"ladder"? Regional hospitals provide tremendous clinical experience, and registrars as well as senior registrars from teaching hospitals should have the opportunity of working in them without prejudicing their future.

MR. G. J. HADFIELD (Aylesbury) said that the term "Teaching Hospital" should cover all hospitals where people were taught. The formation of an Association for the Study of Medical Education showed that this idea had spread and should be recognised as having done so. Research could also be done at the periphery: it was important for everyone, as part of our education. Many Boards give prizes for research by registrars. Regional hospital surgeons should encourage this.

PROFESSOR MCGIRR asked how much formal instruction should be given to registrars. How much is done to rotate them through different firms to enlarge their experience? Are we going to rotate them through narrow specialties or just give them general training? He thought that it was written in the conditions of service that everyone should have a year off. Do we use the membership examination to set standards of training or achievement? The Scottish Membership may not be regarded as the equivalent of the London one for this, which is unsatisfactory. It should be the responsibility of universities within their own sphere to provide facilities for research for registrars and senior registrars.

DR. PAULLEY thought there was some danger in elevating the status or financial rewards of tutors. This might estrange their colleagues. It should be the job of all consultants to teach, and their cooperation must not be lost.

DR. D. H. CLARK (Cambridge) remarked that other groups besides physicians in the N.H.S. have to be trained. Dr. Paulley had not mentioned psychiatrists. They had their problems for there was no real undergraduate training and other disciplines had to be mastered. This applied to other specialties—e.g., anaesthetics.

MR. P. GILROY BEVAN (Birmingham) answered the question of what the Colleges were doing from the

surgical point of view. The pilot scheme for surgical training initiated nearly three years ago by the Royal College of Surgeons of England deserved tribute. Recently surgical tutors had been asked for preliminary ideas for putting the scheme on a permanent basis. More tutors would be needed—should every hospital group have one? He was against full time tutorial appointments, but the work took a considerable amount of time. Registrars had to fit their studies in amidst full time clinical duties. Now that postgraduate training was gaining official recognition, the inescapable conclusion was that sessions would have to be allowed for it, and this would mean some increase in establishment for both teachers and the taught.

DR. I. J. VOSS (Kettering) said that the clinical tutor should interest himself in the amount of teaching residents were getting. There were great variations in the amounts given by different chiefs. He challenged the idea that where a job was done was more important than what the job was. The old prejudice against regional hospital registrar jobs was going. The registrar must have the broad experience that only a regional hospital can give.

DR. PATON said that teaching hospitals must decide what they were going to do. There was no distinction now—we must all teach. The universities might create units for postgraduate education in regional hospitals with or without our help. A register of specialists was necessary. "One year off service" for senior medical registrars in the Birmingham region was intended for research or travel, or for work in a specialized centre; it was paid. He found that he had to spend 25% of his time on postgraduate activities and the work of the centre was increasing this. Of course, no one worked in isolation. As to the fears of young men losing their places on the ladder, he thought that they might be allowed to study something other than medicine. We must train general physicians and surgeons "with an interest"—research was essential for all. The problem of the proliferation of higher qualifications must be tackled.

SPECIAL VOCATIONAL TRAINING FOR GENERAL PRACTICE

J. P. HORDER, M.A., B.M., B.Ch., M.R.C.P.

Chairman, Committee on Vocational Training: College of General Practitioners

The Present

In this country we give the shortest training to our largest group of doctors, the group which has the largest power to decide whether or not patients will get what medicine can offer them. Other countries give as little or less training to their general practitioners but few other countries still give them so much power and make it so difficult for patients to by-pass them. Here is a situation crying for reform. Let us look more closely at the present position.

No one believes any longer that undergraduate medical education can or should turn out a safe general practitioner. Its purpose is to provide a basic education in medicine. Special vocational training must be provided after qualification. General practitioners need special vocational training just as surgeons do. The provision of it for them is long overdue and I believe that this failure has a fundamental bearing on the dangerous situation which we have recently been witnessing in the general

FIG. 1.

practitioner service.

It is open at present to any doctor to set up in general practice after completing the compulsory pre-registration year. There is no obligation for him to train in any way after that. What he learns thereafter can be just by trial and error. Fortunately many intending G.P.'s do complete two or three years of house appointments and some do a year as trainee assistant in addition. The trainee assistant scheme has been with us since 1948 and Fig. 1 shows the proportion of doctors who have entered it compared with the total entering general practice.

