On the other hand, failure to refer certain cases at once may result in delay in the diagnosis of important pathological conditions in the pelvis. For example, irregular bleeding or offensive discharge in parous women are sinister features, particularly if the woman is over 30, and may be the earliest evidence of malignant disease in the genital tract. In other types of case the general practitioner, by instituting treatment without reference to a gynaecologist, may obscure and even complicate the clinical picture. We have already stressed the need for careful hospital investigation in most cases of discharge and pruritus before any treatment is begun. In this category we would also include the use of endocrine therapy by the general practitioner. We believe that there is a limited yet important place for hormone treatment in gynaecology and that cases suitable for treatment require careful selection and supervision. With very few exceptions the decision to give endocrine treatment should be left to the gynaecologist. The patient with menopausal symptoms such as we have described above and the younger woman suffering from premenstrual tension seem to us to be the type of case where the family doctor might himself prescribe endocrine treatment.

Whereas in this study we were content to record the number of patients who consulted their doctor because of gynaecological conditions, we know that this does not present the total picture of gynaecological responsibility within the practice. There are occasions when the family doctor will consider it his duty to offer advice. We made no record of the number of occasions on which this circumstance arose, but we are well aware of the responsibility of the general practitioner in this respect. The family steadily progressing over the years towards becoming a problem family, perhaps because of a rapid sequence of pregnancies and poor circumstances, presents a challenging problem. We appreciate that there are people whose religious views debar them from giving or receiving advice on family planning; their views must be respected. The general practitioner who watches such a situation unfold must exercise considerable discretion. We have known families in this practice who at one time would readily have qualified for the title "problem family," yet five years later, once the older children were out earning money, have improved their physical circumstances out of recognition and seemed then to be very happy. We have seen standards fall steadily in other families where the mother has suffered from some physical handicap. Such a mother may well survive the hazards of successive pregnancies, but those who come into daily contact with the family will bear witness to her failing ability as a good mother. Whether the family doctor, in the absence of any request, should make a positive move towards helping such women is never an easy decision to make.

There are other occasions on which the doctor, in the absence of any request from the patient, may think it advisable to suggest investigation or treatment, but it has been our experience that when advice has to be offered in this way by the family doctor it is seldom so readily taken up as when it is actively sought by the patient.

Repeatedly during our year's study we had evidence of the respect that the patient has for her family doctor, and of the importance she attaches to his opinion. Many patients, after a visit to hospital, would call on their doctor and discuss with him what had been said at hospital. Complete reliance was placed upon his ability to interpret the opinion of the gynaecologist in regard to treatment and prognosis. This presupposes a very close link between general practitioner and specialist—much closer, we suspect, than generally holds in medical practice to-day.

Much of what we have learned from this study of gynaecological responsibility in general practice is of interest and great importance in relation to undergraduate teaching. So many textbooks and teaching programmes, although they deal adequately with the common gynaecological disorders, fail to guide the student in regard to the relative parts to be taken by practitioner and specialist in the management of these disorders. Too often the student must guess the stage at which a patient should be referred for specialist opinion.

We consider that investigative work of the type we describe should be undertaken at regular intervals, for the practice of medicine is constantly changing. In this way the general practitioner might periodically review his sphere of responsibility and thus ensure for his patients the highest standard of medical care.

Summary

The results of a field study of gynaecology in a general practice in Northumberland are reported.

Details are given of the various gynaecological complaints which brought patients in this practice, during a period of twelve months, to seek the advice of their doctor. The part to be taken by the general practitioner in the management of these cases is discussed.

There is a need in teaching to define more clearly the spheres of responsibility of practitioner and specialist in the management of patients with gynaecological complaints.

We are indebted to Professor Evers for his helpful advice and encouragement.

THE TEACHING OF DERMATOLOGY TO UNDERGRADUATES*

BY

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It is a common experience for a dermatologist called out in consultation by a general practitioner to be met with the remark, "Of course, I know nothing about skins," uttered almost with an air of boasting. Many a sound practitioner will adequately cope with cases of heart failure or pneumonia, but is only too willing to surrender patients with the most trivial skin disease to the specialist. This is largely due to inadequate study of dermatology as a student, the unsatisfactory state of which in many medical schools has been shown by Peck (1955).

Need for Training in Dermatology

A comprehensive and thorough training in dermatology is an essential part of undergraduate medical education for two reasons. Firstly, skin diseases form a substantial part (about 10%) of everyday general practice; many doctors have told me that if they could go back to their medical school the first subject they would study would be skin diseases. It is surely reasonable to equate roughly the proportion of student time given to dermatology with the proportion of skin diseases in practice. Even the budding surgeon or general physician would benefit by a sound knowledge of dermatology. Too much attention is given to dramatic highly specialized subjects such as neurosurgery and cardiac surgery, and much time is wasted in theatre attendance at other operations which have little bearing on general practice and the knowledge of which should be acquired by postgraduate study. The elements of dermatology should form part of the basic training of all doctors. Secondly, the study of skin conditions displays better than any other the fundamental processes of disease, such as inflammation and repair, the effect of allergy on bacterial infection, and the influence of the mind on the reaction of tissues and disease.

Dermatology must not only be given its proper share of the students' time, but it must also have its proper status in his mind. It must be presented so that he sees it as an integral part of medicine, like cardiology or neurology, and not as some curious specialty set apart. For example, in the introductory clinical course instruction should be given

*An address given to the Dermatologists Group of the British Medical Association on May 9, 1957.

in the examination of the skin just as much as in that of the heart or nervous system.

