graduate medical education covered a wider field it would widen the choice of career specialties which medical graduates would consider and solve many of the problems of postgraduate training. Finally there is the problem of hidden patronage—which still exists.

The biggest threat to junior doctors in training in this country comes from the royal colleges. Standards set by such organizations are always rising. Some years ago the F.R.C.S. was considered adequate to practise as a surgeon, but today it is regarded as being adequate only to start specialist training. I do not think this is a good thing—the royal colleges are trying to maintain their exclusiveness. When they realized that specialist registration in E.E.C. terms (measured by an approved course of training) would mean freedom of establishment as a specialist, and that the diplomas of the colleges might become irrelevant, they put forward their scheme of specialist accreditation. Clearly this will be limited to senior registrar establishment, which, in turn, is related to consultant establishment. The latter is regulated by the Department of Health. This places the colleges in the unfortunate position of endorsing a standard which is set by the employing authority, rather than an academic one.

Mutual recognition of basic qualifications presents few difficulties.

At international meetings, a doctor's right to be regarded as a doctor is never questioned. The only problem is that of a period of adaptation since medical ethics vary from one country to another. In the United Kingdom I feel that the preregistration year would be better regarded as a probationary postregistration year. The recognition of postgraduate training is more complex, as training differs throughout the countries of the community. Here, again, the overriding principle should be that no truly educated man will ever consider that his education is complete. What we have to consider is how much specialist training a doctor in each specialty should have before acquiring the right of freedom or establishment as a specialist. The belief that a consultant, or chef de service, knows all that can be known about his specialty is false. Yet this appears to be the thought behind specialist accreditation as envisaged by the royal colleges. As Europeans we must strive to overcome the fear that doctors or specialists of another country are not as good as our own. This fear is totally unjustified, since few Europeans would be attracted by the salaries which we could offer.

Specialist registration must be based on the admission of a doctor to the specialist register of the country in which he undergoes specialist training. It may be possible to fix European guidelines for specialist training, and these guidelines should include quantitative as well as qualitative criteria. These will fall far short of the criteria the royal colleges are trying to establish. Specialist registration will carry freedom of movement as a specialist under Article 48 and it appears that the royal colleges intend to place young British doctors at a disadvantage compared with doctors attaining specialist registration in the Community.

I do not think that many British doctors will migrate to Europe and if they do they will initially obtain posts which local graduates would not consider—this has happened in America. The important principle is the freedom to move. If the royal colleges have their way it might well happen that a young British doctor seeking specialist training would realize that he could save many years of his life by migrating on the basis of his primary qualification, obtain specialist registration elsewhere, and return as a specialist.

Middle Registrars as Specialists

It is at middle registrar level that we must equate our specialist registration with Europe. College accreditation is irrelevant in a European context; its application is limited to N.H.S. hospitals, with their predetermined consultant establishment. This unfortunate misunderstanding has arisen because in Britain the term specialist has become equated with N.H.S. consultant complete with junior staff, and in clinical specialties with beds. A specialist has a different significance in Europe, and a clinical specialist is quite likely not to have beds or junior staff. What he does have is the right to charge a different scale of fees, and this is im-

portant where there is a larger private sector. While our monopoly employer controls consultant establishment the European specialist cannot be a threat to the standard of N.H.S. consultant practice.

The danger in the colleges' action is that it may deplete the N.H.S. of doctors, especially in the shortage specialties such as radiology and anaesthetics, where language does not present such a problem. When the choice in these subjects lies between seven years' training in this country and four years in other European countries with higher remuneration some doctors will be lost to Britain. It is in these sensitive specialties that a crisis will affect the whole of the Service.

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West Germany

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After six years' study the medical student in Germany has to pass the final medical exam called "Staatsexamen." Until recently it was followed by a two-year internship. With the introduction of the new curriculum, however, the practical knowledge will be gained during the university studies and the final exams will be taken together, after which the doctor will be licensed to practise. But hardly any of my colleagues feel that they have acquired sufficient knowledge, and as a rule they stay on full time in hospital or work as civil servants.

