Middle Articles

AROUND EUROPE

Medical Education in France

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There are about 50,000 doctors in France, which is not nearly enough to serve the needs of the country. Many potential students are discouraged from taking up medicine as a career since the curriculum badly needs total reform, and there is still no agreement on how this should be carried out, though there has been no lack of proposals.

One of the problems in most urgent need of resolution is the present arrangement whereby the hospital and university courses run in parallel instead of being integrated. The student who has no particular ambitions to specialize or hold a university appointment can pursue the course without stepping inside a hospital or ever seeing a patient, taking his annual examinations and finally his State examination for a *doctorat* at the end of the sixth year. He then sets up in general practice. His cleverer and more ambitious colleague will take the same course, but in addition he will pursue studies in hospital punctuated by competitive examinations in order to climb on the promotion ladder to consultant status and a university career.

The integration of these two systems and the fusion of the hospitals with the universities is one of the main reforms presently being made.

Undergraduate Education

To become a medical student the candidate must have passed the secondary-school final examination—the *baccalauréat*. All school-leavers take this examination, but only those who pass in the science or mathematics section (the third section being philosophy) are eligible to enter a medical school. Until five years ago a candidate could become a first-year medical student by passing the *baccalauréat* in any of the three sections. Most of the large French cities have faculties of medicine—that is, a section of the university where the student can receive his entire education. There are, in addition, medical schools which can offer education up to the third year only, after which the student must enter a faculty. As a first step in educational reform the majority of medical schools are now being transformed into faculties. The largest of them, in particular that of Paris, are reorganizing themselves into "university-hospital groups" so that the students can do their clinical studies and take their lectures and theoretical work as a combined exercise. Each of these university and hospital centres, of which there are now 10 in Paris, will consist of a medical school and a number of affiliated hospitals each with a dean as head of the centre.

The first-year medical course comprises biology, physics, chemistry, and mathematics, and these are taught by members of the science faculty. After passing an examination at the end of the first year the student, who is now 18 or 19 years old, enters the medical school proper. The course lasts for six years, with an examination at the end of each year which has to be passed before the next year's course can be started. The last year of the course is a hospital residency post, and it ends with a clinical examination in medicine, surgery, and obstetrics and gynaecology. After passing these examinations the student has to submit a thesis in order to get his doctorate of medicine. This thesis must report some original work done under the supervision of his chief in the hospital, and is not usually submitted until the end of his internship if he decides to compete for one.

Academic Career

The first step for those students who want to follow an academic career is to become an *externe*. In the past this was by competitive examination at the end of the second year of the medical course. The examination is no longer held, but the title of *externe* is now given to the students who have the best results at this stage. Those who do not get this title then may apply for it at the end of the third or fourth years. The *externe* looks after several patients, carrying out the duties of ward clerk and dresser, under the guidance of the houseman. He changes his firm every six months and remains an *externe* for two to four years. At one time it was very difficult to become an *externe*, and the title was regarded as a great honour. However, now there is room for many more *externes* and about half the students will be able to hold this appointment. The next step towards an academic career is to become an *interne*, which means that another examination has to be passed, often considered the most difficult of all. To sit this examination the candidate must be under 25 and have been an *externe* in one of the hospitals of the city concerned for at least 18 months. The examination is held every year, and consists of written papers and orals, all conducted in strict anonymity. Candidates may attempt it four times, but nowadays the pass rate is rather higher than it used to be because it is linked to the number of internships available. Even so, only about one *externe* in eight becomes an *interne*. During his four years' internship the *interne* is responsible for the patients under his care, and he spends six months in the wards of each specialty. In addition to the advantages this gives him of studying clinical material and carrying out treatment himself, it gives him an opportunity to develop a close association with his "chief." This is fundamental to the development of his own practice once he has completed his course.

Some reforms are imminent in this system. It has been proposed that from this year an *interne* should take a national examination six months after he has become an *interne*, and if he passed he would be assured of an academic career. Although this has the advantage that a man knows where he is going at an early stage in his career, it also has the disadvantage that he has to choose his specialty item and stick to it.

