1. All great literature, poetry, art, music, enlarges the human spirit and helps to build character—that is *why* it is great. Whenever a Beethoven writes a symphony he is expressing the experience of his spirit in a language whose technique he has mastered. We, without the technique, may catch his message and be enriched and ennobled by it.

2. The wisdom of saints and seers is freely available. There is a spiritual library worthy of study as careful and exact as any we give to our professional textbooks. The library includes authors such as Thomas à Kempis, Henry Drummond, John Bunyan, Professor B. H. Streeter, and the recent writings of J. B. Phillips. It includes that portable library the Bible—Phillips's translations of certain books are most refreshing. Mark Twain complained that the Bible upset him—not the things therein which he didn't understand, but the things he *did* understand. But don't let Mr. Twain put you off.

3. The art of making men "whole" demands a shrewd combination of activism with quietism. To understand man's mind and spirit (including his own) the doctor must practise quietism; to understand and heal man's body he must be activist. We need therefore to meditate daily on great truths. In meditation the horizontal plane of routine meets the vertical plane of eternal values. Such meditation, best undertaken in the morning, gives detachment, perspective, insight, and direction. It is the critical act which makes every day significant. It is a time which saves time, for it clarifies what is important. It adds to the day both direction

and inspiration. As a daily habit it transforms the way you live, your ambitions, your interests, your methods. It emphasizes that the real purpose of life is spiritual development, since for every man physical death is certain. Practised by the seers for centuries, it is powerful to-day in the lives of those who learn to explore its secrets and who accept its discipline. It is essential now as never before, for it is potent in the upward struggle of mankind. Apart from extremely busy periods the average doctor needs at least half an hour of such meditation daily; when exceptionally busy he requires longer.

Further, more than a personal religious faith is necessary. The atomic age is also the Ideological Age, and for the first time in history a highly organized materialistic ideology has captured the minds and wills of one-third of the whole human race, and is extending rapidly. Against so ominous a background a religious faith devoid of the plan and passion of an ideology looks like a personal luxury. Moreover, medicine itself is in dire need of a dynamic new philosophy fed by deep spiritual roots. It is possible that, hampered by its upbringing and agnosticism, the profession as a whole will be unable to rise to this fundamental challenge of our times. It may therefore fall to you to discover and apply the spiritual ideology which is the only possible answer to contemporary materialism in all its forms. Without that spiritual ideology man may disappear into the night of self-annihilation; with it he will move confidently forward into the light of day.

POSTGRADUATE MEDICAL EDUCATION IN PREPARATION FOR ENTRY INTO GENERAL PRACTICE*

BY

J. K. PATERSON, M.B., B.S.
Upton, Huntingdon

"The one essential, whether he be regimental medical officer or general practitioner, is that your doctor should be a man: and he may adorn his manhood with such elementary knowledge of medicine and surgery as he may pick up in five years, ten years, or a lifetime of study." This statement was made by a colonel of the Royal Artillery at the close of a lengthy discussion in a native hut, some five thousand feet up in the foothills of the Himalayas. The truth of his observation has been impressed on me time and again in the years that have passed; years which, for me, have been filled with a great variety of experience, and which have seen a very junior combatant officer become successively commando, medical student, father, houseman, and general practitioner. And at each stage of this metamorphosis it has become more apparent that the pre-eminent quality of the good general practitioner is that, being a man, he should adorn his manhood in the manner required by this rather unusual soldier.

A prerequisite to any intelligent discussion of postgraduate education for general practice is a clear picture of what constitutes the perfect general practitioner. Only with this in mind is it possible to appreciate the shortcomings of the newly qualified doctor and of the system which has nurtured him, and to formulate a plan to fashion the product of the undergraduate system for the Herculean task awaiting the doctor in general practice.

Attributes of the Perfect G.P.

