These are all spheres in which the clinician and the research worker must be in the closest harmony.

While there are many specialists who may be attracted into the essentially scientific aspects of research, there are many others who find their satisfaction in working clinically in some particular field. I might mention, for instance, psychiatry in relation to eugenics—a grossly neglected subject, but one which is fundamental. I know there are those who blatantly exclaim, “Hereditry is bunk”; but those of us who have experience, who see family groups involved seriously from generation to generation, or who have been impressed by the significance of similar twin studies, or of the spread of various forms of mental deficiency or of conditions characterized by organic brain disease—for example, Huntington's chorea—cannot take such a facile attitude. It is dangerous to accept all such states as a sort of *fait accompli*, but rather must we do everything that is possible to improve the quality of the race. All this work has its place in our mental hospitals and colonies for mental deficiency, which should be live places for clinical research, and not merely custodial institutions.

These hospitals require improvement and modernization both in equipment and in medical and nursing personnel. They are grossly overcrowded, the ward units are much too large, but even with all their defects they constitute important organizations which call for the highest degree of administrative and medical skill. It is intensely disappointing to-day to note that the highest positions in the mental hospital service, posts carrying with them so much responsibility and which were so greatly prized, seem to have lost much of their former appeal and attract comparatively few candidates. I believe that the main reason for this unfortunate state is because at the time of the introduction of the Mental Health Act the special conditions in relation to mental hospital work did not receive sufficient consideration.

Other Fields

If, however, your inclination lies in some other direction, then I might offer you child psychiatry, a subject which is calling out for more workers. Here you see team-work in action. The psychiatrist, the psychologist, and the social worker pool their resources not only in an effort to deal effectively with the child and the conditions surrounding it, but also because the child is much more likely to react to satisfactory treatment than the adult. Childhood, it has been said, is the golden period for mental hygiene; it is the plastic period of development, the time when prophylactic work is likely to prove fruitful. Indeed, the vast majority of the problems of childhood can be dealt with admirably by a modification of environment and social circumstances and by dealing with the particular problem at a conscious level. But again we need the full co-operation of parents, schoolmasters, and all organizations dealing with children. Our aim in all such work is to produce a state of *emotional and social security*, which is the greatest safeguard for all subsequent disorder of health and conduct.

Then there is a great need to improve our relationship to the law, to the Church, and to industry. Each one of these fields is teeming with problems of great significance and importance which would require separate consideration, and which I cannot attempt to deal with here. I feel, however, that I must mention them, because psychiatry has a great contribution to make to each of them. And then when one has accumulated one's experience you may feel that your duty and your inclination is to spread the gospel of mental hygiene so as to educate the public to take a more realistic and more humanistic attitude towards a subject which is vitally concerned with human betterment.

These, then, are some of the reasons which have led me to ask the question, Why or why not Psychiatry? I trust many of you may answer it affirmatively and that those of you who do will find in it work which will prove of infinite value to you personally, and to those whom you may be privileged to help.

THE TEACHING OF DERMATOLOGY TO MEDICAL STUDENTS*

BY

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Of recent years much attention has been focused on the changing face of medical practice. In no field are the changes more pronounced than in general practice, especially since the advent of the National Health Service. In the special subjects there are consultant teachers to keep the curriculum for higher qualifications up to date, but so far as general practice is concerned there is, and always has been, considerable difficulty in placing the right emphasis on the various subjects in the medical course. General practitioners, once they have qualified, usually put examinations and organized learning behind them, and rarely feel strongly enough about any aspect of medical training to give guidance to the bodies who control the qualification of future doctors.

For some time it has been felt that the teaching of dermatology to students has borne no relationship to the amount of skin disease met with in general practice. Most of one's colleagues, regardless of where or when they were trained, will agree that their knowledge of dermatology on qualification was negligible. The following is an attempt to place dermatology fairly on the map of medical education so that in future no newly qualified doctor should be able to claim that he knows “nothing about skins.”

