Newborn infant with gastroschisis, absence of right leg, and left clubfoot.

tion about antiemetic prescribing habits in NW England. In Leeds at the time of our study more than 20% of pregnant women were given Debendox. We agree with Drs Donnai and Harris that their report should not be interpreted as meaning that Debendox is teratogenic.

R W SMITHELLS
SHEILA SHEPPARD

Department of Paediatrics and
Child Health,
University of Leeds

¹ Smithells, R W, and Sheppard, S, *Teratology*, 1978, 17, 31.

Who discovered the circulation of the blood?

SIR,—It is impossible to resist rising to Mr E G Tomich's bait or allow his letter (1 April, p 852) to pass without comment.

"Discovery" has to be shared to have reality. Many others before "stout Cortez" may have looked upon the Pacific and not realised what they had stumbled on. Equally they may have had neither the wit nor the means to publicise it. Among cognoscenti acclaim or rebuttal is an inevitable part of any "discovery" of a fundamental departure from established thought. The storm of controversy the publication of *De Motu Cordis* caused and the time and trouble Harvey and his proselytes spent refuting criticism markedly contrast with the vague and confusing (then and now) writings of Caesalpinus, Servetus, Fabricius, and others, which caused hardly a ripple. Had these latter great men really realised what they were so nearly saying it is inconceivable that there should not have been comparable interest and controversy.

Furthermore Harvey, in his fair and comprehensive survey of the state of relevant knowledge in his introduction to *De Motu*, while giving due credit to Fabricius and others, is modestly sure of his own originality.

These are just two of the many aspects that could be commented on, and the primacy or not of Harvey will be discussed for a further 400 years. Many would say that Harvey has been over-eulogised; after all, he bigotedly refused to accept the existence of lacteals and seems to have had a predilection for un-

necessary vivisection. But all this is irrelevant in any consideration of his greatness. The most important fact is that, original or no, *De Motu Cordis* is irrefutably the seed from which all modern physiology has grown. Of this we "Angli" can be justly proud.

P G BENSON

Aylesbury, Bucks

Topical glucocorticosteroids for psoriasis

SIR,—We write to support the opinion of Dr A Y Finlay and others (1 April, p 855) that the use of strong topical steroids for psoriasis is generally unacceptable. Delegates at the recent International Congress of Dermatology in Mexico held similar views. It has been departmental policy here for the past 10 years not to advise their use in the treatment of psoriasis, and in all probability this is why none in the catchment area have developed generalised pustular or exfoliative psoriasis. It has just been shown that the addition of local steroids to established regimens significantly worsened the relapse rate with photochemotherapy (PUVA)¹ as well as with dithranol therapy.²

D B BROOKES
R H SEVILLE

Beaumont Hospital,
Lancaster

¹ Morison, W L, Parrish, J A, and Fitzpatrick, T B, *British Journal of Dermatology*, 1978, 98, 125.

² Seville, R H, *British Journal of Dermatology*, 1976, 95, 643.

Fellowship in medical communication?

SIR,—“Minerva” is hardly impertinent in calling for a fellowship in medical communication (18 March, p 725). There can be few doctors who would claim that we adequately realise the possibilities of teaching medicine, but surely there is a hidden danger in implying that the problems are peculiar to our own subject?

There are, of course, aspects of any subject that require a specialised teaching approach or technique. This is certainly true of medicine, as the existence of the Association for the Study of Medical Education shows. However, I believe it is wrong to concentrate on these details without first considering the basic problem of how to teach. In medicine we still assume that if someone is an expert in his subject he is automatically qualified to teach it. This is of course a fallacy: teaching is a separate skill that one acquires by personal inclination or application, and is different from the skills inherent in removing a gall bladder or cultivating a bedside manner.

While it would no doubt be ideal to have a large number of departments involved in teaching doctors to teach, this is highly improbable at present and is in any case unnecessary. The basic problem of teaching is common in all forms of higher education¹ and has already been raised (and mostly solved) by teachers in other fields. Surely we would do well to learn from their trials and their errors. Courses specifically for doctors, like that recently organised by the Postgraduate Medical Federation, are as yet few and far between; but there is a solution much nearer at hand. The nursing profession already has a teaching structure where nurse teachers are

required to have postgraduate training in teaching methods and educational psychology. Much of the content of these courses would be good training for a senior registrar at a teaching hospital, and the attendance of doctors at courses like this is not impossible. It would simply require course places to be available to doctors and teacher training to become an acceptable reason for study leave.

Other teachers are solving problems that we have only recently started to consider. I believe we can learn from them, and with them. By all means let us set about developing specialised departments of medical communication, but let us start learning the basics from our colleagues in other fields now.

STEPHEN GOLDING

Guy's Hospital,
London SE1

¹ *Improving Teaching in Higher Education*, p 5. University of London Teaching Methods Unit, 1976.

Continuing study for doctors?

SIR,—In order to practise medicine efficiently and with humanity the doctor must continue his studies throughout his professional life. It is likely that hospital medicine will change greatly in the next decade. Now is the time to plan changes in the working week that will provide realistically for continuing study. I submit that clinicians should set aside Wednesday afternoon for academic pursuits. The advantage of a fixed half day would be great—enabling interdepartmental and interhospital visiting. At the outset it would not suit everyone, but over a time clinicians could make the necessary adjustments and new contracts should provide for this right away. The basis of a clinical afternoon could be a ward round, case demonstration, and an invited lecture. There would be time for modest research.

If it would seem to be an indulgence to provide an afternoon for this purpose it should be remembered that clinical work goes on for seven days a week and 24 hours a day. I believe the plan has merit and would like to know what others think.

E A WILLIAMS

Maternity Department,
John Radcliffe Hospital,
Oxford

Do we really care?

SIR,—As the partner of a professional firm of insurance brokers actively dealing in the life assurance market I feel that I must write to you to draw your attention to the problems encountered by brokers and insurance companies caused by delays in doctors completing medical attendants' reports. I have experienced recently excessive delays, and this could have very serious implications. For example, what would be the situation if someone who had proposed for life assurance died whilst his doctor delayed completing the medical attendant's report? To some extent we have attempted to overcome these problems by obtaining facilities from certain insurance companies allowing us to issue immediate cover where a completed proposal form is entirely free of any medical problems.

Can I suggest that the BMA and LIA really get their heads together to solve this problem before an unfortunate family is left fatherless and at the mercy of an insurance company