On 1 January 1973, there were 125,000 doctors in the West German republic and in West Berlin—one doctor for every 523 people. Just over 40% were in private practice. The doctor population increases yearly by about 4,000—mostly in hospitals, while the number of doctors in private practice has stayed constant. 87% of hospital doctors are between the ages of 30 and 34, 62% between 35 and 39.

There are few permanent positions in hospitals and the interest, for instance, in surgery has noticeably declined. Of the 5,000 foreign doctors working in German hospitals most are surgeons. To be a specialist in Germany the qualified doctor has to have four to six years training in his specialty but does not need to take any exam.

The pay of young hospital doctors used to be incredibly low but has improved in the last few years, and is now equivalent to other academics working in the civil service. For the last two years they have also been paid for overtime, night, and weekend duties. "Consultants" increase their earnings by seeing private patients in hospital. They are required to pass on any fee for which they have not themselves performed a service. Recently several schemes have been introduced whereby income was pooled and then divided up according to a fixed schedule. In this way up to about half the private income of consultants was divided up among their medical colleagues.

The hospital structure and the medical practice in hospital is still largely controlled by old-fashioned rules and procedures. At the university as a rule a subject will be represented by only one doctor. At the general hospital also all the doctors are under the orders of the consultant in charge. Where democratically-run groups do exist in hospitals, they have only advisory and supporting roles.

Many young doctors use the hospital only as a stepping stone to private practice (mainly specialty practice), and they have formed various associations to try and change the situation, the most important of which is the "Marburger Bund." This corresponds to a labour union and has the right to negotiate contracts for its members. It maintains that the present drain of highly-qualified doctors to private practice can be stopped by creating new permanent positions in hospitals. Already there are clear indications that young doctors are tending towards specialization: they prefer to stay in hospital rather than enter private practice; to work in a team rather than by themselves; and show little inclination to enter public health medicine.

Hence the hospital structure in Germany is likely to change in the near future and will allow medical training to be adjusted in accordance with other European systems.

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Italy

FRANCO PERRARO

The problem of young hospital doctors in Italy has now acquired social, economic, and political implications. The proportion of doctors to the total Italian population is very high; one doctor for every 560 people in Italy, compared with 590 in Germany, 640 in Belgium, and 900 in Ireland. In 1971 there were 101,300 doctors, and of these 87,600 actively practised medicine. Of these 57,000 worked for I.N.A.M. (National Health Insurance Institute), which is the most important medical body in Italy; about 40,000 worked for other health insurance institutes; 43,000 worked in hospitals; and 10,500 were medical officials. Another 6,300 worked in private nursing homes. Thus in 1971 each doctor had roughly 1.7 public appointments.

This dramatic rise is due partly to the liberalization of university courses and to the expectation of high earnings and prestige. The faculties of medicine in Italy are finding it difficult to organize adequate courses for students, and the situation is hampered by the forthcoming health reforms. The reformed health service will require a new type of doctor, some specializing in the previously neglected fields such as perinatal, industrial, and preventive medicine. There will thus have to be a very careful re-allocation of medical manpower in Italy both among disciplines and in different regions—at present there is a large concentration in urban areas.

Until two years ago specialist courses were open to anybody—in many cases it was not even necessary to attend. This resulted in a proliferation of specialists, many in name only. Now faculties of medicine have set a very low limit on the number of students attending specialist courses. If a young doctor wishes to enrol in such a course he has to promise to work freely at the clinic where it is held for the whole period.

However, apart from radiology and anaesthetics, it is not necessary to be a specialist to find a job and make a career in a hospital: he can work for some years in a specific branch after which he takes part in a "competition" to become assistant and then head physician. This mechanism of competition tests is being fought fiercely by the A.N.A.A.O. (Society of Young Hospital Doctors). After the establishment of a 40-hour week for full-time doctors and a 30-hour week for part-time doctors, the first collective agreement was reached in 1969 by the representatives of the medical profession and the hospital administration. But after a prolonged dispute this contract has now expired.

