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References

1 Anonymous. Aids in the UK. *Lancet* 1987;i:641.
2 Anonymous. *Acquired immune deficiency syndrome (AIDS)—United States.* Glasgow: Communicable Diseases (Scotland) Unit, 1986:10-1. (86/36.)
3 Anonymous. Human immunodeficiency virus (HTLV3/LAV) antibody reports England, Wales and Northern Ireland: weeks 84/50-87/04 and acquired immune deficiency syndrome: United Kingdom: January 1987. *Communicable disease report.* London: PHLS Communicable Disease Surveillance Centre, 1987:3-4. (87/05.)
4 Anonymous. Human immunodeficiency virus (HIV) infection. *Communicable diseases Scotland weekly report.* Glasgow: Communicable Diseases (Scotland) Unit, 1987:10-1. (87/04.)
5 Peutherer JF, Edmond E, Simmonds P, Dickson JD, Bath GE. HTLV-III antibody in Edinburgh drug addicts. *Lancet* 1985;ii:1129-30.
6 Robertson JR, Bucknall ABV, Welsby PD, *et al.* An epidemic of AIDS-related virus (HTLV-III/LAV) infection among intravenous drug abusers in a Scottish general practice. *Br Med J* 1986;**292**:527-30.
7 Brettle RP, Davidson J, Davidson S, *et al.* HTLV-III antibodies in an Edinburgh clinic. *Lancet* 1986;i:1099.
8 Robertson JR, Bucknall ABV, Wiggins P. Regional variations in HIV antibody seropositivity in British intravenous drug users. *Lancet* 1986;i:1435-6.
9 Brettle RP. Epidemic of AIDS related virus infection among intravenous drug abusers. *Br Med J* 1986;**292**:1671.
10 Centers for Disease Control. Recommendations for assisting in the prevention of perinatal transmission of HTLV-III/LAV and AIDS. *MMWR* 1985;**34**:721-32.
11 Scott GB, Fischl MA, Klimas N, *et al.* Mothers of infants with the acquired immunodeficiency syndrome. *JAMA*, 1985;**253**:363-6.
12 Follet EAI, McIntyre A, O'Donnell B, Clements GB, Desselberger U. HTLV-III antibody in drug abusers in the west of Scotland: the Edinburgh connection. *Lancet* 1986;i:446-7.
13 Jesson WJ, Thorp RW, Mortimer PP, Oates JK. Prevalence of anti-HTLV-III in UK risk groups 1984/85. *Lancet* 1986;i:155.
14 Spira TJ, Des Jarlais DC, Marmor M, *et al.* Prevalence of antibody to lymphadenopthy associated virus among drug detoxification patients in New York. *N Engl J Med* 1984;**313**:467-8.
15 Levy N, Carlson JR, Hinrichs S, Lerche N, Schenker M, Gardner MB. The prevalence of HTLV-III/LAV antibodies among intravenous drug users attending treatment programs in California: a preliminary report. *N Engl J Med* 1986;**314**:446.
16 Franceschi S, Tirelli U, Vaccher E, *et al.* Increased prevalence of HTLV-III antibody among drug addicts from Italian province with US military base. *Lancet* 1986;i:804.
17 Centers for Disease Control. Human T-lymphotropic virus type III/lymphadenopathy-associated virus antibody testing at alternative sites. *MMWR* 1986;**35**:284-7.

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How To Do It

Take a teaching ward round

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The traditional form of teaching in British medicine has been an apprenticeship and for many specialties the cornerstone of this teaching has been the ward round. This approach of basing teaching on close contact with patients is not typical of medical teaching in all countries, and in some British schools there has been an unfortunate drift away from the bedside and into the lecture theatre and seminar room. Medical educationalists have emphasised the importance of problem based learning—which is the essence of patient based teaching ward rounds where the problem presented by the patient has to be not only dealt with but identified in the first place.

What makes a good ward round? We all have memories from our own student days, many relating to charismatic, sometimes fearsome, consultants' ward rounds but these memories often include the patients and their conditions. Our recall of these patients presented on rounds, far superior to our memory of pages of textbooks, testifies to the effectiveness of those teaching rounds.

The medical curriculum is becoming more and more crowded as everybody wants to teach the essential facts of his specialty. A course covering all possible options would have to be several years longer than at present, and teachers therefore need to be selective and deal with the principles and approaches entailed in different subjects rather than with straight facts. If the division of time in the course is right then during each attachment the student will see on the wards the conditions that are important for hospital practice in that specialty.

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There is increasing pressure on teachers' time as well as on students' and you may be tempted to combine business and teaching rounds. Resist this temptation. There is no harm in taking students on business rounds, particularly if they know about all the patients as they should, but don't fool yourself that this can replace their teaching round. It is impossible to devote enough time and thought to teaching in the context of the business round.

There are four main elements to the teaching round; the ward, the patients, the students, and the teachers.

The ward

For many of us cuts in the numbers of beds and shared wards have deprived us of a personal ward and a devoted sister, who would control the ward and maintain absolute silence in it during the teaching round. Sanity is best maintained by arranging ward rounds clear of meal times and regular floor polishing sessions. There are advantages in having notes and *x* ray films available and an accompanying nurse, not least because it introduces the students to a team approach to care.

Hospitals concerned in teaching should have a room available on each ward where the ward round can go to discuss the patients and the problems presented.

Patients

Some patients take great pride in displaying their clinical signs to anyone who shows the slightest interest, but such professional patients are in the minority. Others subject themselves to student ward rounds for a variety of reasons: realisation that students need to learn, obligation to the staff looking after them, and even a worry that refusal may prejudice their future care. Refusal to participate is unusual if patients are consulted beforehand, but they should be given the opportunity to decline. They are more likely to agree if they have a student, who sees them regularly and whom they identify as part of the team looking after them.