There have also been valuable training schemes for general practice at Inverness, in Wessex, and at Canterbury, but the total number of doctors involved to date must be less than 100. The British Postgraduate Medical Federation and the College of General Practitioners have run a number of 1 week introductory courses for the last four years. The Tavistock seminars in one aspect of general practice have involved 250 doctors over 10 years. These are all valuable beginnings but they do not amount to a national vocational training for general practitioners which must eventually cater for 500 entrants each year. There has until this year been no guidance about which are the relevant house appointments, very little attempt to set down what the intending general practitioner ought to learn, and no incentive to take further training except the active enthusiasm of a minority. Indeed there is a very strong financial disincentive.

So much for the present. It is very unsatisfactory. Let us look at the future.

The Future

There are two central questions. *Ought* we in this country to train generalists in medicine? *Can* they be trained?

The first question was brought home to me very forcibly last year when I visited Israel. I met two extreme views on the same day. One doctor said "To train general practitioners is to follow a religion which is outmoded, unreal and which demands the sacrifice of many good doctors". Another said "Your English practice of uniting all first-line curative care for the whole family in one doctor represents a more advanced state of medical organisation than any other in the world". Both these men held posts of influence in Israeli medicine.

In this country 40% of our graduates have hitherto entered general practice. The consensus of opinion is that we should continue to have generalists in the front line of medical care even in cities. There has, it is true, been an important proposal from the University of Birmingham that the present general practitioner should be divided into four parts—a paediatrician, a geriatrician, an obstetrician and one for the rest. But this proposal still means training generalists. Majority opinion does in fact still favour having one doctor for the whole family. In doing this we are doing something which many other countries are no longer doing. I myself believe that we should now make a whole-hearted experiment in doing it properly by training young men for this role.

Can generalists be trained? This is the second central question. The answer has yet to be proved. On our success or failure in this must depend whether we continue to have a

TABLE 1
TRAINING FOR GENERAL PRACTICE
RECOMMENDED HOUSE APPOINTMENTS

General Medicine	—	6 months
Obstetrics, with Gynaecology	—	6 months
Surgery, with Casualty Experience	—	6 months
Paediatrics	3 or 6	months
Psychiatry	3 or 6	months

Ear, Nose and Throat	}	Combined Appointments	3 months
Surgery			
Eyes			
Skins			
Geriatrics			3 months

general practitioner service as well as our specialist service. Unless we general practitioners are properly trained, how can we expect an increasingly educated public to respect our judgments? How can we retain the respect of specialist colleagues? How can we expect the state to pay us at a rate comparable to the rate of the specialist? How can we retain our self-respect? Above all how can we expect young men to choose this role when they can see that it demands no special training and does not have the advantages that stem from that?

There is no doubt of the need but this does not prove that the training can be successfully provided. What is proposed?

The College of General Practitioners published proposals this summer for a 5-year period of in-service training after qualification. This length of time had the unanimous support of 3,000 members of the College who answered a questionnaire in 1964. The same length has just been chosen by the Australian College of General Practitioners. If 5 years seems long it has to compare with a minimum of 7 years laid down by the Royal College of Physicians in each of that College's sub-specialties.

Of this 5 years, 3 years would be spent in junior hospital appointments. The College report states which appointments are most relevant to general practice and these are shown in Table 1.

The remaining two years of the programme would be spent in training practices—2 different practices. For these two years the report has a very detailed syllabus of topics which a general practitioner ought to be taught but which he could not expect to have learned in hospital. The main headings of this syllabus are shown in Table 2.

If this syllabus is to be taught there will be a need for many more general practitioner teachers and for them to be carefully selected for their desire and ability to teach. They must also be taught to teach and have some

TABLE 2

A SYLLABUS OF GENERAL PRACTICE
SUBJECTS WHICH ARE NOT ADEQUATELY
COVERED IN UNDERGRADUATE TRAINING
OR HOSPITAL EXPERIENCE

(main headings)
SOCIAL MEDICINE
PSYCHOLOGICAL MEDICINE
PREVENTIVE MEDICINE
GENERAL MEDICINE AND SURGERY
OBSTETRICS
ORGANISATION

supervision and help in this aspect of their work. They must not have too large lists of patients if they are to have time to teach. The experience of the College till now has shown that there is a fund of hidden talent in the 24,000 general practitioners of this country.

