you are leading the struggle to find the best way in which the family doctor can best serve their patients in the modern state.

DISCUSSION

Question: Dr Medalie mentioned that he had succeeded in ensuring that doctors would not be always on duty for emergencies. If that is true, how did he manage to arrange the appointments system, and to arrange that they have regular times when they are not on duty?

Dr Medalie: We work in pairs. I work in the health service, but within the health centre each two doctors work together. We have our appointments system, but the emergency cases are seen by the doctor on duty. The duties alternate. If I had an appointments system from eight o'clock to twelve o'clock this morning, say, the other physician would be on home visits, but in the vicinity, and he would see the emergency cases. I am sorry if I gave a wrong impression. I was not working on my own, except for six years as a rural practitioner and then, of course, the only way we organized off-duty periods was to have week-ends off, and the nearest rural practitioner took all our calls.

Dr M. E. Arnold (*Wembley*): Could Dr Medalie give us a few brief points on the population of Israel, the health service structure, so far as general practice is concerned, the number of persons participating in the health service, the number of doctors and patients? Could he give us a few statistics and figures for comparisons?

Dr Medalie: Our country has 2½ million people. About 90 per cent of the population is insured with one or other form of sick benefit society. About 5–6 per cent of social welfare cases are paid for by the local authority, the medical part of it, and the other 4–5 per cent are true private patients. There are many doctors in Israel. If you work it out on paper, you find one to probably about 600 people; but, unfortunately, the average age of the doctors is high, well over 50—I think it is 56—and many doctors are not in active practice. In addition to that, the hospitals have a very high ratio of doctors per patient, whereas the general practitioner has a much lower one. But, in general, we have many fewer patients than you have here. I would imagine that, as a rural practitioner, one had about 2,000 patients, although they were spread out.

Dr D. H. Ryde (*South London*): Dr Medalie said that he had tried to encourage patients taking their friends along to have a group meeting. Over here it would not be so easy because some might be a colleague's patients. You could not ask ' opposition ' patients to come over. This would not do. I have tried this idea on a number of occasions. I have had young mothers' clubs and other discussion groups. They keep coming for a few months but, having

started with 12, the number drops to ten, then eight, and the whole thing fizzles out. Perhaps it is partly our fault, but when these people get to know each other well they no longer need to go to the doctor. How do you keep your groups going?

Dr Medalie: We, too, notice something that was said to me by one of my old colleagues. He found that most of his patients would come because they could speak to each other in the waiting room, not because they wanted to see him. We tried an experiment in this. We formed an old-age group—what the Americans call a ' golden age group '—and asked an occupational therapist to come once a fortnight. She helped my colleague to organize and do things. We found that out of ten patients eight dropped off very considerably. In one case there was no effect, and one case for some reason showed an increase.

The other point about the groups is this. I think the person to ask about this point, which is valuable, is a skilled group worker. We had certain groups for a specific purpose, and when that purpose was over we abandoned them. These were successful groups. People came in knowing that it would take 8–12 sessions, and then it was over, so they kept coming. But the friendship groups kept going in the homes. In one case, I know personally that a group was started and I participated in it for 18 months, but it went on for four years before it was disbanded. Perhaps you have more problems with the London patients; I am not sure. But out of these discussions a skilled group worker can utilize points which arise.

To give examples, in our country one woman was posing two points on education. First, she had young children and there was nowhere for them to play. Secondly, what language should she speak in to the children—Hebrew, in which she was not very proficient, or her mother tongue? Another woman replied to the second point that, whether or not she liked it, she could not speak in Hebrew to the children because she did not know it well enough. Out of that arose a demand, which we were able to help, for teaching Hebrew—night classes for parents. Then, three women in that club went to see the mayor, by special influence, and after pounding on his desk, playgrounds started to appear in the vicinity. So very constructive things can come out of these groups. It is important to direct efforts towards constructive action, if necessary. One group not, in my practice, had a meeting of patients, and the doctors in desperation put it to them that they were coming to the doctors too often, and the thing which happened was the patients demanded an appointments system, so they would not have to spend a day waiting to see the doctor.

Chairman: Dr Huygen, have you anything you would like to say

about the education of patients in the Netherlands? This is a problem we are always facing here, rather unsuccessfully.

Dr Huygen: I have not anything to contribute. What is being done in this field is not done by general practitioners in my country; it is done by the public health nurse, but not the general practitioner.

