Where Shall John Go?

West Germany

MARK BALL

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If John comes to Germany and makes a serious attempt to become integrated here, he may well find it difficult to return to Britain. This will be particularly so if he has (as I do) family ties in Germany, but I fancy there is something in the German way of life, an all-embracing quality, which together with the material attractions may well hold him here.

The first few months

I myself came over for one or two years in 1971, partly out of interest, partly out of fairness to my German wife, and partly to enable our children to feel at home in both our cultures. I certainly underestimated the difficulties and overestimated my own resilience and command of the German language. The first step—finding a job—was surprisingly, and perhaps deceptively, easy. An introduction to an anglophile German psychiatrist, kindly provided by Dr Winstanley of the Anglo-German Medical Society, led to my visiting several psychiatric hospitals and very soon being offered a junior post (that of Wissenschaftlicher Angestellter) in the Universitäts-Nervenklinik at Tübingen. At first this was on a temporary basis, the plan being that I should apply as soon as possible for a research grant—but, when my application failed, I was offered a long-term contract. This was a stroke of good fortune as the waiting list for junior training posts was, as is usual in university hospitals, a long one. A sense of moral obligation on the part of the professor was no doubt partly responsible, but I believe the high standing of British psychiatry and the friendly feelings of German doctors towards the British also played a part. I should, however, pass on a warning which several anglophile colleagues have given me: this friendliness may well go sour if the market is flooded with British graduates whose main reason for coming here is for material gain.

There was a great deal of paperwork to be tackled before taking up work but, as that procedure is now out of date, with relief I can leave the details of this first encounter with German bureaucracy in my subconscious. The first few months were very hard. The German language, which in the mouths of my German colleagues sounded bewilderingly scientific and gave an impression of colossal diligence, was when I spoke it a sort of grotesque baby language. And the hierarchy, paternalistic though it was, increased my sense of inadequacy.

Niedersächsisches Landeskrankenhaus, 3050 Wunstorf 1, West Germany
MARK BALL, MB, MRCPSYCH, consultant psychiatrist

Transfer after six months to a newly opened day clinic some way from the main hospital provided welcome relief and the chance of seeing how relaxed and pragmatic (how almost English?) the younger generation of Germans can be. Speaking German had by then become relatively easy; writing it, on the other hand, was, for much longer, a fairly agonising experience.

Private amenities

Settling down, in our private life, was less difficult. I would, however, strongly warn against attempting to move your own belongings. I tried it with an estate car and a very temperamental trailer, and being held up for a whole day in Boulogne awaiting customs clearance provided experience of existential anxiety which I shall not forget. Finding a flat took some time but was probably easier than in Britain and the one we found, though humble by German standards, was pleasant and well built. The availability of accommodation seems to vary a great deal from time to time and place to place, the quality is much better than in Britain. Many universities, incidentally, provide special flats for foreign research workers.

I should perhaps say something about life in Germany. After five years here, I find it difficult to do so without a host of reservations. There are, for instance, definite regional differences. In the south it is the obvious prosperity, the preoccupation with quality, hard work, and orderliness, and the capacity for enjoying life despite this, which most impress. Over and again we had the feeling of being on holiday there and this was no doubt the influence of the southern warmth, both climatic and temperamental. The north in many ways is more like Britain, not least in respect of the weather, and possibly someone coming directly from Britain would therefore find it easier to settle down there. The presence of the British Army of the Rhine could also help him to maintain contact with other British people, and with British doctors in particular. Those with children might want to send them to Army schools, although this is quite expensive. The presence of the American forces in central Germany could prove useful in similar ways.

German cultural life is justly famous and, for historical reasons, much more evenly distributed than in Britain. Leisure facilities for adults and children are, at least in the larger towns, good—this is particularly important for children, as German schooling tends to be somewhat narrow. Great emphasis is laid on access to the countryside, particularly to the extensive forests, which in many areas is very pleasant, in some really beautiful. The road system is exceptional and heavily used at the weekend for excursions (when many people also eat out). Alcoholic consumption, judged from the hospital admission rate, has reached an alarming level. This, no doubt, is reflection partly of the high standard of living enjoyed by most of the population and of the relatively low price of alcoholic drinks. Class differences, whether material or social, are much less obvious than in Britain.

German medicine

Although many hospitals are run by charities or public bodies, private enterprise still plays a large part in the health service. The doctors' various representative bodies are politically powerful and strongly resist any move in the direction of state control.

There seems to be much more money available for health care than in Britain, the system being indirectly financed by insurance contributions. Almost everyone is insured against illness. Those with an income below a certain level must be insured with an official insurance company ("Kasse") and medical bills are then sent directly to the company. Others can take out insurance with private companies which will cover treatment as a private patient. In this case the patient pays bills direct and is later reimbursed by the insurance company. There is another major difference between the German and British systems. Most of the patients who would attend outpatient departments in Britain, in Germany are treated privately by specialists—to protect the interests of these specialists, most hospitals are allowed to treat only a limited number of outpatients each year.