Much of this syllabus would have to be taught by sending the trainee doctor on courses. Several types of course are needed. I shall be talking in a moment about one particular type but this will not necessarily prove to be the best.

It has not been too difficult for the College of General Practitioners to write a report about its proposals for vocational training and the report has been well received. But the problem now is to get these proposals (or something like them) implemented throughout the country. To this the College is committed, but it cannot possibly do the task alone. We need the help of many people—the Ministry of Health, the staffs of teaching and non-teaching hospitals, the Postgraduate Deans and the staffs of Postgraduate centres, the British Medical Association—all these in addition to the hard work of our own members, many of whom must become teachers.

The next step, I think, may well be the setting up of a series of regional committees to take a closer look at the content of general practice and to make local plans for organising vocational training for young doctors intending to be general practitioners.

Postgraduate Centres

In this sort of general framework Postgraduate Centres might clearly play a most important role. The postgraduate education of general practitioners has always been thought of as one of their main purposes. They might contribute in a number of ways to vocational training at the early postgraduate stage. I propose to concentrate on one way only—the provision of a particular type of training course. Successful examples exist already and I happen to have some experience of one of them.

The Kent Postgraduate Medical Centre at

TABLE 3

KENT POSTGRADUATE MEDICAL CENTRE
AT CANTERBURY. TRAINING COURSE FOR
GENERAL PRACTICE

MAIN HEADINGS OF SYLLABUS, WITH PROPORTIONS
OF TIME ALLOTTED TO EACH

Practice organisation	10%
Social medicine	20%
Ethical and medico-legal	10%
Clinical	
(1) Psychological and Psychosomatic	20%
(2) General clinical subjects	40%
	<hr/> 100%

Canterbury is running a 2-year course for general practitioners who have recently settled in the area. It started just over a year ago. Notices were sent to 90 doctors 3 months before the start of the course—15 accepted, the farthest living 30 miles from Canterbury.

The working party which runs the course is drawn from the Academic Committee of the Centre with representatives of the British Medical Association, the British Postgraduate Medical Federation and the College of General Practitioners. The main burden of organisation has been carried by one man, Dr. John Lipscomb. It is undoubtedly due to his personal involvement in organising each session that the course has succeeded so well.

The syllabus concentrates on the topics that a doctor is least likely to have learned as a student or house officer but which he will need as a practitioner. The main groups are shown in Table 3. Table 4 gives the programme for the present term.

The students are not trainee assistants, since this is a 2-year course. They are all within 10 years of qualification and have already committed themselves to practice in Kent. They come to the course with some experience of the problems and therefore with a lot of questions in their minds. Their attendance rate has been high, as Table 5 shows. After a year they know each other well and form a very good debating group around the table.

Most of the teaching is of seminar type—two sessions of an hour divided by tea on a Wednesday afternoon. The speaker is allowed up to 40 minutes. The rest is discussion. The level of discussion has been high. Speakers are chosen both locally and from a distance, about 50% of each. A quarter of them have been general practitioners. An important finding has been that there are a number of local practitioners who have a gift for teaching. Beside the majority of sessions which take place at the Postgraduate Centre, there have