Professor R. Scott (*Edinburgh*): I wonder whether Dr Huygen could say just a word about general practitioners using drama classes for therapeutic purposes. I should be very interested to hear more about that.

Dr Huygen: This is a misunderstanding. I did not speak about drama classes. But general practitioners between themselves can play roles. We try to train ourselves by letting someone play the role of the patient, while another doctor plays the role of the doctor; and the other doctors watch this and criticise themselves and try to understand better the roles of the patient and the treating doctor. It is more a question of interviewing technique than drama playing.

Dr Marjory C. Hogg (*Dundee*): I should like to ask a question and to make an observation. Dr Huygen said that one of the aims of the small discussion groups is to develop the doctor's personality, to change, modify or enlarge his outlook. Does Dr Huygen think that the quality of the general-practitioner's practice in part depends on the degree that he understands himself, and does he think that doctors must encourage each other on this point? That is the question.

I should like to make this observation. The speakers this morning have made a great impact on me. They have spoken of things I understand. I have felt part of the community; I have felt 'in it'. In recent years I have much enjoyed hearing speakers from other 'pigeon holes', but I have never felt I could completely understand them. Today I feel that the general-practitioner approach has been demonstrated in a very telling fashion. It is obviously unique. I do not mean that it is better or worse than others, but it is different. This must be preserved and believed in and matured in all ways possible, using our neighbours' inspirations and all modern knowledge.

Dr Huygen: I think that, in being more conscious of his own role, and in becoming more conscious of it, the general practitioner's service which he renders to his patients will be bettered; I am quite sure of that. I have often noticed that people have blind spots, and by being in small groups you come to recognize your own blind spots. This is a great help. It is our experience that after a time in such a group your whole approach to your patients and the way of doing your surgery is much changed, I think for the benefit of the patients.

Dr R. C. Veldhuyzen van Zanten (*Netherlands*): May I follow up a

former question about discussion groups? I think it is a new trend in general practice. It is an essential element of preventive medical attitudes and of health education. May I, therefore, put this question to Dr Huygen, to Dr Stampar and to the whole audience? There are general practitioners here who have something of a beginning of experience in this field, and may I as a stimulation add my own very small experience? I started with a home team, after the example of Dr Huygen, two years ago. At first it was with only my district nurse every two weeks; now it is every month with a district nurse and a social worker and, *ad hoc*, a clergyman, schoolteacher or someone like that. We discuss problems I have met, and from this develops a real in-group discussion, which I have twice a year now, with all the top teachers in my village. This is interesting because with the school teachers we discuss problems of mental retardation, speech problems and so on. This is only one example, and if there are other experiences it would be interesting for us to hear of them.

One more point for clarification. In addition to Dr Huygen's answer about the control doctors in Holland, I have noticed that some people think this ' control business ' is done only by full-time doctors. This is not so. I would say that about 70 per cent of the patients controlled for sickness benefit are dealt with by full-time doctors; the others by part-time general practitioners. I myself deal with about ten control visits from my surgery every day; I control patients of my colleagues, and I think it is very interesting indeed.

Chairman: We are immensely interested to have details of these control systems, because it is one of the problems we struggle with in practice. When we hear of its working out, it is of interest to all members. I think we should like to hear from Dr Stampar about the discussion between family doctors.

Dr Stampar: It is very easy to organize in my country, as we have public health centres, and we are attached to them, so it is not really so difficult as it is perhaps at different levels. There we have integrated all services, social, preventive and curative. It is a custom that we meet once a fortnight or month and discuss professional problems or some cases of patients. But we have meetings every day with our colleagues to discuss some cases and family problems.

Dr J. Horder (*North London*): We have heard three extraordinarily interesting papers this morning. I have had the luck to visit three foreign countries: Yugoslavia, Czechoslovakia and Israel, and also had the chance to spend a little time with Dr Stampar in her practice and to meet Dr Medalie in Israel. I was asked to say a little about what I found.

These three countries give the work which we do to more than

one person. Essentially, I think, they divide it between the medical specialist, the paediatrician and the gynaecologist. I had to look back at our own country, and I saw it as rather lonely in the world in supporting this idea of one man, the family doctor. Our hand is firmly held by Holland and Denmark and perhaps one or two other countries. But this is a principle which is rather lonely in the world now. We have to choose in this country: Are we going the way of most other countries? Are we going to follow, for instance, the way of Professor McEwen, or are we going to develop our family doctor? So I am utterly delighted to hear in the paper this morning that we should press our ideas and skills in the direction of whole patient medicine and family medicine.