Patients need to be aware of what is happening in the round. They should be warned that discussion they may hear often applies to general principles and differential diagnoses and not necessarily to their particular case.

Patients to be seen on a ward round are, of course, chosen on the basis of availability. Few patients in hospital are incapable of generating a worthwhile ward round. There will always be interesting aspects in the history, examination, investigations, social background, or treatment. If not then there is unlikely to be a good reason for their being in hospital at all.

Some discussion and examination will have to take place at the bedside, but, in general, it is best to move away from the patient to explore the importance of the findings and the management. A side room is best for this, out of earshot of other patients, who are less likely to understand the context of a ward round and quite likely to relate a garbled version of the story back to the patient—the ward bush telegraph works at impressive speed and range.

Students

Departments in most hospitals vie with each other to have the largest retinues available for their ward rounds. Anybody in a white coat will do and ability to understand English is not an essential qualification. These large, white coated armies have no place on teaching rounds. The optimal number depends a little on the experience of the students but is probably three to five. Larger numbers than this will be unable to see or elicit abnormal physical signs or to take an adequate part in discussion. There is no need for all students to hear a murmur or feel a mass on the round. Once the techniques have been demonstrated and one or two students convinced there is no reason why others cannot return to see the signs for themselves later. Ward rounds should, however, be used to check on the ability of students to elicit histories and to examine.

If learning is really based on patients then students should look after the inpatients on a firm and should be able to present cases without notice. Some units do not run in this way and it is usually best to give prior warning, at least for the main case on the round. This allows the student and the teacher to prepare for the session. Most teachers have some topics that they would prefer not to teach unrehearsed. It is possible to do so but it may limit the directions the round can take.

One of the best stimuli to student learning is the fear of examinations. The ward round has advantages here since it can mimic either short or long case format.

Teachers

The function of the teacher is not to give out information but to inspire the student to do the work. When students have seen and discussed a problem on a ward round they should be left feeling keen to go away and read further on the subject. This sort of patient based or problem based learning sticks much better in the mind because it has some immediacy and interest which reading page by page through a textbook or listening to a formal lecture can never have.

Few medical teachers are taught how to teach and much of their technique comes from their own earlier experience of teachers. There are different approaches but the essential feature is enthusiasm on the part of the teacher. Students will respond to enthusiasm, and learning depends on the response of the student; it is not a passive transfer of information.

Teaching rounds are not lectures. If you want to give a lecture it is much more comfortable and efficient to move to a lecture theatre and talk to larger numbers. The ward round needs interaction —with the patient, and, most important, with the students. The round can be used to elucidate points in the history and communication with the patient, to show physical signs, and to explore the techniques of diagnosis and management. Symptoms and signs in a textbook are just components of a list contributing to a diagnosis. In real patients they are individual experiences with their own unique features that can be further explored and interpreted. Few lecturers are gifted enough to bring their descriptions to life in the same way.

The round should be used to explore the students' diagnostic methods and cognitive processes. Students should be taken through the processes they have used to come to their conclusions. So far as possible questions to the students should bring out this exploration, not to force a student's thinking into a rigid format but to let him see the processes he is using and the alternatives available. This form of questioning and exploration is far more valuable than the provision of a list of the causes of clubbing or the familiar "guess what I am thinking of" approach. It is problem based learning and the problem is the patient lying in front of them. Facts and understanding will change during the students' careers, some even before they qualify, but the basic techniques of how to deal with these facts and fit them to patients' needs never change.

The number of patients to be seen on a ward round will vary. A reasonable length for a round is probably about an hour and a half allowing time for hearing the history, demonstrating physical signs, and discussion. This allows time for reasonable discussion of one patient, or two if specific aspects are to be dealt with. Longer rounds are a physical as well as a mental strain.

The great importance of the ward round is that it deals with patients not diseases, it develops thinking processes, and it introduces the approach to patients that most doctors will follow for the rest of their working lives.

People suffering from eczema are often refused entry to nursing training. Are there any specific guidelines regarding history, sight, extent, type, or intensity of treatment that may be used as a guide?

Atopic subjects are particularly susceptible to skin damage by irritants, and nurses' hands are so often exposed to wet work, detergents, and chemicals that the nursing profession is a potential hazard for anyone with atopy. The diagnosis of atopy may be made on a personal history of eczema, asthma, or hay fever or on such a history in a first degree relative. The special danger for atopic nurses is the development, perpetuation, or worsening of eczema of the hands, which often becomes secondarily infected, causing them to lose time in training and preventing them from working in the theatres or on the wards. A study of hospital workers showed that wet work nearly doubles the likelihood of hand eczema developing as compared with dry office work,[1] and hand eczema in nurses is particularly likely to be a recurring problem.[2] Not every atopic subject, however, needs to be debarred from nursing, and many complete their training without difficulty. Regardless of occupation, bad prognostic factors for the development of hand eczema in any atopic person are the occurrence of hand eczema in childhood, severe eczema in childhood, the persistence of eczema on any part of the body, and the presence of dry itchy skin.[3]—E CRONIN, consultant dermatologist, London.

1 Nilsson E, Mikaelsson B, Andersson S. Atopy, occupation and domestic work as risk factors for hand eczema in hospital workers. *Contact Dermatitis* 1985;**13**:216-23.
2 Lammintausta K, Kalimo K, Aantaa S. Course of hand dermatitis in hospital workers. *Contact Dermatitis* 1982;**8**:327-32.
3 Rystedt I. Factors influencing the occurrence of hand eczema in adults with a history of atopic dermatitis in childhood. *Contact Dermatitis* 1985;**12**:185-91.