TABLE 4
KENT POSTGRADUATE MEDICAL CENTRE AT CANTERBURY
TRAINING COURSE FOR GENERAL PRACTICE
SECOND YEAR — FIRST TERM

		1st Hour	2nd Hour
October	13	ALCOHOLISM Dr. G. K. Shaw, Psychiatrist	SUICIDE Dr. P. H. Mitchell, Psychiatrist
	20	RESPIRATORY PHYSIOLOGY Dr. J. Ainley-Walker, Anaesthetist	CHRONIC BRONCHITIS Dr. R. H. Andrews, Chest Physician
	27	VISIT TO IN-PATIENT ADOLESCENT UNIT FOR BOYS BEECH HOUSE, ST. AUGUSTINE'S HOSPITAL, CHARTHAM Dr. George Turle, Psychiatrist, and Staff	
November	3	JUVENILE COURTS Sir Alan Moncrieff, Paediatric Physician	THE PROBATION SERVICES Mrs. K. M. Law, Probation Officer
	10	THE CATARRHAL CHILD Dr. W. J. Radcliffe, General Practitioner	ACUTE EARS AND SINUSES Mr. A. P. Ardouin, E.N.T. Surgeon
	17	SUPERFICIAL SEPSIS Mr. R. R. Hunter, Surgeon	PAIN AND PARAESTHESIAE IN THE ARM Mr. F. G. St. Clair Strange, Orthopaedic Surgeon
	24	RESPIRATORY VIRUSES Dr. A. L. Furniss, Virologist	PULMONARY TUBERCULOSIS TO-DAY Dr. Owen Clarke, Chest Physician
December	1	THE CORONER AND THE GENERAL PRACTITIONER Dr. R. Hunt Cook, General Practitioner	EXAMINATION FOR INSURANCE Dr. R. Hale-White, Physician
	8	EMOTIONAL PROBLEMS OF THE AGED Dr. John Agate, Geriatric Physician	MANAGEMENT OF THE INCURABLE AND THE DYING Dr. Cicely Saunders, Physician
	15	INSTITUTIONAL CARE OF THE AGED Dr. R. G. Stevens, Geriatric Physician	THE ELDERLY AT HOME Dr. R. O. F. Hardwick, Physician

TABLE 5

KENT POSTGRADUATE MEDICAL CENTRE
AT CANTERBURY. TRAINING COURSE FOR
GENERAL PRACTICE

PERCENTAGE ATTENDANCE FOR EACH TERM
(16 doctors)

First Term (autumn)	85%
Second Term (winter)	82%
Third Term (summer)	64%
<hr/>	
Fourth Term (autumn) (incomplete)	84%

been a number of visits for instance, to a hospital for sub-normal children and an in-patient psychiatric unit for adolescents. It is only possible to pay expenses to the speakers—no lecture fee. This is wrong.

The results of the course can be judged at this stage only by the expressed enthusiasm of the members. More detailed and accurate ways of evaluating its effects on the doctors are under discussion with the Faculty of Social Science at the University of Kent at Canterbury. Invitations for the second course have been sent out, a month ago, a year in advance of its start. Nine doctors have signed on so far; this is encouraging. In the meantime an important result has been the start of a 1-year course at Winchester and Southampton, which takes place for a whole day a week and therefore has the same total of learning time. Fifteen doctors have started there. This is of course a separate scheme from the Nuffield Wessex experiment which is continuing in the same area.

Here then is one possible contribution of a Postgraduate Centre to vocational training of general practitioners. I am sure that many others will be suggested and discussed in this conference. I want to end with one other—the general function of the Postgraduate Centre as a place where doctors meet.

It is going to be important to the College programme that general practitioner teachers should meet each other and that there should be an attractive place where this happens and from where they can be to some extent organised and helped in their training function. But in the immediate future it is even more important that the Postgraduate Centre is a place where generalists can meet specialists, as people each of whom can learn from the other. This has been a real feature of the

Canterbury experiment. One of the things that it has brought home to me is that the problems are not all in the G.P.'s side of the service. We are *all* short of time, short of manpower and short of money. In the face of these common problems it is vital that specialist and generalist should continue to meet as equal colleagues. This cannot possibly continue unless generalists have a training for their particular role, to give them confidence, and to balance the extensive postgraduate training of specialists.

If we want to keep a general practitioner service and attract young men into it, we *have* to make this career an equal challenge to a specialist career in hospital—and give equal rewards. General practice is what you make it. At its best it's as fascinating as any other career in medicine and it calls for all the intellectual and emotional assets a young doctor can bring to it. I for one never enjoyed medicine fully until I became a G.P. The real doubt about this career is whether it's too difficult—whether it is possible to train a man so that he can think simultaneously in terms of biochemistry and psychodynamics and so that he can act in such very different ways as are required if he is to deal in quick succession with the active emergency of left-ventricular failure and the passive unravelling of the emotional difficulties of a married couple. We certainly cannot go on expecting men and women to stand up to the increasing responsibility of this career unless we provide the intellectual and emotional support which proper training can give.

Only by increasing the challenge at entry can we expect to attract a fair proportion of the best young men. Let us not delude ourselves that a satisfactory general practitioner service can be staffed from those who have fallen off the specialist ladder. We need our quota of the best men.

In pleading as I do for equal opportunity based on a comparable length and intensity of training, I am pleading both for the understanding and for the active involvement of specialist colleagues in the problems of general practice. We practitioners are going to need to understand their problems too. No more practical way can there be of mutual understanding than in the interchange which vocational training involves and no more suitable place than the postgraduate centre.

