A NOTE ON "UNDERGRADUATE TEACHING IN DERMATO-VENEREOLOGY"

By

*Dr. SHARAT C. DESAI,

As a teacher in dermato-venereology for 25 years and having had opportunities of observing the teaching schedules at some of our medical colleges in India as well as assessing students for admission to postgraduate studies and examinations, I have realised that as yet, we teachers, have not given adequate collective thought to establish a uniform pattern of teaching desirable for both undergraduates and postgraduates. Undergraduate teaching varies from no lectures and a few demonstrations to 16 lectures and 12 clinics in our medical colleges. If we want to establish a certain level of proficiency in our disciplines by graduates, we should think in terms of adopting basic uniformity in our approach to undergraduate teaching. With these views, I have endeavoured to make the following draft on undergraduate teaching for consideration of our colleagues and others concerned with laying down the curriculum for the undergraduate teaching. I hope this may serve the purpose of formulating a policy which should then be adopted by all of us. This is urgently necessary to give a direction to our speciality towards improving the proficiency of our graduates who will be handling a major load of skin and V. D. problems, as well as set certain norms of performance by our teachers

We have to determine the issues of:

(1) time to be apportioned to teaching in dermato-venereology including leprosy;

(2) the content of teaching, and

(3) the methods of teaching.

(1) Time to be apportioned for dermato-venereology:

Having participated at the policy making body for medical education such as the Faculty of Medicine of the University of Bombay, I have watched with dismay that every medical specialist has a magnified vision of his speciality which after all is only one of the many to draw upon the available teaching time for a student. This is not more than 2½ years of clinical teaching after First M. B B. S During this period, a student has to acqqire knowledge in many important disciplines of medicine. Teachers seem to forget their student days with difficulties of absorbing thousands of new data in the limited available time, when they demand more time for their speciality. To view this problem objectively, we should answer several questions, viz (a) how much our speciality contributes to the understanding and knowledge required to make a good general practitioner, and how much time can be reasonably asked for from the undergraduate curriculum for this, (b) how much

*Honorary Professor, Dermatology & Venereology, Seth G. S. Medical College & K. E. M. Hospital, Bombay-12.

time should be given to pure dermatologic problems which should be those that are common in general practice, and (c) which is the best time after First MBBS at which we should introduce dermatology in the teaching programme I am sure everybody has his own views on the above subject. I propose to answer above querries which have guided my approach.

(a) A good general practitioner in India has to be a good clinician first, particularly in view of the non – availability of diagnostic laboratory facilities or of specialists' services for a large majority of patients. Hence the contributions of dermatologic clues for developing diagnostic acumen in the fields of deficiency dermatoses, dysmetabolic dermatoses, endocrinopathies and infectious diseases should be brought in at appropriate tim- during medical terms. A dermatologist should ask for 2 lectures during medical terms preferably at the end.

(b) In addition, we should select for teaching in depth the common dermatologic disorders which account for a large percentage of skin and V. D. outpatients and which will also be reflected in dispensary pracice. I have considered these problems in detail below, and the time required for teaching would be 18 lectures, and additionally 10 clinics to demonstrate common conditions listed below.

(c) I think the best time to introduce dermato-venereology should be after the medical term is over because by that time the student has some idea about the medical problems which he is likely to face. Similarly after the surgical term, one may introduce venereology in view of the differential diagnostic surgical problems of ulcers, bubo and urethritis. I have come to the conclusion that the internship training for 2 – 4 weeks should be utilised for intensive theoretical indoctrination and practical management of venereal diseases and communicable dermatoses (see 4,5,6.7,8,14,15,16).

(2) Content of teaching: Every thing appears important to a speciaiist who has daily acquaintance with 400 odd diseases of his speciality. From analysis of the nature of skin and V. D at the out-patients, I have realised that those of importance for a non-specialist graduate to study in depth would not be more than two dozen diseases, which account for 70% of the out-patient attendance and skin morbidity. In addition taking into account the objective menti ned in item No. 1 above, I have listed following topics to be taught in the class room in didactic lectures and followed up by clinical teaching.

