Where Shall John Go?

Norway

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Norway is a large country with a small population, and it can, therefore, offer a different experience to traditional, and largely urban, British medical practice. Sometimes doctors (and especially country general practitioners and doctors in smaller hospitals) are physically isolated and have to manage without specialist help. The university hospitals in Oslo, Bergen, Trondheim, and Tromsø, and several other large hospitals, in contrast, provide opportunities for specialist training and advanced scientific research.

The country

Norway, which is much larger than Britain, has a population of only four million. The country extends from the southernmost tip (about the same latitude as Aberdeen) in a north-easterly direction to 71°N (level with the northern tip of Alaska). The landscape is extremely varied, but always beautiful. Most tourists visit the fjord area north of Bergen; Sognefjord is the largest fjord and the best known. The area around Oslo is less dramatic—fewer mountains, more fields and farms—and is reminiscent of the lowlands of Scotland. To the north are the dramatic Lofoten Islands—bare mountains descending steeply to the sea; and, for European tourists who don't mind a long drive, Nordkapp (the North Cape) is a popular destination.

Outdoor activities excell those of any other European country. Cross-country skiing is the national sport, and the Norwegians jokingly say that they are born with skis on their feet—I can almost believe it. Sea fishing is superlative and there is almost unlimited salmon and trout fishing in the many rivers and lakes (most of which are clear and unpolluted). Walking in the mountains is popular in the summer and there are many "turisthytter" (tourist huts) where one can stay overnight. Sailing is increasingly popular, especially in the south. Generally speaking, the winter is much colder than in Britain, especially inland and in the north. Summers are similar to British ones but can be warmer and drier. The climate varies greatly within Norway, and many Norwegians who move to the north are depressed by the long dark winters, though the midnight sun almost compensates for this.

In some ways the Norwegian language is similar to English. Many words are identical and English words and phrases are used widely to supplement Norwegian. North country English and Scottish dialects use many words which are found in Norwegian (for example: bekk=beck=stream; kirke=kirk=church; barn=bairn=child). For English speakers the grammar is straightforward, but unfortunately Norway has many regional

dialects and there are even two written languages. The best way to learn Norwegian is by living in Norway, but there are several good courses available in Britain. Foreigners in Norway are entitled to free instruction in Norwegian.

There are good plane connections between Britain and the major Norwegian cities. A ferry service operates between Newcastle and Norway, but I find it quicker to travel to Gothenburg and then motor on into Norway. People travel by air more often in Norway than in Britain as road and rail travel can be very time-consuming, roads are generally of poor quality, and there are many ferries.

Living in Norway

Adapting to Norwegian life is not difficult. To begin with, most Norwegians are reserved and it is easy for a foreigner to misinterpret this as unfriendliness, but when the ice is broken, they become warm, sociable, and open people. Most speak English well, many are anglophiles, and their sense of humour is similar to ours. It is quite possible to survive in Norway speaking only English but a knowledge of Norwegian is very useful for patient-doctor communication and it enables one to develop a more natural social life than the somewhat strained, artificial existence one has if all one's Norwegian friends have to speak English.

Most hospitals provide good rented accommodation for doctors. In larger towns this might be a flat, whereas in smaller places probably a wooden house at a reasonable rent. Education is of a high standard, and children begin school at 7 (but many towns have kindergartens). There is a British primary school in Oslo. Cars in Norway are expensive (about double British prices); it pays to use a British-registered car in Norway if you are working there temporarily; if you intend to settle in Norway it is possible to import a duty free British car, but there are strict regulations. A car is essential if you want to see the country, fish, ski, and so on.

Norwegian diet appeals to the more adventurous palates. A typical breakfast is bread and knekkebrød (crispbread) with different kinds of topping—such as cheese, herring, or smoked sausage. Middag (dinner) is the main meal of the day (eaten after work, any time between 12 and 6 pm). Fish dishes are excellent and varied; I can recommend rakørret (partially rotted trout), and cod tongues in white wine sauce. Spirits and wine are expensive and are sold by a State-controlled wine monopoly; beer is more readily available in some areas. People entertain at home; restaurants and hotels are few and expensive. Tradition plays a large part in Norwegian life: 17 May is National Day which is widely celebrated; Christmas and New Year customs are similar to our own. The Norwegian flag is hallowed, and many houses have flagpoles, the flag being hoisted on every possible occasion.

One of the most difficult aspects of living in Norway is learning to cope with the bureaucracy. There seem to be offices, departments, directorates, and forms for everything. Most offices have very restricted opening hours and one can waste

days on seemingly simple things like renewing a work permit, registering a car, or arranging income tax payment.

The Health Service

Until recently Norway was unable to produce enough doctors from its own medical schools in Oslo and Bergen (new medical schools have now been founded in Trondheim and Tromsø). Entry to a Norwegian faculty was dependent on top school examination results, and often nursing experience after this. Many Norwegians, therefore, have studied medicine abroad—including a large number in Great Britain. Once qualified, they usually return to Norway, where they undergo a compulsory course in hygiene, social medicine, forensic medicine, psychiatry, and prescription writing. After this comes an 18-month pre-registration period (one year in a recognised hospital and six months as a GP assistant). Some foreign doctors, most of whom are married to Norwegians and intend to settle in Norway, also follow this pattern, which leads to full authorisation. For a British doctor intending to spend a year or two in Norway it is time-consuming and necessitates a good grasp of Norwegian; temporary licences can be arranged in these cases.

