EDITORIALS

Determining the curriculum

WHAT decides the undergraduate medical curriculum? Are the needs of our society, or different societies, the best guide? Or should the academic power structure continue to determine what goes in and what is left out? How sure are we that science-based school performance is the soundest criterion for student recruitment to medicine? If anatomy, biochemistry, and physiology teaching are too detached from medical pactice, could this be because clinicians have not taken the trouble to advise pre-clinical teachers on their requirements? As hospitals become more and more concerned with sophisticated disease and high technology, should clinical medical education not be shifted towards the community health centre? As institutions of all kinds get bigger and less personal, should primary health care teams be helped to practise and teach whole-person medicine?

Formal undergraduate medical education has been going on for a century, during which time responsibility has shifted from producing a ready-made practitioner to producing a graduate who chooses and trains for a specialist career (specialist in the sense of knowledge, skills, and attitudes). Since the ultimate distribution in society of general practitioners, hospital-based specialists, community physicians, doctors in the armed forces, and others, is known, why not base the content of the curriculum on their frequency of occurrence? To some extent this may be so now, with the conspicuous exception of primary medical care, which should surely rapidly come to occupy a more prominent curricular place than it does now. Not that medical education should be based on frequency of disease only—the common cold has rather limited educational value—any more than it should be based exclusively on the severity of disease or the technology thereof—paraproteinaemias are relatively rare.

Central to the difficulty of defining the content of the curriculum is of course the problem of curricular aims. If we knew more precisely what constitutes a good or competent doctor, be he a family physician, a gynaecologist, or cardiac surgeon, then we could define aims in terms of knowledge and behaviour. The fallacy in this of course, is that there is one commonly agreed 'best', whereas in practice there are many. It also seems likely that medical educationists have paid too little heed to the profound importance of social learning.

So where does this thinking lead us? Surely to a greater than ever need to examine the medical educational structure, process, and outcome. Has the value of the 1968 Royal Commission Report been forgotten? How has ten years' further experience of social change altered the conclusions of the report? Will the reconstituted General Medical Council have the courage of its more strongly supported convictions and promote new experiments in the medical schools? Will the needs of society for health care, and especially for primary prevention, really become the determining influence on the curriculum? To argue that we do not have the resources to do anything except wring our hands deserves contempt—*now* is the time to prepare for better times ahead.

Reference

Royal Commission on Medical Education (1968). Report. London: HMSO.

Urinary tract infections in general practice

AGREEMENT about the best management of urinary infection in general practice has been impeded by lack of understanding of the natural history of pyelonephritis and its associated complications—hypertension and renal failure. It has long been apparent that not all patients suffering recurrent urinary infections will proceed to renal failure. It is becoming increasingly accepted (Smellie, 1972) that it is in the period of active growth of the kidneys, that is, childhood, that recurrent infection may lead to permanent scarring and long-term complications.

The symptoms, frequency of micturition and dysuria, are much more common in women than men, and are encountered four times as often in married women as compared with single women. It has been estimated that about four per cent of non-pregnant adult women have asymptomatic bacteriuria, and that about 10 to 20 per cent experience symptoms of urinary tract infection during their lifetime; many suffering recurrent symptoms (Wing and Morrell, 1972).

Quantitative bacteriology has aided the management of urinary infection, and the use of the dip slide has