Middle Articles

CONTEMPORARY THEMES

Medicine and the Treaty of Rome

N. G. C. HENDRY,* M.B., CH.B., F.R.C.S.ED.

Brit. med. J., 1967, 2, 431–432

Article 3 of the Treaty of Rome calls for "the abolition, as between member states, of obstacles to the free movement of persons, services, and capital." Article 52 requires that "restriction on the freedom of establishment of nationals of a Member State shall be progressively abolished." Article 57 makes it clear that freedom of establishment means, for the medical and other professions, the "mutual recognition of diplomas, certificates, and other qualifications." If Great Britain joins the Common Market it will be because the major aims and provisions of the Treaty are considered on balance to be to the eventual political and economic advantage of this country and of the present signatories—a judgement in which the very considerable implications for medicine are unlikely to weigh heavily. It falls, therefore, to the profession itself, through the various channels that are open to it, to set about ensuring not only that its own interests are represented but also that the public is safeguarded against any possible ill-effect on its medical services, and that any potential influence for good is recognized and exploited.

Divergences of Views

There are divergences of view about the degree to which accession to the Treaty might affect medical practice in a country where the State is virtually a monopoly employer and where, by tradition, professional status and responsibility derive much more from appointment to a specific vacancy than from possession of a particular qualification. It can be argued on the one hand that this convention, and the existence of conditions of appointment that are uniform and prescribed by law, will of themselves insulate both general and hospital practice from any major change. At the other extreme there is the view that Article 3, in virtue of its embodying the intent of the Treaty, will be held capable of overriding any provision that runs contrary to it, and that the laws or regulations of a member nation may have to be amended if in theory or in practice they prevent the free movement which the Article enjoins. On even a strict interpretation of this view, a period of transition is allowable provided the necessary reservations are made in advance, so that there is no serious possibility of a supranational authority's imposing immediate dramatic changes on the structure of the Health Service; at the same time, it would be unrealistic to expect the Service to emerge unaltered from the kind of pressures to which comparison with other systems will inevitably subject it.

Argument on this legalistic level, however, meantime involves so many imponderables that its value is limited: there is indeed a danger of our looking so closely at the provisions of the Treaty that we overlook the aspirations which gave it birth and the change in attitudes which it reflects. We are wise to be occupied with our standards, but less than wise to be preoccupied to the extent of ignoring the evolution of new concepts within which these standards may shortly have to be viewed. Scientific communication has always been international, but the discussion of educational levels, of the forms of medical practice, and of the relationship between medicine and the community has not hitherto enjoyed the benefits that can derive from these wider exchanges. This is the process which is now at work, and which has led individual members of the Six to study the organization of hospitals and the methods of selecting and training specialists in every European country, including our own.[1 2]

Safeguarding General and Specialist Practice

Within the community itself this process of mutual examination and criticism has been intense and detailed, with the result that the educational requirements for general practice and for every recognized specialty in each of the six countries are now fully documented. Agreement has been reached, over almost the whole of this wide field, upon conditions which the appropriate professional organizations regard as adequately safeguarding the levels of general and specialist practice, pending a move to the next stage, where an attempt will be made to ensure that courses of training, without necessarily being identical, are in fact of equivalent value. Many discrepancies among the practices of different nations have come to light in the course of these reviews. The attitude of the Commission towards suggested criteria for harmonization is still unknown, but the profession's recommendations have overwhelmingly been for a levelling upwards, which may reassure those who have feared—not entirely through chauvinism—that there might be a move towards a lowest common denominator and that Great Britain might be a principal sufferer therefrom.

Paradoxically, this otherwise encouraging tendency redounds in one respect to our present disadvantage. The examination of the differing usages among the Six has been carried out with objectivity and with a determination to select from each whatever has been shown to be the most effective: little may have changed so far in practice, but the gradual adoption of the best of the concepts of six advanced and advancing nations represents a formidable challenge to any single nation outside. To this extent, the relative position of British medicine in the world is already potentially affected, and could be increasingly threatened if we were to remain isolated indefinitely from a corporate effort of this magnitude. There is much to be said, therefore, for our associating ourselves as closely as possible with the doctors of the E.E.C., whatever our opinion of the political and economic probabilities.

* Orthopaedic Department, Aberdeen Royal Infirmary. Official Observer of the B.M.A. on the Union Européenne des Médecins Specialistes and the European Association of Senior Hospital Physicians.

[1] *La Médécine Hospitalière*, 1966, 8, 37.
[2] *KrankenhausArzt*, 1966, 8, 303.