Medical training

There is intense competition to enter medical school and at present only those with extremely high grades in the school-leaving certificate ("Abitur") are accepted. The basic training lasts six years and is becoming increasingly practical, though probably still less so than in Britain. The traditional final examination is now more often replaced by continuous assessment and multiple-choice questionnaires. Traditionally almost every student has produced an MD thesis on a piece of original research, and, although this tradition seems to be weakening, it is still an offence for a medical practitioner who has no doctorate to call himself "Dr (med)."

As in Britain, after qualifying the graduate must serve a year in hospital before receiving the equivalent of full registration ("approbation"). After this most doctors start specialist training which lasts from four to six years according to specialty. Until now recognition as a specialist has depended on acquiring sufficient experience in stipulated areas of the specialty, but probably examinations will increasingly be introduced. For some years it has been possible to obtain recognition as a specialist in general practice.

Opportunities for British graduates

Until recently a British graduate could be only temporarily registered in Germany, permission to practise being restricted to a given hospital. Registration had to be renewed every two years and, after a certain time, could be renewed only under special circumstances. The new EEC regulations have, however, changed all that and a fully registered British graduate (with certain reservations) now has the right to practise medicine in Germany on the same footing (more or less) as his German colleague. This means that someone coming for a short stay may now consider the possibility of staying longer.

Another useful provision (as I understand it) is that periods of postgraduate training in different countries within the EEC should be regarded as equivalent—that is, if a graduate interrupts his postgraduate training in Britain for a year and works in a German hospital which is recognised for training purposes, this time may be accredited to him as time spent in training. It is also possible, in certain circumstances, for someone with a higher British qualification in Britain to obtain specialist recognition ("Facharzt Anerkennung") in Germany (though he will not be allowed to display his British qualification publicly). It may well be that he will have to prove that he has worked in his specialty for a number of years after receiving his higher qualification.

I myself have recently applied for the German "approbation." As a foretaste of what is to be expected, I give a list of the documents required: handwritten life history; birth certificates, and certificates of nationality of self, wife, and children; "Amtliches Fuhrungszeugnis" (which is an official certificate of legal innocence); personal statement that no criminal proceedings against me are impending; medical certificate; diplomas (and translations of these by an official translator); and proof of how long I have been in the country. Typically the body to which applications should be sent varies from one part of the country to another, but I will resist the temptation of going into further detail for fear of boring all but the most dedicated student of bureaucracy. The important thing is to keep calm.

Further information concerning the application of the EEC regulations in Germany can be obtained from the "Bundes-Ärztekammer" in Cologne. Incidentally I have almost always found officials much more helpful over the telephone or across the desk than the tone of their letters suggests.

I would now like to give an idea of possible openings for British graduates. Academically, of course, university medicine is the most interesting. The universities are well established throughout the country, often in extremely picturesque old towns, and each one that includes a medical school also has a whole group of specialist teaching hospitals. Many doctors do their postgraduate training here and this is where most of the research is done. The chances of getting a regular junior post in one of these are probably poor unless the graduate has both a definite research interest and the ability to *speak* and *write* German well. A British graduate with a research grant would, however, almost certainly be welcomed and allowed to take a full part in the research and clinical life of the hospital. Research has until recently been well endowed but I am told that the present financial cuts have made it more difficult to obtain grants. Possible German sources are the German Academic Exchange Service or the Alexander von Humboldt Stiftung. The British Council should also be contacted, as it acts as intermediary in the awarding of grants. Advice and possibly financial support may be obtained through the Anglo-German Medical Society. The German Institute gives grants to people wanting to learn German in Germany.

Another practice, which I hope will become more prevalent, is that of exchanging posts for a time with a German graduate. I have heard of at least one fixed arrangement between a British and a German medical school. It might, however, be better to do this on a more personal, informal basis.

Those interested primarily in research might consider the possibility of working for a drug company or research foundation not directly associated with a hospital. Advertisements for such jobs occasionally appear in the *BMJ* and usually call for at least some knowledge of German.

For those not seeking academic work, there are many hospitals both public and private where foreign graduates are employed. Most of them are more modern and better equipped than the average British hospital and the doctors' pay, especially when supplemented by overtime payments and fees for medical reports, supports a considerably higher standard of living. Many of these hospitals are partly or fully recognised for postgraduate training and there is a particular shortage of doctors in junior surgical posts.

Psychiatric hospitals, too, need doctors. Psychiatry suffered very badly under the Nazis and it has taken a long time for it to recover, particularly outside the universities. In spite of this gradual recovery, the general psychiatric hospitals are still extremely varied—some being up to date and alive with new ideas; others very much the opposite. Even the latter, however, could prove attractive to someone with a pioneering spirit and an interest in the history of psychiatry.

