Letters to the Editor

Arab medicine

Sir, — While I appreciate the initial compliment in his letter (July, p250), Dr Lofti is incorrect in stating that my article (October 1989, p277) referred to Rhazes and Avicenna as 'Arabian physicians'. It is well known that Rhazes and Avicenna were Persian but it is traditional to include their work under Arab medicine in medical texts.

For example, Guthrie in his history of medicine (1945) explains that the words 'Arab' and 'Arabian' are applied solely in respect of the language which these physicians spoke and wrote. All were not natives of Arabia; some were Syrian, some were Persian and some, as the Muslim empire extended, were Spaniards. Nor were all of them Mohammedan; many were Christian and some were Jews. Lyons and Petrucelli, in their history of medicine (1978), use the name Arabists to include Nestorian Christians, Persians and Jews who were not ethnic Arabs.

Both Rhazes and Avicenna were Muslims. Avicenna knew the Koran by heart before he was 10. Their philosophy and work was in total harmony with the Arab and Muslim world. It was in this context that I referred to Rhazes and Avicenna, also the Jew Maimonides, under 'Arab medicine'.

Dr Lofti's reference to Harvey is irrelevant. He was a European physician, as well as an Englishman, who wrote his great work in Latin, as did other Europeans at that time, and published it in Frankfurt. The Arabic or Muslim empire which engulfed much of Persia was in the days of Rhazes and Avicenna at least as extensive as Europe. This was the basis of my use of the terms 'Arab medicine' and 'European medicine'.

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The new dermatology

Sir, — I should not like your readers to believe that Professor Greaves's astonishing article (April, p87) on the future of dermatological practice represents the views of the majority of dermatologists. Most colleagues to whom I have spoken disagree strongly with him.

Many of his *ex cathedra* statements are purely speculative. For example, he forecasts that in the next 10 years we shall have a range of new, safe systemic drugs that will 'drastically alter the pattern of referral to hospital skin clinics' and thus reduce our work. Time will tell whether he is right, but despite the plethora of powerful new drugs in the past 10–15 years our workload has increased considerably — with a corresponding improvement in the dermatological health of the community. He also suggests that OTC drugs will be a 'major factor' in determining referral patterns. Although OTC hydrocortisone has been available for some years there is no evidence that it has made the slightest difference to hospital referrals.

Much more misleading than these matters of opinion are some of his statements on factual matters. For example, it is simply not true that severe psoriasis was 'almost untreatable' before the advent of cyclosporin, and I do not believe that 'much of the routine care of patients with skin disease is already being done by non-specialist clinical assistants', even at St Thomas's Hospital.

These speculations and inaccuracies, damaging as they are to dermatologists, would be relatively unimportant to the College as a whole were it not for the fact that the main thrust of his argument seems to be for the establishment of an 'exit examination' as a prerequisite for specialist accreditation in dermatology. The introduction of such an examination might eventually lead to dermatologists abandoning the MRCP examination and setting up their own college, as in Australia.

Certainly we should have informed debate on the issue, and further articles arguing for or against exit examinations would be welcome, but the 'special pleading' in Professor Greaves's polemical article should not pass unchallenged.

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Are more consultants needed for dermatology?

Sir, — Dr Verbov, in his response (July, p249) to my prediction (April, p87) on the future of dermatology in the UK, expresses the view, frequently voiced in dermatological circles, that a substantial general expansion of consultant posts in dermatology is needed. I have yet to see national data to support this supposition. That there are too few dermatologists in some regions, including Dr Verbov's, is evident but there are others, outside London, where to my personal knowledge waiting lists at dermatology clinics have shortened dramatically in recent years — even if the consultants concerned do not write to journals about it. A redistribution of consultant sessions could be a more sensible alternative and I do not discount Dr Verbov's hint that despite a need for teaching and research in 'centres of excellence' some urban areas seem overendowed with consultant sessions. The often quoted DHSS 'recommended' ratio of one consultant per 200,000 of population does not help because it is already exceeded in the UK, and no one seems to know the basis for this figure. It would be naive to expect the Ministry of Health to fund the creation of additional consultant posts in the absence of support-