METHODES ET OUTILS DE RECHERCHES EN MEDECINE GENERALE

I - LA CLASSIFICATION CODÉE DES RESULTATS DE SEANCE EN MEDECINE GENERALE (R.N. BRAUN) - REVISION EN COURS

II - SELECTED REFERENCES FOR TEACHING AND LEARNING IN FAMILY MEDICINE

(publié avec l'autorisation de la revue : "CANADIAN FAMILY PHYSICIAN"

I - LA CLASSIFICATION CODEE DES RESULTATS DE SEANCE EN MEDECINE GENERALE

selon R.N. BRAUN

- Rappelons qu'il s'agit de résultats à finalité décisionnelle pouvant correspondre à une des quatre positions diagnostiques possibles : le signe cardinal, le syndrôme, le tableau d'une maladie, le diagnostic d'une maladie complet au sens scientifique du terme.

- La classification, telle qu'elle a été traduite, est actuellement utilisée par un grand nombre de chercheurs généralistes de la S.F.M.G Bien entendu, s'agissant d'une première mouture en langue française, des précisions de dénomination apparaissent nécessaires, certaines concernant des germanismes, d'autres des erreurs de traduction, voire de dactylographie, qui se découvrent à l'usage.
  R.N BRAUN lui-même, vient de nous en faire parvenir une première liste. Celle-ci sera complétée au fur et à mesure par les précisions que nous chercherons à apporter à toutes les demandes que vous voudrez bien nous faire parvenir sur tous les points qui vous paraissent obscurs.

  Un comité permanent a été constitué par le bureau élargi qui se réunira une fois par mois à cet effet et travaillera en liaison avec R.N BRAUN
  (Drs J de BUTLER - J de COULIBOEUF - J GOEDERT - Ph JACOT - O. ROSOWSKY - G. VERY).

  Nous publierons dans chaque livraison des "DOCUMENTS DE RECHERCHES en MEDECINE GENERALE" la liste des précisions et modifications que nous vous prions d'introduire au fur et à mesure dans la codification en votre possession (Documents n° 6).

La commission a commencé la révision de la classification pour les chapitres XIII : Maladies du système ostéo-articulaire et IX Maladies de l'appareil digestif.

On trouvera, ci-après, les modifications proposées sur lesquelles un accord a été atteint, toujours après discussion par correspondance régulière avec R.N. BRAUN. Les utilisateurs du code général actuel (1ère traduction publiée dans les "Documents de Recherches en M.G." n°6) peuvent porter eux-mêmes les corrections voulues dans les tableaux I et II de la nomenclature en leur possession.

Notons, à cette occasion, que toute nomenclature médicale doit s'adapter à l'évolution des faits médicaux dans le temps.

Lorsque la première mise en forme de notre traduction première à laquelle nous travaillons actuellement, sera achevée, des révisions à intervalles de temps suffisamment longs et définis à l'avance, devront être programmées.

MALADIES DU SYSTEME OSTEO-ARTICULAIRE

1°/ Trois codes ne correspondent pas à une fréquence régulière de cas atteignant 1/3000 résultats de séance de médecine générale

- soit qu'il s'agisse de situations qui correspondaient à une série occasionnelle de patients rencontrés par R.N.BRAUN lors de la création de sa nomenclature en 1955-59,
c'est le cas de :

	code initial	code 1977/80
. atrophie des muscles (de l'éminence Thenar)	266	(236)
. Craniotabes rachitique	153	(324)

- soit qu'il s'agisse d'un problème lié à une technique médicale dont l'emploi s'est raréfié.
C'est le cas de :

. Blocage articulaire chirurgical	376	(360)

Ces trois situations et leurs codes sont simplement à supprimer.