Opportunities in private practice have been most affected by new EEC regulations and, while few would want to set up practice for one or two years, some might find working as a locum rewarding—culturally and medically, as well as financially. According to the regulations the necessary official pro-

cedure is quite simple. I should mention here that general practice, in spite of there being a specialist training, is in a poor way. There is a great shortage of GPs, particularly in country areas and some suburbs, and the average age of existing GPs is high. Possibly a British doctor prepared to work hard in areas regarded as medically less attractive by his German colleagues would be given considerable encouragement and even financial support from the community to do so.

In the interest of clarity I have omitted a great deal of detail. Someone who is seriously considering coming over should pay some attention to questions of health insurance, social security, superannuation, and medical defence insurance but what he should do about each of these depends on what he is planning to do.

Further information

Useful addresses are given below, and if I can give anyone help or advice I shall be pleased to do so.

Dr D P Winstanley, Secretary of the Anglo-German Medical Society, Harold Wood Hospital, Romford, Essex RM3 0BE.

Informationsabteilung für E G Fragen Bundesärztekammer, Haedenkamp Str 1, 5000 Köln-Lindenthal, West Germany.

German Academic Exchange Service, 11 Arlington Street, London SW1.

British Council, 10 Spring Gardens, London SW1.

German Institute, 45 Prince's Gate, London, SW7.

Alexander von Humboldt Stiftung, Kennedy Allee 50, 5300 Bonn-Bad Godesberg, West Germany.

Bone and Joint Diseases

Perthes's disease

A CATTERALL

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Despite all the advances of recent times, discussion and controversy still continue on the management of Perthes's disease. Not even the name is finally agreed, varying from coxa plana[1] and osteochondritis coxa juva, on the one hand, to Perthes's disease, Legg-Perthes's disease, or Calvé-Legg-Perthes's disease on the other. Central to the whole of this discussion is the major underlying problem of the indications for and methods of treatment and whether or not the treatment advised really alters the natural history of the untreated disease. This thought introduces and underlies the importance of control in evaluating results of reported series.

In published reports on this problem trends may be seen maturing over the years. The course of the radiological changes was clearly described by Waldenstrom,[2] and indeed he mentions cases in which the posterior part of the femoral head was radiologically normal. This point was further emphasised by O'Gara[3] in ascribing a good prognosis to his anterior Perthes's disease. Ponsetti[4] continued this concept, suggesting that the prognosis was proportional to the degree of radiological abnormality of the epiphysis. Eyre-Brooke,[5] in an earlier comprehensive review, suggested that the important prognostic factors at the time of diagnosis were age of patient, stage of the disease at diagnosis, and efficiency of treatment. These factors have stood the test of time, and many authors would add that girls have a worse prognosis than boys.

Many authors are concerned only with short-term prognosis and the hope that treatment may influence this. They tend to forget the importance of long-term changes, particularly remodelling and premature fusion of part or all of the growth areas of the femoral head and neck, on the ultimate fate of the head and the development of osteoarthritic changes. Sundt[6] considered that treatment does not prevent the onset of osteoarthritis of the hip, which depends on the sphericity of the head. Ratliff,[7] however, considered that these changes may be long-delayed provided that there is a state of congruous incongruity. Sommerville states that satisfactory development of the femoral head will occur even if it is ischaemic, provided that the head is contained within the acetabulum.[8]

Trends in treatment follow a similar pendulum, swinging between no treatment and treatment combining the principles of weight relief and containment of the femoral head in the socket of the acetabulum. Every method had its supporters but results have seldom been compared with those in untreated controls. In 1929 Parker[9] and later Bristow[10] advised treatment with legs in wide abduction so that the deeply contained femoral head would be moulded by the bony acetabulum. In considering the question of weight relief, Evans and Lloyd-Roberts[11] showed that in carefully matched series treated by bed rest or a weight-relieving caliper there was no difference in the overall results. More recently, containment of the femoral head by either femoral[12,13] or innominate osteotomy[14] permits this principle to be applied in the ambulant patient, but this may also be achieved by containment splints or plasters. For the non-operative treatments, opinion is not clear on when the treatment should be discontinued.

Before treating any child with Perthes's disease the following questions must be answered: What is the natural history of the process? Is it possible to anticipate the poor result? and What are the indications for treatment and on what principles should it be based?

Natural History

During a review of a large series of patients in 1971 I collected 95 patients whose hips had not been treated during the active phase of the disease.[15] The cases were subdivided into four groups, based on the degree of radiological involvement. The results showed that the overall prognosis is proportional to the degree of radiological abnormality (table I).

Charing Cross Hospital, London W6 8RF
A CATTERALL, MCHIR, FRCS, orthopaedic consultant