age, and sex. We take care of peoples' ears so as for them to hear, maintain their balance and learn, and be able to acquire speech. We take care of the larynx so as for them to breath, to speak, produce good voice that communicates what they hear and understand. We look after their pharynx and oesophagus so as to be able to swallow, eat and drink. We take care of the nose so as to perceive odour and breath filtered air and live healthy lives. Even when people sleep, we ensure they sleep soundly and not have airway obstructed by any defects of the body. The quality of life of all persons of every age and race depends on our work. In all these we take care of the ear, nose and throat head and neck network systems.'*[1, 2]

## EVOLUTIONAL HISTORY OF OTORHINOLARYNGOLOGY (ORL)

The history of otorhinolaryngology can be classified into the following periods:

1. What has come down to us through the ages by way of legends and folk medicine.
2. Information from the prehistoric age (before 4000 BC).
3. The Egyptian, Minoan, and Chinese periods;
4. The Greek and Hindu periods;
5. The Roman, Byzantine, and Arabic periods;
6. The Middle Ages and the Renaissance periods; and
7. The modern period (19th and 20th centuries) .[2]

Hunter K in an article traced the laudable contributions of our forebears in the evolving specialty of Otolaryngology [3]. Otology, laryngology, and rhinology started as separate specialties and only merged into Otorhinolaryngology later in the 20th century. The same schism in Medicine and surgery was present in the early decades. Then Otology was practiced by the Surgeons while laryngology was by the physicians.[4]
Those who pioneered Otorhinolaryngology training in Nigeria were products of the British Otorhinolaryngology training of the 20th century. Some of them, viz FD Martinson, BC Okafor, PA Okeowo, GTA Ijaduola, Ogan, MN Obiako (W Germany trained) and Olu Ibekwe were the ones that started Otorhinolaryngology Manpower training locally in Nigeria in the 1980s and the first primary Fellowship examination ever conducted by the National Postgraduate Medical College of Nigeria was in 1985. This was followed 6 months later by the West African College of Surgeons conducting its own primary Fellowship examinations. Prior to this Primary Fellowship examination, the faculty had advertised that success in Primary Fellowship in Surgery is accepted as equivalent to proceed to Part one Fellowship Training and that those holding the Part 1 Fellowship or full Fellowship of the Royal Colleges in General Surgery, (equivalent to Part 1) to be admitted for Residency training leading to Part 2 Fellowship in Otorhinolaryngology. The three centers in Ibadan, Enugu and Lagos were given pioneer blanket approval to start the Residency trainings in Otorhinolaryngology.
From this humble beginning, training in ORL had expanded to about 20 accredited centers across Nigeria by the two Colleges as of June 2018. Similarly, graduates of these training programs and trainees in different stages of completion of the Residency training in Otorhinolaryngology are counted in hundreds today.

## PROFESSIONAL MANPOWERS IN SPECIALTY PRACTICE OF OTORHINOLARYNGOLOGY

However, are Otorhinolaryngologists the only cadre of manpower in the specialty? I think that they are not the only ones. We work in a health care environment where teamwork is the order of the day and that working teams deliver the best care for the patients. We have Otorhinolaryngology **Specialist Nurse Practitioners**, **Speech Therapists**, and **Audiologists** who work most often with us and may have overlapping responsibility of care. These are professionals on their own right that I will call **Associated professionals** to the Otorhinolaryngologist. In addition, there are other health care providers we occasionally need to be involved in the care of our patients, as a member of a team.

The medical definition of **sub-specialty** is that it is' *a subordinate field of specialization'* [5].

Sub-Specialization is becoming fashionable these days. Even some of those answering Otorhinolaryngologist some years ago now want to be known and addressed as **Otologist**, or **Neuro-Otologist**, or **Skull base Surgeon** or, **Rhinologist** or **Laryngologist** or **Phonosurgeon** or **Endoscopist**, or **Head and Neck Surgeon**, or **Audiovestibular Physician** or any other exotic appellations. The specialty is being dissected into its anatomic parts. Some want sub specialization along patients' age lines such as **Paediatric Otorhinolaryngologist,** and **Geriatric Otorhinolaryngologist.**

We are discussing sub-specialty manpower development for the ORL practice in Nigeria. How do we do it so that it will serve the peoples of Nigeria and humanity best? Should we aspire to embark on sub-specialty manpower trainings in Otorhinolaryngology at this time in our country's level of ORL development?

