

# Teaching of genitourinary medicine (venereology) to undergraduate medical students in Britain\*

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**SUMMARY** Twenty-six medical schools in the United Kingdom have recently taken part in a survey on the teaching of genitourinary medicine (venereology) to undergraduates. Four of the schools were unable to run their own formal lecture courses and a further three could not offer clinical attachments. The mean number of lectures given per centre was six, clinic attendances 10 hours, and total teaching time (lectures and clinical attachment combined) 15 hours. This represents a reduction in teaching hours over the last 15 years and contrasts with the ever-increasing clinical problems associated with the sexually transmitted diseases.

## Introduction

Throughout this century there has been increasing competition for teaching time in a number of "newer" subjects and a questioning of the importance of the more "traditional" ones and the number of hours devoted to them. With an ever-increasing load on the curriculum the time spent in studying the sexually transmitted diseases (STDs) in the medical schools of the United Kingdom has been slightly less than average. A survey carried out by Webster<sup>1</sup> in 1966, which covered 437 out of 709 of the world's medical schools, showed great variations. The total hours spent in the study of the STDs, either alone or with another subject, ranged from five or less in Belgium, Israel, and Thailand to over 100 in Bulgaria, Iran, Jamaica, Poland, and the USSR. The mean number for all participating schools was 42.7 hours and for the United Kingdom 19.2 hours.

The STDs now constitute the major infectious diseases seen in the United Kingdom, and since 1966 the number of cases per 100 000 population treated in clinics in England has risen by 35% for primary and secondary syphilis, 42% for gonorrhoea, and 130% for non-specific genital infection in men, with

a trebling of the total number of patients attending treatment centres. The scope of the specialty has widened so that many other conditions are now seen and represent an ever-increasing workload. The increase in the number and type of conditions seen together with the fact that many patients may present in other departments such as general practice, surgeries and gynaecological and family planning clinics, makes it even more important that all medical students should receive adequate teaching about the STDs.

To determine how much time is now devoted to genitourinary medicine a survey of undergraduate training was undertaken jointly by the academic department of genitourinary medicine of the Middlesex Hospital Medical School and the British Co-operative Clinical Group of the Medical Society for the Study of the Venereal Diseases. It was hoped that the information obtained would highlight both merits and deficiencies and thus stimulate a more general constructive and critical discussion likely to be of assistance in formulating future policies.

## Methods

A self-administered questionnaire covering the organisation, content, curriculum time available for teaching, and methods of assessment was sent to the departments of STDs of the 30 medical schools in the United Kingdom. Twenty-six of these schools agreed to take part, a response rate of 87%. No replies were received from two London schools and two in England outside the capital.

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## Results

### LECTURE COURSES

All the schools gave lectures in genitourinary medicine. Four of the 26 centres were not given time within the curriculum to run their own courses but were invited to contribute lectures within courses run by other disciplines or as part of a topic teaching programme.

It is desirable that a teacher should be able to design, run, and control his own course of lectures, but its adequacy and comprehensiveness will to some extent depend on the amount of teaching time available. Of the 22 centres running their own courses nine (40%) gave four or less lectures and 12 (50%) five or less; in contrast, three (14%) centres gave 10 or more (fig 1). The national mean number of lectures per centre was six. Virtually all the lectures lasted for only one hour. Ninety per cent of the lectures were given by consultants and the rest by other medical staff, such as senior registrars or clinical assistants, or paramedical staff such as contact tracers.

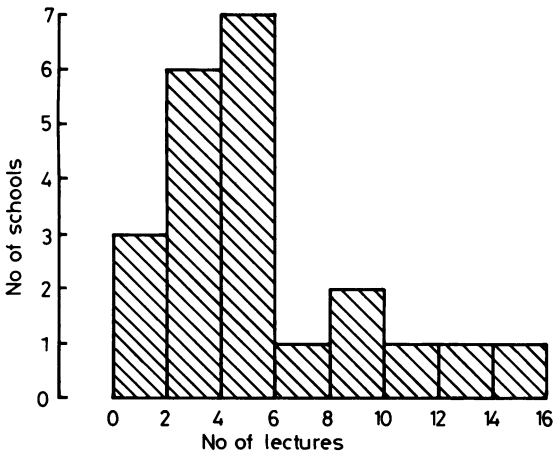


FIG. 1 Distribution of the number of lectures per course. (The number of schools running their own courses was 22.) (N = 22)

Four schools had no lecture courses of their own; one contributed six lectures to a topic teaching course on infectious diseases and the other three were less fortunate in the amount of time given to them. One school contributed three and another two lectures to courses organised by bacteriologists and gynaecologists, and the fourth centre gave only one lecture in a course on human reproduction run by the obstetricians and gynaecologists.