British and Norwegian hospital services are organised on similar lines. Hospitals are publicly owned and admission is free. Most have good laboratory and intensive care facilities. Preregistration doctors have resident duties. Junior posts are difficult to get, especially in popular specialties (internal medicine, surgery, paediatrics). Other specialties (such as anaesthetics, laboratory medicine, psychiatry) are comparatively underdoctored. Diagnosis and treatment are much the same as in Britain and should present no fundamental problems. Rather overwhelming at first is the ubiquitous use of Latin terminology—but one quickly adapts. Case notes are dictated, and then typewritten, which makes them easier to read but not so personal. The junior medical staff salary is much higher than in Britain (for example, 1st year SHO, 1 in 6 rota £8500 pa)—even taking into account high income tax and the cost of living. Consultants' salaries are higher than in Britain but the difference is not so marked as for junior staff.

The primary health team in rural areas consists of a "distriktslege" (district doctor) often with a preregistration doctor, health visitor, midwife, and receptionist. There is usually easy access to laboratory, x-ray, and physiotherapy services. In addition to

treatment of patients the distriktslege is appointed chairman of the local council health committee and is responsible for infant clinics, school children examination, and control of such things as hygiene and epidemiology in his area. Country general practitioners earn good salaries (often £20 000 pa) but they have large work loads, with much travelling by car and sometimes by boat or helicopter. The isolation of many rural practices calls for frequent nights on duty. Towns have a medical officer of health and so-called "private practising doctors" (who are not really private because patients pay a small standard fee and the State pays the rest). Most primary medical care is remunerated by item of service; many minor procedures which would normally be referred in Britain are carried out by general practitioners. General practice posts are easier to obtain than hospital posts. They do, of course, require an intimate knowledge of the language and full authorisation.

Jobs for foreign doctors are not plentiful as Norway will soon have enough of its own doctors. Locum posts are sometimes available, especially in the non-Norwegian-essential specialties such as anaesthetics. The Norwegian Health Directorate in Oslo will provide information about regulations for foreign doctors and can grant temporary licences. Vacant appointments (especially locums) are sometimes advertised in British journals. The university teaching hospitals have foreign graduates in training posts—many of whom are from developing countries. Work permits are strictly controlled (Norway is not an EEC member) and you must apply from Britain.

Final thoughts

I think the most useful thing I have learnt in Norway is the value of co-ordination and co-operation between groups of health workers. Most general hospitals have a morning meeting of medical staff where results are discussed and the day's work is planned. A night report from the nursing staff is read and often provides valuable clinical information. A morning x-ray conference with the radiologist precedes the daily ward rounds. There are also regular meetings with physiotherapists and social workers. This organised communication benefits the patient and leads to the best use of staff.

Living here, I find it hard to decide what I value most in Norway: probably the fantastic scenery outside the back door and the free time to enjoy it.

Up to what age can it be considered that there is minimal risk to the mother and fetus during pregnancy?

This begs the question of when is a risk a risk? All living includes risks, and these can sometimes be expressed statistically. The very nature of statistics excludes personal factors. When the numbers are assembled, manipulated, and expressed there has to come an individual value judgment on whether the risk is worth taking. The expectations of childbearing women for themselves and their babies are now high and come near to a requirement for perfection, which is as it should be. Perinatal mortality is around 15 per 1000 total births in developed countries, which is 1.5%. Hence doubling, trebling, and quadrupling the risk, for whatever reason, still means that more than 90% of births will end satisfactorily so far as the baby is concerned. The maternal mortality rate is about 13 per 100 000 total births,¹ which is 0.013%, so that, again, vastly increasing the risk still leaves a high percentage of women alive, though death is horribly final for individuals. So what is an acceptable risk?

The commonest of the chromosome disorders arises in about 1.7 of every 1000 births. If the commoner autosomal and sex chromosome abnormalities are added together they amount to about 7 per 1000.² The incidence of Down's syndrome in the child of a woman aged over 40 may be about 1 in 50 or 2%. Perinatal mortality varies with age, parity, social class, and height.³ It is least in those aged 20-29; with the second and third pregnancies; in social class I; and women over about 160 cm (5 ft 3 in). It is higher in older women, in higher parities,

in social class V, the unmarried, and women under 155 cm (5 ft 1 in). Is a five-fold or seven-fold or x-fold risk acceptable to a particular woman? Only she can decide with the help of her obstetrician.

¹ Report on Confidential Enquiries into Maternal Deaths in England and Wales 1970-1972. London, HMSO, 1975.

² Beischer, N A, and Mackay, E V, *Obstetrics and the Newborn*. London, Saunders, 1976.

³ Butler, N R, and Bonham, D G, *Perinatal Mortality Survey*. Edinburgh and London, E and S Livingstone Ltd, 1963.

Do non-respiratory infections with the pneumococcus (for instance, septicaemia or peritonitis) cause a specific rise in the respiratory rate due to something specific in the bacterium? If so what is the mechanism?

Patients with acute illnesses, and this includes septicaemia and peritonitis, often have a raised respiratory rate. This is thought to result from increased metabolic demands of disease and is not in any way specific to the pneumococcus. It is not unusual to see patients with acute septicaemia or other non-respiratory infections caused by various micro-organisms who have a raised respiration rate. In this acute condition there is often high fever and, indeed, the increase in fever and in respiration rate often go in parallel. It is, of course, possible to have acute septicaemic states without a rise in respiration rate. Non-respiratory infections with the pneumococcus do cause a rise in respiration rate, but this appears to be non-specific and is not confined to the pneumococcus.