Incidence of Skin Disease in General Practice

Within the past few years there have been many surveys of the work involved in general practice. Sir James Mackenzie (1919) found a “high” incidence of skin diseases in general practice. Marien and Ardouin (1954) listed twelve dermatological diagnoses made in a total of 234 cases—that is, just over 5%—seen during a three-week period in 1953. Horder and Horder (1954), in presenting two series of 1,000 diagnoses made in their practice, one in the summer and the other in the winter of 1953, listed 89 skin conditions seen in the summer and 65 in the winter—an over-all percentage of 7.7. Fry (1952) showed that in 1951 approximately 8.5% of his patients had diseases of the skin. He classified his diagnoses into disease groups; skin disorders were fifth in order of incidence, the first four being upper respiratory infections, general respiratory diseases, digestive disorders, and neuroses. Stocks's (1949) list is the same as Fry's with the addition of rheumatic conditions. Backett *et al.* (1954), who described a year's work in a general practice in 1950–1, stated that skin disease was indicated in 11% of all diagnoses and involved between 6% to 12% of their work. A small personal (unpublished) investigation showed that 10.6% of all new cases seen during four weeks in May and June, 1950, were dermatological. The figure for a similar period in November and December of that year was 7.4%—an average of 8.8% over the combined periods.

In a survey of over 17,000 prescription forms issued in a wide variety of areas in England in September, 1949, Dunlop *et al.* (1952) found that 12% dealt with “skin preparations.” Presumably these consisted of ointments, pastes, creams, lotions, and powders, and did not include the mixtures, tablets, injections, and dressings which must also have been required. Thus the amount of work involved must have

*Based on a paper read to a combined meeting of the Sections of General Practice and of Dermatology of the Royal Society of Medicine on February 16, 1955.

been more than that represented by the figure given. A similar study by Dunlop *et al.* (1953) of Forms E.C.10A issued in Scotland in October, 1951, showed that almost 13% of prescriptions were for skin preparations, compared with approximately 8½% for "cough preparations." It appears, then, that dermatological problems account for up to a tenth of the average general practitioner's work.

Proportion of General Practitioners

In spite of the difficulties encountered by new entrants, it can be shown that well over half of British medical students are destined for general practice. Meiklejohn (1953) traced 800 graduates of Glasgow University, still alive after 25 years, and found that 59% were in general practice. McGregor (1953) showed that in Scotland in 1953 there were 2,398 general practitioners out of a total of 4,172 doctors in active practice—that is, 58%. In 1955 the British Medical Association published statistics which showed that general practitioners in active practice in 1954 constituted about 55% of established doctors. Figures for 1953 supplied recently by the Ministry of Health (personal communication) also indicate that 55% of settled doctors were general practitioners.

Of the remaining 45% of students who will not enter general practice, a certain number will become school or industrial medical officers or will serve with the armed Forces. These groups too will deal with approximately the same proportion of patients with skin disorders as will their general-practitioner colleagues.

Present-day Dermatological Teaching

The teaching of dermatology varies from medical school to medical school. It seems generally to be considered as a special subject, and as such is classed with subjects of such varying importance to the general practitioner as cardiology, E.N.T. surgery, vaccination, neurosurgery, ophthalmology, and venereology. It is surely most unrealistic that equal stress can be laid on, and the same time allowed for, the study of dermatology and, say, radiotherapy or thoracic surgery. Depending on the particular medical school, the student has up to a dozen lectures on dermatological subjects. In some schools no systematic lectures are given; in others a short course is optional, and so the student may, if he desires, miss them altogether. In yet others the lectures are given during the course in general medicine, when their significance is partially lost in the absence of cases on which to demonstrate, though the use of colour photography and lantern slides is increasing. Most of the teaching is done at out-patient clinics while the physician-in-charge carries out his routine consultations. The average time spent on demonstrating skin cases to students is twenty hours, made up of between eight and twenty-four weekly or twice-weekly sessions. At only three medical schools is the more leisurely method of teaching at ward rounds a regular feature. In only one school is some system of sifting out interesting and typical cases used, so that the amount and scope of teaching must vary considerably at different times in the same medical school.

As regards changes in method or quantity of tuition in skin diseases, in most schools the situation has remained static over the past ten years. Widely divergent views are held on the usefulness of systematic lectures in dermatology. Some teachers consider that formal lecture-demonstrations are more popular than they used to be because the medical curriculum has become so large that the student welcomes having his problems sorted out for him so that he is presented with a ready-made answer. Others feel that the clinical approach to an essentially visual subject produces the best results. It appears to be exceptional for any reference to dermatological problems to be made at qualifying examinations. There may be an occasional case of skin disease shown at the viva or the clinical part of the examination, but as there are usually no dermatologists among the examiners the value of this is questionable.