### Attendance

The size of the group of students attending the lectures varied greatly between schools (table I). In 23% of schools the size of the group was 19 or less students, and the median-sized group was of 40-59 students. The old well-tryed adage of medical education is that students vote with their feet. All consultants were asked how many students should attend the lecture courses. Obviously centres varied in the attendance rate, but in virtually all the schools this was judged to be good. Nationally, just over 77% of students attended the lectures, although only one-quarter of the schools maintained that this was compulsory.

TABLE I Number of students that should attend lectures in each school

Size of group	No of schools (%)
0-19	6 (23.0)
20-39	5 (19.2)
40-59	3 (11.5)
60-79	2 (7.7)
80-99	1 (3.8)
100-119	2 (7.7)
120-139	4 (15.4)
140-159	
160-179	2 (7.7)
>180*	1 (3.8)
Total	26 (100.0)

\* 260 students

### CLINIC ATTENDANCE

Attendance at a clinic is a vital part of training, since it not only reinforces theoretical knowledge but allows the student to learn by example. Twenty-three of the 26 centres had arrangements for clinical attachment. The three centres that made no such provision were not the same as those without their own lecture courses.

To be of maximum benefit and to capitalise on the theoretical lecture courses, clinical attachment should take place at the same period in the course as the lectures. In one-third of centres this did not occur, and attendance was divorced in time from the theoretical teaching. As with the lecture course, each centre varied in the time that students spent in the clinics (table II). At the lower limit, students spent only 1-2 hours sitting-in at a clinic whereas the upper limit was 40 hours. The mean number of hours spent by a student in the clinic was 10 hours.

Most clinicians agree that the nature of the specialty makes it undesirable that large numbers of students should be present at an interview and examination of a patient. In 70% of centres only one student was allocated to each doctor, but the others—probably not from choice—allocated 2-4 students to individual clinicians. Even though only

TABLE II Total number of hours of clinic attendance by students

Hours	No of schools (%)
1-2	2 (8.7)
3-4	5 (21.8)
5-6	3 (13.0)
7-8	3 (13.0)
9-10	2 (8.7)
11-12	3 (13.0)
13-14	
15-16	2 (8.7)
17-18	1 (4.4)
>19†	2 (8.7)
Total	23* (100.0)

\*Only 23 out of 26 schools provided clinic attendance  
 †1 clinic 30 hours; 1 clinic 40 hours

half of the schools stated that clinic attendance was compulsory, the majority (74%) were satisfied with the level of student attendance.

Teaching experience is important in a training post and although most formal lecturing was carried out by consultants with hardly any participation by junior staff, this lack of input to the lecture course was amply compensated for by the junior staff participating in the teaching within clinics. The consultants were nevertheless responsible for teaching about half of the clinic sessions, but the senior registrar, registrar, and senior house officers and clinical assistants were involved with the remainder.

#### TOTAL TEACHING TIME

The distribution of total teaching hours for the STDs, combining the time for lectures and for attending clinics, is shown in figure 2. For the lectures, the hours for all the 26 participating centres have been taken so that the four schools that did not run their own courses but contributed to topic teaching or other courses are included. The distribution of total teaching hours is wide; 13 (50%) schools had a teaching time for lectures and clinic attendance of less than 10 hours, whereas four schools had a total of 35 hours or more. The mean length of teaching time was 15 hours.

#### OTHER METHODS OF TEACHING

##### *Electives and assessments*

Five of the 26 schools provided laboratory demonstrations and one of the centres, unable to offer clinical attachments, provided clinical demonstrations. Two centres also used small group-teaching apart from that provided in the clinics and lectures. Three centres had access to audiovisual material to which students could refer in their own time. Eighty-five per cent of departments offered the option of

