TALKING POINT

The "necessary" strike—French medicine in turmoil

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Arriving in Paris last October for a year's internship, I had hardly anticipated that my visit was to coincide with the most violent demonstrations that Paris has seen since 1968 and with a strike by medical students and my fellow interns. Although the disruption has been less than in 1968, Parisians have once again witnessed the water cannon, the tear gas, and the baton charges by the Compagnie Républicain de Sécurité, the special force set up in the 1950s to police the mountain areas and beaches but used increasingly by successive governments as a riot control force. Such events, however, are not uncommon in France, and newsreaders report the latest "manifestation" with about as much excitement as they would the weather forecast. True, there have been certain nights when a jogger would have been advised to divert his route away from the Quartier Latin, but the life of the city has been largely undisturbed.

The present turmoil arises because there are several dissatisfied groups protesting about a wide variety of issues in different ways. The most violent demonstrations have been carried out not by medical students or interns but by students of other faculties protesting against the Loi Savary, which concerns the reorganisation of the French universities and is now being hurried through parliament.

Since coming to power the socialist government has attempted to grasp the nettle of reform of a health system that faces the ubiquitous problems of the rising costs of technological medicine, and for which the appropriate number of doctors need to be trained. The mushrooming of the health services over the past 20 years—practising doctors have increased from 44 600 in 1960 to 127 992 in 1982—is straining the existing structure, but the nature of the reforms and the lack of prior discussion between the concerned groups have outraged doctors of all political persuasions.

The nature of the reforms

Four contentious issues have surfaced: firstly, limitation of the extensive private sector (some private hospitals have permanent on call staff and are fully geared up for emergencies); secondly, the reorganisation and regrouping of hospital services into larger departments where the chief consultant would be elected to his post for only four years by a committee made up not only of doctors but also of paramedical staff; thirdly, the reorganisation of the hospital career structure; and, fourthly, measures that would bring the medical faculties more under the central control of the whole university.

It was the latter two issues that particularly exasperated the interns and the chefs de clinique (the equivalent of the registrar grade in the United Kingdom). Take a hypothetical example of a newly qualified doctor: Dr X has completed the medical course and is about to embark on his career. Like many but by no means all of his colleagues, he has been studying for one or two years for the "internat." This competitive written examination is a selection procedure to choose the interns, and only about 10% of the doctors who take it will pass. If a doctor fails he may take it again or try for an internat in another university town. If he still fails he will be unable to become an intern and must either set himself up in general practice (no easy task) or take a further

period of study in a specialty of his choice but with little clinical responsibility. If Dr X passes the internat he becomes an intern in a teaching hospital for four years. Stages are split into six month periods and he has the right to choose not only his specialty but also which consultant he works for according to his position in the examination and his seniority. After four years of internship he has two choices: either he can apply for posts as a chef de clinique or he can set up in a town as a specialist seeing patients at his own surgery premises. In any event, once he has passed the internat he need never take another examination as there is no equivalent of the membership or fellowship exams that specialists have to obtain in Britain. So Dr X finds a "patron" who gives him a post as a chef de clinique for two to four years. After this the real problems start. To find a consultant post will not be easy as the bottleneck for promotion is as bad in France as in England.

Why the interns went on strike

Under the new regulations the intern system would be transformed. It would be compulsory for all doctors and would last two years only. After working in a chef de clinique post lasting two years the doctor would take an exam to gain entrance to a two tier system. Level A doctors would be able at a later date to become consultant equivalents or head of a service, but level B doctors would have a function rather like a permanent registrar, with no prospects of further promotion or financial advancement. Level B doctors would work not only in teaching hospitals but in general hospitals as well, where they would have considerable on call commitments. Thus the new reforms would divest the intern of his hard fought advantages. For many young doctors who had worked long hours at a low rate of pay it seemed like a marathon race where the rules are suddenly changed three quarters of the way through. The other main issues for the interns were, firstly, that the medical faculties should retain their financial, administrative, and teaching autonomy; and, secondly, that there should be improved on call remuneration. Thus on 22 March the interns and chefs embarked on a six week strike in which emergency cover was continued as normal. Nationally the strike received 90% support from the interns, and the consultants clearly sympathised. Finally, after an intervention by Pierre Mauroy, the Prime Minister, promises were obtained that satisfied the interns on the major points and the strike was suspended although not officially called off.

What French doctors fear

That the interns' strike reflected an undercurrent of dissatisfaction and a crisis of confidence within the medical profession is shown by the fact that in a recent poll 62% of general practitioners said that they would ultimately be prepared to close their surgeries in support of the interns and medical students. And at a meeting of the interns Professor Milliez, one of the most famous names in French medicine, showed his support for the movement by declaring "votre grève est nécessaire" (your strike is necessary). Clearly, French doctors are keen to maintain the delicate balance between public and private sectors and cling strongly to the principles of pluralism, competition, and free

The Community Medicine Conference

The annual conference of community medicine met on 18 June, with Dr A W Macara in the chair. A selection of its decisions are published here; a fuller report of the meeting will be published in a future issue.