Perhaps foremost amongst the attributes of the perfect general practitioner comes a sense of humour: the patient wants to consult a human being rather than an encyclo-

paedia, and in a sense of humour the doctor has at his elbow the most potent antidote to frustration, petty irritation, and anger. Next I would place courtesy. Patience, too, must be found a place, with tact and honesty, and a certain humbleness in the knowledge that no man can aspire to know the whole field of modern medicine. Adorning the man covers many and varied aspects, and the good general practitioner must have an up-to-date grasp of general medicine and surgery upon which to base his other knowledge and upon which to found his wisdom. In many districts he must also have a high degree of knowledge and skill in obstetrics, although there appears to be a trend towards the hospitals in this branch of medicine.

The general practitioner must know how to assess and treat the multitude of minor ailments he will see daily in his surgery, and about which he will find little information in textbooks, and he must be prepared to do rather more than "sort" his E.N.T. from his ophthalmic cases. He must be fully conversant with the infectious diseases, for on these alone can his reputation as a doctor depend, and he will find a knowledge of dermatology of the greatest help. Of much importance is his ability to deal with children, not only as possible pathological specimens, but as young human beings with a great capacity for fear, yet usually impressionable enough to win over to co-operation. Much has been written about the care of old people, but, whether or not it is wise to remove them from the general practitioner's care, there will long be a number of old folk to be cared for in general practice. The chronic rheumatic conditions also will demand much of the general practitioner, and, perhaps most tiring of all, he will have to deal with numerous cases of neurosis and tension states, and with the occasional certifiable patient. Then there are the inevitable deaths, and the problems of comfort and succour to the bereaved.

*Abridged version of the Claire Wand Fund Prize Essay.

The G.P.'s Duties

Few newly qualified doctors would have the temerity to think that they have an adequate professional knowledge of these things. But what of the multitude of non-professional or para-professional facets of general practice? The general practitioner may need to do his own dispensing, and he may be fortunate enough to be in a position to do minor pathological and radiological work. He will also have to be acquainted with all specialties, and in particular with the local public health services. He will find it essential to establish a liaison with the local consultants and medical officers of health, as with school medical officers, children's officers, probation officers, and district nurses and health visitors. He may find that the National Health Service has enhanced the tendency for all these people to live in a world of their own, and it will be to his advantage if he can achieve a ready transmigration from one to another. He will find himself in frequent contact with the Ministry of Pensions and National Insurance and the Public Assistance Board, of which a working knowledge would save much time and unnecessary irritation. Again, he will be consulted over contraception, infertility, possibly even artificial insemination, adoption, and various domestic problems, in each of which he is looked to for sympathy, understanding, and guidance. With all this he must apply himself to the organization of his surgery premises and hours, to domiciliary visiting, and to preserving the proper relationship of his National Health Service to his private work, and, if he is wise, to a sensible plan for being off duty. He must attempt to preserve some privacy for himself and his family, and to strike a suitable balance between professional and social life. There must be added the administrative work of the practice and finding leisure for continuing education.

Here I must digress. It is clear to me that, from the point of view of most patients, a single-handed family doctor is preferable to a collection of doctors, any one of whom may be seen on attendance at a surgery or health centre. But the life of a conscientious single-handed doctor can become scarcely worth living. The practical solution is for two doctors to practise in partnership, each with his own list of patients, but with a firm association as a business and with a clear-cut system permitting each partner to escape from the dual practice at specified times.

Shocks of Entry into General Practice

As a prerequisite to intelligent discussion of the problem I have attempted to draw a picture of that theoretical figure the perfect general practitioner, a picture which includes his environment, the hurly-burly of general practice. To any young doctor whose education and environment have not included systematic training devoted to it, entry into general practice must provide a series of major and minor emotional shocks, and he either succeeds or fails in interpreting his postgraduate experience in terms of educational value and thus to the benefit of himself and his patients. If he is honest, he will find many gaps in his undergraduate education, gaps which he will slowly fill from that reservoir of experience which is life. He will find the gaps to be widely varied in nature—some social, some professional, and some which may best be described as appertaining to "lifeman-ship."