Lectures.—I will not tackle the vexed question of whether students should or should not be given lectures, but will assume that some at least are to be given. These should certainly not be factual rehashes of textbooks but should seek to cover some aspect or reveal some principle which the student could not get from his ordinary reading. A lecture on rosacea might serve to show how a final disease picture may be the result of the interplay of several factors—gastric, endocrine, psychological, etc.; whilst a lecture on skin tuberculosis would teach the evolution of bacterial allergy and help the student to understand what happens in tuberculosis elsewhere in the body. Such lectures fully illustrated by slides could usefully be given early in the student's clinical years, but they should not be used to try to teach him masses of facts about skin diseases he has not yet seen.

Period in Skin Department

Later in his clinical training—but not too near his final—the student should spend three months in the skin department; this need not be a whole-time appointment but could be fitted in with some other subject (in Leeds it coincides with orthopaedics), but the student must devote a substantial part of his time to dermatology. During this three months he must attend the out-patients clinic regularly at least three times a week. The object of this is threefold: he must see a sufficient number of cases so that he can begin to acquire that comprehension of skin diseases and knowledge of what he is looking at which only comes with experience; he must learn to make his own rational diagnosis—by that I mean he must be able to make a reasoned diagnosis and not just turn over the pages of some skin atlas till he sees a picture which fits the patient; and he must watch the dermatologist really dealing with cases and providing an example, and I hope an ideal picture, which the student can carry with him and imitate in later life.

The first of these objects can only be achieved by frequent attendances in the ordinary out-patients clinic. It cannot be replaced by the didactic demonstration of a few selected cases, though this may be a useful adjunct at times. A student does not really grasp the difference between psoriasis and nummular eczema until he has seen many cases of each; in the selected demonstration method he is only likely to see such cases once or twice. Some selection will still be necessary to weed out an endless procession of warts, etc., from the teaching material.

Teaching the student to think and to make a rational diagnosis is the supreme aim of all teachers and for various reasons the most difficult to achieve. It cannot be done with big classes where most of the students not on the front bench sit like fledglings with open beaks waiting for the teacher to drop a nice factual worm into their mouths. With a small group of about six one can practise the Socratic method and each student in turn can tackle a patient. It is time-consuming and limits the number of patients that can be seen at a session, but it is rewarding. A further development of this is for each student to interview a selected patient in a side-room and then to present his case to the class. This can only be done in a very limited way in an average English clinic, but under ideal conditions where there are plenty of instructors it is an excellent method. I have seen it used very successfully in the Maryland Hospital in Baltimore, where each student discusses his case individually with an instructor.

Finally, the student must have the opportunity of seeing the dermatologist really dealing with cases and not just giving a demonstration, of hearing how he takes a history and watch how he carries out his examination. A great responsibility rests on our shoulders to set a good example; we must take the history carefully, we must examine the patient all over; we must do a general examination, not neglecting a rectal examination where indicated; and there must be no short-cuts. The student will also see something

of how we approach the psychological side, and, not least, he will see how we deal with a difficult patient and get rid of a garrulous one without being rude. Each one of us looking back will remember some chief whose manner and methods we consciously or unconsciously imitate, and we must realize the rather sobering fact that we ourselves are now the ones who may be copied.

During his time in the out-patient clinic the student will attend on one or more occasions the special clinics, such as those devoted to leg ulcers, lupus vulgaris, ringworm, minor operations, etc. Above all, he will take part in the daily treatment clinic and learn how to put on elastic adhesive bandages and how much ointment it takes to cover a given area of skin.

Besides the work in the out-patient clinic, he will become clerk to a number of in-patients in the same way as on the general medical firms. This will not only give him deeper knowledge of his own patients' skin conditions which he will read up, but will also enable him to develop an intimacy with a skin patient and learn what having a skin condition means to the patient in a way that cannot be done with out-patients.

Arrangements in Leeds

At some stage the student should systematically cover all the common skin diseases. Some students benefit from set lectures, but this is not a good method for the majority. In Leeds we favour a rather informal tutorial carried out by our senior registrar, who is called the dermatological tutor, during their three-months skin appointment. This occurs once a week and is illustrated by coloured slides and is part lecture, part discussion, and systematically covers the major skin diseases. An alternative is for the student to read systematically himself. Some students will do this, but many will not, and so the method of "assigned reading" may be used. The class is given some subject to read up and the next morning they are quizzed for 10 minutes on their subject. Here, again, time and adequate instructors are required.

The question of incentive is an important one. Idealists say a good teacher will attract the students, and if they do not attend it is his fault and the students cannot be blamed. But students do not always recognize what is in their best interests, and many live to regret their failure to attend certain clinics or take certain subjects seriously. Some form of examination is essential not so much as a test of knowledge but as a stimulus to the student to work. Any subject which is not represented in the final examination loses status in the strictly practical eye of the student, and this attitude is likely to persist even apart from examinations. On the other hand, one does not want to increase the heavy burden of the student at his final examination. I feel our arrangements in Leeds are reasonable. There is one compulsory skin question in the finals, set and corrected by a dermatologist, or rather by two dermatologists, one internal and one external; in the clinical examination one short case is a skin condition on which the student is examined by a dermatologist and a general physician. Edinburgh has a somewhat similar system, as they have a class examination at the end of each clinical appointment and dermatology falls into line with all other clinical subjects.

What I have suggested here is practical and possible and suited to the British type of medical education. These are the basic requirements, though one could suggest many other useful additions such as discussion groups, visits to industries with an occupational skin risk, etc. A student trained as I have outlined would be turned out with an adequate practical knowledge of skin diseases and at the same time a grounding in basic ideas which would support him when he has forgotten most of the details he has learnt. Finally, such a student would have an interest in skin patients and an ability to treat them which would give him lasting satisfaction in his later medical career.

REFERENCE

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