2°/ D'autres dénominations ont été précisées et doivent être rectifiées comme suit :

. Prothèse articulaire devient prothèse articulaire (problème relatif à)	315	(274)
. Anomalies posturales devient Anomalies posturales d'attitude (sans modification fixée du squelette)	231	(270)
. Tarsalgie devient Talalgie (douleur durable sur la région plantaire du talon. Pas de spicule. Thérapie par réduction de la pression au niveau de la zone de douleur maximale)	249	(253)
. Troubles par affaissement de la voute plantaire, devient Pied plat étalé, affaissement de l'arche antérieure	295	(224)
à ne pas confondre avec pied plat (troubles consécutifs à)	111	(133)
. Autres plaintes statiques devient autres anomalies statiques (englobe toutes les plaintes autres que celles concernant les pieds plats/étalés et anomalies posturales d'attitude)	172	(196)
. Oedème des pieds devient autres oedèmes des pieds (dans le cas où aucune autre étiologie précise ne permet une meilleure classification)	122	(135)

/ou/et

	code initial	code 1977-80
. Orteils déformés devient autre déformation des orteils	435	(403)
. Faiblesse musculaire localisée	238	(271)

note : dans les cas où on ne peut conclure à une origine myogène ou neurogène)

MALADIES DE L'APPAREIL DIGESTIF

Quatre dénominations ont été précisées et doivent être rectifiées comme suit :

. Dyspepsie du nourrisson devient Diarrhée du nourrisson	36	(263)
. Ulcère peptique devient Ulcère gastro-duodénal	37	(55)
. Hernie incarcérée devient hernie étranglée	195	(197)
. Vomissement et/ou diarrhée devient gastro-entérite	5	(11)

L'ETUDE DE CERTAINES DENOMINATIONS EST EN COURS DE DISCUSSION NOUS EN DONNONS LES TERMES A TITRE D'EXEMPLE DES PROBLEMES TECHNIQUES QUI SE POSENT :

- Extraits d'une lettre du 14.10.83 adressée par la Commission de la Nomenclature de la S.F.M.G. à R.N. BRAUN :

  - 2 : Myalgies et 221 : myalgies exogènes (de quoi s'agit-il ?)

    ainsi que 240 : myalgies fébriles

    ainsi que 30 de votre définition nosologique : SCHMERZEN IM WEICHTEILBEREICH (sacralgo - lumbago - dorsago - trapezoidago - cervicalgo, etc...)

  ou bien tout est myalgies

  sauf peut-être 221 et 240, mais non pas lumbago, ou bien ne faut-il pas décomposer myalgies et ramener myalgies à autres myalgies

  Dans ce cas, on aura :

myalgies (cadre général)		2
"	a) cervicalgo	2 a
"	b) trapezoïdago.....	2 b
"	c) lumbago.....	2 c
"	d) sacralgo.....	2 d
	etc.	
"	e) autres myalgies.....	2 e

Du point de vue des fréquences 2a - 2b- 2 c - etc.. nous paraissent justifiés, du point de vue de la théorie de la médecine générale, après tout il s'agit bien de douleurs dans les domaines musculaires et les parties molles, reste qu'on trouve souvent une douleur localisée à la pression, percussion d'une vertèbre dans la zone radiculaire correspondante.

Par ailleurs, les phases douloureuses alternent avec des phases muettes alors que l'appareil articulaire vertébral reste radiologiquement identique. Ces problèmes nous paraissent encore insuffisamment clairs et nous aimerions connaître les raisons de vos choix.

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- REPONSE DE R.N. BRAUN

Extrait de sa lettre du 27.10.83

La Commission de la S.F.M.G. s'efforcera de trancher à sa prochaine séance de travail de janvier 1984.

221 - Myalgies exogenes : Ce sont simplement des douleurs musculaires après efforts, mais non après blessures, spécialement comme dans le sport (en Anglais pain after muscular exertion)

