Pointers

Immunopathology: Professor R. R. A. Coombs, F.R.S., reviews immunological reactions and their mechanisms in the Fourth Foundation Lecture to the College of Pathologists (p. 597).

Viruses: Description of immunofluorescent antibody techniques for rapid diagnosis of respiratory syncytial virus infection (p. 602); evaluation of techniques for cultivating viruses in the "common cold" syndrome (p. 606).

Necrotic Cervicitis: Virus of herpes simplex incriminated as the causative organism in six cases of severe necrotic cervicitis (p. 610).

Missing Loop: An incidence of 8.7 dislocations per 1,000 first insertions of Lippes Loops reported from Singapore (p. 612).

Occupational Hazard?: Incidence of post-mortem lung smears with asbestos bodies suggested an association with occupation rather than neighbourhood contamination by asbestos dust (p. 614).

Lead: Comparison of biological tests for lead exposure shows that blood estimation gives best indication (p. 618).

Case Reports: Tetany and hypomagnesaemia (p. 622); toxic epidermal necrolysis (p. 623).

Perforated Peptic Ulcer: An up-to-date look at one of the commonest causes of emergency laparotomy (p. 625).

Work-load in Practice: While visiting is important in comprehensive family care, survey shows home visits can be much reduced without apparent detriment (p. 633). Letters on general practice as worth-while career (p. 644).


Glandular Fever: New evidence for viral origin (p. 593).


Burkit's Lymphoma: Incidence in Canada questioned (p. 637).

Suicide in Pregnancy: Better notification (p. 638).

Severe Asthma: Debate on treatment continues (p. 639).


B.M.A. Board of Science: Memorandum on its establishment (Supplement, p. 67).

G.M.C. Disciplinary Committee: Supplement, p. 71.

Bedside Teaching

Most lay people probably realize the advantages of being treated in a teaching hospital. Consciously or unconsciously they appreciate that they are likely to receive skilful investigations, diagnosis, and treatment in a setting where exemplary standards are the aim and where the consultants and senior residents are under the constant critical eye of each other and of medical students. But more might yet be done to allay patients' fears and embarrassments and to respect their privacy and feelings. Patients, though only a very few, still ventilate grievances in the newspapers about being taught upon and claim they have not been handled with reasonably sensitive concern.

Two recent surveys, one in London2 and the other in Aberdeen,3 have sought to define more precisely the attitude of patients to clinical teaching. The London survey, of 504 outpatients and 258 inpatients in all departments, was made at Westminster Hospital by two students to establish if the patients' "comfort and well-being was in any way adversely affected." Of the 504 outpatients, 30% had not realized that students would be present when they saw the consultant. This clearly represents inadequate communication between the patient on the one hand and the general practitioner and hospital doctors and administrators on the other. Apparently the consultations were carried out to the satisfaction of the patients, because 93% did not object to the presence of the students; 94% said they were made to feel at ease, though 13% were embarrassed. The survey indicates that surgeons tended to be less adept than physicians at putting their patients at ease, and that the embarrassed patients were largely females. Over a quarter of those attending the gynaecological clinics expressed embarrassment despite the hospital's practice of each patient being seen by only one student. As the authors realistically state, embarrassment in a high proportion of gynaecological patients is to be expected, and the proportion could well be as high in private practice without the presence of students. National characteristics and social customs are important in this context. It is generally conceded that a pelvic examination is best carried out with the patient on her back and her legs supported by a nurse or in stirrups. This is the technique used as routine in Canada and the U.S.A., whereas in Britain we employ the less satisfactory left lateral position because patients here are said not to tolerate anything more. But such attitudes change. For example, the incidence of dysmenorrhoea among nurses is a fraction of what it was 20 years ago, a reduction which can be attributed only to a change in mental attitude to a normal biological event.

Of the 258 inpatients in Westminster Hospital 98% thought the students "had been good with them," and only 3% "objected to" the presence of students, though 18% (mainly female) "disliked" it. During teaching rounds 97% said they had been made to feel at ease, though 16% (mainly female and particularly gynaecological patients) had experienced some embarrassment; 80% said they had been treated with courtesy
during the round and only three patients complained of off-handedness. More than 70% had found the students cheerful, interested, considerate, or helpful.

