national classification of disease.

All migrations are followed continuously. The inhabitants have their individual cards in the family folders with the data on socio-economic and the housing conditions, and on some characteristics of the family morbidity. The further data are supplemented during the regular visits of the family nurse and the doctor.

The general practitioner contacts with the specialists on the history of disease form, where all the findings both of general practitioner and specialist are noted. The admission to the hospital or consultation of the specialist is followed by a ticket. In this way it is easy to see how many patients were treated by general practitioners and how many patients were in need of an additional examination by specialists. Such a system might enable evaluation of the effect of work of the general practitioner, if the morbidity pattern is being changed in a period of observation, taking also into consideration factors not depending on him.

The training of medical students has been changed since 1953 and 1961 respectively. Education has been extended also to the community based health centres (G.P.U., etc.) in addition to the teaching at the bedside. The students are learning and working in the same conditions as they will work as future general practitioners and Ms.G.M. are their teachers.

For better understanding of the new profile of the general practitioner, a brief account of the organization of the health service in Yugoslavia is given.

The three-year courses for M.G.M. have raised the social status and increased the income of M.G.M., so that this is now level with those of other specialists. The courses have stimulated research work in the field of general medicine.

DISCUSSION

Dr McClay: Can you tell us what proportion of home visits to office consultations you make?

Dr Stampar: It depends mostly on the communications. Throughout rural areas it is not so easy to visit as in town, so the proportion may vary. I think the proportion in the towns would be one-tenth, and in rural areas it depends on communications. But we do not spend so much on home visits; we spend much more time in our surgeries. We spend six to seven hours in our surgeries.

Dr McClay: Can you tell us a little about the training of the general practitioner and his place in the organization of the treatment of accidents and the prevention of accidents?

Dr Stampar: You mean in accident training?

Dr McClay: Yes. First-aid.

Dr Stampar: We spent a fortnight as an intern in an accident hospital. But in Yugoslavia accidents are in the care of emergency units.

Question: I thought I understood Dr Stampar to say that, since taking this course, general practitioners not only practise treatment of illness but also go out of their way to practise preventive and social medicine. Could she perhaps tell us how the patients are approached in this way? How do you make contact with them, and what form of preventive work do you do?

Dr Stampar: General practitioners take part in team work. Such a team includes a social worker and a family nurse who works according to the health visitor. But a family nurse is attached to a general practitioner's unit which works as a team. It may solve social problems, which are discussed very often. One nurse is attached to two general practitioners, and every morning she goes and consults with them about her cases. If you want to speak of secondary prevention, I think we spend most of our free time on secondary prevention. We are interested in a survey of the populations. There are units which are engaged in the early diagnosis of diabetes and genital cancer. It depends on the interest of the general practitioner. Rural general practitioners are engaged in 'well baby' clinics and antenatal care. We cannot expect him to be interested in everything.

Dr Lennard (*Bristol*): Do you have enough time to do what you want in the preventive side of your work, or does the curative side weigh too heavily on you sometimes?

Dr Stampar: Yes very often.

Dr Lennard: You are in a rural practice?

Dr Stampar: Yes.

Question: I should like to know how the authorities provide doctors for areas where doctors would not like to go. There are such places. Is there some conscription or something like that?

Dr Stampar: I think we produce a lot of medical students now, and most rural areas will be covered.

Question: I wondered whether anyone is forced to go somehwere to work.

Dr Stampar: No. We have a system of advertising vacancies, and those who are interested reply.

Question: Do you think that the system at present in force in the towns in Yugoslavia, where primary medical care is divided between three people . . .

Dr Stampar: Two people.

Question: I was thinking of the gynaecologist as well. Do you think this is likely to continue or do you see any trend back towards giving this work all into the care of one doctor?

Dr Stampar: I am afraid that it is very difficult to go back. If you wanted to alter the system concerning general practitioners it would be very difficult. But I think it depends mostly on the doctor's own interest. If he wanted to deal with a particular group of patients or a group of the population he could do so.

II

Dr F. J. A. Huygen (*general practitioner, Netherlands. University lecturer in 'Family Medicine'; president of the Netherlands College of General Practitioners*): I would like to begin by expressing my thanks for the honour of being invited to speak at this symposium, held in a country which I consider to be in the forefront of the revival of general practice.

Although in some countries, for example in the United States of America, similar organizations may be older, I have the impression that your College is far ahead of others in promoting the renaissance of the real values of general practice. This impression has been consolidated during the study tour in the United Kingdom preceding this symposium which was offered to us by your College. During this tour I was again struck by the fact that there is a close similarity between the work of the family doctor in your country and in the Netherlands. There are only minor differences: for example, a quarter of our population are still private patients. It is not only in the position, circumstances and the kind of work of the general practitioner that there is a great resemblance, but also as regards ideas and desires for the future. In one respect, however, there is a difference as regards ideas, on which I should like to comment.

Reading your journals and talking to visiting British doctors, I have often heard the wish expressed to reintroduce the general practitioner into the hospitals. Again and again ideas are launched to establish a kind of intermediate form between general practice and hospital. In the Netherlands we also think that the communication between the hospital and the family doctor is not an