Politicians, and indeed people in other parts of the country, like to believe that the higher cost of the London health services is due to extravagance, plus an unfair share of special resources such as teaching hospitals and centres of excellence and a corresponding increase in the proportion of junior staff. Certainly, as the capital city, London has attracted a generous share of such centres, and there is a case for some redistribution, which indeed has already started. But the extra cost is not due primarily to higher standards and more centres of excellence but to conurbation factors. Because of its size and magnetic attraction London, like all other big cities, is more expensive, and it is unlikely that the additional cost of hospital services in London is adequately reflected in the London weighting; indeed, this is acknowledged by the RAWP. London has more than its fair share of old, decrepit, inefficient Victorian hospitals, many of which still await refitting. Few have been rebuilt. There is plenty of scope for reducing their costs, but to do so is expensive. The higher cost of London is not due to extravagance: it is due to extra need from conurbation factors.

EAST ANGLIA *v* LONDON

Low costs may indicate less need or more efficiency, or both. Here again politicians and the RAWP have misinterpreted some regional figures. There are parts of the country, and East Anglia is a particularly good example, where low cost is related to an efficient service and less need. The East Anglian health services are splendidly organised but, like everywhere else, still need much modernisation. Almost every index of health is consistently better in East Anglia than in London, some to a quite extraordinary degree, especially cardiovascular disease. The proportionate demand on the accident and casualty services is about half the load of London. No doubt the doctor and the patient who are miles from Norwich or Cambridge may deal with the cuts and sprains, whereas in London the patient expects to be sent to the nearby big hospital. With comparable waiting lists in East Anglia there are proportionately only half the number of new outpatient attendances as there are in London NW10 (Willesden and Park Royal). Perhaps the East Anglian general practitioners are more selective in whom they send. Perhaps these practitioners are self-selected for their ability to cope on their own. In East Anglia social deprivation is far below the London level. In East Anglia there is good neighbourliness; in London there is anonymity. East Anglia has the worst weather, with the bitingly cold north-easterly wind in the winter. Nevertheless, the incidence of respiratory diseases is much lower than in London. In spite of its lower cost East Anglia, too, has its centres of excellence, and the orthopaedic work at Norwich has for many years attracted visitors from overseas. It was here that the technique of total hip replacement was first evolved. Cambridge, too, has been responsible for much medical progress.

MORALE

Why did the RAWP fail so abysmally in their initial comparative estimate of the needs of East Anglia? There is no mystery about this. The working party consisted of medical and lay administrators, statisticians, epidemiologists, treasurers, works officers, but not a single practising general practitioner or consultant. One would have thought that the politicians would have appreciated some clinical perspective in making such an important review. The error in omitting all reference to special needs for social deprivation will become acute when the regions are translating allocations to districts. The guidelines so far produced by the RAWP are dangerously inadequate.

The mathematical approach should be abandoned, and in its place there should be small review parties such as those that have proved so successful in the past. Such working parties would have a reasonable opportunity to evaluate social deprivation factors and the quality of primary care which makes such a difference to the work of a district general hospital. Once allocation figures and reality begin to converge there will be a chance for morale to start its long road to recovery.

References

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Where Shall John Go?

Sweden

DOUGLAS MACLEAN

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If you feel like a change, a struggle with ample rewards in the end, then Sweden could be the place to come. If you happen to be an anaesthetist the toil is considerably reduced, as there is no compulsory language examination. This is the one almighty barrier, but, for those who feel like pitching their neurones against something completely different, come to Sweden. The language takes time to learn, a lot of effort, but in the long run is a satisfying and enriching experience.

I came to Sweden as a so-called qualified obstetrician and gynaecologist—that is, with the MRCOG. They fully recognise our degrees and will readily load us with much responsibility. The first six months, however, must be conducted as a provtjänstgöring (trial job as house officer). After this period the chief will send a report to the Socialstyrelsen for foreign doctors, and, assuming this is satisfactory, you can then take off for a higher plane and salary. An underläkares (houseman's) salary is, however, not to be sniffed at, and in fact more than adequate for ordinary activities. All this applies to those who wish to come and work more or less permanently, especially those who are not anaesthetists. Short-term locums are a different matter and

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altogether easier to obtain, as no doubt many English anaesthetists have discovered. I shall relate some of the difficulties I encountered in penetrating their highly efficient bureaucracy.