- congratulated the board of science and education, welcomed its report on the medical effects of nuclear war, and believed that it was necessary to plan for (a) all major emergencies, including conventional war; (b) a nuclear attack on the United Kingdom.

- believed that present planning guidance was wholly unrealistic to deal with the health problems which would occur following a nuclear attack and called on all doctors to take no further part in such planning until guidance was issued which took into account the criticism outlined in the BMA's report on nuclear war, and asked the BMA to advise the government on the preparation of such guidance.

- believed that NHS staff, who as a matter of conscience did not wish to take part in civil defence planning for the consequences of a nuclear attack, should be excused from such work without detriment to their contracts or job security.

- carried as a reference a proposal from the Oxford division that the council should ask doctors to withhold confidential medical information from local government authorities until its confidentiality could be assured.

- asked for a radical review of the funding available for recruitment to the specialty of community medicine in view of the serious undermanning of the specialty, which had been accentuated by significant early retirements following the recent restructuring and by long standing underrecruitment.

- recommended the urgent establishment of norms for community health doctor staffing levels.

- deplored the first appointment to community physician posts of doctors who did not have membership of the Faculty of Community Medicine and were not accredited by the Joint Committee for Higher Medical Training, and demanded an immediate stop to this practice.

- thanked the CCCM for its thorough review of the application of the distinction awards system to community medicine and endorsed the proposals contained in the CCCM's report.

- urged the CCCM to continue its campaign for posts of consultant status in community health and to explore all possible avenues for achieving this. (Carried as a reference.)

- believed that general practitioner services and the associated community services should be properly planned to meet the health needs of the community.

- called for the setting up of a national health promotion authority, a parliamentary select committee on health promotion, and local health promotion committees. (Carried as a reference.)

- wanted the DHSS to look into all aspects of the national immunisation programmes with a view to improving the present figures for uptake.

- urged the government to introduce legislation to prohibit the advertising of tobacco products on local authority property.

- recommended that adequate facilities should be provided within reasonable distance of all health districts for treating alcohol related disorders.

- asked the CCCM to support actively the training needs of community health doctors with responsibilities in child health, family planning, and environmental health.

- reaffirmed its opposition to any hierarchical relationship between a district medical officer and other specialists in community medicine.

- considered that doctors should be fully involved in the development of performance indicators for ministerial review in order to reflect effectiveness as well as efficiency.

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choice for the patient. These are seen as the best means of achieving quality in health care, and the government's proposals are feared as a move towards a state system of medicine, which would reduce doctors to faceless government functionaries, thus stifling initiative and discouraging effort. In short, "la médecine populaire, c'est la médecine en retard" (popular medicine is backward medicine).

Most British doctors would maintain that a state system of medicine does not necessarily lead to a loss of autonomy, provided that the profession is careful about how the terms of service are negotiated. And that is precisely the point. The health minister, Jack Ralite, formulated the new reforms, initially planned to come into force in January 1984, with a minimum of discussion and a maximum of haste. Edmond Hervé, the minister who has now replaced Ralite, has promised further talks in an attempt to arrive at a consensus but has expressed himself in favour of medical care that depends less on high technology and more on a consideration of the individual in society and the relation of health to daily life. Such concepts are mistrusted by French doctors, who fear in this "médecine globale" the undermining of the traditional French values of individualism and the pursuit of excellence.

Politically, the medical students' strike has been less important. Unlike the interns the students were protesting against a law that had been passed by parliament in December 1982. This law

changed the nature of the final year and the means by which the students could choose a specialty. The protest techniques of the students were considerably more dramatic than those of the interns, including such stunts as the occupation of the Arc de Triomphe, the plastering of government officials, and the ritual ripping up of paving stones outside a Paris hospital. (The stones were not thrown, just placed in a symbolic pile.) Such manoeuvres were their only weapon in the absence of truly damaging strike action. The reforms are to go ahead anyway, although the students have obtained certain concessions over the final year exam, and for those who are caught between the old and the new systems there is to be a transition period. From a constitutional point of view it has not been easy for the government to back pedal, and it has had to make amendments to the forthcoming Loi Savary in order to change the law of December 1982—what has been described as "un exercice de trapèze juridique" (a legislative trapeze act).

The position has been changing daily and further strike action is still possible though much less likely. This is just a sketch of a complex dispute that many doctors admit to not fully understanding. One thing, however, is clear: the government has misjudged, to its cost, the determination of the doctors to be consulted and to take part in the planning of their own futures and of the future of French medicine. Edmond Hervé, the new minister of health, will have to go more slowly to achieve the reforms. It remains to be seen whether he will have sufficient time.