If I may spend the rest of my time on Yugoslavia and what Dr Stampar had to say, I think she was reporting a tremendously important experience from the practical point of view for us. I am thinking of the early postgraduate education of the general practitioner as it is in Zagreb. In Yugoslavia the situation of the general practitioner seems to me to be rather worse than it is here in general until this happened. The morale of the general practitioners did not seem to me to be very high. They were referring the majority of their cases. All patients wanted to go to specialists. Now a minor revolution has taken place in Zagreb and this has been achieved in four years. Patients speak differently about general practitioners; general practitioners are treating their own patients and they are referring an appropriate number and not too many. Above all, specialists have changed their view about general practitioners. Something has really been achieved, and quickly.

How has this been achieved? I think that at one point it depended entirely on the enthusiasm of one man. How can we apply this in our own country? We have to tackle the problem of general practice on many fronts, but this is one of the most important fronts. I do not think it is a question for one man in this country, but I do think it is a question for this College. We are the people who care most about this subject. It cannot be done by us alone, but it is not going to be done unless we provide the driving power.

Dr G. S. R. Little (*South London*): I should like to follow Dr Horder. I think what he says is absolutely right: this College can provide the driving power. I should also like to say that this College has already, in south-east London, provided an enormous amount of driving power. I will try to put my remarks in chronological order. I think it is only by discussion and example that anything will be done at all in medicine, because basically we must admit that doctors are individualists. By virtue of our training, by the decisions we have to make and the responsibility we have to accept, we do

not really take very easily to direction. Tomorrow morning at nine o'clock, if someone puts a notice on my desk from the Ministry of Health saying that I must do something, or saying that there is only one hospital that I can admit a patient to, I shall immediately rise with a sort of righteous indignation, however correct and proper that is. Therefore, if we discuss things among ourselves and are stimulated by something, then much more is likely to occur.

Some nine or ten years ago, some of us got together, and eventually we established in south-east London a general-practitioners' centre at Peckham, where we have facilities for diagnosis and treatment and, above all, where we said from the word ' go ' that there must be a common room where general practitioners can meet and invite anyone to meet them. We now work in local authority clinics; we do our antenatal work in local authority clinics. In south-east London pretty well all of this is done. This has come about, I would say, through Peckham, and through meeting people and through some of Dr Horder's leaders, stimulated by the College. Now we work as a team, we work together. Those general practitioners who do not do obstetrics accept us as doing obstetrics and send us patients. We have obtained, whether this is right or wrong—and I think we are the first in London to do so—the right to admit our own patients to our own general-practitioner beds, not only for general medicine but for obstetrics. We have this right now in three different places. Two years ago we established a General Practitioners' Obstetrics Society, with 42 members and never less than 30 or 35 attending. This is the kind of thing we must do. If we do not—I say this sincerely—I think we can only adopt an attitude of hopelessness towards general practice, an attitude of total and complete collapse. I do not think there is a lot of future unless we get together among ourselves and work out better things.

Dr M. B. Lennard (*Bristol*): The whole nub of this question is in education. It seems to me that what we are saying is that there must be a sort of careers structure in the early years, from either qualification, or graduation, whichever you like, that must be followed by anybody intending to go into general practice. A structure like this implies, I think, two things: one is an academic structure, and in this I am quite sure that the College can be, and is, and should continue to be, the driving power.

The other part of the structure is the financial part, and it seems to me that the College is in no position to provide a financial structure yet. In fact, I cannot think of any body which is in a position to do this, except the Ministry of Health. The Ministry of Health do provide this to a certain extent at the moment in the traineeship year. They provide it really for specialists in training by making the establishments in teaching hospitals in registrars and so on very

favourable. But what is needed is some sort of financial careers structure at least in the training years and perhaps in the very early years of practice; and I wonder whether any of the Ministry's representatives here would like to comment on this and say what is likely to be possible of achievement. Because all our ideas on how we do this will fall to the ground completely without financial aid. We cannot go on for ever relying on charitable trusts.

Chairman: Members of the Ministry's staff present are, I hope, considering whether they can reply to that question. At any rate, their ears have been listening to it.

Dr P. H. Hopkins; I want first to say how much I have enjoyed listening to this morning's three speakers, because I have personally visited their three countries and seen their health services at work and met all three of them in their own countries. I should like to say this, and I hope Harry Levitt will not mind. When he told me several months ago of his intention, or the intention of the College, to organize this Conference and make it international I suggested to him the names of Dr Stampar and Dr Medalie as possible speakers from Yugoslavia and Israel, and I am delighted to see what a good choice I made. I am sure you showed this by your applause for their talks this morning.