Perhaps the commonest failing in the young doctor is a lack of ability to adjust himself to his patient's widely varying intellectual, emotional, and social levels. This ability is rarely a natural gift, and is usually poorly developed by the time a young doctor enters general practice. Yet it is the essence of establishing that mutual trust and understanding which should underlie that doctor-patient relationship, and is closely linked with the rather vague conception of the general practitioner as a man. We may accept that the average entrant to general practice has a sound grasp of the fundamentals of medicine and surgery, but we cannot hope to fool ourselves into believing that

this applies also to the special departments. The average young general practitioner has the sketchiest knowledge of these subjects, especially perhaps of public health, which should be the closest ally of general practice. He will probably be at a loss to know how to secure the willing co-operation of the district nurse and health visitors. He will most likely have a flimsy understanding of dispensing, which can loom large in the work of a country doctor, and which I feel is of considerable value as an intellectual exercise. He may have little knowledge or experience of contraception, and a limited view of the functions of the Ministry of Pensions and National Insurance or the Public Assistance Board. He may never have heard of societies for adoption or for the blind, and he may be ignorant of the numerous administrative details which go toward an efficient practice. With all these gaps to fill, and with a certain feeling of urgency in their filling, he may find himself struggling in a quagmire of inadequacies, and so find it almost impossible to continue his postgraduate education on systematic lines in the first few years of general practice.

B.M.A. Reports

The British Medical Association (1950) has published in its report, "General Practice and the Training of the General Practitioner," the most comprehensive contribution there is on the subject. This is largely based on the previous report, "The Training of a Doctor" (B.M.A., 1948), and the members of the committee are at some pains to point out that the recommendations of their later report are applicable only if those of the first are to be implemented. Thus the scope is widened to include both general premedical education and the continuing education of the established general practitioner. Without such recognition of the problem as a whole, from the time the would-be doctor embarks upon his general education until he retires or dies, little of value can be contributed in any one part of the whole education of a doctor. It is with this in mind that I intend to put forward my proposals on the subject-matter of this essay.

The British Medical Association report suggests that the newly qualified doctor intending to enter general practice should spend a period of three years according to a flexible scheme, including experience in both hospital and general practice. It suggests that these years be employed in special posts where the educational aspect is uppermost, and makes a particular point that they should not be spent in supplying willing labour in understaffed hospitals and practices. Here I heartily agree, though I feel that such posts may be hard to find and almost as hard to maintain. If new posts are to be created the taxpayer must be convinced that they will pay rich dividends in the emergence of a better quality of general practitioner and also that he can afford such an investment. At a time when costs continue to soar and the National Health Service bill mounts wildly, and when high priority is being given to the allocation of capital to hospital building, the task of obtaining Ministerial and Parliamentary acceptance of such a scheme will be formidable.

Again, the report suggests that as most young doctors are eligible for national service, and as this normally occupies the 24 months immediately following full registration, this should count as one year of the proposed three years' general practice training. What the report fails to do, after assessing 24 months' military service at one year's civilian service, is to say which part of their otherwise excellent scheme is to be sacrificed. I cannot see any rational way in which this could be decided, particularly as the Service experience the young doctor is likely to have had will be so variable. The heads of the medical branches of all three military Services are quoted in the report, and all speak of the possible opportunities for professional experience available during the period of national service. The impression I received from a number of national service doctors is that if they go into the Services immediately on full registration they will probably gain little professional experience, but if they are permitted to delay their military service a further

year or more, and are thus enabled to obtain a higher degree or diploma, then they will benefit enormously from their brief military experience. But, in either case, what they gain will depend on their attitude to Service life and on their ability to adapt themselves to Service conditions; this is a non-professional experience which has an intrinsic value of its own.

Views at the World Conference

In his contribution to the First World Conference on Medical Education, Sir David Campbell (1954) emphasizes the value of an internship. He welcomes the Medical Act of 1950, whereby this becomes compulsory, with an accompanying delay of one year before full registration, and quotes the report of the Planning Committee of the Royal College of Physicians, as drawing a distinction between the strictly educational nature of undergraduate teaching and the vocational training of the internship. This, of course, applies only to approved posts, and he goes on to mention that approval of hospitals and internships is the province of the universities, and that their natural pride is sufficient to guarantee an adequate standard. As a first year of postgraduate work, this is clearly quite admirable.

