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Letters to a Young Doctor

Careers outside hospital and general practice

PHILIP RHODES

A great advantage of qualifying in medicine is that so many different careers are then open to you. There are between 50 and 60 specialties, so that a satisfying career is available for virtually every taste. There is no need for blinkered vision, believing that there are only the two mainstreams of general practice and hospital medicine. It is perhaps unfortunate that most graduates think only of these, though there is tremendous variety in each of them. Yet not everyone is happy in hospital medicine or general practice, nor is everyone successful in them. The reason may be a lack of motivation caused by inadequate

understanding of oneself and one's vocation. You should not feel like a failure in recognising that the classic traditions of medical practice are not for you. You must recognise the immense complexity of medicine today in both its internal and its external relations. Doctors are needed at many points in the machinery to keep the whole of it functioning.

It is a curse of medicine that an informal snobbish hierarchy has developed, so that some occupations in medicine may appear intrinsically more important and worth while than others. Medicine is probably no worse in this than other vocations, but it may result in a scramble for places at the top of the hierarchy while other parts lack the manpower for their proper purposes, which have their place and importance. Indeed, the mainstream of medicine may very well depend on medical education, administration, journalism and communication, the pharmaceutical industry, military service, and many other activities.

In 1982 there were relative shortages of manpower in general

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practice; all branches of pathology except haematology; radiology; radiotherapy and oncology; ear, nose, and throat surgery; ophthalmology; clinical pharmacology; and others. Service in one or other of these would often be more socially valuable than attempting to struggle into the ranks of general physicians, surgeons, and obstetricians and gynaecologists, where competition may be unnecessarily fierce and unrewarding. Satisfying and valuable careers are to be had in all of these shortage specialties. They are all important in the nexus of medicine.

Basic medical sciences

The basic medical sciences of anatomy, physiology, biochemistry, psychology, genetics, and sociology as applied to medicine all lack teachers who are medically qualified. Together with pharmacology, these subjects are taught more and more to medical students by scientists, none of whom have clinical experience and so must teach their subjects as pure science. Medically qualified teachers see the basic sciences more in relation to patients because they have had clinical experience. This is attractive to medical students, who see medicine as applied science and want what they learn of the basic medical sciences to be relevant to their future work, which is more likely to be clinical than not.

Thus, medically qualified teachers have an important role to play in bridging the concepts of the many separate disciplines. They can help to motivate students to learn the basic medical sciences because they witness its relevance. I do not denigrate

the real contribution of scientists, but they need doctors in their midst to lighten their teaching. This helps to keep the eyes of every teacher on the main task of undergraduate teaching in medicine, which is to prepare students for clinical work and to understand its basis. This needs medical teachers who are devoted to the twin causes of their subject and basic medical education, which cannot be sustained purely by a stream of junior doctors who may revert temporarily to a basic science to work for part I of their higher clinical diplomas.

Medical education

There is now a demand for the study of medical education in its own right and not linked to a specific subject. Education and its techniques in imparting knowledge, skills, and attitudes and in assessment are of more than passing interest. They are central to the functions of medical schools, faculties, and universities, and all other medical educational bodies such as royal colleges and faculties, and even of the General Medical Council and the councils for postgraduate medical education. In medicine education has developed haphazardly—in an almost amateur fashion. It now needs professionals to take heed of advances in educational method and theory outside medicine and relate them to the specific requirements of medicine, and also to contribute to general education elsewhere. Many of the professionals will be non-medical, but they need to co-operate with medical professionals too, as in many other disciplines.

In the next article I shall discuss a career in community medicine.

Lesson of the Week

Leg ulcers that do not heal

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We report on three patients to illustrate the different ways in which malignancy may be neglected or misdiagnosed in a skin ulcer of long duration.

Case reports

Case 1—A 63 year old Portuguese man presented in 1976 complaining of recurrent ulceration of his foot. When he was 7 years old his foot was crushed under a stone, and he had had a subtalar amputation. The stump was first ulcerated in 1973 but healed when new boots were fitted. In 1974 diabetes mellitus was diagnosed and was controlled with diet and chlorpropamide tablets. In 1975 he had numb patches on one hand and on his face that were thought to be due to mono-

A skin ulcer that fails to heal within four months should be biopsied

neuritis multiplex secondary to diabetes. He was also a heavy smoker. At admission his diabetes was poorly controlled, and he had an infected shallow ulcer on the dorsum of his amputation stump. Blood pressure, measured by the Doppler technique, was normal at the ankle, but on arteriography his arteries were diffusely calcified, with only the anterior tibial artery filling below the popliteal trifurcation. His ulcer was thought to be due to a combination of trauma and diabetes, and possibly ischaemic disease. He returned to Portugal without further treatment and reappeared in 1979; he still had the ulcer. A biopsy specimen showed a moderately differentiated squamous cell carcinoma. His leg was amputated below the knee.

Case 2—In 1976 a 71 year old woman presented with a short history of an ulcer on the posterolateral aspect of her calf. Excision and graft were advised, but she failed to attend because

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