

## SOCIETY FOR SOCIAL MEDICINE

### XV ANNUAL MEETING, SEPTEMBER 9-10, 1971

*Held in the Moyné Institute, Trinity College, Dublin*

#### FIRST SESSION (Chairman: W. J. E. JESSOP)

**Social Medicine Participation in an Integrated Pre-clinical Course.** J. P. KEVANY (*Department of Social Medicine, Trinity College, Dublin*).

The changing patterns of health and disease that have occurred in recent decades have substantially altered the requirements for medical education in contemporary society. The teaching of social medicine is an important step in response to these changes; however, courses in this field are not always supported by a knowledge of the basic principles of sociology as they refer to public health and medical practice.

In 1970 the medical school introduced a nine-hour course in medical sociology as part of the integrated pre-clinical teaching programme. In addition to the mandatory course, electives in medical sociology can be undertaken during the summer term. The course includes subject areas in sociology, demography, social structure and organization, education, the sick role, social factors in the provision of health services, and the evolution of the medical profession. Topics for electives are left as far as possible to the students provided they fall within general guidelines.

The course has been well received to date and 25% of the class prepared electives in this field in 1971. Difficulties have been encountered in providing a suitable text-book. The benefits of this course will be identified in 1972 when the first class will receive the course in social medicine.

**Objectives in the Clinical Section of the Curriculum.** P. G. S. BECKETT (*Department of Psychiatry, St. Patrick's Hospital, Dublin*).

In any educational exercise it is most important to specify precisely one's objectives. These may be thought of at five levels of increasing complexity: (1) recall of information, sometimes vulgarly called 'regurgitation'; (2) transfer or generalization of this recalled information to a wider field; (3) the solution of simple problems at a theoretical level; that is, from a written (or taped) history and examination the student should be able to answer questions about diagnosis and management; (4) problem-solving at the clinical level, which is always unpredictable and varied; (5) therapeutic intervention. This, however, is mostly concerned with postgraduates rather than undergraduates.

The nature or quality of the objectives in medical education is another matter. What qualities do we hope a doctor will have? It is suggested that four aspects of a

doctor can be separated. (1) He should be a biological scientist; traditionally one learns this from lectures, text-books, and practicals. (2) He should be an expert in clinical technique, traditionally learned from his supervisors in hospital work. (3) He should have an interest in the human condition of his patients; but he is traditionally not taught this, rather it is learned by 'osmosis'. (4) He should be a man of high ethical principle, learned from the example of his teachers.

It is suggested that additional techniques could be used to facilitate the learning of these objectives. In learning to be a biological scientist, programmed instruction and tape-slide teaching machines have their place. In learning to be an expert in clinical technique the use of actors as subjects, television tape to see oneself in action, and computer-controlled simulators might all be used. As regards interest in the human condition, movies and television tapes on interviewing technique, and assignment to families for a period of several years are most useful. Finally, in the learning of ethical principles, a plea is made that the lecture should not be abandoned. This format offers the student a chance to identify with the complete doctor standing before him, warts and all.

**Screening for Vitamin C Status.** C. M. W. WILSON and J. P. KEVANY (*Depts. of Pharmacology and Social Medicine, Trinity College, Dublin*).

It is being recognized more and more that measurement of the vitamin C status of the tissues is of clinical importance. The tissue status is low in gastrointestinal disease; ascorbic acid (AA) plays a role in rheumatoid arthritis; it has been shown to be involved in haemopoiesis; and there is controversy about its beneficial effects on the common cold.

During the last four years a simple measure of tissue AA status has been examined, namely the 2:6 dichloro-indophenol tongue test in which a drop of the 3% blue dye is placed on the tongue. As the reduced AA in the tongue reacts with the dye, the blue colour disappears. A short tongue test indicates a high concentration of AA in the tissue, and a long test indicates a lower concentration. The characteristics of the tongue test in three groups of individuals—two student groups and a third group from a government service agency (G.S.)—have been investigated. There was no significant difference in characteristics between the two student groups, however the G.S. group in addition to being older had a significantly longer tongue test time (TTT). The students had an early peak at 31-50 seconds whereas the latter had a less marked peak