purposes by the central research organization. It can be adapted to the special interests of the practitioners or modified to incorporate any particular line of investigation which they may wish to follow. Any modifications are best discussed with the staff of the Research Unit in advance for some existing data recording sheets may be easier to adapt to a particular purpose than others. New standard designs will, no doubt, continue to be added as time passes.

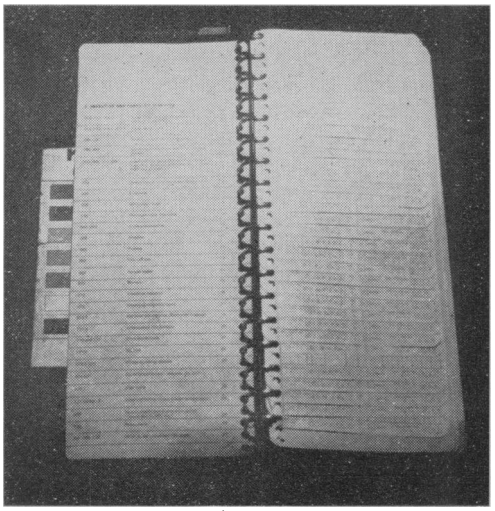

Figure 2
Diagnostic index

Figure 3
Transfer ledgers

The diagnostic index is a research instrument with a future. It can provide epidemiological information of both clinical and operational interest which increases in value as the years go by.

It can be predicted that the method will form the basis of community disease-monitoring systems set up to establish disease patterns for localities and to bring to light changes possibly due to some environmental hazard. No other existing mechanism can achieve this.

The diagnostic index is, also, an indispensable tool for use in undergraduate and post-graduate teaching. An essential basis for the full exploitation of the potential of the disease index is an age–sex register. The two are complementary, the register enabling recognized morbidity to be set against the population background in which it occurs. In the diagnostic index the layout for the recording of each episode of illness is standardized with basic recording methods such as the 'S' card or 'L' ledger, again with mutual comparability as the object.

The Research Unit has limited analytical capacity so it is unable to undertake the analysis of every index which it supplies. It can, however, recommend ways in which analysis can be carried out by practice staff at practice level in a standardized fashion to give comparable results. The unit's staff is always ready to advise newcomers to practice data recording and anxious to hear of new uses to which its methods can be put. Those with problems to which this, or any other practice research method can be applied can contact the Research Unit, The Royal College of General Practitioners, c/o Birmingham Regional Hospital Board, Arthur Thomson House, 146 Hagley Road, Birmingham B16 9PA.

EUROPEAN TRENDS IN TEACHING GENERAL PRACTICE

Report on the European Conference on Teaching General Practice, organized by the Scientific Society of Flemish College of General Practitioners held in Brussels, 2–4 October, 1970

From deliberations at this conference it is clear that in medical schools all over Europe there is a trend towards affording the undergraduate opportunities to deepen his education by some experience of medicine outside the hospital.

In these opportunities most medical schools appreciate the distinction between education

and vocational training although at Louvain University undergraduate education culminates in a form of vocational training for those who choose it in the final (seventh) year. In addition to complementing the undergraduate's knowledge of hospital morbidity by additional information on patterns of illness and the natural history of disease, the aims of such experience include the demonstration of general practice as a potentially satisfying professional way of life. General practitioners may also play an important part in the process of 'socialization'—*ie*, transforming the school leaver into a physician. Methods vary in their emphasis from country to country. In Great Britain, the Netherlands and in the Federal Republic of Germany attachment of students to teaching practices is now being implemented in a more systematic fashion. Indeed, at Ulm University the students' introduction to medicine is not the familiar dissecting-room corpse, but patients, and in their own environment. In some universities attempts are made to assess the impact of teaching and the student's progress by examinations in general practice.

The problems of postgraduate vocational training, among them lack of sufficient incentives for recruitment and teaching the teachers, are not unique to Great Britain. Despite these handicaps several European countries have developed systems of vocational training of varying degrees of sophistication. The German Democratic Republic, for example, has, since 1967, geared its approach to the status of 'specialist in general practice' with minimum examination standards duly sent out, akin to the American Specialty Boards. In Holland the approach lays less emphasis on the status of specialist and postgraduate examinations, and plans are being made to implement a university-based year of vocational training, first at Utrecht, and later at all other universities.

The relationship of colleges and other extramural organizations to the university, shows wide variations in different countries, and there is uncertainty as to the extent and nature of the responsibility each should assume.

There appears to be broad agreement about the content of the emerging academic discipline of general practice, with a greater accent on the behavioural sciences and health education as well as on practice organization, clinical medicine and more traditional subjects. There is a need to assess on a large scale the impact of varying schemes of vocational training, and the outcome of the wide-scale research project being co-ordinated by the department of general practice at Manchester University is awaited with interest.

With regard to continuing education there is evidence of a greater awareness amongst general practitioners of their own need to assume greater responsibility in their education. In this part of the spectrum of medical education, the need is not so much to learn new tricks and techniques as to break down the isolation which in the past has been so notable a feature of general practice. General practitioners have much to contribute to each other's benefit.

These trends in general practice thinking are shared on a wide scale, and Common Market or no, Britain shares with other European countries in this move towards a more 'community' and 'personal' orientation in medical education.

"Our youth loves luxury, has bad manners, disregards authority and has no respect whatsoever for age: our today's children are tyrants; they do not get up when an elderly man enters the room—they talk back to their parents—they are just very bad".

Socrates (470–399 B.C.) quoted by Dr Ronald Gibson in address to Portsmouth BMA. (*British Medical Journal*, 1971, **2**, 549).