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THE TEACHING OF GYNECOLOGY TO THE ADVANCED PUPIL.*

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THE pedagogics of gynecology in general and of postgraduate gynecology in particular, present intrinsic obstacles to teacher and student, that are not encountered in other specialized departments of medicine and surgery.

Its diagnostic fundamentals demand, as an essential prerequisite, the cultivation of a keen tactile perceptivity, which can be acquired only among ample clinical facilities.

Such clinical facilities are circumscribed by obvious prohibitive restrictions, which limit the utility of the average gynecological patient for objective class demonstration, and create a relative paucity in opportunities for specialistic cultivation.

He, to whom these initiatory obstacles have proven no hindrance, will behold gynecology in the dawn of a new era.

The mechanistic empiricism that dominates the votaries of the established practice, is slowly but surely merging into the realm of the obsolete.

Surgical virtuosity alone no longer constitutes a gynecologist: Healed incisions and operative correction of purely objective deviations from hypothetical normals do not prove the cure, while the use of symptomatic nosology does not establish a diagnosis.

We were taught to see a passive retention wedge in the "perineal body"—where we now recognize an active myodynamic deflector of intraabdominal pressure in the levator ani muscles.

The time is passing when "endometritis" encompassed the beginning and end of all uterine pathology; when "reflex neurosis" presented the shibboleth of its symptomatology and "curettage" the slogan of its therapy.

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Henricius in 1889 unwittingly laid the foundation of uterine physiology, when he graphically demonstrated that the normal non-gravid uterus is a rhythmically contracting organ; Leopold in 1874 blazed the path to its rational pathology when he revealed the myometrial lymph channels; Kundrat in 1873 exposed endometritis as a normal manifestation in pathological guise, thus transposing the pathogenesis of its cardinal symptom, namely, hemorrhage, from an anatomical to a biochemical basis.

This biochemical genesis projects its whole dominating hierarchy of the internal secretions upon the gynecological horizon, where in the haze of the "reflex neuroses," we begin to discern the lineaments of insidious sepsis and toxicosis.

Current terminology, accurate and inaccurate, dominates our concept and concept determines practice, so the term "metropathic hemorrhage," for instance, links fact and fancy, the hemorrhage is the fact, the "metropathic"—a fancy, nevertheless this term is conventionally synonymous with hysterectomy, notwithstanding that the purely functional nature of the hemorrhage as a result of inefficient thyroid or pituitary metabolism has been demonstrated in many cases successfully controlled by appropriate organo-therapy.

The same line of research will divert many a case of sterility from utterly futile cervicoplastic operations, while on the other hand, the controversy as to the clinical significance and choice of corrective measures in uterine displacements will frequently find its solution in the recognition of those skeletal abnormalities, congenital or acquired, in which misdirected intraabdominal pressure induces *necessary compensatory* deviations from normal lines of visceral topography.

These few phases from among the many will serve to indicate the broadening scope and wider range of advanced gynecology.

The student must be taught to see beyond his finger tips: an organism, not an organ is the object of his study. He must learn to calculate in terms of gonad and endocrine denominators, to balance and correlate—orthostatic, dynamic and biologic factors in his clinical definitions.

He must be enabled to differentiate the gynecological manifestations of systemic disorders from the systemic disturbances of gynecopathic origin.

This wide diversity in essential contributory and complemental elements has not and cannot be crystallized to the concrete homogeneity of a text-book stage, so that an adequate proficiency in this

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technical complex must be sought among ample polyclinical facilities under judicious guidance.

Individually, post-graduate students are ardent, earnest men who seek knowledge at personal sacrifice; collectively, however, they present a mental and technical heterodoxy, that ranges from specialistic endowments down to an absolute lack in first principles—and in the present status of post-graduate instruction, the teacher must adopt a course that ranges from the needs of those who cannot locate a fundus uteri, to those who seek the last word on the chemotaxis of ovular nidation.

In the New York Polyclinic, each of six gynecological divisions, conducts two clinics weekly, one operative and one ambulatory.

The morning sessions are devoted to details of surgical technic and the incidental study of operative findings in their anatomic, pathologic, symptomatic and diagnostic bearings.

It is the ambulatory clinic, however, with its wider range, that affords opportunities for the discussion and elucidation of advanced gynecological problems.

In the ambulatory division of my clinic, I have adopted a course which meets as nearly as possible the requirements of those seeking only a practical working knowledge as well as those interested in the more academic phases of the subject.

My class is divided into sections of two members, each section having its case assigned for examination under my supervision and that of my staff.

Sounds and specula are discarded and the previously established diagnoses and histories are withheld for the time.

The students are supplied with the blank forms, here reproduced, on which their dictation of objective abnormalities are noted in strict topographic sequence.

During the manual examination of the patient, any deficiency in method or tactile perception on the student's part is corrected, while his verbal delineation engenders differential precision.

Based upon these objective findings, the functional disturbances are deduced and their incidental symptomatology postulated.

The whole class participates in the diagnostic equations thus propounded, this elicits their individual conceptions and misconceptions, and affords the teacher opportunity to correct the latter and amplify the former by elucidating those higher phases of the subject embodied in the term "Advanced Gynecology."

The final conclusions are now compared with the history of the

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DEDUCTIVE GYNECOLOGICAL DIAGNOSIS

No. .....

Name .....

Topographic Sequence	Objective Features	Functions Involved	Symptoms Deduced	Diagnosis
VULVA				
INTROITUS				
VAGINAL-CANAL				
CERVIX-UTERI { Os-outlines; Direction; FORM; Consistence				
FUNDUS-UTERI { Direction; Size; FORM; Consistence; MOBILITY				
ADNEXA { Situation; FORM; Consistence; MOBILITY				

case and the diagnosis corroborated by the approximate coincidence between the objective deductions and the subjective data.

Advanced gynecology was an art and is a science.

The teacher can demonstrate its practice and elucidate its theories, but he cannot impart aptitude, and when all is said and done, he becomes convinced, that advanced gynecologists are born and not made.

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