## ISSUES THAT DRIVE SUBSPECIALISATION AND MANPOWER TRAINING

Factors drive growth and development of a field of study that would lead to sub-specilisation and its attendant manpower training for specialist health practice are multifactorial. Some are consciously known, and deliberate actions put in place to achieve them. Others just occur by happenstance, without planning. Some of these factors are listed below and are not exhaustive:

i. Societal needs and demands
ii. Emergent of new diseases or changing pattern of known diseases
iii. New and expanded knowledge base
iv. Innovations and improvement in science and technology
v. Availability of new tools and adaptation of known tools to other newer uses
vi. Economic/financial gains pursuit of the Practitioners

A historical survey of the progress leading to our present-day practice of the specialty will show that step by step improvements were achieved over the centuries [5]. An analysis of the above enumerated factors will guide us in our decision-making journey into time for sub-specialty training of manpower development in ORL practice in Nigeria.

*Societal needs and demands:*
The Nigeria society is currently underserved by the number of Otorhinolaryngologists and associate professions in the ORL practice. One issue with the specialists available presently is that they are not found practicing in our rural communities and even the urban areas are underserved. Thus, in addition to paucity of available numbers, there is inequality in their geographic distribution.

*Emergent of new diseases or changing pattern of known diseases;* examples here are the debut of HIV infection in the 80's and Ebola fever resurgence a few years ago.

*New and expanded knowledge base:*
Any specialty practice will be expanding with more knowledge of the diseases they treat. The knowledge base will accumulate more data and evidence that it will take more years for trainees to acquire all required skill before graduation.

*Innovations and improvement in science and technology*
In this specialty, the impact of cochlear implant and hearing aid opened a vista that some people want to subspecialize in cochlear implant surgery.

*Availability of new tools and adaptation of known tools to other newer uses*
The microscope enabled visualization of microbes and later it was its utility adapted in surgical operative procedures, creating microscopic procedures and subspecialty. We also have the endoscopic surgery evolving with the advent of endoscopes.

*Economic/financial gains pursuit of the Practitioners* Some practitioners would opt to carve out a niche for themselves to keep away competitors and play in an exclusive league of the subspecialty.

## "NO ONE GETS LEFT BEHIND": GLOBAL AGENDA 2030

Considering all the factors above, I will posit that we need to train sub-specialist in ORL practice but NOT at the detriment of General Otolaryngology. We need to guard against the problems associated with super-speculation. May I quote Kennedy *Hunter "... we must not forget what Susruta, said in the fifth century A.D.: "He who knows only one branch of his art is like a bird with one wing."* [3]

The underserved communities will be provided for by the training of more numbers of General Otorhinolaryngologists to reach the underserved rural communities. The larger numbers of those completing general Otorhinolaryngology training will be the pool to draw those who may wish to train further in any of the subspecialty areas. This will be achieved while still having more General Otorhinolaryngologists extending services to larger proportions of the underserved populace.

This will be matched with concurrent establishment of centers to train professionals who are associates of ORL professional at the highest level. If we fail to train associate professionals, the work output of the super specialists will not be efficient nor impact efficiently on the community. In addition, while pursuing sub-specialty training, we must not widen the inequalities of access to care that are already existing.

In embarking on training sub-specialists, we should adapt and align the manpower development in ORL with the national strategic health plans. Presently, the world is pursuing a *"Global Agenda"* know as Sustainable Development Goals (SDG) and its targets. The time frame for achieving these 17 goals is in the year 2030. The 17 goals are applicable to all developed and developing countries of the world. The goals are interdependent and are inseparable.