Myalgies fébriles : Fièvre non caractéristique avec douleurs musculaires comme symptôme capital.
Il s'agit le plus souvent, probablement d'une affection à virus cosackie (auparavant maladie de Bornholm). Mais ces cas sont très peu fréquents dans la pratique on les compare à la fréquence des fièvres caractéristiques avec des myalgies non significatives.
De plus, on a aussi nommé cette maladie, à cause de son début brutalement hyperalgique la "devils grip" (myalgie épidémique - maladie de Bornholm - myosite épidémique).
Donc, je distingue les rares myalgies fébriles et exogenes de toutes les autres qui sont très fréquentes. (Myalgies). En cas de subdivision, je classe selon les muscles les plus touchés = ainsi :

a) deltoïdago
b) trepozoïdago
c) pectorago
d) intercostago
e) supraspinago
f) interscapulago
g) dorsago (autres muscles dorsaux)
h) lumbago (parties molles entre le thorax et les hanches)

A intercostago, lorsque des douleurs électives sont présentes dans la région intercostale dorsale, suit

i) glutaego

et j) autres myalgies de localisation rares (biceps vastus etc).

Sacralgies : douleur entre la crête iliaque et le sacrum et d'une articulation sacroiliaque à l'autre sont pour ma part localisés dans l'articulation sacroiliaque, pour une autre part, il n'exite pas de douleurs à la pression du tout, la maladie est apparemment localisée aux insertions tendineuses.
Cette dernière collection ne devrait pas être incluse dans myalgies d'autant que les sacralgies sont très fréquentes.

...

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Aussi serai-je partisan d'une rubrique spéciale comme jusque là j'ai fait. Tout le reste devrait être laissé à des recherches ultérieures à travailler un temps.
suffisant pour voir comment on pourrait le mieux définir les groupes.

Déjà, depuis quelques années, pour ma part, je distingue les douleurs des parties molles avec douleurs à la pression (myalgies), des mêmes douleurs sans douleurs à la pression. Cela a eu pour effet de faire croître les fréquences des **nevralgies** en météore et que les fréquences des myalgies ont diminué dans la même proportion. Ce n'était qu'un glissement de classification.

Le role des douleurs à la percussion des vertèbres etc.. doit d'abord faire l'objet d'une recherche.

Ce que vous écrivez sur les rapports entre les plaintes et les constatations au niveau de la colonne vertébrale correspond exactement à mon expérience personnelle. Il est naturellement facile de poser le diagnostic d'une spondylarthrose, lorsque des plaintes correspondantes existent et qu'une image radiologique correspondante est trouvée aussi. Ensuite les plaintes cessent sans que rien n'ait changé dans l'image radiologique. De plus, on trouve aussi de ces images de spondylarthrose par hasard, sans que jamais la personne concernée n'ait eu de symptôme radiculaire. C'est pourquoi, je suis très prudent dans ma nomemclature et préfère classer une "névralgie " ou "névrite" plutot qu'une arthrose.

Sur le plan des principes, il s'agit en réalité d'un champ pour des recherches futures. Il y a là du travail pour de nombreuses générations de généralistes.

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II Selected References for Teaching and Learning in Family Medicine

Reprinted from

Canadian
Family Physician

Selected References for Teaching and Learning in Family Medicine

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Ouvrant sa rubrique "RECHERCHES PEDAGOGIQUES", le Dr Gérard VERY nous a présenté une réflexion sur l'enseignement de la médecine générale dans une faculté de médecine canadienne de langue française.
Les canadiens généralistes anglophones poursuivent, de leur côté, une réflexion approfondie sur l'enseignement de leur discipline et viennent de publier une remarquable bibliographie de textes anglais consacrés à ces problèmes. Ces publications ne peuvent servir qu'à des chercheurs aptes à une lecture en langue anglaise ; nous publions telle quelle cette bibliographie.

W. Wayne Weston

Part 1: General Education and Medical Education

Dr. Weston is course coordinator for a course in teaching and learning in family medicine in the Graduate Studies Program, Department of Family Medicine, University of Western Ontario. Reprint requests to: The Canadian Library of Family Medicine, Medical Sciences Building, The University of Western Ontario, London, ON. N6A 5C1.

THIS LIST of references began in 1970 when, as a part-time teacher in the department of Family Medicine at the University of Western Ontario, I felt a need to understand better what I was doing as a teacher. When I began this literature search there seemed to be only a small amount of relevant material; since then I have discovered an almost limitless array of books, monographs and journals. But nowhere did I find a guidebook to lead me through this maze.