If we join the Community we will be the better for having taken every opportunity of making our principles and our practices known, of looking objectively at what others have achieved, of accustoming ourselves to criticism whether well- or ill-informed, and of finding how to overcome the misunderstandings that are unavoidable in international exchanges on this scale. If we do not join we still have a duty to ensure that everything of value that emerges from these co-operative studies is examined here in the context of our own traditions. The question, therefore, is not so much for or against involvement, for we are already involved: it is rather through what channels can we most effectively establish communication ; and by what means can we turn our involvement to the best advantage, both in the present phase of political uncertainty and if we find ourselves full members.

Medical Bodies

The only official forum which exists for the discussion of medical practice within the E.E.C. is the Council of its individual Ministers of Health, in which, of course, this country cannot participate at the present time. Our own eventual access to it, whether professionally or nationally, could only be by way of our own Health Ministers, upon whose advocacy we should have to rely in influencing whatever recommendations were made to the Commission, in which all executive powers are vested. This is not a mechanism upon which the profession in existing member countries has been inclined to place much reliance. Because of this, there was formed in 1956 a Permanent Medical Committee of the E.E.C., drawn from representatives of national medical associations, accompanied often by lawyers and economists, and taking the initiative in discussng and in tendering advice on any subject bearing on medical practice. The decisions of this committee carry some weight, and it is by their exertions that acceptable conditions have been agreed for the reciprocal recognition of basic medical qualifications from next January onwards.

Within the sphere of specialist practice a similar need for reciprocal study exists, because of the acceptance throughout Europe of a system of laying down educational and other criteria for assessing fitness to take full responsibility in a specialty. The need has been met by the creation of the European Union of Specialist Doctors (U.E.M.S.), whose recommendations have been channelled through the Permanent Committee to the Commission. The Executive Council of the U.E.M.S. is derived, like the Permanent Committee, from national medical associations: it draws advice from 21 multinational specialist groups, each representing a single discipline and made up of nominees of the appropriate scientific associations from each of the six countries.

In the last few years several other groups have set themselves up with the object of furthering particular interests ; but it is clearly through the two relatively long-established bodies that influence is to be obtained. Each of them sought the participation of a British observer some years ago, and both have continued to show a lively if critical interest in the organization of medicine in this country. There is therefore, through them, a channel of communication and influence which is already in being, and which we can and should develop in advance of any changes in the political situation. This is something which only the profession can do, and which it will do the better the more widespread is the acceptance of the need for it. The Government, in the meantime, should be engaged in contingency planning with the several medical interests involved, and must at least make clear that it will exercise its prerogative in the obtaining of an adequate period of transition for medicine in the event of the Treaty being signed.

Insularity is a not unreasonable attribute in an island people, and has indeed been responsible for the growth of many of the qualities which we now have the opportunity of deploying in a new field. Our success or failure in benefiting from the opportunity may influence not only the National Health Service but also the status of British medicine for some years to come. The challenge we face may reside not so much in the assault on our standards which many have feared as in the demand for an adaptability to rapidly changing circumstances to which we and our institutions are largely unaccustomed. Here, as perhaps in other sectors of our national life, we have nothing really to fear except complacency.

Future of the Public Health Service

J. J. A. REID,* T.D., M.D., B.SC., M.R.C.P., M.R.C.P.ED., D.P.H.

Brit. med. J., 1967, 2, 432–434

Dissatisfaction with pay is often no more than a symptom of a more basic pathology, and this is in part true of the position in which the public health service now finds itself. There are, in fact, several major problems facing those who work in this field, one of which is the whole question of how medical care in this country should in future be organized. Related to this is the fact that, though public health is nominally the third branch of the National Health Service, and though its practice has wide and increasing relevance to the work of the other two, it is also part of local government, which, in turn, has its own serious problems, the solution of which still lies in the indefinite future. In the meantime, local health authorities display enormous disparity in size and resources, and, though all nominally provide the same range of sociomedical services, some do so to no more than indifferent standards, and many offer careers which are likely to attract only the dedicated or those who have failed to make the grade in other branches of medicine.

There are three broad groups of public health doctors, the largest of which comprises those engaged predominantly in clinical work. Next, there are the medical staff of local health authorities, whose work is primarily administrative ; while the third group consists of county district medical officers of health, who usually have a mixture of administrative and clinical duties to perform. All three have problems in relation to their present and future functions, their career structures, and their salaries. In addition, considerable attention is currently being paid to the relation between medicine and the social sciences, and this, in turn, has given rise to feelings of insecurity which have been particularly felt by the public health branch of the profession, as well as to the taking of rigid attitudes by both sides.

* County Medical Officer of Health, Principal School Medical Officer, and County Welfare Officer, Buckinghamshire.