You must first apply to the Socialstyrelsen in Stockholm for permission to work in Sweden as a doctor, with as many sound reasons for doing so as possible. The first year I applied I was turned down. It helps greatly to be married to a Swede, about to marry a Swede, or to have some kind of Swedish connections. Swedish connections seem to be more important than qualifications in deciding who shall be accepted.

The second time that I applied I was accepted. I then travelled by ferry from Harwich to Esbjerg in Denmark and thence to a small town in Sweden with high hopes of starting in a new post as an avdelnings läkare (registrar). I had previously made contact with an överläkare there who seemed sure that if I had mastered a Linguaphone course there should be no difficulties. This turned out not to be the case: I was not an anaesthetist; the plot was laid bare by the authorities; and I was duly informed that I should sit a language examination in Uppsala within three months. If I could then show that I was able to speak the language permission to work would be granted. Having crossed the North Sea with all my paraphernalia I decided to stick it out.

A lean period

I then enrolled upon a language course, run by Kursverksamheten in Lund. During this time I applied and waited for my work and residence permits. It was a lean period financially, but it was a good opportunity to meet folk of many nationalities and walks of life who were similarly struggling to penetrate the Swedish system. It's an effective and rapid way to learn the language and way of life. It was also an interesting introduction to many Swedish authors. It had, of course, its tedious moments when one could reflect on the circumstances that had led one to sit in such a classroom, far remote from any hospital, let alone stethoscope. Each month there was a short test, not difficult to pass, given that one had done all the necessary homework. This enabled one to pass on to higher classes. Finally, after three months, including a short Swedish medical course one evening each week, I was ready for the dreaded test in Uppsala. I passed.

The above is roughly what any other doctor might expect to go through in order to pass the Uppsala language exam. It should be possible to manage this from England, through diligent study and by thoroughly completing a Linguaphone or similar course. One could thus avoid the lean period of having to sit through three months of language classes. Even then, of course, it takes longer to converse fluently, let alone understand a newspaper or news broadcast with any satisfaction. I was compelled to listen to crackling English programmes, and read ancient English newspapers to maintain some kind of contact with the outside world. My progress was correspondingly slower with the language. It definitely pays to strive continuously with dictionary close at hand, preferably permanently in the pocket.

Anaesthetists can still bypass this exam, partly because there is a shortage of them and partly because they do not have to speak so lengthily to their patients as do their colleagues in other specialties. This does not detract from the fact that their job can be frustratingly difficult if they cannot communicate adequately with both patients and staff. Fewer Swedes speak English than one might expect. It is now a compulsory subject in schools so that the number of English-speaking Swedes is increasing. It is well worth a little study even if you intend to do only a summer locum job.

There are plenty of academic openings for research in all the teaching hospitals, and fruitful ideas are encouraged. There appear to be no lack of funds and State aid for this purpose. Swedish academic output is quite prolific from all the teaching centres, as indeed one may observe by reading the English and American journals. The opportunities are generally good for promotion even to överläkare (consultant) in all the specialties, particularly if one produces a certain amount of forskning skrivelser (research work). There is not the same desperation to reach the heights of consultant as there is in England. This is partly because the pay differential, after the heavy taxes, leaves the överläkare only a short way ahead of his junior colleagues. There are many therefore who openly and willingly stay as so-called bitradände överläkare (senior registrars) for life. Again unlike Britain, the pay differential between the distriktsläkare (general practitioner) and the junior hospital doctor is minimal, so that there is no feeling of compulsion to become a family doctor on the basis of pay alone. One of the few dubious rewards an överläkare may expect is a heavy administrative burden. Hence there are some doctors in the hospitals who are not particularly interested or in any conceivable hurry to achieve the post of överläkare.

