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

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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.

There are important differences for the training of a young doctor according to whether he is in a teaching hospital or not.

There are two categories of young doctor in France—interns and assistants. The interns are recruited by a special examination taken in the final year as a student organized by the Ministry of Health. They spend three to five years in hospital, being responsible for patient care, normal medical practice, and emergency problems. But differences are beginning to emerge between the interns in teaching hospitals and those in non-teaching hospitals, where the doctor receives a more practical training. At the end of the internship the doctor can become a general practitioner, enter private practice, or follow a hospital career. From non-teaching hospitals interns generally become general practitioners, but after a long struggle it has recently become possible to enter private practice or hospital posts. There are more facilities for qualification and specialization in the teaching hospitals and the interns there hardly ever become general practitioners.

The assistants spend two to six years in hospital. In the teaching hospitals they are co-opted by the professors, have university status, and at the end of the course can choose between becoming private specialists or consultants and then senior consultants in non-teaching hospitals. In non-teaching hospitals assistants are appointed for one year after a special examination. If this first year is satisfactory they are reappointed for a further two years. Normally assistants can obtain only full-time jobs in non-teaching hospitals.

Part-time assistants also exist, who are appointed after a special examination. The posts exist only in non-teaching hospitals and are held for five years. The assistants can then become private doctors or continue in hospital medicine as a consultant or senior consultant.

Reforms have been long delayed in the training of young doctors. The differences between interns of teaching and those of non-teaching hospitals should be eliminated. The old problem of the supremacy of the universities in the health service should be abolished. Assistants face difficulties because of the low fees paid during their first years: moreover, they cannot obtain jobs in teaching hospitals and so are forced to go into private practice. There should also be a better organization of specialist training.

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Medical Students

Great Britain

R. FRACKOWIAK

Not all students accept the vision of a European Community. The European medical student is aware of the fact that the free movement of doctors throughout an E.E.C. where there is no broad common health policy implies that doctors will be able to move, offering themselves for employment, from one type of health system to another. The movement will be governed purely by economic principles, and there will be a tendency to move from socialized health systems to private systems. We in Britain are particularly anxious not to participate in the erosion of the achievements of the last 25 years of the National Health Service.

Another major problem confronting us is that of education.

The exchange of teachers, students, clinicians, and medical educationalists would lead to a wider dissemination of new ideas. The doctors of Europe will become better acquainted with each others' ways of working. Perhaps we will see the day when the average British medical graduate will be able to converse in one or two European languages other than English. We welcome the opportunity of being able to study in other centres, but we reject the tendency towards a levelling of courses, a harmonization of training programmes by some supranational body, because this would suppress the advantages that a united Europe can offer. Basic medical education needs to be organized locally. Each country means something different by the

"final product" of basic medical education. As European medical students we believe that the product of a basic medical education should be a man who has undergone periods of theoretical and practical training not necessarily in the same centres, which has led to the licence to practise. We purposely make a distinction between the licence to practise and the attainment of a university diploma. Each country in the E.E.C. has different governmental or statutory bodies which lead to the licensing of doctors. It is at this level that mutual recognition of the doctor creates problems. The mutual recognition of a degree is a comparatively minor problem which can be solved on the basis of mutual confidence. The people of the Community, however, wish that the licence to practise anywhere in the Community should be strictly regulated, and we see great sense in this.

We believe that the opportunity for free movement of newly licensed doctors could be used to greatest advantage in the sphere of a European programme of "specialist" general-practitioner training. We feel that the automatic recognition of a newly licensed doctor as being capable of setting up in general practice in any part of the E.E.C. is unrealistic. In the specialist field the situation appears simpler. The movement of graduates between hospital training posts to get more experience is very desirable. The situation already exists to a certain extent, in that many British graduates travel to the U.S.A. for periods of study. I should like to see "Been in France" or "Been in Denmark" regarded as highly when applying for senior posts as "Been to America." Thus in terms of education the potential advantages of free movement for the population and the doctor are great.

Let us not forget that when free movement becomes a reality it is the youth of Europe which will comprise the majority of migrating doctors. The established professional man will be very loath to pack his bag and start moving around. So it is on the shoulders of the younger generation that will rest the true task of cementing European unity. Medical students in Europe have met, discussed, and worked on the problems of the construction of a medical Europe. Above all, it is essential that Europeanism is seen to be a progressive movement which is for the benefit of the peoples of its constituent states. We do not see the free movement of doctors as an end in itself, but rather as a step on the road to the development of a common European health policy and service.

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During the last six or seven years the students' role inside their faculties and their communities has changed. Most students no longer see themselves only as the lower degree of candidates for medical examinations. They want to influence those parts of medical education with which they are concerned, and participate in all commissions on changes in medical education.

As soon as I begin to explain medical care in Europe—its changes and its status—it leads me directly to the career structure medical students see for themselves. Any discussion in medicine is influenced by whether there is a nationalized medical care system or not. The United Kingdom and Denmark have such a system but in the non-nationalized medical systems in Europe students view the work of a doctor from a financial point of view. In Germany the structure of the health care system gives us a picture of a general practitioner who takes three minutes to examine and treat his patient and another ten minutes to write out the form for the patient's insurance company. He has been termed the short-time treatment profit maker. In Germany only 5% of medical students want to work as general practitioners in the country, but quite a lot of them