DISCUSSION

PROFESSOR F. A. R. STAMMERS (Royal College of Surgeons of England) explained the origin of the College tutors, namely that 4-5 years ago there was throughout the country very little activity in the way of organised postgraduate instruction for those training in surgery, particularly from the Commonwealth. Although, from the legal point of view it would seem that continued postgraduate teaching was the responsibility of the Medical School of each region, such activities at this time consisted of little more than week-end courses or conferences on some particular subject, there were no regular organised meetings in hospitals. The College's committee on the Training of Surgeons was worried by this situation and felt strongly that something should be done. They therefore approached the Nuffield Foundation seeking financial help to enable them to create surgical tutorships in each region. This arrangement was to be on an experimental basis for three years. Some regions whose geography was compact were allotted one tutor; some with widely scattered hospitals were given up to five. As so often happens, these same thoughts were occurring to others at the same time, and somewhat rapidly a much wider interest in continued postgraduate training was emerging. As a result and with the full co-operation between the Regional Hospital Boards and the postgraduate deans, tutors both medical and surgical were appointed. At a recent meeting at the Royal College of Surgeons of surgical tutors appointed by the English College, under the Chairmanship of the President, general experiences and problems were discussed. The President laid particular stress on the great importance of smooth co-operation between all tutors and the department of postgraduate studies of the medical school. Concerning the question of the Royal Colleges of Edinburgh, Glasgow and Ireland also appointing tutors, Professor Stammers thought this unlikely and explained that there was a standing committee representing all the surgical colleges of the U.K. whereby agreement between Colleges concerning training programmes, pattern of examinations and the like is achieved.

MR. J. A. ROSS (Royal Collge of Surgeons of Edinburgh) agreed with Professor Stammers' remarks. The Royal Colleges were working in close agreement and a great deal of information about postgraduate educational activity had been collected and was being sifted.

PROFESSOR HUBBLE was delighted to hear about the work at Canterbury, and general practitioners' proposals for vocational training.

SIR GEORGE PICKERING asked about the other side of general practice—the business side—ancillary help, administration etc., the most difficult part of all.

DR. HORDER: We have used the word "business". Plenty of time is given to it at Canterbury and by the College of General Practitioners.

PROFESSOR HUBBLE: Have you tried to cost the Canterbury experiment?

DR. J. LIPSCOMB (Canterbury): No. It has not been costed, but expenses at present are not great. Lecturers were given their fare plus a fee of three guineas.

DR. LEWIS said that there were many invisible costs—the contributions made by the organisers, fetching

and carrying lecturers and entertaining them, the work of the hospital secretary, the catering officer and so on.

PROFESSOR HUBBLE: Are the Ministry of Health going to bother to support this or are we going on as apostles, wearing a badge of poverty and courage?

DR. P. SHACKLETON (Wessex Region) said that this region had started a course on the Canterbury pattern but lasting for one year. Several trainees as well as assistants and junior principals were taking part in the course. He felt very strongly about the costing. Assuming that lecturers should be paid as they are when they take part in a junior staff course, then they would be roughly £60-£100 out of pocket every term, after allocating the Section 48 fees.

DR. T. M. L. PRICE (Lewisham) asked if provision of beds for general practitioners in district hospitals would help. (Cottage hospitals should be absorbed into the new district hospitals).

DR. HORDER: 80% of those general practitioners who had been asked would like to have their own beds; less than 40% are actually able to look after their own patients in hospital. But there is a minority view that their job is to keep patients out of hospitals and to confine their contact to direct access to investigations, postgraduate training etc. He himself felt this, but most of this colleagues would disagree.

DR. S. A. MCKEITH (Southampton) said that there was an increasing danger of separating hospital from general practitioner work. The postgraduate centre must aid the active exchange of information between those inside and those outside hospital. In Wessex, a hospital consultant, was allowed to sit in at evening surgeries and to join in seminars with general practitioners in their group practices. It was terribly important that the centres should draw everyone together. DR. WHITTAKER said that Birmingham had put in the loss on some courses in their estimates—as much as £2,000—and had been granted this, rather to their surprise.

DR. A. W. WILLIAMS (Oxford) said that they read HM 64(69) as telling them to ask for money—and they had got it. It was impossible to become a consultant without reasonable training, but with decreasing medical man-power how could general practitioners be prevented from starting up without this?