These "Selected References" are my attempt to provide such a guide to the literature on teaching and learning as it relates to family medicine. It is a very personal list reflecting my tastes and bias, but I have tried to be flexible and eclectic. If your favorite reference is missing let me know; together we can make the next edition better.

Dorothy Fitzgerald of the Canadian Library of Family Medicine has been extremely helpful in providing expert advice and assistance. Special thanks to Jennifer Elphee for her untiring work tabulating the references and typing the manuscript.

References and Journals

1. Landsburg, June and Lee, Linda: *Annotated Bibliography of Print Materials on Instructional Development and Related Matters*. Second edition. Ottawa: Office of Instructional Development, Carleton University, 1977 (Paperback).

2. Hammond, Margaret: *New Readings for General Practitioners*. Prepared several times a year for the Royal College of General Practitioners, 14 Princes Gate, London, England.

Contains sections on education, teaching and teaching methods.

3. Cohen, Barry F and Friel, Ted W: *Teaching Interpersonal Skills to Health Professionals. Resource Document Volume I*. U.S. Department of H.E.W., 1978. p. 290.

This document includes a lengthy annotated bibliography of materials related to the teaching of interpersonal skills to health professionals using videotechnology.

4. *Journal of Medical Education*. Published monthly by the Association of American Medical Colleges.

This journal includes a bibliography of material from Index Medicus listed under selected MeSH terms.

5. *Medical Education*. Published bimonthly by Blackwell Scientific Publications.

6. *Medical Teacher*. Published six times a year by Update Publications Limited.

7. *Family Medicine*. Published six times a year by the Society of Teachers of Family Medicine.

8. *Journal of Family Practice*. Published monthly by Appleton-Century-Crofts.

Most issues contain one or more articles related to teaching family medicine.

9. *FAMLI Family Medicine Literature Index*. Published quarterly by the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) in cooperation with the National Library of Medicine (Bethesda, Maryland, U.S.A.).

10. Canadian Library of Family Medicine: *List of Bibliographies Compiled*. London, Ontario: Canadian Library of Family Medicine (the library service of the College of Family Physicians of Canada), 1980.

This is a keyword index to the more popular of the approximately 800 bibliographies compiled by the Canadian Library of Family Medicine.

General Education

1. Whitehead, Alfred North: *The Aims of Education and Other Essays*. Toronto: Collier-Macmillan, 1929, p. 165.

2. Silberman, Charles E: *Crises in the Classroom—The Remaking of American Education*. New York: Vintage Books, 1970. Especially Part IV: The Education of Educators.

3. Postman, Neil and Weingartner, Charles: *Teaching as a Subversive Activity*. New York: A Delta Book, 1969, p. 219.

Fun to read, this book challenges all teachers to consider the meaning of their work.

4. Barzun, Jacques: *The House of Intellect*. New York: Harper and Row Publishers, 1959.

5. Peters, RS (editor): *The Concept of Education*. London: Routledge and Kegan Paul, 1967. p. 223.

A collection of papers on philosophical issues relating to teaching—"What is an Educational Process?"; "The Logical and Psychological Aspects of Learning"; "Rules and Routines"; "Teaching and Training"; "Philosophical Models of Teaching"; "On Teaching to be Critical".

6. Knowles, Malcolm S: *The Modern Practice of Adult Education—From Pedagogy to Andragogy*. Revised and updated. Chicago: Follett Publishing Co., 1980, p. 400.

A practical guide to the theory and practice of adult education. Knowles discusses self-directed learning, designing and managing learning activities, setting a climate for learning and contract learning. The text is full of numerous appendices and examples to bring the concepts to life in a practical way that the reader can use.

7. Rich, John Martin: *Innovations in Education: Reformers and Their Critics*. 3rd edition. Toronto: Allyn and Bacon, 1981.