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After Qualification

About half the *internes* will become *chefs de clinique*. Getting this appointment depends largely on whether a man has got on well with his *patron* or not. The appointment can be part- or full-time. The part-timer, who is appointed for one year with the possibility of renewal for another year, can set up in private practice at once in his own premises. The full-timer, whose appointment is initially for four years with possible renewal of three years, is allowed to see private patients at his hospital only two afternoons a week. The hospital duties of both are similar, and consist in teaching students both on the wards and in the lecture theatre. At the end of two years the full-timer may take an examination for the title of *maître assistant agrégé*. The examination is not anonymous, and hence a patron who is well disposed to his *chef de clinique* will do his utmost to get him through. After passing this examination a doctor may have to wait as an assistant for many years before having a department of his own.

Professorial chairs are filled by election, and professors from all over the country have the right to vote for the appointment of a colleague to a vacant chair. These appointments are full-time, but a professor is allowed to see private patients at the hospital two afternoons a week—as when he was *chef de clinique*—and he may also be called out in private consultation. Faculty deans are chosen by the professors, and hold their post for two years.

In the near future it is proposed to hold a national examination for admission to consultant rank for all French doctors under the age of 35, irrespective of their actual position in the academic hierarchy. This would give any doctor of merit whose work has reached the required standard a chance of becoming a consultant, and would minimize the effects of social standing, political prejudice, and personal favour or animosity, which up to now have had a profound influence on the career advancement—or otherwise—of every French doctor.

Registration

The *Conseil de l'Ordre* is the controlling body of all doctors in France, and to practise medicine after qualification the doctor has to be placed on the register of the *conseil* in the county (province) where he intends to work. Each county has its *conseil* which is responsible to the national *Conseil*, and the members of this body are elected by the profession itself. The *Conseil* has many powers in a professional respect. It can take disciplinary action against a doctor, and suspend him from practice temporarily or even permanently. It considers itself responsible for the profession's ethical and moral standards, and is very conservative in outlook. For example, it is firmly opposed to contraception, and did all it could to delay the repeal of the Act of 1920 relating to this subject.

Specialization

More and more doctors are specializing and now have to take specialist diplomas. Studies for these can begin in the final year of the medical course and last for three or four years. For example, to obtain the diploma in obstetrics, which was created in 1955, a doctor has to do a three-year course. The first year consists of half-time clinical work and half-time anatomy and physiology with special reference to obstetrics and gynaecology. There is an examination at the end of this year, and usually only about a quarter of those who take it pass through to the second year. There is no further examination until the end of the third year, when there is a national written examination and an oral examination held locally.

Those who want the double diploma of obstetrics and gynaecology have to study a fourth year and take a further examination at the end of that time. This double diploma is now essential for registration as a specialist in obstetrics and gynaecology, although doctors already recognized as specialists and practising as such are not obliged to take the newly established diploma.

Thus at all stages of medical education and practice there are those who embarked on a particular phase before any changes were made, and those who started later and must conform to the new regulations. This has added a certain confusion to a situation which is already complex, and my British colleagues must forgive me if what I write today is not completely true tomorrow.

HOSPITAL TOPICS

Dressings in Hand Sepsis

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A number of patients attending hospital daily for dressings is a depressing sight for patients, nurses, and doctors alike. It is an accepted but I consider an unnecessary facet of the work of a casualty department, and, as Lowden (1953) has said, patients regard a visit to the casualty department as a reason for not going to work, even if the lesion is not incapacitating.

Since the exposure treatment of burns has been shown to be so successful, and in the belief that frequent dressings at a hospital department are more likely to introduce fresh infection rather than prevent it, an attempt has been made in the casualty department of the Royal Hospital, Sheffield, to reduce ttendance at hospital to a minimum.

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Though this method has been used successfully in the department for all varieties of lacerations and abrasions, both clean and infected, patients suffering from septic hands were selected for the trial and a comparison was made between the traditional methods and a minimal dressing technique.

Present Study

Forty-six patients suffering from a septic condition of the hand treated between 14 November and 11 December 1966 were required to attend daily for a week unless healing had occurred earlier. Dry gauze dressings were applied by the nursing staff after the doctor had seen the patient.

Between 2 January and 29 January 1967, 60 patients suffering from septic hands were treated under the new regimen