populations. With such an expansion of medical school size, the faculty is in dire need of training, particularly in basic medical science for medical practice. (This type of curriculum exists in the second year at Brown.)

The Department of Community Medicine at New Jersey College of Medicine and Dentistry, Brown, and IEMT have worked out an arrangement where faculty members from the United States spend between 1 and 3 months a year in Nicaragua. The faculty member will work with counterparts in Nicaragua to develop curriculum materials appropriate for an individual medical science topic.

In addition, we have discussed a clinical research project that may be organized in conjunction with faculty at Brown. Through the community clinics, the medical school in Managua is interested in setting up a surveillance program for diarrheal diseases. This surveillance project would provide needed information to local practitioners on the types and resistance patterns of organisms in the community. In addition, in conjunction with public health personnel at the Ministry of Health, information developed through the diarrheal surveillance project will permit public health teams to make a more rapid response to breakdowns in sanitation and water systems.

IEMT has sufficient funding to organize planning meetings and develop proposals. We hope that proposals like those described above will be funded by public or private agencies. In the long run, we hope that faculty contact and joint research projects will perpetuate the exchanges long after the initial projects are completed. We hope that the models we develop will be applicable to other medical and nursing schools in the United States.

We feel that programs like these are the most cost-effective way to focus United States medical training expertise on the very pressing health care needs of the developing world. Addressing those needs is also likely to improve United States relationships with the poorer nations of the world and to reduce the likelihood of conflict.

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**Dermatology**

Dermatology crystallized in the eighteenth century, as is reflected by Lorry's pioneer treatise of 1777. Jean Louis Alibert (1768–1837) was the real founder of the discipline, although his system—he was strongly under the systematizing influence of the eighteenth century—was soon superseded by the more modern approach of the English Quaker Robert Willan (1757–1812). Ferdinand von Hebra (1816–1880) of Vienna, the founder of a great school, introduced the histological or pathological approach. The important repercussions of bacteriology on dermatology are represented by the work of Raymond Sabouraud (1864–1938) and Paul Unna (1850–1929). Dermatology as an independent specialty was established in the 1870's.

Dermatology had been traditionally combined with syphilology and the study of venereal diseases in general. Probably the two greatest syphilologists of the century were the Baltimore-born Frenchman, Philippe Ricord (1799–1889), and Jean-Alfred Fournier (1832–1914). Ricord definitely established the independent existence of gonorrhea and syphilis and laid down the division of syphilis into its three stages. Fournier's work covered the whole field of syphilis, but he is particularly remembered for establishing statistically the connection between syphilis and tabes (locomotor ataxia). His work in this field was almost simultaneous with that of the German neurologist Erb. Sir Jonathan Hutchinson (1828–1913) is remembered for his work in heredosyphilis. The discovery of the causative organisms of venereal disease by Neisser, Ducrey, and Schaudinn was followed by important progress in diagnostics and treatment in the twentieth century. The far-reaching recession of syphilis during the last forty years has changed considerably the physiognomy of the specialty dermatology-venereology, as well as that of psychiatry and neurology. The latter disciplines were also strongly influenced by the rise of neurosurgery.—Ackerknecht EH. A Short History of Medicine. Baltimore: Johns Hopkins, 1982:201–202.
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