subject as well as in the new methods of its presentation.

This is a problem very similar to that which has to be faced in the field of medical education. There is a new and important job for universities in this matter. It is their business to collaborate with professional organisations of a variety of kinds as well as, in the field of teaching, with Local Authorities, to try to facilitate this continuous process of re-education which now has to be carried on.

It might well be that the future of extra-mural studies in universities really lies in this direction; that they should progressively abandon their present form and take over in close collaboration with the internal depart-

ments the whole business of providing additional training for graduates over a wide range of subjects and in collaboration with a variety of outside agencies. That is why I especially welcome the foundation of the Postgraduate Centre at Canterbury, coinciding as it does with the establishment of the new University here. They both have an opportunity to work out a new and fruitful relationship in this developing field of postgraduate training and education. I hope very much that the meeting today will only be the beginning of a whole series of such efforts where the profession and the University collaborate closely and harmoniously in an important common task.

POSTGRADUATE MEDICAL EDUCATION IN A PROVINCIAL HOSPITAL

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THE KEYSTONE of all postgraduate medical education is an adequate medical library; this is no reflection on this morning's speakers who so ably demonstrated the uses, and possibly the limitations of such valuable aids as teaching machines and tape recordings.

There are obviously many ways of going about starting a library, but I will give you our experience in Ipswich for what it is worth. The years 1949 and 1950 saw the appointment of several young consultants. Most of them wanted to teach their junior staff and also realised that without this exercise and the stimulus of discussion they would themselves stagnate. However, the lack of a medical library which had formed the background of their own postgraduate training and research immediately frustrated them, because without it they knew that their efforts to train their juniors to attitudes of research-mindedness and enquiry would come to naught.

The Ipswich Medical Library opened in 1953 after the usual obstructed labour. The staff committee of that time late one foggy evening, grudgingly acquiesced by a single vote to its inception and amid gloomy prognostications about lost books and even the hazards of reading!

Needless to say it has been a great success. Our policy has been that it should be a periodical library because textbooks are mainly out

of date by the time they are printed, and the cost of purchase of an adequate number by a small library is prohibitive. Latterly the textbook problem has been met by departments being allowed to spend £10 0s. 0d. p.a. on books which are regarded as essential articles of equipment, and by subscription to a medical lending library for twenty volumes which may be changed on application to the librarian.

About 90% of the periodicals are given by the consultant staff a month after receipt, much to the relief of their wives! H.M.C. and R.H.B. financial support has certainly been encouraged by this contribution by the doctors worth about £200 p.a. The cost of binding is met by an annual H.M.C. grant as is the Index Medicus and the part-time librarian's salary. Initially she put in eight hours a week and now does 16 hours. A librarian is essential, but need not necessarily be trained because many of her duties will be secretarial, and flexibility is an advantage. To begin with the library was open at fixed times but the committee very soon decided to open it at all times so that it could fulfill its maximum potential especially for junior staff. Very few journals are lost because of the vigilance of our librarian who posts a notice as soon as a periodical is missing, and because the library stamp is placed on each journal on arrival. So highly is the library prized by the residents that public opinion dis-

courages pilfering or neglect of the rule against removing unbound volumes from the library. Bound volumes, needles to say, are neither portable nor easy to conceal!

Where to put a library is the next problem, and this applies equally to a medical institute of which a library should be an indivisible part. Our view has been that both must be in the precincts of the main area hospital, because this ensures its use by the maximum number of junior staff which a distant site would inhibit. Consultants and general practitioners are more mobile. It is in such places in future that young men will painlessly acquire experience from their seniors in exchange for the incomparable stimulus of their minds.

It is a sad reflection on our undergraduate schools that even today it is rare to find a newly qualified doctor who knows the use or delight of a medical library, and worse still at present most of them never learn. Until they do we shall continue to have too many backwoodsmen in our profession. Before I leave the question of libraries may I say that a library will only reach its full potential if it is warm, comfortable, pleasantly decorated, well lit and accessible. Offers of cellars, wood-sheds and other substandard accommodation should be politely refused.

The next consideration is the provision of continuing education for junior staff, consultants, and general practitioners. The first two I think are interdependent, but although consultants increasingly recognise their responsibility they continue to fall down over technique. This is largely due to an inherent fault in our whole educational system—not only medical—which remains too didactic. We are all addicted to the disease of lecturing, and the cult of infallibility; and the attainment of seniority finds us imprisoned by our experience and poorly equipped to encourage discussion and accept criticism.

The following anecdote seems relevant. A staff member about to lead a discussion was asked how he would like the chairs arranged, and was told of the usual informal pattern. "This won't do" he said, "I must have a table between them and me."

At present, however, junior staff continue, more or less, to accept didactic methods because of their recent indoctrination. But this does *not*—repeat *not*—apply to the general practitioner. Not for him any longer the old relationship with the consultant of reverence sweetened by the right of patronage which was his alone. Indeed, many believe they could do

the consultant's job as well given the time and facilities. You may recall the general practitioners' reaction to Lord Moran's unfortunate remark a few years ago about "the academic ladder." The significance of that reaction cannot have escaped you.