I saw in these three countries, and indeed in others I visited, problems we all face as general practitioners are very much the same. No matter what language we speak, or which country we are in, the problems are basically the same; and, whereas we thought a few years ago we had all got somewhere when we spoke in terms of ' whole person pathology ', we are now at the stage of seeing that what we need is whole family pathology and perhaps even community pathology. But it seems sad to me that we, as it were, preach to the converted at these conferences. Because here we have perhaps 200 practitioners who, I think, all agree with much of what has been said and who are all aware of what is being said. I am worried about the other 22,800 practitioners who are not with us today, who also, I think, need to know what is being said and to see the need for it.

I am delighted that the College provides this platform for discussions of this sort, and particularly to hear of the need not only for us family doctors to press on to see that general practice is not lost for ever, but also for specialists and others to know about this. I am pleased to see the Press here today, because I hope they will help us in this, for it is not enough for us doctors to talk to one another. It is not enough even for us to tell the Government what is needed. The public must know what they require, and it is only in this way that the Government may eventually be persuaded to provide what is necessary. The last speaker referred to it, and Dr Horder told

us what is needed; Dr Little talked about the College being the driving power, and I was going to say that we cannot afford to pay for the fuel; it is the Government who must do it.

I was interested to see this morning in one of the Sunday national newspapers two whole pages, one devoted to an account of the mystery miracle of the magic needles of acupuncture, written by a doctor, I believe, under a pseudonym. He was telling of the marvels of this treatment and of the thousands of people benefiting from it and the thousands of people prepared to pay for it. Another whole page of one of this morning's Sunday papers was devoted to an explanation, a description, of what goes on, for 38 guineas a week, at one of the many nature cure establishments in this country. People in large numbers are prepared to pay for these things, acupuncture and nature cure and fringe medical treatments, but for the medical services it seems that they are reluctant. I think it is for this College not only to tell doctors what is needed but perhaps in some way to get help from the Press to get this matter over to the public. Because it is only by the public saying, " This is what we want " that the Government will increase expenditure on the general practitioner services.

When I was in Jerusalem four years ago I talked to Dr Medalie about his health centre there, and I was interested to hear one of his references this morning to the woman in a group who spoke about the difficulty of knowing what language to speak to her children in. I was told at the time that Israel is indeed the only country in the world where the children teach their parents how to speak the mother tongue.

Dr Gallagher: May I say that I do not propose to answer any questions, but the meeting may be interested to know that there are four members of the Ministry staff concerned with general practice here, not as observers from the Ministry, but as members of the College. Dr Talbot Rogers and I had the privilege of sitting with the Fraser Working Party, and in this context there are also, I recognize among members of the College present, three who are members of the Fraser Working Party, apart from Dr Talbot Rogers and myself. So I should like to offer an assurance that we are listening interestedly, intently, and I am sure that all of us will carry away great benefit from our presence here which will no doubt be reflected in other spheres.

Dr P. O'Brien (*Warrington*): I was very interested in what Dr Huygen had to say about obstetric services in Holland, because I have a great admiration for Holland's obstetric care. In Holland they get tremendously good results with a large proportion of home confinements. In Britain our results are nothing like so good,

although we have a higher proportion of hospital deliveries. Why is this? I believe that basically it is because of lack of co-ordination in this service. On our side I think the fault is that many of us do not take our responsibilities seriously enough when we book patients for antenatal care. But, even worse, I think, is the attitude of many consultant doctors. I am sure that subconsciously many of them have the attitude that if they give us enough rope, sooner or later we are going to hang ourselves and the service will revert to them.

This is not just a casual observation. I have sat for some years on the Obstetrics Advisory Committee of one of the regional hospital boards. The consultants on this Committee are quick enough to criticise some of the appalling things that happen—and, let us face it, some of the things that happen are appalling—but when you try to suggest to them that by co-operation on their part this service might be improved their frigidity is amazing.

Oxford is, I believe, the one region in Britain where full co-ordination occurs and where it has borne real fruit because the results both for hospital deliveries and home deliveries in the Oxford region are comparable with those of Holland and with the best abroad. When I mention this, the only reply I get is that Oxford is different, Holland is different. I cannot see it. The only difference I see is that they are better organized and better co-ordinated, and I believe that throughout the country we could achieve equally good results by better co-ordination.

