vocation for medicine and the development of economic acumen. These are interrelated and overlapping.

As a clinician the general practitioner is first a doctor, whose medical knowledge and skill must, having first been obtained, be constantly practised. He is independent but has support from colleagues in his practice, unless single-handed, in hospital and in the community, from other health workers, ancillary staff, and outside agencies. He must learn how to make the best use of their help for his patients. He must keep up to date.

He must learn the dynamics of continuing primary care: how to listen, observe, support, and comfort; how not to judge and how to manipulate individuals and their environment. He must learn how continuing primary care differs from hospital, industrial, and community medical care. He must, as a personal doctor, learn to deliver care, monitor it, and appreciate how it is received in terms of the individual patient, the family, and the community.

On the vocational aspect, he must learn that his transactions with patients are governed by ethics, and with colleagues by medical etiquette, and that these differ in important aspects from what he has been used to in hospital.

As a businessman, he is an independent contractor with a contractual obligation with a health authority for the care of his patients. He will learn that he has responsibilities to partners (if any); *financial obligations to his family;* managerial functions with regard to his employees, and co-operative functions in relation to colleagues and other health workers.

All this he must do without losing the devotion of his wife and family.

He will recognize the achievement of these objectives by personal satisfaction in a well performed job, the esteem of his colleagues, the gratitude of his patients, a diminishing bank overdraft . . . *and the continuing affection of his family.*

The Surgery
Church Street
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Lincs.

R. MacG. AITKEN

Sir,

We read with interest Dr Nelson's article on "Some Dynamics of Medical Marriages" (October *Journal,* p. 585) and the editorial (October *Journal,* p. 579), and were amused to find that we personally identified with many of the comments made.

The editorial suggests that in the UK little or nothing is done to help trainees' wives to adjust to their new role, and Dr Nelson claims that medical education is often dehumanizing and deprives human beings of their emotional and social needs. We agree entirely with these observations and would like to offer some of our experiences in this area, which have arisen from running a day release course for trainees.

The course at the University of Surrey which we organize allows some time at two residential sessions a term for members to explore their feelings and how they relate to each other, and commonly at these sessions trainees have allowed some of their distress at the effect of their work and training on themselves and their families to surface.

Even though this course is self-directional, in that trainees plan their own programme, and this distress is commonly acknowledged after such residential sessions, the pressures of other training and family needs (plus the denial by many of their seniors in our profession that such needs exist at all) crowds out further exploration.

Nevertheless, time has been found in our programme for sexual awareness re-orientation days to which spouses, fiancé(e)s, or 'significant other halves' are invited. These have proved extremely successful and popular. However, a full weekend session devoted to exploring the effect of a general practitioner's work on his family was asked for and arranged, but could not take place because members found it impossible to fit it in. Clearly the need is felt, but the pressures of time that doctors have, or allow themselves to have, permit these needs to be pushed to the background. Dr Nelson's comment that our training makes us repress our own needs may be significant here.

Thus, we are both delighted that your *Journal* has given prominence to the effect of his work on the doctor's own feelings and personal life. We are sure that this is a subject which should be explored by our profession, and that special time should be given to it during our training.

JOHN TOMLINSON
JOHN WESTON
Department of Adult Education
University of Surrey
Guildford.

MEDICAL LIBRARY OF THE UNIVERSITY OF PAPUA NEW GUINEA

Sir,

Most medical school libraries in the developed world have a stock of 30,000 books or more. In addition, they are likely to have the support of other biomedical libraries within easy reach, either physically or by telephone or telex.

Here in Papua New Guinea, we have a medical school library of only 10,000 volumes. But this does not serve just the staff and students of the faculty: it is itself the national medical library and as such, it serves the needs of all medical, dental, paramedical, and research staff in a remote and inaccessible area larger than the State of California. Many of these people work in isolated hospitals whose only contact with the capital is the airstrip and the radio or telephone. The challenge of providing a medical library and information service to the nation is one we are happy to accept, but our resources are too slender to be effective. We shall soon also be serving a new dental school, but with no special funds for extra book provision.

Papua New Guinea has many health problems, and there is a need for developing primary health care and health education projects as well as other research. Papua New Guinea is known throughout the medical world for its rare diseases like kuru and pigbel (enteritis necroticans), but we would like you to think of it not as a medical curiosity, but as a place where students, practitioners, and researchers need good information services.

Our immediate need is to improve the library's bookstock, increase our range of journals, and provide more extensive sets of back runs. On behalf of the present and future medical profession of Papua New Guinea, we are seeking your assistance.

We should be most grateful if your readers can send books, gift subscriptions, back runs of medical, dental, or nursing journals, or health education material of any kind (including audiovisual material). All will be useful.

A. C. BUTLER
Librarian
Medical Faculty Library
PO Box 5623
Boroko
Papua New Guinea.

HEALTH HAZARDS OF GARDEN BONFIRES

Sir,

In a recent discussion on the health hazards of passive cigarette smoking *(British Medical Journal,* 1978), it was concluded that benzpyrene from cigarette smoke is responsible for at least some of the cases of lung cancer that occur in non-smokers. Subsequently, I pointed out that whereas the benzpyrene content of cigarette smoke is only 0.2 parts per million of free carbon, that of bonfire smoke is 70 parts per million; moreover more bonfire smoke is produced in this country than cigarette smoke (Stock, 1978). Depending on