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Acute ENT care, cochlear implantation and otitis media in the pandemic, and ENT post-graduate education

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Editorial

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We reach this month, the first anniversary of the West hearing the word 'lockdown', in relation to a large city in China. Wuhan is an important academic and commercial hub, but was perhaps not a place known to the majority of the world's population until a year ago. We at *The Journal of Laryngology & Otology* continue to receive a flow of articles in relation to coronavirus disease 2019 (Covid-19) from around the world, and endeavour to publish those that we feel add something new, interesting or useful.

Colleagues grapple globally with the basic sciences relevant to ENT, the practicalities and the implications for ENT services during this 'war' with a virus and its aftermath. Despite the increase in article submissions, being a journal editor at the moment is surely more comfortable than being a local or national politician.

The Oxford English Dictionary notes a dramatic increase during 2020 of words such as 'circuit breaker', 'lockdown', 'shelter-in-place', 'bubbles', 'face masks' and 'key workers'. The over-use of 'unprecedented' is often mentioned, but the Oxford English Dictionary comments: '…what was genuinely unprecedented this year was the hyper-speed at which the English-speaking world amassed a new collective vocabulary relating to the coronavirus, and how quickly it became, in many instances, a core part of the language'.[1] We approach the anniversary of the coining of 'Covid-19', which first appeared in February 2020.

This issue covers the matters of otitis media in the Covid-19 era, from Iran;[2] the feasibility of paediatric cochlear implantation, from the North of England;[3] rapid access (urgent) ENT care,[4] protection during microlaryngoscopy,[5] dysgeusia symptoms[6] and transnasal humidified rapid-insufflation ventilatory exchange ('THRIVE') during the pandemic.[7] This supplements and complements recent articles in *The Journal* on acute care, by Osborne and colleagues,[8] on ethics, by Leonard,[9] and on smell and taste dysfunction, by Jain and colleagues.[10]

The imposed unwelcome revolution in working practices has been superimposed on an evolution of education and training in ENT, not only in the UK, but around the world. Surgical colleges, regulatory bodies (such as the General Medical Council), specialty associations, hospitals, deaneries and universities have all been grappling with this. How to reconcile a need for ENT skills in the general medical workforce (general practitioners and others) and specialists with the barriers imposed by a crowded undergraduate and post-graduate curriculum? Undergraduate and post-graduate curricula are increasingly time-pressured, and a political imperative to increase throughput must be balanced against a professional desire to maintain or improve quality.

One such scheme in the UK has been 'run-through' training, in which young doctors make a firm commitment to the specialty (shortly after qualifying in medicine) and are carried right through to independent specialist practice. This issue of *The Journal* includes a representative survey of a cohort of recent trainees,[11] and shows the pluses and minuses of this pattern of selection and training, and will be of interest to both sceptics and enthusiasts of such schemes. The run-through scheme increased trainer engagement and gave geographical stability to the trainees, who were well motivated from an early stage in their medical careers. This complements surveys of the attitudes and experiences towards ENT training of students and general practitioners, investigated in recent issues of *The Journal*,[12,13] and a more historical but seminal article in *The Journal* on undergraduate ENT education.[14]

We hope sincerely that our January 2022 editorial will have a more optimistic tone and give more prominence to non-coronavirus matters.

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