

Editorials

A BALANCED MEDICAL CURRICULUM

IT is generally accepted that medicine covers every aspect of the maintenance of health and of the prevention and care of illness. The need for medicine in the community has increased in breadth over the centuries as populations have become larger and more complex, medical teaching has, in contrast, developed in depth.

With advances in medical science and technology traditional medical education is concentrated on an increasingly complex body of theory and its application to ten per cent of the known illness in the community. Some scant attention is paid to preventive medicine and the application of epidemiology to large populations but extra-hospital medicine is virtually ignored.

Certain qualities characterize the illnesses of patients selected for reference to hospital. These include the severity of the condition, whether it is dangerous to life or livelihood; the stage which the condition has reached, usually one at which irreversible pathological changes have taken place, and the relevance of available medical technology which may be diagnostic or remedial.

Thus the band of the spectrum of illness which reaches hospital is narrow and selected. It is this restricted area of each specialty that provides the experience of those who teach and the material for them to teach upon. The material is used to illustrate the principles of medicine and to demonstrate the application of those principles to medical care. Inevitably the impression is given that this unbalanced picture is the whole of medicine and students at undergraduate level may be convinced of this.

The selection factors are not exclusive to any one specialty, they apply as much to surgery as to psychiatry, to dermatology as to medicine. In each specialty there is an area of the spectrum, small or large, which conventional teaching ignores. Each specialty should therefore review its spectrum to see what is required to restore the balance and enable the student to learn the application of the subject right across the board.

This may be achieved by recognizing that 'applied medicine' requires to be taught and drawing on teaching resources from among those with experience of it. On each clinical firm or attachment a student should be able to see the source material from which cases are referred and how they are selected for reference from among comparable cases managed in the community. They should observe technology in its hospital setting and proceed to follow the patient through recovery, reablement and return to full function. At each stage a teacher should be at hand to guide him.

Those responsible for a given specialty should examine their particular spectrum in this light and may find that appropriate outside experience has to be called upon to reinforce and supplement what is already available, and in providing outside help the faculties of the Royal College of General Practitioners may be of assistance.

Each faculty of the College, geographically related to a medical school, has machinery whereby it can bring to the surface and evaluate those with desire and ability to

teach at both undergraduate and postgraduate levels. Experience of the application of the different specialties can be identified and it is not unlikely that needs can be matched with means.

A prerequisite to a balanced curriculum of medical education is the recognition that no single specialty is at present adequately covered and in consequence no subject can be adequately taught.

THE HOPEWELL HYPOTHESIS

ON 9 OCTOBER 1761 the ship *Hopewell* arrived at Halifax with between two and three hundred immigrants destined to settle in Nova Scotia. Many of these were of Scottish extraction who had sought to escape oppression of the Presbyterians during the reign of James I by migrating to Ulster, and the group of immigrants became known as the 'Ulster Scots'. From a first settlement in Colchester County, Nova Scotia, descendants of this immigrant group have spread throughout North America.

During the last 20 years Bode and Crawford observed a number of families in which nephrogenic diabetes insipidus was prevalent among patients seen at the Massachusetts General Hospital, and noticed that many of these claimed descent from the original settlers of Nova Scotia. This observation led to a study of the genealogies of families known to have been aboard the *Hopewell* and into the folklore surrounding the 'water-drinkers'. Both folk-legend and genealogical evidence strongly suggest X-linked transmission of the trait.

Thus historical and medical research can meet and complement one another. In this instance the observation was made at a general hospital but the next might as easily be made in a general practice. It may well be that practitioners in the British Isles or in Canada can carry this story further, adding more to our knowledge not only of nephrogenic diabetes insipidus but perhaps also identifying other conditions which may be associated with it. This fascinating paper in the *New England Journal of Medicine* (280, 750-754) 3 April 1969 is a challenge to us.

MATERNAL DEATHS AND MATERNITY SERVICES

THE current triennial Report on Confidential Enquiries into Maternal Deaths in England and Wales¹ relating to the years 1964-1966 brings together interesting items of background information relating to the maternity services. The birth rate, which had been rising since 1955, reached a peak of 18.8 in 1964 and fell steadily to 18.0 in 1966, a fall which continued after the review period to 17.2 in 1967. This was so complete a reversal of trend that it fell in three years by more than it had risen in the previous five.

The number of first births, which had been rising for several years, continued to do so. On the other hand second births, rising until 1964, fell in 1965 and remained at the same level in 1966. Third and subsequent births each reached a peak in 1964