The Aberdeen survey was made on 100 consecutive patients admitted to general medical wards for acute cases. Only half the patients realized that they might be seen by students during their hospital stay and 73% were unaware that they could refuse to be examined by students. However, 97% said on discharge that they would not object to being examined by students if a subsequent hospital admission was necessary. Little adverse comment was made about bedside teaching, and only one patient made the unfavourable comment that "it was a bit embarrassing," though others would have preferred the session to have been held in a private room out of possible earshot of other patients. This satisfactory report is in contrast to the survey made in 1962-3 in a medical ward at King's College Hospital in London, where 20% of the women and 5% of the men disliked being taught upon.

In Aberdeen only 36% of the patients appreciated the advantages of being in a teaching hospital. Failure of the others to understand this was not related to socio-economic class but probably due to the absence of a non-teaching hospital of comparable size to the Royal Infirmary in the Aberdeen region. This Scottish survey shows that patients understand and accept the need to take part in the clinical training of medical students. The majority co-operated willingly, but a small minority, while not refusing, found that examination by students is an unpleasant experience. The "unpleasantness" was largely compounded of embarrassment and, to a small extent, of colour prejudice, 9% of the Aberdeen patients, mostly in the older age groups, admitting that they would prefer not to be examined by coloured students.

What can we as a profession do to further the relationship between patient and student? Firstly, we must set an exemplary standard of courtesy and good manners in our dealings with all patients. Secondly, we should ask all patients if there is anything they would like to discuss privately with us, out of earshot of students and nurses. Thirdly, we must improve our communication with patients so that they appreciate that in a teaching hospital they will encounter students, and that this encounter has advantages outweighing the disadvantages. Fourthly, we must "identify" with the patients and by using our imagination anticipate what will be embarrassing to them. Fifthly, we must treat our students as adults in the knowledge that if we do we will behave more maturely. We cannot afford to be complacent, but it might help to remember what one Westminster Hospital patient wrote at the bottom of his questionnaire: "Whatever you do, human nature being what it is, people will go on complaining, some with reason, some without, about the presence of students in hospital."

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**Early Diagnosis of Large Bowel Cancer**

In contrast to growths of the stomach and the lung early detection and adequate excision of a bowel cancer leads to long-term survival in most cases. The outlook is so different for patients with early and late colonic and rectal tumours that early detection, preferably in the still asymptomatic patient, is really worth while. Possible methods of screening the population are examination of the stools for occult blood, routine sigmoidoscopic examinations, barium enemas, and cytological examination of colonic washings.

D. H. Greegor has recently reported the results of routine testing for occult blood in adult patients who presented for routine annual medical examination. Using a commercially available guaiacum test on at least two or three portions of three separate stools he obtained positive results in no fewer than 23% of 128 patients. This was in contrast to only 7% positives in an earlier single-stool study. Patients with positive tests were then examined by barium enema. Full investigation of a group of the patients with positive reactions for occult blood showed that 45% had some disease in the gastro-intestinal tract (6% had carcinoma). Over 2,000 patients were screened and eight were found to have tumours. Four of these had strongly positive occult blood in the stool, three weakly positive, and one was negative—this patient had a malignant polyp picked up on a sigmoidoscopic examination.

At the Cancer Detection Centre of the University of Minnesota over 12,000 patients of 45 years or over have been reviewed repeatedly from 1948 to 1965. Sigmoi dscopy is routine at the initial examination and this has detected 19 adenocarcinomas. The 46,000 follow-up examinations have yielded nine further carcinomas. Statistical studies suggest that between 30 and 34 cancers could have been expected in this time. The probable explanation for the discrepancy is that benign polyps and adenomas were removed from 9% of men and 5% of women at the initial examination and from no fewer than 28% of patients who underwent two or more annual examinations. There is no doubt that benign adenomas and papillomas of the bowel precede overt cancer and that their detection and removal is an important prophylactic measure. C. G. Moertel and his colleagues found no frank cancers in 1,020 routine examinations in asymptomatic patients, but they did detect benign polyoid lesions in 7.5% at sigmoidoscopy.

The barium enema is the most reliable diagnostic tool in the detection of large bowel tumours, though small lesions, especially in the caecum and rectum, may be missed. Yet a routine barium enema repeated at yearly intervals in asymptomatic middle-aged and elderly patients would hardly be acceptable to the public nor practically feasible. Reasonable indications for this examination are the presence of benign polyps at sigmoidoscopy or occult blood in the stools of otherwise asymptomatic patients.

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