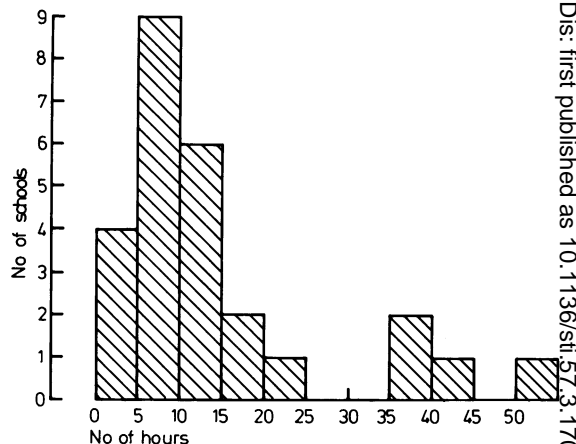


FIG 2 Distribution of the total hours of teaching: lectures and clinic attendances. (Twenty-two schools ran their own lecture courses and four contributed to other courses; three schools provided no clinical attachment.) (N=26)

electives to their students, and in the last five years 44 students had availed themselves of this opportunity.

Only about half (46%) of the schools used an end-of-course assessment; of the 12 centres doing this, nine used a multiple-choice examination and three essays. One of the centres using essays also held an oral examination. Members of the clinic staff at two schools had examined in the final clinical or oral MB examination, and staff at half (54%) the centres had contributed to the written paper at some time; this usually occurred only occasionally.

#### Discussion

It is always difficult to define the optimum amount of teaching time required for individual subjects. Physicians working in genitourinary medicine have to accept that their primary responsibility towards students is to teach them how to recognise the major STDs and refer patients to specialised units and not to produce over-confident doctors who feel competent to deal with every aspect of the subject. It is disturbing that the average amount of time devoted to the teaching of genitourinary medicine within the United Kingdom has decreased since Webster's survey in 1966 from 19 to 15 hours, especially as the number of patients now seeking care for the STDs is increasing.

Those responsible for teaching genitourinary medicine can and should debate the optimum amount of teaching time that is required and make appropriate recommendations. However, the finding of no, or little, teaching time in some schools is of more urgency. Four schools were unable to run their

own lecture courses and a further three were unable to provide clinical attachments; even though the mean number of teaching hours nationally was 15, most schools offered substantially less (15%, 5 hours and 50%, 10 hours or less).

Many of the physicians taking part in the survey were unhappy and frustrated by the lack of teaching time. One participating consultant stated, "The official teaching time allocated (at our) university for the teaching of the sexually transmitted diseases is 1¾ hours only. For the past six years no time whatsoever has been allocated in the curriculum for clinical instruction. Despite this, we invite all the medical students to attend our clinics on a voluntary basis during their fourth year so that they might possibly acquire a slight knowledge of the clinical handling of patients suffering from STD. In practice, however, very few of them—less than 10% of the class—ever avail themselves of the proffered opportunity; the reasons for this are given as 'pressures of other academic subjects in the curriculum'".

It is to be hoped that this survey will prompt deans of medical schools to question the lack of suitable time and facilities for teaching about the STDs and allow those working in these schools to glean some or further teaching in the subject. It is salutary to read the words of the Royal Commission on Venereal Diseases written 64 years ago: "The average education of medical men in the diagnosis and treatment of venereal disease(s) is insufficient . . . We are impelled to regard this defect of medical education as

of grave import to the health of the community . . . medical students and practitioners should have access, for educational purposes, to the treatment of venereal diseases at any institution dealing with these diseases".<sup>2</sup> A week is a long time in politics but half a century appears too short to have changed our approach to educating medical students in this important subject.

We wish to thank the directors of the following participating teaching centres for their help in this study: Aberdeen, Belfast, Birmingham, Bristol, Cambridge (Addenbrooke's Hospital), Cardiff, Charing Cross (West London) Hospital, Dundee, Edinburgh, Glasgow, King's College Hospital (London), Leeds, Leicester, Liverpool, London Hospital (London), Middlesex Hospital (London), Manchester, Newcastle upon Tyne, Oxford (Radcliffe Infirmary), Royal Free Hospital (London), St Bartholomew's Hospital (London), St George's Hospital (London), St Mary's Hospital (London), St Thomas's Hospital (London), Sheffield, and Westminster Hospital (London). The full data of the survey can be obtained by those interested by application to the authors.

#### References

1. Webster B. Teaching of venereal diseases in medical schools throughout the world. *Br J Vener Dis* 1966; **42**: 132-3.
2. Royal Commission on Venereal Diseases. *Final Report of the Commissioners*. London: HMSO (ed 8189), 1916.