I subscribe to the position that our subspecialty manpower training and practice will make beneficial impact on our citizens if we link the ORL manpower development project to the Global Agenda 2030 especially goals numbers 3 (Good health and Wellbeing) and 4 (Quality Education) in Nigeria. Manpower training should have in focus the SDG of economic, social, and environmental dimensions of development of the country especially as it pertains to aspects of the ORL specialty. We must adopt the **5 Ps**: People, Planet, Posterity, Peace, Partnership the centerpieces of our actions. (cf. UNESCO)[6]

## THE WAY FORWARD

The sub-specialty manpower development for ORL practice must recognize our peculiar setting. We have multiplicity of training needs. The medically qualified candidates enter the training through a different gateway from the nursing officer. The gateways for entry into some of the subspecialties may be non-health such as in Audiology or Speech therapy. These diversities should be blended to build a formidable team of ORL manpower. Which areas should be made a subspecialty of its own? What will be the relevance of learning impacted? What skills and

competences will the subspecialty bring to the wellbeing of our people? Will the super specialist have enough volume of workload to justify his contract? So, which comes first; to specialize and attract large volume of work or to be designated a specialist and the volume will come there after?

We have a complexity of sub-specialties in Otorhinolaryngology. Additionally, we have multiplicities of training needs. These multiplicities of training needs could be better coordinated by a specialized institution or agency. Let me suggest we call it **Institute of Otorhinolaryngology** or any other name. It is not to be like the present *National Ear Care Center.*

This Institute will have the mandate of teaching, service delivery and research in all aspects of Otorhinolaryngology. It should have as its component bodies Colleges for awarding undergraduate and post graduate degrees of Specialist Otorhinolaryngology Nursing, Audiology, and Speech Therapy. It would be a Center for Fellowship and post-Fellowship training in General Otorhinolaryngology, Otology, Rhinology Laryngology and Head and Neck Surgery. In addition, it should have post-Fellowship training programmes in Paediatric Otorhinolaryngology, Geriatric Otorhinolaryngology as well as Primary and Community Otorhinolaryngology

This Institute will be a facility for periodic retraining and update courses for practitioners on new techniques and emerging trends in the specialty. It shall have physical presence across the various part of Nigeria.

Such Institute will most likely facilitate linkages with global partners of development. This will help in financing the manpower development needs of Otorhinolaryngology practice in Nigeria.

We must adapt to the changing times by changing our curriculum to meet the needs of the specialty. The training of manpower should have innovative approach that emphasis the patient, teamwork and aware of social determinants of health. The training should be such that the super specialist should still be able to practice general Otorhinolaryngology in addition to the sub-specialty. There is a general belief that the *best* practitioners remain in general practice as well as specialist practice, the *better* ones migrate to the subspecialty arena while the *good* ones go to the non-teaching service centres.

## CASE FOR PRIMARY AND COMMUNITY OTORHINOLARYNGOLOGY

On 30 May 2017, the 70th World Health Assembly approved a document ED139.R1 titled: Development of a new Health Assembly resolution and action plan for prevention of deafness and hearing loss [7]

*"Mindful of the Sustainable Development Goals in the 2030 Agenda for Sustainable Development, specifically Goal 3 (Ensure healthy lives and promote well-being for all at all ages) with its target 3.8 on achieving universal health coverage, which implicitly recognizes the need for persons with disabilities to have access to quality health care services, and recognizing that the targets of Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) explicitly mention persons with disabilities, and that unaddressed hearing loss greatly hinders their education and academic outcomes;.." [7]*

In reaching their resolutions,

*"URGES Member States, taking into account their national circumstances:*

*(1) to integrate strategies for ear and hearing care within the framework of their primary health care systems, under the umbrella of universal health coverage, by such means as raising awareness at all levels and building political commitment and intersectoral collaboration…"*

*(3) to establish suitable training programmes for the development of human resources in the field of ear and hearing care; …*

*(9) to work towards the attainment of Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) in the 2030 Agenda for Sustainable Development, with special reference to people with hearing loss: "[7]*

## CONCLUSION

The training of manpower should have innovative approach that emphasis the patient, teamwork and aware of social determinants of health and the national strategic health plans. The training should be such that the super specialist should still be able to practice general Otorhinolaryngology in addition to the sub-specialty.

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