Chairman: Dr Huygen, would you like to say what you feel is the basis of the merits of the obstetrics service in your country?

Dr Huygen: I will try, but it is not so easy. It is true that in Holland antenatal mortality is the lowest in the world. But I think the cause of this is something of a mystery. I think it is not only medical care but also social developments. It is true that most of our confinements take place in the home. We are trying to do our best, but I cannot say that our mortality is the best in the world because our confinements are in the home, or because our care is so good; I could not say that.

Dr P. S. Byrne (*Westmorland*): Several meetings this week have left me full of stimuli and, hot from impressions, I should like to make one or two points. One of our difficulties in getting improvement of the educational schemes going is the basic difficulty of ' selling ' them primarily to universities. We are rather in the position of a foreigner coming into the country who cannot get a work permit because he has not got a job, and he cannot get a job because he has not got a work permit. We are not accredited teachers, and therefore the universities on the whole are not very keen in helping us to

become so. To consider the paucity of student attachment schemes throughout the country, this is not for want of general-practitioner volunteers to help man them. Financially if worthwhile schemes are put up, there is an increasing climate of acceptance, or temporary acceptance, of them as experimental ones. I think it would be unrealistic to expect any widespread unification of any particular type of method until in fact we have tried many methods ourselves. With our peculiar temperament, with our traditionalism and conservatism in general practice the blend of new ideas must—and it is right that it should—take a long time to determine.

Again, we have a weakness in our general-practitioner system: the difficulty of people, however keen, in finding time. The general attitude that general-practitioner time is cheap and the derisory size of payments made to claimants make it easy to see that it is possible to get simply the quality one pays for. Until there is a general revision by higher authority of the need for medical education and appreciation that there is a growing body of opinion and feeling that it might have some part in assisting it—until that happens, we are not going to achieve very much.

A member: As to north-east Scotland, I am stimulated to rise on my feet by what Dr O'Brien was saying about the obstetrics service. I should like to spring to the defence of some obstetricians. In the north-east of Scotland the consultative committee of the regional board met and the obstetricians were very helpful. At the request of the practitioners, they organized postgraduate meetings once a quarter to bring to the attention of practitioners the recent advances. In addition, we persuaded them to produce a news letter once in six months, for more remote doctors. I think the point of this is that closer co-operation and meetings between practitioners and obstetricians can produce very friendly and helpful results. I am not aware of the figures, but I think the figures of mortality in north-east Scotland are fairly good.

Dr Lask (*Ealing*): Such meetings usually stimulate so much euphoria that perhaps you will allow me to be slightly iconoclastic. I much appreciate the speakers this morning, and I was completely taken with Dr Huygen's comment. One of the arts of general practice is that of being clinically effective with scientifically inadequate data. We have not had time to think about it. Has he heard of the 'quack'? The quack gets very good results and we do not know how; but we do know that it is wrong! Someone commented about quantity-quality ratio and the problem that it poses. We do not know how the problem is to be solved. The fact that there are only 8,000 members of the College among 23,000 general practitioners gives us a suspicion that, faced with this problem, apparently insoluable, there is frustration and despair. It is very

difficult indeed. Dr Medalie said that something has to go; and for many practitioners, their interest goes.

We here, by definition, are interested and keen. There are so many aspects of general practice that there is going to be no easy solution. I would emphasize the plea for a continuation of experiments in given methods and organization, different methods of work. Let us see what happens. Do not let us impose one particular one. But, having said that, we must be ruthlessly honest in our own assessment of the results of our work. Do let us have the courage of our convictions and present our failures as well as our successes.

Listening to Dr Medalie's most interesting case, the thing that impressed me was this: how many doctors would take how long to reach a solid conclusion as to how best to dispose of that case? It is a problem. I do not know. In my practice I am pretty sure that we should be on to it quickly. I suspect that in most practices represented here the same would apply. But one just does not know.

Perhaps you would allow me a moment to tell you how I do my work. Something has got to go. With me what goes is the keeping of, to my mind, petty, unimportant records, the detailed occasions which to my mind do not matter. I concentrate on the whole person problem of the patient—perhaps a little further, on the total person as a patient in the community. In consequence I bother very little about their colds and coughs and tummies, except as presenting symptoms. We do not deal with illnesses; we deal with people. People come to us with problems and what we do with them determines how we practise our work. After ten years of Tavistock work in this country I still feel a little surprised that we should have to be impressed by the fact that whole person medicine, family psychiatry, is worth pursuing. To my mind, by this time it should be self-evident.