General practitioners

A word or two now about the distriktsläkare (general practitioners). The foreign doctor must achieve Swedish legitimation before being allowed to work in such a post. This means passing a test in social medicine, for which one can take a short and rather tedious course. The Swedish legal system must also be studied. Otherwise no clinical exams are necessary. They receive fine salaries, of course, work from eight till five, five days a week, and have roughly one night's duty a week, and one weekend each month. They have a heavy work load, with virtually no house visits. The patients must, therefore, usually come to the central clinics, if necessary in State-reimbursed taxis. If they are too ill to do so, their ailments are usually diagnosed over the telephone and they are directed instead by ambulance to the nearest casualty or acute unit of a general hospital. All this tends to annihilate the family doctor image. It is impossible for house calls to be made regularly, as the distances are often too great. Out of the towns, the country is sparsely populated; and each distriktsläkare group covers many kilometres in every direction. The service is worsened by the overall shortage of doctors practising in the rural areas.

Previously in abundance, private doctors have been heavily trodden on by the State, and now have restrictions on their fees, and on the numbers of consultations they may make each year. This has resulted in increased work for the other sectors of the health service. If a private doctor works too quickly and sees his quota of patients too soon he must be content to sit and twiddle his thumbs for the rest of the year. This is a system which is difficult to administer fairly, when one considers how long a psychiatrist must spend with one patient and how short a dermatologist may spend with another. It will be interesting to see how they resolve this problem over the years.

Something I found rather surprising is that the patients may at any time read their own notes. It is not an uncommon sight on the wards to see a patient casually wading through his own notes and investigations. Not a bad idea, perhaps, in this liberated world, but it creates an unwanted and annoying censorship. Nothing in fact is drawn or written by hand in the notes, every word being dictated first and typed in later by an unseen secretary—all rather impersonal.

Surviving comfortably

But how does one survive in Sweden? Survive, perhaps, is not the right word, as one can live very comfortably, as I hope to show. Between 50% and 65% of a doctor's salary is deducted in tax. Handsome tax relief is given on money which is used in paying back bank loans for houses and even boats. House prices have risen sharply (by a quarter) over the last nine months so that they are no longer cheaper than the equivalent houses in England. Flats, however, are still fairly cheap to rent: a fine flat may be rented for between £70 and £90 a month. With some flats one must set down a deposit of, for example, £500-£1000;

the rent is then often considerably less. This deposit is, one hopes, retrievable on handing over to the next tenant, and it is therefore related to the demand for flats.

Children begin nine years' compulsory free schooling at the age of 7, and I have not heard of any difficulties from friends in finding schools or nurseries for their children. Educational and nursery facilities in Sweden are really unbeatable; child allowances are high; other allowances and benefits to which one is entitled can be studied in the "social catalogue" obtainable free from any post office.

The table below may well be of interest, and shows the current yearly rates of pay for five different grades of doctor, before and after tax. The figures are for those working up to 45 hours a week. Over 45 hours is recorded as overtime, from which one has 80% tax deducted. Instead of accepting overtime pay, many choose to take free days, which often may amount to an extra four weeks' holiday a year. The cost of living is, of course, higher in Sweden than England—in particular, cars, clothes, and food. I have not worked it out in detail, but it is clear that one is materially better off in Sweden. If only the beer didn't cost four times as much. If only . . . .

Holidays and festivals

The Swedish people have many public holidays centred on traditional festivals. Many are older than Christianity. Christmas is celebrated more elaborately than in Britain and is an amalgam of pagan and Christian customs. The Lucia festival, on 13 December, is a combination of a Christian celebration of a saint's day and a pagan custom of marking the passing of the longest night, and reaches its climax on Christmas Eve with the exchange of presents, and Christmas Day with an overindulgence in food and drink associated with the Viking period.

From the alcoholic angle I believe that the Swedes are unfairly criticised as having a Utopian-type problem. By that I mean an increase in alcoholism related to the enormous and rapid rise in their standard of living over the last 80 years. They have had such a problem since Viking times, strengthened in the nineteenth century by the discovery of potato schnaps. It is not uncommon to see alcoholics swaying around the systembolag, or off-licence. There are no English-type pubs for them to retire to; hence alcoholics tend to be rather obvious and one may receive a distorted view of the proportion in the community.