Speaking at the same conference, Professor A. L. Richard (1954) adds a delightful and sane picture of what is required of the modern general practitioner, reminding us that the physician can "cure sometimes, relieve often, but comfort always." He defines the general practitioner as a "combination of scientist, healer, psychiatrist, father confessor, and social worker," and heralds a return to the old conception of the general practitioner, though on a much higher scientific plane. For this he advocates a general education in the humanities on which to base the necessary scientific knowledge required of the general practitioner to-day, and makes a plea for effective co-ordination of the whole educational team involved in the training of a doctor. He reveals an unusual clarity and depth of vision in what he says, but in the brief space allowed he makes no suggestion on how the schoolboy may be transformed into father confessor, a role of great importance in general practice. This is a part of becoming a man, and there seems to be a tendency to allow it to happen, rather than actively to encourage it: it is a matter involving the "lifemanship" I have already mentioned.

Of recent years a number of experiments have been made in an undergraduate introduction to general practice. One such experiment is reported by Marien and Ardouin (1954), and most interesting reading it makes. In the brief space of three weeks they managed to find a wide variety of interesting subjects to see and discuss, and I am convinced that this must have been of considerable value not only to the student but to the general practitioner taking part in this introduction. The main arguments against this proposal must be its necessary brevity and the imminence of final examinations. I am close enough to the marathon of "finals" not to have forgotten the frightful "sweat" of their preparation. To have three weeks of the pre-examination turmoil occupied by such an interlude as this, however fascinating and ultimately valuable, would be to add greatly and unnecessarily to the burden of the final-year student, and if this same experience can be made available at a less crucial time in his life I feel it is only wise to postpone it.

Balance in Medical Education

Sir Harold Himsworth (1953) has surveyed the current position of medical education, with emphasis on its essential balance between change and permanence. Perhaps his most profound pronouncement in that speech is his insistence that modern general practice must be regarded as a special branch of medicine. This is a fundamental point, and it implies a welcome raising of the status of the general practitioner, since nationalization has done much to limit his activities to the simpler tasks. It also implies a parallel raising of the standards of general practice, which in turn demands a revision of existing methods of education, both undergraduate and postgraduate. As Dr. C. W. Walker

(1955) has said, "Time is too short for anyone to be a real general practitioner. We must all be more or less degraded into becoming specialists." He stresses the importance of intimate contact with a hospital as being the most satisfactory method whereby the general practitioner may keep abreast of the advances in medical knowledge, and goes on to suggest that this is best achieved by means of general-practitioner beds in cottage hospitals, attended by a specialist staff in their proper capacity as consultants. He also advocates the appointment of general practitioners to general hospitals, either as part-time specialists or as paid clinical assistants. Only third place is accorded to a variety of refresher courses for general practitioners, run by the general and teaching hospital staffs. A further method of broadening his horizon is in the assumption of the Sabbatical year, when the general practitioner leaves his practice for a temporary hospital appointment (not necessarily for a year), his place being taken by a suitable locumtenent, possibly a registrar. This would have the added advantage of helping to bridge the gap which has developed between the hospital staff and the general practitioner.

Preparation for General Practice

In common with the committee of the British Medical Association, I maintain that it is meaningless, and therefore of no value, to make plans for preparing the newly qualified doctor for entry into general practice without taking into account his antecedent education; so I would expand my proposals to cover the entire education of the doctor until he attains the status of principal in general practice.

If the embryonic doctor has not an early education in breadth he cannot hope to fulfil his mission in general practice. Therefore it is essential that his education at school be as wide in compass as possible. It is sheer folly to begin, as I did, premedical subjects while still at school. It may be argued that, later, it is more difficult to discipline the mind, but this is not necessarily a point against postponing these subjects, as it is equally arguable that the student can resume his academic studies after a non-academic interlude, perhaps with some difficulty but certainly with greater purpose. This I have done, and I believe it to be sound practice, provided that it forms a part of an integrated plan of education. My first proposal, then, is that the student's school should aim to give him the broadest possible education, without bogging him down with premature premedical teaching. We will then have a broadly educated subject to mould, with the ability to read critically and the academic discipline essential to his further and professional education. But we have not a man: he is yet a schoolboy, however well he may have been tutored this far.