Part I contains representative selections by today's leading educational reformers e.g., John Holt, Herbert Kohl, Edgar Z. Friedenberg, A.S. Neill, Carl Rogers, Ivan Illich and Paulo Friere. Each chapter contains a piece by the innovator and a critical review by another eminent educator. Part 2 is composed of selections, both pro and con, on the latest and most prominent educational innovations e.g., accountability, competency-based education, mainstreaming of retarded children, educating the gifted, cognitive moral development, the 'Free School' alternative and 'Back-to-Basics'.

8. Rogers, Carl R: *Freedom to Learn*. Columbus, Ohio: Charles E. Merrill Publishing Co., 1969.

This is Rogers' tour de force in which he describes his philosophy and practice of education. The elements of experiential learning are:

1. It has a quality of personal involvement.
2. It is self initiated.
3. It is pervasive.
4. It is evaluated by the learner.
5. Its essence is meaning.

9. McCracken, Samuel: *Quackery in the Classroom*. A commentary report published by Commentary Magazine: 165 East 56th Street, New York, New York.

McCracken argues in favor of a curriculum and of the importance of reason.

10. Epstein, Joseph (editor): *Masters—Portraits of Great Teachers*. New York: Basic Books, 1981.

Part 2: Medical Education: General References and Family Medicine

Medical Education: General References

1. Miller, George E, et al: *Teaching and Learning in Medical School*. Boston: Harvard University Press, 1961.

This book is a classic—one of the first books to discuss seriously the principles of learning and teaching as applied to medical school. It is beautifully written and still very relevant to the present situation.

2. Simpson, Michael A: *Medical Education—A Critical Approach*. London: Butterworth, 1972, p. 198 (paperback).

Well documented and witty, this is a superb introduction to medical education.

3. Sinclair, David C: *Basic Medical Education*. London: Oxford University Press, 1972, p. 212.

A solid overview of medical education, particularly the British scene.

4. Hubbard, William N Jr; Gronvall, John A; DeMoth, George R: The Medical School Curriculum. *Journal of Medical Education* 45(11): Part 2, November 1970.

A study of the curricula of medical schools in the U.S. and Canada. Articles describe the institutional change process, social demands on the university and the education process.

5. Armstrong, D: The Structure of Medical Education. *Medical Education* 11:244-248, 1977.

6. Simpson, MA: Problem-Based Learning in Medicine, *Allgemeinmedizin* 2:63-65, 1977.

7. Purcell, Elizabeth F: *Recent Trends in Medical Education*. New York: Josiah Macy Jr. Foundation, 1976, p. 297.

A report of a 1975 conference discussing the most significant events that have taken place in medical schools in recent years, eg., the admissions process, the three year curriculum, independent study, education for primary care and problems in evaluation.

8. Jason, Hilliard: The Relevance of Medical Education to Medical Practice. *JAMA* 212(12):2092-2095, 1970.

9. Flexner, Abraham: *Medical Education in the United States and Canada*. A report of the Carnegie Foundation on the Advancement of Teaching. New York: Arno Press and the New York Times, 1972 (reprinted from the original 1910 edition), p. 346.

This is undoubtedly the single most influential book ever written on medical education in North America. The authors discuss principles of professional education and compare this with the actual state of affairs at the time and then make recommendations for sweeping changes. The last half of the book provides a summary report of each of the schools visited.

10. McWhinney, Ian R: The Reform of Medical Education: A Canadian Model. *Medical Education*. 14:189-195, 1980.

The author discusses five major changes which contribute to reform of medical education, and the role of family medicine in these changes:

1. a change in the environment of learning,
2. a reawakening of concern with the subjective aspects of medicine,
3. a shift of emphasis from content to process,
4. a change in our concept of health,
5. a rapprochement between personal and population medicine.

11. McMaster University: *The McMaster Philosophy—An Approach to Medical Education*. Hamilton, McMaster University Faculty of Medicine, Education Monograph No. 5, January 1974.