DR. HORDER did not know the answer. They must rely on the enthusiasm of the minority.

DR. LOWE (Leeds R.H.B.) was interested in the schemes for training generalists as specialists. But there was a risk that all general practitioners would ultimately be specialists—in all other branches there were career grades other than those at the top. Recently an advertisement had appeared in the Journals for two general practitioners in the new town of Livingstone, W. Lothian, to do half-time in general practice and the other half in the hospital service.

DR. Horder's scheme assumes that at best the general practitioner is on the same level as the consultant.

DR. HORDER did not expect all general practitioners to equal the status and rewards of consultants but would like some to.

DR. PATON said that surely we must make general practice a speciality. He had several suggestions to

make, e.g., rotating internships of interest to general practice. Why could previous house officers not come back from general practice as registrars for two weeks? Why should general practitioners not conduct rounds in hospitals at times? Would the Royal College of Physicians of Edinburgh allow General Practice to be taken as a specialty in their membership examination?

DR. HORDER asked whether the rotating house officer worked for several specialists simultaneously or consecutively.

DR. PATON replied that several posts were held at the same time—but this was merely a geographical convenience.

DR. HORDER thought it an excellent idea that the practitioner should return as a registrar. When he conducted rounds, was it on his own cases, or on the consultant's?

DR. PATON meant the practitioner should take the round, discussing the later domiciliary management of all the patients with the consultant present.

DR. HORDER thought this experiment would be well worth while, but it was not easy to do a round on another's cases. Perhaps a number of general practitioners should take part, each seeing their own patients.

CONTINUING EDUCATION

J. W. PAULLEY, M.D., F.R.C.P.

Consulting Physician, Ipswich Hospitals.

THERE may be little left to be said about Postgraduate or Continuing Medical Education, but there will always be room for opinion on emphasis. For example, when just now Professor Le Quesne suggested that the pregraduate period should be mainly academic and untrammelled by technique, while the preregistration period should be essentially practical without too many distracting seminars, this was rather too "either—or" for me. Although we both believe in a continuum, I see the need for the junior medical student to meet more, not less, patients, if he is not to lose enthusiasm, and the preregistrand to attend more not less, seminars and journal clubs, if continuing education is ever to have any meaning.

As I have spoken and written too much on this subject already (Paulley, 1963, 1965) I propose today to speak to it, rather than about it.

Firstly, there is the Medical Library. In some circles reading has become unfashionable. Tape-recordings?—Of course. Teaching Machines?—Mandatory. Postgraduate Courses?—Naturally, one is paid to be a captive audience. Television?—Could we say it is in vogue, even if like the Welfare State it flows over us in a treachy stream hardly leaving a memory? But when it comes to reading, apart from certain dubious accretions to the Medical Press the contemporary answer is unenthusiastically damning. Frankly, I believe this is nonsense, and until every doctor spends one hour, or better still, two half-hours a week in a medical library continuing education will continue to fail. Furthermore it should be a periodical library, and not one full of text-books most of

which are out of date by the time they roll off the presses. To achieve this there has to be a convulsion in the medical schools and the minds of the examiners. The student must be taught to use libraries so that by the time he graduates the reading of periodicals will have become an ingrained habit, and it follows that every doctor in future must have a periodical library within reasonable access. Bars in the new postgraduate centres are all very well, but could it be that libraries are more important?

Even today in those last remaining bastions of reaction what happens to the student who quotes the "B.M.J." (let alone "*The Lancet*") to his chief or registrar? It is usually "Don't waste your time with that stuff, you won't need it in finals". What is so sad is the excellence of the advice.

It is said that libraries in postgraduate centres have trouble over losing books. One sympathises, but it really serves them right for not concentrating on periodicals! A bound volume of J.A.M.A. is no vade mecum, and the *New England J. Med.* is equally unattractive in bed. It is true that unbound periodicals have been known to reach odd places such as lavatories, but if the library stamp is lurid and prominent, and if the library is sufficiently prized by its users, as we have found in Ipswich, then public opinion discourages pilfering and losses are very small indeed. An efficient librarian is, of course, essential, and the library should be open at all times. As the story of the Ipswich Medical Library has been described elsewhere no more will be said about it now.

My second plea is directed against didactic