It is certain that the day boy compares favourably with the boarder in maturity at any age, and, as the intake for a medical education derives in good measure from the boarding school, the premedical student is probably at a further disadvantage by virtue of his relatively sheltered, monastic upbringing. If he is to make the most of his further education the schoolboy must become a man. What better way of achieving this could be evolved than the ready-made course in "lifemanship" provided by the Services? I submit that this is the time for the student to enlist for national service, and that he should do so in a combatant role. The boy, not far removed from adolescence, enters life as a participant rather than as an observer, and in the 24 months or so of his military service becomes transformed into a man. A small point in favour of this procedure is that for the first time he is employed at a wage, however meagre, and it is up to him to use this and his experience to the best effect.

Several contemporaries of mine returned from their somewhat longer war service with the rank, pay, and responsibilities of lieutenant-colonel; an experience invaluable to them in their subsequent approach to human problems, and far outweighing the loss of even seven years' medical practice. Others, not rising so rapidly in rank, found an

immense variety of experience. I, for one, qualified in five different "trades" in a technical corps, in the 16 months prior to receiving a combatant commission, an experience adding greatly to my interest in many matters, and one involving close comradeship with and understanding of a representative cross-section of the young male adult population of the country. I can think of no better way of employing the student in the prescribed period of national service than by making the break in continuity of his academic education at this early stage, so that he re-enters the academic field a man.

Against this proposal is the probable opposition of the Services to the loss of national service medical officers, but this should not be insuperable. There must always be a hard core of regular commissioned and non-commissioned officers in any national service formation. While there is no more than a threat of war the regimental medical officer and his Naval and Air Force counterpart are probably the least employed and most overpaid members of the armed Forces. A further improvement in the pay and conditions of service of regular medical officers would ensure an adequate number of contented permanent medical staff for national service units, and this could well be afforded in view of the saving to the Treasury made by not having a large number of relatively highly paid idlers. Admittedly this would slightly upset the balance of national service formations, but this would be offset by the advantage to be gained from using the period of national service as an integral part of a co-ordinated educational plan, rather than permitting it to remain an unsought and often unwelcome interruption in a professional career.

Evolution of the Doctor

If this plan is followed, it is a rather different student who enters upon the next stage in the evolution of a doctor. The countless opportunities of university life are afforded to one of far greater maturity than is now customary, and again I would stress that the ex-Service student views his further academic learning with firmer purpose, even if he finds the discipline of reading a trifle harder to resume than if it had never been interrupted. At this stage he is likely to take greater advantage of his course, and his Natural Science degree will be the more securely founded. And this, too, is a point to consider; that the premedical and preclinical subjects, although necessarily taught with due emphasis on their clinical bearing, form a natural group and one which may be suitably concluded by the award of a degree.

A double graduate in Arts and "Lifemanship" thus proceeds to his teaching hospital for the clinical period. Of clinical teaching I will only say that this new-type student will be less tolerant of unnecessary detail, and will be the better able to appreciate the fundamentals of medicine; this implies a revision of clinical teaching aimed at discarding detail wherever it obscures fundamentals. Even so, on qualification and provisional registration the gaps will be many and wide, and I welcome the statutory intern year as the beginning of the doctor's vocational training, a period of consolidation culminating in full registration; but I would suggest that this year be employed only in general medical and surgical posts. Only at this stage does specific postgraduate education for general practice begin, and I make no apology for having taken so tortuous a course to this point. It is necessary to survey the field in detail, and to view the various happenings upon it with a critical eye, before the final assault can be planned and executed.