12. Tosteson, DC: Learning in Medicine. *New England Journal of Medicine*. 301(13): 690-694, 1979.

A well written essay arguing that "love of learning is the philosophy on which medicine is based". Three areas should be emphasized in medical education: defining more clearly what all physicians need to know; placing greater emphasis on problem solving and information management, and giving more attention to encouraging the desire and will to continue learning in medicine. "We must acknowledge again that the most important, indeed, the only, thing we have to offer our students is ourselves. Everything else they can read in a book or discover independently, usually with a better understanding than our efforts can convey".

13. Charters, Alexander N (Project

Director): *Project Continuing Education for Health Manpower*. Part 1 Fostering the Growing Need to Learn. Part 2 A Selected Annotated Bibliography for Continuing Educators of Health Manpower. Rockville, Maryland: U.S. Department of Health, Education and Welfare, 1973.

This volume consists of a series of monographs covering "all important parameters of continuing education for health manpower". The book was intended primarily for practitioners rather than scholars. The first seven chapters deal with the educational process based solidly on accepted principles of adult learning. The last three chapters deal with larger social issues. Of special interest is a chapter by Hilliard Jason on "The Instructional Role of the Practitioner" in which he describes the expanding responsibilities of health professionals in both the instruction of others and self-instruction.

14. Miller, George E: *Educating Medical Teachers*. Cambridge, Massachusetts: Harvard University Press, 1980.

Miller reviews the history of "The Project in Medical Education" in Buffalo: "the first organized effort to study and evaluate the broad spectrum of the teaching and learning processes in medicine". Beginning with a fascinating review of the germinal ideas on education in the 19th century, he goes on to describe how the project began and grew and had its influence throughout the world. In his concluding chapter on "Problems and Prospects" he refers to the continuing struggle of the medical educator for recognition and support and the need to take more seriously the educational role of medical school faculty. "Faculty development of the kind most needed in health professions schools must be an integral part of the academic setting with which participants identify, not a peripheral attachment to that world; the content must be clearly related to the problems they face, not to those that require an intellectual act of transfer for perceived relevance; the language must be that of the biomedical scientist, not the "jargon" of the educational scientist".

15. Armstrong, D: The structure of medical education. *Medical Education* 11:244-248, 1977.

The author argues that the structure of the learning experience in medical school shapes the conceptual frameworks of the students. An example of this "implicit knowledge" is the concept of disease as a "discrete phenomenon constituted in pathology of bodily structure or process".

The curriculum is organized so that "an anatomical structure becomes an histological one; a physiological event a biochemical one". But in general practice many of the illnesses the doctor encounters cannot be explained solely in terms of the disease concept. "The current structure of undergraduate medical education may ensure a correspondence with hospital work but not with that of primary health care. Reforms of curriculum content without a critical look at educational structure are unlikely to change this state of affairs".

16. Miller, George: Educational Science and Education for Medicine. *British Journal of Medical Education* 1: 156-159, 1967.

17. Engle, George L: Enduring attributes of medicine relevant for the education of the physician. *Annals of Internal Medicine* 78: 587-593, 1973.

18. Pickering, Sir George: *Quest for Excellence in Medical Education—A Personal Survey*. London: Oxford University Press, 1978.

Medical Education: Family Medicine

1. Byrne, PS and Long, BEL: *Learning to Care—Person to Person*. Second edition. Edinburgh: Livingstone, 1975, p. 118.

A good general introduction for teachers of family medicine. The authors present an introduction to educational terminology and provide a general model of the training process. There are chapters on teaching and learning in attachment, instructing skills, non-directive teaching, role-playing and simulation, using audiotape and evaluation and assessment. This book is particularly valuable because it discusses principles in the context of teaching in a family practice setting.

2. Fabb, WE; Heffernan, MW; Phillips, WA; Stone, P: *Focus on Learning in Family Practice*. Melbourne: Royal Australian College of General Practitioners, 1976, p. 253.

An introduction to principles of learning and teaching for the teacher unfamiliar with the literature on educational theory and practice. The authors discuss educational objectives, adult learning, what and how to teach in the setting of family practice. It is well written, practical and goes further than most books in making the connection between learning theory and practice.

3. Working Party of the Royal College of General Practitioners: *The Future General Practitioner—Learning and Teaching*. London: The British Medical Journal, 1972, p. 265.

