Editorial

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Preparing to put pen to paper, I reflected that this might prove to be the last edition of the Journal before we are engulfed by the gathering disaster, still misnamed "swine flu"—though it is now very definitely a disease of mankind. Coinciding marvellously with a global economic catastrophe that has all our politicians clamouring for efficiency savings, and a (slightly less catastrophic) European Working Time Directive that promises to stop junior doctors working over 48 hours a week (as one-third of them currently do), what will this mean for the practice of medicine?

In this edition of the Journal, solutions for challenges such as these, and for the melting of the polar ice caps, the energy crisis, the disappearance of bees, global famine and terror, are nowhere to be seen. But many other problems, also perplexing, if less apocalyptic, will find answers. As one who feels out of my depth at least once a day when I'm on duty in the Medical Admissions Unit, I'm greatly reassured to see so many of my colleagues—including many of those hard-working junior doctors—still making time to reflect on their clinical experiences, so that we all can learn from them.

We certainly must not hesitate to be taught by our trainees. According to respected educational theories and research, such reciprocal learning (students doing the teaching) provides the best and most enduring changes in their understanding and knowledge. Papers written by our junior colleagues teach on two levels—making the author momentarily an expert on the topic, and bringing back to the rest of us much that we'd forgotten—or never learned. Certainly, many of the papers in this edition of the Journal do that for me. So let's continue to welcome papers from our trainees, and be prepared to give them protected time for study and writing.

The advantages of teaching and being taught on real clinical encounters, through case presentations and on the ward, need our protection too. In fact, the teaching ward round is still among the most valuable resources in medicine, if the teacher makes time to establish what the learners need to know, and gives skilful feedback on their performance. That needs negotiation and planning, to meet the needs of patients as well as trainees.

This benefit of the ward round was not always apparent. Demonstrating and discussing clinical problems at the patient's bedside were advocated by Hippocrates, and we know that they happened in the first great Arab centres of learning, but not in the early European universities. Not until 1543 was bedside teaching introduced to the medical school in Padua, by Giambattista da Monte (1489–1552). After his death the practice lapsed, but was revived around 1578 by his students, one of whom, Jan van Heurne (1543–1601), brought this still unconventional teaching strategy to the new medical school in Leiden.

We have much for which to thank the Netherlanders besides pancakes and Dutch elm disease! Whereas Maastricht is today among the most innovative and prestigious centres of medical education in Europe, Leiden held that reputation in the 17th century. Leiden's professor of physiological chemistry, Franciscus de la Boë (1642–1672), also called Sylvius—he of the Sylvian fissure—was the pre-eminent clinical teacher of his day, having as his pupils many who would become the leading physicians and teachers of Europe. (They included the Englishman, Thomas Willis, whose name we now associate with the Circle of Willis, puerperal fever, myasthenia gravis and the sweet taste of diabetic urine). In particular, in his 12-bedded infirmary at Leiden, Sylvius was famed for insisting upon regular bedside teaching for all physicians.

Hermann Boerhaave (1668–1738), also of Leiden, was the dominant physician of the early 18th century, consulted by kings and emperors as far afield as China. Nowadays, he is best known for describing oesophageal rupture in his patient, the Baron de Wassenaer, in 1724; but he also wrote and taught on pleurisy, rabies and smallpox (being the first person to prove that smallpox was spread by contagion), and

the clinical usefulness of Fahrenheit's thermometer. Boerhaave gave lessons in chemistry, physics and botany as well as medicine, and was famed as a brilliant teacher. He also staunchly advocated teaching at the bedside; and from that time onwards, in all medical schools in every society, the hospital ward round has been respected, by patients as well as by staff, as a vehicle for learning.

Are we coming full circle? The clinical workload is increasing for all staff, and postgraduate education becomes harder to deliver, as limits on working hours bring the necessity of shift working. We have plenty of good settings for teaching on the job—including primary care and A&E, as well as wards, theatres and clinics—but the pressures under which we operate, the increasingly technical nature of our work and the multiplicity of tasks competing for our time with "bedside" teaching, sometimes make it unfeasible. Clinicians at all levels now learn the skills of on-the-job teaching, but opportunities to do it are too often missed.

Which is really just a rather convoluted plea that we should all—clinicians and managers—strive to protect time for teaching and learning. For the moment, however, I'm grateful to learn whatever I can from this edition of the Journal. From birth (a history of obstetric forceps) and childhood hypertension to adult ulcerative colitis and its intriguing relationship to multiple sclerosis, via Noonan's syndrome, ocular lymphoma and tibial fractures, there's something for everyone here. And coming back to medical education, I urge you to try Peter Trewby's wonderful account of teaching in Ethiopia. Happy reading!