A Trainee Year in General Practice

For those dedicated to research, administration, or purely academic work I feel that full registration may legitimately mark the end of their general medical education. For all those destined for clinical medicine it is the point at which the horizon is suddenly broadened, and academic studies take second place to experience. Now is the time for the clinician, whether heading for general practice or for

other specialist fields, to leave the hospital for the bustle of general practice. Some may say this is a waste of time for the aspiring consultant, but I am convinced that all clinical consultants would benefit greatly by early experience of general practice, and it would also stand the aspiring consultant in good stead if he should for any reason fail to achieve his ambition and be forced to return to general practice. The system of trainee assistantships seems admirably suited to this purpose, and worth expanding to embrace all those whose bent is for clinical medicine.

An introduction to general practice at this stage would bring many advantages: the trainee would be very much more useful than the undergraduate novice of Marien and Ardouin (1954), taking many responsibilities, although under some supervision by his principal, and he would be able to put his whole effort into his work, without the threat of impending examinations. A year thus spent would entail a thorough initiation into general practice. On the other hand, the principal would derive even greater benefit from discussions with a younger man, fresh from his alma mater, so that the system would be of reciprocal value to those engaged in it. There has been some criticism of the trainee system as it has existed, on the grounds that it has been open to abuse as providing cheap assistants for unscrupulous principals; but then it has never been under any sort of control. If the whole trainee scheme came under the direction of a dean of postgraduate studies, this argument would, I think, become invalid, and I do not suppose it would prove difficult to find an adequate number of principals able and willing to take trainees for a reasonable remuneration. Further, it would help to bridge the gap between these general practitioners and the teaching hospitals, to their common advantage. The year in general practice would serve to show up most of the gaps in the trainee's previous education, some of which would be filled automatically, and the end of this year would be a time for taking stock, when the trainee would need to make the final decision on his future course.

A Further Year in Hospital

To fill the gaps remaining after his year in general practice the trainee will need to return to hospital; not necessarily to a teaching hospital, but to a post designed to afford educational facilities. The trainee will return to hospital a much wiser man than he left it a year before, and the aspiring consultant will return to a senior house appointment in the specialty of his choice; and again I must stress that this choice is made *after* his initiation into general practice. But the man who has set his heart on becoming a family doctor will return to hospital with a mission; he will be acquainted with the gaps in his education, and these he will best fill by spending the second year following full registration in a rotating internship, embracing as many special departments as possible.

The ideal scheme would be to divide the year into six two-month periods, of which five would be spent in hospital and one working as an assistant to a medical officer of health. Ideally, the five special departments in which the young doctor works during this year should *not* include that specialty in which he is most interested, but, coming after both a general medical or surgical house appointment and a year in general practice, this rotating internship should be adequate to fill the gaps in his undergraduate education. These brief appointments would be of reasonable value to the departments concerned, because the ex-trainee intern would have relatively more and wider experience than is at present commonly found in such posts, although the argument must remain valid that the special departments stand to lose continuity. If, however, each department were graced with one rotating intern as a junior, and one senior intern appointed for a whole year, the junior being drawn from the general-practitioner faction of the ex-trainees and the senior from either the consultant or the general-practitioner faction, this disadvantage would be largely overcome.

This rather complicated rotating system would balance out quite well. The number of general medical and surgical junior house appointments suitable for the statutory intern year approximates closely to the total number of special department junior house appointments, thus giving rise to no difficulties involving too great or too small a number of applicants in either the first or the second year of hospital work following qualification. If, in addition, each special department offered a registrar post to be filled by an aspiring consultant, the balance would remain readily adjustable by the appointment of either general practitioner or consultant intern to the senior house post. If this system were extended to the senior house appointments and registrarships in general medicine and surgery, the whole scheme could be readily adjusted to meet the changing requirements of consultant and general practice.

Schematic Plan of Education

* Under control of postgraduate dean.

Conclusion

I have quoted Dr. Walker as saying that "we must all be more or less degraded into becoming specialists," and by the end of the first year of specific training for general practice the doctor's natural bent must be clear. By then he will have had a broad general education, a sample of life as some of his future patients may well see it, a professional grounding followed by experience as an intern in general medicine or surgery, and an introduction to general practice. He will be in a position to make a final decision on what particular aspect of his work interests him most, and in what way he may wish to add to the scope of his work in general practice. With this in view, he will be able to decide in which special departments he wishes to work for only two months, and in which one he feels inclined to spend a whole year. I have already discussed the rotating internship, and the final year of the specific general practice training should therefore be spent in the general or special department of his choice, in a post of the status of senior house officer. Here he may develop his particular skill, which he will carry with him when he finally leaves hospital for his chosen career, and which will enable him to approximate closely to Dr. Walker's real general practitioner.