An outline of the content of vocational training in general practice in Britain. Contains an excellent chapter on strategies and tactics of learning and teaching.

4. Hudson, James I and Nourse, E Shepley (editors): Perspective in Primary Care Education. *Journal of Medical Education* 50(12): Part 2, 1975.

5. Taylor, MP: Continuing Education for General Practice—A Learning System. *Journal of the Royal College of General Practitioners*, March 1977, pp. 137-142.

6. Bryan, Thornton E: *Academic Missions of Family Medicine*. U.S. Department of HEW, a publication of the John E. Fogarty International Centre for Advanced Study in the Health Sciences, 1977.

A report of a conference held in 1975 to identify problems and discuss possible solutions related to the evolution of the academic discipline of family medicine.

7. Geyman, John P: Insecurity in Medical Education: A Preventable Problem. *Journal of Family Practice* 6(2):229-230, 1978.

8. College of Family Physicians of Canada: *Canadian Family Medicine:* Educational Objectives for Certification in Family Medicine 2nd edition, 1981.

Outlines the content of family practice and describes in behavioral terms the broad educational objectives for residency training in family medicine.

9. Cormack, Jack; Marinker, Marshall and Morrell, David: *Teaching Practices*. Brentford, England: Kluwer Medical Handbooks, 1981.

This handbook was written primarily for part-time teachers of family medicine in community practices. It

contains chapters on the principles of teaching and learning and on teaching methods. There are specific chapters on teaching clinical method, whole person medicine, the doctor/patient relationship, the family, ethics etc. There is also a section on standards which discusses audit, describing the practice population, sampling and how to ask questions. The final section on assessment describes record review, observation of the consultation and oral and written methods of examination.

10. Shires, David B and Hennen, Brian K: *Family Medicine—A Guidebook for Practitioners of the Art*. Toronto: McGraw Hill Book Company, 1980.

This is a short textbook of family medicine and contains a brief and practical chapter on teaching in a community practice. The authors provide useful tips on planning before the student arrives, ideas about the variety of things that can be taught and how to do it.

11. Geyman, John P: *Family Practice: Foundations of Changing Health Care*. New York: Appleton-Century-Crofts, 1980, p. 543.

This is a detailed, well documented reference book on the development and present state of family medicine in the U.S. There are chapters on the supply and distribution of physicians, barriers to health care, the changing health care system and practice patterns of family physicians. Geyman also describes undergraduate, graduate and continuing education for family practice as well as the clinical content of family practice, the family and research. The appendices are jammed with useful information, e.g., a summary of the Virginia study, an approach to prevention and a guide for initial planning of a research project.

12. Geyman, John P (editor): Profile of the Residency Trained Family Physician in the United States 1970-1979. *The Journal of Family Practice* October 1980, Vol. 11, no. 5, pp. 715-784.

This special issue of the journal describes practice patterns, perceptions, and geographic distribution of representative samples of residency trained family physicians in the U.S. Four regional graduate follow up studies are reported, representing different parts of the country and almost 600 graduates. Also, a study by the American Academy of Family Physicians is included, involving over 3,000 respondents.

13. Brennan, Michael and Stewart, Moira: Attitudes and Patterns of Practice: A Comparison of Graduates of a Residency Program in Family Medicine and Controls. *Journal of Family Practice*. Vol. 17, No. 4: 1978, 741-748.

This compares two groups of graduates of the University of Western Ontario. The study group completed a two year residency program in family medicine and the control group, a one year internship. The study group were more satisfied with practice than the controls and placed more importance on emotional factors in illness. They also conducted proportionately more non-hospital care.

14. Anderson, J and Graham, A: A problem in medical education: Is there an information overload? *Medical Education:* 14: 4-7, 1980.

The authors determined the number of "facts" and "concepts" to be learned in medical school by reviewing the indices of standard textbooks. They determined that medical students must learn 24 new facts/concepts per hour (assuming a 40 hour week) during the basic science portion of the course and nine new facts/concepts per hour during the clinical years (not counting time needed to learn practical skills). This compares with six new facts/concepts per hour in a languages course. The authors quote another study that suggests six new facts/concepts per hour is a more acceptable learning rate.