To return to their traditions, further links with the past are preserved on 13 March, when Vasalopp (the Vasa Race), the largest and the longest ski race in the world, is run. Many Swedes are skilful skiers and every year now over 9000 (plus a handful of foreigners) enter this gruelling national event. It is an 85-kilometre ski-run, which ends at Mora, the point from which the men of Dalarna set off to overtake the young Gustav Vasa in 1520 and to offer their support in the bid to expel the Danes and their tyrant king. This year I entered the event, having trained beforehand on roller skis, owing to the lack of snow in southern Sweden. I managed to complete the distance thanks to the numerous stops for food. The rear of the race was largely occupied by foreigners, who for the most part had travelled great distances in order to participate. It was an unforgettable experience, run through beautiful snow-clad mountain scenery, across frozen lakes, up and down dale, kilometre after kilometre. The hardest part, however, was to stand in the early morning darkness and wait well over an hour for the mass start to begin, with —17 C to contend with; at this stage five skiers were admitted to hospital suffering from hypothermia.

In August there is a relaxing open air celebration, which heralds the season of the crayfish. There are other days, too, when one can sample delicious smörgåsbord and schnaps, remembering at the same time that on no account may you drive an automobile afterwards. Their strict drinking and driving laws take care of that, rightly so, and no Swede will tolerate even an Englishman driving if he has had anything to drink. Even the host of a party can be penalised if one of the guests is reprimanded by the "polis" on the way home for having an excessive blood alcohol level. It is usually decided well beforehand who shall be the driver.

Hunting, shooting, and fishing

No reference to Sweden would be complete without an appreciation of its abundant open countryside, with, thanks to strict controls, minimal industrial pollution. Botanical and ornithological interest abounds; many migratory birds pass through Skåne and over the island of Öland. It was a great moment this winter when I spotted two rare species, the golden eagle and the osprey. Their wild life is prolific and a veritable paradise for those with a craze for hunting, shooting, and fishing.

Archeological remains are not in short supply, particularly from the Viking period, and many well-preserved runic stones and Viking ship-setting graves dot the coastlines, serving to remind us how vulnerable Britain once was from these North Sea pirates.

The Swedes are serious both at work and in play. They are rather slow in making acquaintance, but once made, friendships are lasting. Like the cars they produce, they are a solid, serious, sensible, and healthy race, with a tendency towards longevity. The women are physically extremely attractive, with natural blondes the rule rather than the exception. Under this beauty often lies a fiery Nordic nature, leaving them with no doubts about achieving equality with their menfolk. Svenskarna certainly have just cause for national pride, as "Sverige" is an equitable, uncorrupt society where everyone is adequately educated, clothed, fed, and accommodated in an atmosphere of complete spiritual freedom. It is too easy to generalise, but there is a definite lack of eccentricity and spontaneity among the law-abiding populus, which can dampen one's humour. Overall the pros outweigh the cons, so I shall stay on for a while longer.

Grade	Before tax £	After tax £
House officer	8 002	4632
Senior house officer	12 990	6084
Registrar	15 780	7230
General practitioner	18 265	7306
Consultant	18 894	7560

£1 = 8 Swedish Kronor

I have recently seen many people arrive in the Sudan from Britain who have had up to six inoculations in one day, including three live vaccines—primary smallpox, yellow fever, and polio. Is this procedure safe?

Simultaneous administration of live virus vaccines need not result either in impaired immunity or a more severe reaction.[1] It would, however, seem sensible to avoid so many immunisations at a single session unless administratively essential.

[1] Karchmer, A W, *et al*, *American Journal of Diseases of Children*, 1971, **121**, 382.

Should lactating mothers be given contraceptive pills, and if so which kind?

After delivery ovulation returns in most multiparae by six weeks and primigravidae by 12 weeks. There is probably no need to give oral contraceptives for about four weeks after birth while lactation is being established. Once it is established and the baby is removing milk regularly from the breasts it is difficult to stop lactation with steroids, though occasionally this will be seen. Because of this possibility low-dose combined contraceptives would seem to be the most sensible. The hormones in the milk seem to have no adverse effects on the baby. Vaginal adenocarcinoma has so far been seen only in those daughters of women given massive doses of oestrogen in early pregnancy. The case of small doses of oestrogen in the milk is probably not comparable.