REFERENCES

- B.M.A. (1948). *The Training of a Doctor*.
 — (1950). *General Practice and the Training of the General Practitioner*.
 Campbell, Sir D. (1954). *Proc. First World Conf. Med. Edn.*, p. 362. London.
 Himsforth, Sir H. (1953). *Lancet*, 2, 789.
 Marien, E. A. W., and Ardouin, A. P. (1954). *British Medical Journal*, 1, Suppl. p. 217.
 Richard, A. L. (1954). *Proc. First World Conf. Med. Edn.*, p. 370. London.
 Walker, C. W. (1955). *British Medical Journal*, 2, 513.

Reviews

PRINCIPLES AND PRACTICE OF GYNAECOLOGY

Integrated Gynecology: Principles and Practice. By I. C. Rubin, M.D., and Josef Novak, M.D. Volumes I, II, and III. (Volume I, pp. 589; Volume II, pp. 496; Volume III, pp. 682. £22 10s. the three volumes.) New York, Toronto, London: McGraw-Hill Book Company Inc. 1956.

By integrated gynaecology the authors mean gynaecology in its widest sense—the study of the whole woman rather than of her genital organs alone. In this book they therefore aim, with considerable success, at relating the behaviour and diseases of the reproductive system to other body functions, and they thereby cover a good deal more endocrinology and general medicine than is to be found in most gynaecological textbooks. Diseases of the breast and urinary tract are described in full. The authors also include comments on all sorts of unusual matters which make the book of value to those who seek the answer to abstruse questions. Even those with encyclopaedic knowledge will discover conditions of which they had never heard and be encouraged into avenues of thought not previously entertained. The difference between the male and female stomach; the influence of the menopause on the skin; a spiral arrangement of the vaginal musculature similar to that envisaged for the cervix and urethra; penicillin as a cause of abortion and uterine haemorrhage; and bismuth melanosis of the vagina—these are merely a few random examples of the kind of subjects discussed. The more standard items, including operative technique, are also present, and the place of those subjects in which the authors have a particular interest is not exaggerated.

Dr. Rubin presents the New World by way of New York, and Dr. Novak the Old World by way of Vienna. They therefore bring to the work the very different outlooks of the North American and Germanic schools. This not only results in much material not ordinarily found in British textbooks, but also necessitates an attempt to correlate ancient and modern knowledge and theories. In this respect the integration is not always successful; the accounts of kraurosis and leukoplakia of the vulva, for example, add to an already existent confusion, while the description of cachexia as a characteristic of panhypopituitarism is a strange relic of the past. One of the benefits of the teamwork, however, is a wider viewpoint not only of gynaecology but of the world literature. There can be few textbooks published in the U.S.A. which contain so many references to European writings. These, which will be much appreciated by readers in this country, are arranged as appendices to each chapter, and they sometimes compete with the text in size. Thus there is a 30-page bibliography for a 70-page chapter on physiology.

The order as well as the nature of the subject-matter is often unusual. The chapter on anatomy has a bias towards histology and function which makes it exceptionally interesting and useful. The classification of new growths departs from gynaecological tradition but is in keeping with modern views, even though pre-malignant states and pre-invasive cancer are placed at the end rather than the beginning of this section. It is surprising to find contraception and sterilization sandwiched between abortion and ectopic pregnancy, but these and other variations are satisfying rather than otherwise. An escape from the orthodoxy which surrounds gynaecology and books pertaining to it is both pleasurable and stimulating.

The work is big, but even so one regrets the absence of four pages which, in the review copy, have escaped the printer's ink. It is divided into three volumes each carrying an identical preface and an index covering all three volumes. The division is arbitrary rather than functional, so that each part cannot well stand alone. The most surprising discovery is that the book is intended primarily for