15. Marinker, Marshall: The Way We Teach—General Practice. *Medical Teacher* Vol. 2, No. 2, 1980, pp. 63-70.

A beautifully written overview of the role of the family physician in undergraduate education at Leicester medical school. "General practice, in its very nature and in the essence of its academic activities, is that branch of medicine which integrates the knowledge, skills and attitudes of the clinical disciplines, the behavioral sciences, demography, epidemiology and much besides . . . Not all the teaching will be done by the general practitioner and not all the learning by the student. They will learn from each other and if the general practitioner is eager to be taught by his student, the student will be twice as receptive to his teaching . . . the process of the teaching in itself will constitute perhaps the most important gift which general practice can make to medical education".

16. Geyman, John (editor): Family Practice in the Medical School: Nine case reports on developments in family practice, education and research 1970-1977. *Journal of Family Practice* Vol. 5, No. 1, 1977, pp. 34-88.

Most of this issue is devoted to describing the development of family medicine, as an academic discipline in U.S. and Canadian medical schools. In each article of this special issue, three programs are described for illustration. Undergraduate education in family medicine at McMaster University, Southern Illinois University and the University of Washington are described. The graduate programs in family practice are outlined for the University of Minnesota, the Medical University of South Carolina and the Medical College of Virginia. The research efforts of the Departments of Family Medicine are described for the University of Rochester, the University of Utah and the University of Western Ontario.

17. The Royal College of General Practitioners: Some Aims of Training for General Practice. *Journal of the Royal College of General Practitioners*. Occasional Paper 6, August 1978, p. 17.

This short monograph starts with "The work of the general practitioner—Statement by a working party of the 2nd European conference on the teaching of general practice".

Then follow outlines of recommendations for training in psychiatry, child care and geriatric medicine. Each section lists broad instructional aims or objectives and then some suggestions on how to teach them.

18. McGlynn, Thomas J; Wynn, Jonathan B and Munzenrider, Robert F: Resident Education in Primary Care: How Residents Learn. *Journal of Medical Education*. Vol. 53, December 1978, pp. 973-981.

19. Noack, Horst (editor): *Medical Education and Primary Health Care*. Baltimore: University Park Press, 1980.

This book includes papers and group reports from a conference of the Association for Medical Education in Europe (AMEE) held in Switzerland, 1976. The main theme of the confer-

ence is summarized in two questions:
1. How does the system of primary health care influence the education and training of medical doctors?
2. How does the system of medical education and training influence primary health care?

These are valuable papers on the medical model, the structure of medical education, the process of becoming a physician, problem based learning, assessment of physician performance, training of primary health care physicians in specialized care settings, the role of behavioral and social sciences, etc.

20. Bean, IW: The Role of Family Medicine in the Health Science Centre. *Canadian Family Physician*. Vol. 27, May 1981, pp. 865-869.

21. Fry, John (editor): *Primary Care*. London: William Heinemann Medical Books Limited, 1980, p. 530.

"Section V Education" contains chapters on evolution of education in family medicine in the United States, undergraduate teaching in general practice, vocational training for general practice/family medicine and continuing education.

22. Knopke, Harry J. and Diekelman, Nancy L. (eds): *Approaches to Teaching Primary Health Care*. Toronto, C.V. Mosby, 1981.

This book discusses organizational and educational approaches to primary health care education. It is divided into four sections.
1. "Planning", which compares primary care education with hospital based specialty training. Curriculum planning and teaching problem solving are also discussed.
2. "Development". Several chapters are devoted to the development of primary care education in the community and the university.
3. "Management" covers organization of community-based education and the relationship between community and university; the need for a team in primary health care; effective team functioning and methods of development and maintenance. Small group learning and instructional strategies for the classroom and clinic conclude the section.
4. "Evaluation" includes chapters on evaluating community learning experiences, primary health care programs and student competence.