Chairman: I think the time has come to offer two minutes to each of the principal speakers, to make points or draw attention to any special points they wish. Dr Stamper?

Dr Stamper: I have no points to make.

Chairman: If you have anything to add afterwards you will say so. Dr Huygen?

Dr Huygen: I think all three of us have been very impressed by what we saw of the work of the College. We think that what the College has done in this country is a wonderful job. We were most impressed also by the research in general practice. We got the feeling that certain circumstances of the general practitioners are not too easy and there may be some discontentment. But nevertheless, the possibilities here are great, especially the possibilities created

by your National Health Service which enables things to be achieved which would not be achieved without it.

We were also impressed by the attitude of your Government and authorities. We felt that trying to help the general practitioners was a general attitude. Speaking on behalf of all three of us, I should like to express our gratitude to the College for offering us this very interesting, very stimulating study tour. We have seen very good things and I think that all three of us have learnt from this. We want to express this gratitude, especially to Dr Levitt, who has proved to be a magnificent organizer. I should like to end by asking you to give applause to Harry Levitt.

Chairman: Dr Medalie, we should very much enjoy a few words from you, too.

Dr Medalie: There have been so many interesting points brought up that it is hard to know where to start. I think Dr Horder hit the nail on the head when he put it almost as if the alternative is the polyclinic, on the one hand and—perhaps Professor McEwan would like different doctors for different age groups—direct access to the specialists, on the other. We in our country have both systems going pretty strongly, and it is for that reason, having seen both systems, that all I can plead is: please strengthen the family doctor team. This is the future for the patient. If I may make a plea it is that.

As regards the colleague who spoke last in the discussion (I forget his name) some things evidently are not so self evident as we would hope them to be. I think it was Dr Little who mentioned the Peckham experiment. I am not sure whether he or others realize how much the Peckham experiment or Peckham health centre influenced our thinking in distant lands, although we never had the opportunity of seeing it in action. To us, the fact that this was closed was something very hard to take, and we could not understand why it was not self-evident that the Peckham experiment was a first-class thing. Similarly, I hope the desirability of family practice will become self-evident. There is a saying, " Out of Jerusalem came the Bible ". I hope that out of Edinburgh will come family practice for students.

Two other things are these. First, I think the three of us think that the general practitioner is carrying the load of the National Health Service. He is overworked, underpaid, and doing a wonderful job. And also his wife is giving him a tremendous amount of support. What impressed us about the College and the medical school people is that the College is at least a decade ahead of the medical schools in its thinking about family practice, and you must, besides the public, influence the medical schools. Really, you need a good public relations officer from Fleet Street, or wherever it

might be, to come to the College and really organize your public relations. As Dr Huygen said for the three of us, it was a wonderful opportunity to come here and I hope that we shall have the opportunity of acting as host to some of you.

Chairman: This is not the moment when we say goodbye to our guests. We very much look forward to having them take part in the discussion and questions this afternoon. But it is the moment when, I am sure, you would like me to make some particular expression of our gratitude for the imaginative way in which they have presented their papers to us—so stimulating, so tactile, almost visible, in the way we have felt their experiences and their ambitions, their achievements and their need to achieve more. I am sure you will want me to say " Thank you " very warmly, and to say how much we look forward to hearing them join with us this afternoon, with other visitors in the audience from whom we have not yet heard enough. I know that you will want to express your thanks.

I think we were all immensely excited and stimulated in listening to our colleagues from Yugoslavia, the Netherlands and Israel this morning: listening to their problems and the methods they are attempting to use to solve them. In moments of depression we are a little apt to imagine that the problems we have here are peculiar to our own country in that by and large our colleagues overseas in different countries are happier, more contented with their lot than we are with ours. After all, distant fields are always greener. We now know that, by and large, their problems are very similar to ours.

This afternoon we have, as it were, to turn the microscope on to the problems in our own field. And, in order to bring us up to date, to clarify our thinking of our own particular problems, we are very fortunate in having with us today four speakers who I know will contribute to our need and to a most interesting discussion. They are Dr Ashworth, a general practitioner from Darbishire House in Manchester, Dr R. F. L. Logan, director of a medical care research unit, Darbishire House, Dr Fulton, a general practitioner from an area in Scotland, and, finally, Dr John Ellis, hospital physician at a London hospital, who is, as you know, the honorary secretary of the Association for the Study of Medical Education.