One is always meeting discouraged or angry consultants embarrassed by a single figure audience for a carefully prepared meeting or an invited national, or international figure; I had the same experience. For years personal invitations to general practitioners to rounds, unit meetings, O.P.'s, journal clubs all failed. In 1956 at a day's symposium, out of four hundred doctors circularised within a 40-mile radius twenty attended and no more than ten at any one time during the day. The nadir was reached when a friend, one of the best G.P.'s in the area, told me he had given up reading the journals because he found the drug travellers more useful. Then one evening at a dinner I met Professor Hewer of Bristol who told me his C.P.C.'s had been successful since he had written to the doctor whose patient was to be demonstrated a personal letter inviting him to come and give his side of the history. He said that about 50% responded, and many of them continued to come to subsequent C.P.C.'s. I applied the same technique to unit clinical meetings in my own department with immediate success. The meetings were very informal, and the time and day were chosen after consultation with a number of practitioners. Very soon doctors outside the group were clamouring to get in, such is the peculiar attraction of exclusive societies. I would still recommend this technique in any area having difficulty in stimulating interest. Thanks to the remarkable offer by the Nuffield Provincial Hospitals Trust in 1961 we were able to extend this venture to a buffet luncheon for practitioners at 3/6d in the residents' mess on every first and third Friday in the month. Luncheon is at 1 p.m., and at 1.45 p.m. there is a group discussion usually initiated by a consultant, but we are delighted at the success of two recent meetings organised by practitioners themselves. Two half day symposia have also been well received.

In terms of statistics about 50% of general practitioners who refer patients to the Ipswich Hospitals have attended "Friday Club" meetings at sometime during the past two years, and the usual attendance is steady at approximately 25% which we regard as satisfactory. Three doctors who previously could not come have changed their surgery times so they may attend. Our failure to attract the other 50% of

G.P.'s who have never come, and probably never will, is sad but less important than our continued ability to catch the young doctors starting up. Active "Friday Club" members are most helpful and make it their business to introduce them.

I would say that success of the "Friday Club" has been due to:—

(1). A choice of time in the middle of the working day. (One must eat somewhere).

(2). Avoidance of normal half-days, Wednesdays and Thursdays. (It must be recognised that this is work, not play.)

(3). Creation of a Club atmosphere.

(4). Establishment of a habit.

(5). Avoidance of didactic teaching in favour of group discussion in which the opener is asked not to speak for more than 15 minutes and not to answer at once questions put to him, but first to put the question back to the group. In this way the group are active participants and not just a captive target for the speaker's erudition.

Finally, implicit in the term "continuing education" is that there has been a "beginning". At present the "beginning" is deficient. Today far too many young doctors leave their teaching schools confused, or bored, their enthusiasm tragically sparkless. Why? It is now a commonplace that medical advancement depends on research—the teacher is no longer esteemed among his peers, and research, and research alone, once the trade of gray men with egg on their waistcoats, is respectable, and teaching is out. The pendulum has swung too far. More teaching is being done by brilliant if limited men who regard teaching as a trespass on their research and may therefore do it badly. Pearls of wisdom are all very well, but with medicine's increasing complexity need special care in presentation for the bottom 80% to pick up and put to good use. Was this always so? Not to the same extent when the teacher knew that the student of today would be his bread and butter tomorrow. Senior men are no longer spurred by this despicable but sadly unfashionable incentive.

It is urgent that medical schools and universities recognise their responsibilities exceed the mere spawning of doctors. At present "parental" concern does not extend beyond

the "top 20%" leaving the bottom 80% more or less deprived of their teachers' interest or approval unless their athletic prowess gains for them an evanescent place in the sun. Today the profession is just as divided as any other family with a number of deprived children. Yearly the gulf between general practice and academic medicine widens, and the hostility of general practitioners increases.

It appears that this disastrous division of the profession starts in the medical schools, but how many consultants ask themselves how far they are responsible for the position they so often condemn? With prominent exceptions, I exempt professors from this stricture, but only because most of them seem unaware of any other form of life but their own, let alone the Brownian movement of General Practice! The dusty halls of power and the academic whirl of jet travel have claimed too many of the men without whose interest and exertions the problem cannot be solved. Reforms in the medical schools are on their way, but it is sad that the amount of new thinking is directly proportional to the mileage from London. After some thought on the matter I now regard it as essential that every school should follow the Edinburgh example by creating a Chair of General Practice, thereby giving status to one half as well as instruction and understanding to both halves of medicine. The College of Practitioners has done well, and will do better, but in the world of University protocol and the professorial scrum it cuts no more ice than its sister colleges, which is remarkably little.

Suffocation of students by the cramming of factual knowledge will continue until much of the present examination system is jettisoned in favour of a satisfactory performance of work done over the years of training and made obligatory for qualification. It should include literary or research projects under the supervision of tutors over the student's last two or three years. Only thus will a capacity for sophisticated thought and enquiry replace those Herculean but sterile feats of memory in the final examination.

I conclude by saying that without such reforms continuing medical education for most doctors will remain an empty phrase.