Modern Medical Education

Any student who decides to specialize will have before him a period of postgraduate study lasting a number of years. But for the graduate who enters general practice the opportunities for postgraduate education are few and consist mainly of lectures and clinical meetings at his local medical society, short refresher courses at a university centre, working as a clinical assistant, or reading the various professional journals. Apart from these the average general practitioner gleanes the greater part of his knowledge of medical advances from the advertising literature of pharmaceutical firms, which is inevitably biased and partisan. Except for what he gains by experience, it is safe to say that what the newly qualified general practitioner does not already know he will never know adequately. It is therefore essential that, as so many of them are destined for general practice, medical students should receive before qualification all the tuition and training required to equip them for that calling. And this must include adequate instruction in the diagnosis and treatment of skin diseases, which, as has been shown, will account for some 10% of their work.

The blame for the inadequate courses of study in dermatology must, in part at least, be borne by the General Medical Council, who are responsible for supervising medical education generally, and through them the examining bodies of the Universities and the Royal Colleges. Almost to ignore one-tenth of the future work of a large proportion of medical graduates and despite this to pass them as fit to treat all the ills of their patients is an error which should not be allowed to be perpetuated. Most censure, however, for this anomaly must fall on the professorial units in our Universities—the anatomists and physiologists, the professors of medicine and surgery, who have become so engrossed in their academic pursuits as to have almost lost touch with the reality of curing the sick. Far too little time is available for undergraduates to attend the skin department, and far too much time is spent standing about in dissecting-rooms, laboratories, operating theatres, and x-ray departments. At present the average newly qualified doctor can expound learnedly on the significance of 17-ketosteroid excretion; he can describe the intricacies of the removal of a cerebellar astrocytoma or a pulmonary neoplasm; and he can recount in all its glories the results of cardiac catheterization. It seems obvious that the potential general practitioner really needs to know more about the diagnosis of skin conditions which he will encounter frequently than the finer points of complicated surgical technique, the estimation of complex chemical abnormalities, or the reading of much-disputed manifestations in x-ray films.

Scope of Basic Medical Training

No patient is benefited by his doctor's knowing the theoretical and practical difficulties of the treatment of his condition if the doctor cannot carry out that treatment. It is more important for him to have a medical adviser who can adequately treat his minor ailments, and who knows when he requires more expert advice and more specialized ministrations. The general practitioner should in the main himself be able to diagnose and treat dermatological conditions. Carcinoma of the breast or rectum, cardiac valvular lesions, traumatic surgical problems, and a host of similarly serious conditions he need only be able to diagnose; treatment can be obtained from doctors who have specialized, to whom patients should be, and usually are, referred. If this were not the case, general practice to-day would be quite impossible. The advances in surgical technique and the development of complicated diagnostic manoeuvres during the past two or three decades have not had the effect of lessening the ability of the general practitioner to treat the innumerable minor complaints he meets. For example, lack of knowledge about how to perform a lobectomy does not hamper the general practitioner in treating acute or chronic bronchitis. The average doctor can deal adequately with

the common headache, and even with the more serious cerebral accident, despite the fact that he has forgotten the minute ramifications of the numerous branches of the carotid arteries. It would thus appear unnecessary for the student to waste time in learning these details and procedures. It would do him more good to spend a longer time imbibing knowledge which would be of use to him in general practice, and a more thorough study of dermatology would surely further this end. If he should later decide to specialize he will be able to learn more of the advanced techniques in his postgraduate studies, and he will be none the worse for having a better understanding of the commoner skin diseases.