1. A survey of the nature of skin diseases (approximately 30% systemic diseases reflecting on the skin, 10% due to disturbed structure or functions of the skin, and 60% due to external environmental noxae) give details of each group and show representative slides of some easy to diagnose skin manifestations of systemic disorders in the introductory lecture.

2. Structures and functions of the skin to correlate functions with structures and show slides of diseases of skin due to disturbances of these.

3. Methods of diagnosis and examinations. Enumerate lesions of the skin and give the idea of different constellations of lesions which may be diagnostic of different diseases by slides.

4. General introduction on infectious and parasitic dermatoses the concept of infectiousness, contagiousness-infectivity rates of 5,6,7,8 (below). Teach details of zoonosis (scabies and other mite infections, pediculosis, insect-bite prurigo) - Treatments

5. Cutaneous bacterioses-General icteric resident and contaminant bacterial flora and degenerating capacity of skin. Details of asepsis and antisepsis, and underlying factors favouring sepsis or infections should be given. Teach details of pyodermas-surface, follicular and adnexal pyodermas. Primary and secondary pyoderma and treatment procedures.

6. Introduction to Fungous Diseases and some details on those of skin and subcutaneous tisssue. More details of dermatomycoses and their management in three groups, viz.

   Dermatomycosis of skin and nails, Tinea Capitis (hairs on scalp and beard) and Mycosis of mucocutaneous junction viz moniliasis

7. Introduction to structures and reproduction of viruses. Details on common virus infections primarily of skin (papular, viz. warts, molluscum,-vesicular, viz. herpes simplex, zoster). General survey (without details) of systemic virus infections and their pictures on skin

8. General review of mycobacterioses and details of polar manifestations of leprosy and their treatment Some pictures of skin tuberculosis and tuberculides.

9. General review of papulosquamous dermatoses and differential diagnosis of common diseases, viz. psoriasis, lichen planus, pityriasis rosea, and syphilis. Management of the first two is in the specialist domain.

10&11. General considerations on allergy. Classify allergic disorders seen on the skin. Details of causes of acute and chronic urticaria.

12. Classification and differential diagnostic features of common types of dermatitis and eczema (contact and parasitic eczema, atopic and systemic allergic dermatitis, seborrhoetic dermatitis). Principles of management.

13. Emphasize Iatrogenic Diseases as the Great Initiator now instead of syphilis before, hence in differential diagnosis of every condition.

Classify multitudinous manifestations of drug allergy and eruptions into morphologic lesions (e. g. Erythematous, papular, vesiculo-bulous, Eczematous, urticarial, fixed drug type and with & without systemic involvements-group common drugs responsible for them.

14 Syphilis: Teach life history, stages, clinico pathological and serologic correlations and treatments. Few words on biologic-false positive tests and interpretations. Show slides of common skin diseases in differential diagnosis.

15. General considerations of urethritis and its many causes. Teach simple diagnostic tests (2 glass, smear frost drop). Details of manifestations of gonococcal infections in males and females. Treatment.

16. Differential diagnosis of venereal and non-venereal genital ulcers. Differential diagnosis in detail of common ulcers viz syphilis, chancroid, balano-posthitis and herpetic ulcers, pyogenic ulcers Clinical and investigative methods

(3) Methods of teaching:

No other discipline than dermato-venerology has so much to gain from adopting visual methods of teaching. Hence teaching slides on each of the above topics should be systematically prepared to be included with lectures to give visual content to our teaching. Lectures without slides would have less than 50% impact on a novice audience.

Additional clinics for undergrduates and interns together on patients with "common" dermatologic problems categorized above would require organization and collection of O.P.D. patients for each disease group. This would mean about 12 clinics, omitting the theoretical aspects mentioned above and concentrating on the clinical variations of manifestations of the above diseases. Generally I have not found it difficult to organize these clinics and show the patients on above topics in view of the large attendance of more than 300 patients a day at our clinic. This may have to be modified for clinics with lesser clinical material.