Hospital Doctors' Collective Agreement

After long negotiations between F.I.A.R.O. (Italian Federation of Regional Hospital Associations) and the associations of hospital doctors A.N.A.A.O. (Society of Young Hospital Doctors), A.N.P.O. (National Society of Hospital Head Physicians), and A.N.M.D.O. (National Society of Hospital Medical Directors), the text of the national agreement on hospital doctors was signed in April 1970, being operative from 1 January, 1970.

The collective agreement laid down general and economic rules and regulations governing the activities and remuneration of hospital doctors. One of the most important aspects of the collective agreement was the elimination of fixed salaries based on the number of patients. At the same time procedures were established for hospital doctors to work full time. The part-time hospital doctor works 30 hours per week—a system which allows him to do other professional work provided he fulfils his duty at the hospital. Full-time doctors must work 40 hours per week and cannot have another job. Full-time and part-time hospital doctors may have another job within the hospital, but

not during working hours or to the benefit of paying patients. The attractions of other well-paid professional jobs has led to a shortage of staff in some hospital departments, such as anaesthetics, radiology, and laboratory.

Young doctors usually prefer a full-time job which does not allow any professional activity outside the hospital. In fact, they would find some difficulty in getting work as general practitioners, though this is the chief alternative open to them. To become a general practitioner it is sufficient to take the qualification test and to be on the list of a national insurance scheme, to select an area where there are no general practitioners, and to wait for patients. A young doctor with 1,000 I.N.A.M. patients is paid 10 million lire a year by the Institute. At the same time such a doctor could easily have another job in a hospital or at a university.

To make a career at a university a young doctor has to spend a training period (as much as four to five years) in the selected hospital and he is not paid at all. Because of the plethora of students, the lack of funds, and the tendency of directors to be involved in highly-paid professional activities rather than teaching and research, university hospital teaching has deteriorated.

At present there is a crisis in scientific research in Italy. Hospital doctors and general practitioners can earn far more than doctors working in governmental scientific institutions. The same is true for the officials working at the Ministry of Health or at the regional health offices. There are few applications for these jobs and many vacancies.

An alternative is to work as a specialist for a health insurance institute—but this requires some postgraduate experience and the academic title of specialist (which is now difficult to get). I.N.A.M. is still the most important health insurance institute; its remuneration is by the hour and is very high. Several part-time hospital doctors also work as specialists. The health insurance scheme leaves little room for the private practitioner, and private practice is confined to the older and already well-known physicians.

The greatest difficulty for hospital doctors in Italy is the hiring mechanism, under which several tests have to be taken in order to move from one hospital to another and at each stage of a doctor's career. A.N.A.A.O. (the strongest association of hospital doctors) is fighting this system fiercely; it favours a national health scheme in which the hospital will be the centre of local health units. The society also favours better organized work for doctors based on "team-work" and "full-time work."

The differences in the time spent, qualifications, and attendances at specialization courses in Italy have increased the obstacles to the free movement of physicians and specialists in the E.E.C., even though there is a similarity of preuniversity and university courses between Italy, Germany, France, Luxembourg, Belgium, and the Netherlands, and university degrees are acknowledged in all six countries. These difficulties hampering the free movement of doctors within the E.E.C. must be overcome, and it is hoped that the predicted changes in Italy—such as an increase in the number of young doctors who may be only partially absorbed into the proposed new national health scheme, the planned changes in medical education, and the limits to be set on the number of undergraduates in the faculties of medicine—will go some way to meeting this objective.

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France

M. BONNEL

There are 500 public hospitals in France. Of these 250 are small local hospitals not concerned with the problems of young doctors—these local hospitals represent only a small part of the total bed population. The other 250 represent, firstly, the 50 teaching hospitals (including 20 in Paris) and, secondly, 200 non-teaching hospitals—which include 100 with more than 300 beds and which are very well equipped.