Dermatology as a Teaching Subject

Dermatology is a visual subject—one eminently suited for teaching and demonstrating the art of clinical medicine. There is something to see, feel, and occasionally smell. All classes of disease processes are there, on the surface, for the student to "get his teeth into." Congenital abnormalities abound; acquired manifestations can be observed and studied, not in bottles in a museum, but in the living subject. Neoplastic, infective, and traumatic changes in the skin can be demonstrated to comparatively large numbers of students at a time. Pathological techniques can be shown, and the elements of bacteriology, haematology, mycology, histology, and occasionally morbid anatomy can be seen and correlated with the living body. Minor surgical procedures, such as taking biopsy specimens, the treatment of warts, and the excision of cysts, can be taught. Freezing, cauterization, and diathermy are practical methods easily shown to and absorbed by the student, not in the awe-inspiring environment of the major operating theatre but in the more informal atmosphere of the minor operating room. Visual results of treatment, whether local, radiological, or general, can be observed. Training in prescribing—and not merely the almost automatic writing of proprietary and formula titles—can be given. The patient is rarely too ill to give an adequate clinical history of his condition—a point of great advantage to the fresh clinical student.

This leads to the suggestion that a large part of the clinical student's introductory course should be taken in the skin department. Most students find the pictorial method of teaching the easiest to assimilate, and dermatology is the subject *par excellence* which lends itself to graphic and dramatic presentation, both clinically and in the lecture theatre. Later on the student should return to the skin department for revision and integration of the knowledge acquired in other departments—for example, the surgical treatment of skin tumours, dermatological manifestations of various internal diseases, ano-genital pruritus, the neurodermatoses, and otitis externa. At this point the large amount of skin disease which is met with in general practice should be stressed. Suitable screening methods should be introduced so that the teacher will have representative cases on which to demonstrate and the student will get a good over-all picture of the type of dermatological work he can expect in general practice. The rarities are undoubtedly extremely interesting, but the statement, "Common things occur most commonly," is as true of dermatology as of any other subject.

It is not suggested that the medical course should be prolonged, but that the time spent in learning to diagnose and treat skin diseases should be at the expense of some of the more academic subjects; that some of the time spent in minute anatomical dissection, in watching major operations, and in attending highly technical ward rounds should be given over to the study of dermatology.

Future of Dermatology

Apart from benefiting the student and his eventual patients this scheme would stimulate a greater interest in dermatology from a scientific point of view. In a recent article on lupus erythematosus Dowling (1954) wrote that, "In view perhaps

of the conditions under which dermatologists must work, they did not succeed in carrying knowledge of the disease beyond accurate clinical observation." Lupus erythematosus is not the only dermatological condition about which this could have been written. Skin specialists who have to spend their time in purely clinical practice because of the excessive number of referrals from general practitioners can never have sufficient time for, or inclination toward, research. And it must be admitted that dermatology is one of the most empirical of the medical specialties. The kidney, the brain, the marrow, and almost all other sections of the body have been and are being investigated to the full. The skin, on the other hand, the largest and most accessible of all the organs of the body, is still practically an unknown quantity. Increased dermatological research must inevitably help towards a better understanding of the physiological and pathological problems involved, with consequent simplification of present-day morphological terminology, and this would lead to more lucid and logical teaching and further advances.

Summary

Skin diseases form a large part of the work of the general practitioner.

As more than half the medical students who qualify will become general practitioners it is essential that they receive more training than at present in the diagnosis and treatment of dermatological conditions. If necessary the extra time required for this should be obtained by shortening the courses in the anatomical and surgical specialties, which should be reserved mainly for post-graduate training of the aspiring specialist.

Only if dermatology is given its rightful place in the medical curriculum can the future general practitioner be expected to be able to care for his patients adequately. If more interest is taken in dermatology a better understanding of skin diseases will follow, with brighter prospects for more enlightened and successful therapeutics.

I should like to thank the heads of the departments of dermatology in the medical schools of the country for replying in so co-operative a manner to my inquiries during the preparation of this paper.

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A pre-vocational training centre for 25 blind boys and girls, aged 16-18, is to be opened early next year at Reigate, Surrey. The experiment is being arranged by the Royal National Institute for the Blind at the request of Sir David Eccles, Minister of Education. The object of the centre is to help students, who will stay for a period up to two years, to choose an occupation suited to them and to receive practical training. They will also continue their general education, and "it is hoped that they will mature in outlook and make a better-informed choice of occupation." Vocational guidance experts will be available, and the centre is to have no bias either for or against sheltered as opposed to ordinary employment. The cost of the training will be met by local education authorities. After a trial period the Minister of Education proposes to see if the continuation and development of the centre are practical. The establishment of such a centre was recommended in 1951 by a working party appointed by the Minister of Labour.