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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R. FRACKOWIAK, Final year medical student

West Germany

H. ALTROGGE

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

want to work in the cities. Not surprisingly, in Germany and France the average age of a rural general practitioner is over 57 years.

Over 30% of German medical students want to start and to finish their career as a clinical specialist. Another 30% have either not decided during their studies or want to specialize as dermatologists or ophthalmologists in a practice or in a clinic. The type of medical education we get may be one of the reasons why, for example, statistics show that over 57% of our doctors work in clinics; only about 40% work in general practice and the remainder in administration.

Today I think that medical students in Europe are more socially than medically orientated. This is one of the reasons why medical care in Europe might change in the direction of

policlinic treatment. No community will be able to afford the amount of money a health care system oriented towards general practitioners would cost and will not be able to educate the necessary number of students.

There are many possibilities for student exchange among the E.E.C. countries. It is very beneficial for a medical student to live and work with a general practitioner of another country, and I hope that these exchanges will increase so that many more students will become aware of the special problems of medical health care in other European countries.

Bonn, West Germany

H. ALTROGGE, Final year medical student

Any Questions?

We publish below a selection of questions and answers of general interest

Semi-solid Diets for Infants

In the last 10-20 years there has been an increasing trend towards earlier introduction of semi-solid foods into the diets of infants. Apart from pressures from commercial infant food companies, what justification is there for this?

There is no acceptable evidence showing that the normal infant requires any food other than milk during the first three months of life. Several reports have shown that most newborn infants—at any rate after the first few days—can take finely sieved semi-solids and cereal mixtures and come to no harm. It is also widely believed that a small amount of cereal added to the feed of a crying baby will satisfy his presumed hunger and that such babies are more satisfied and progress better than on a purely milk feed. It is possible by adding cereals or sugars to feeds to increase a baby's weight to the point of obesity, with the possibility of persisting obesity in later life¹ or an increased risk of respiratory infection.² Adding solids to the diet may result in the child taking less milk. In one survey some infants taking solids³ had about the same total calorie intake as those taking none. Most infants in the process of being weaned on to protein feeds probably have only a very small increase in their total calorie and protein intake. A possible advantage in the early introduction of mixed feeds is that the infant may receive an appreciable extra amount of vitamin A, thiamine, and iron.⁴

Early introduction of wheat gluten may cause the early appearance of the symptoms of gluten enteropathy, even if it does not increase the risk. More importantly, small babies may be given more dried milk powder in each feed than the makers recommend.⁵ This alone increases the protein and electrolyte load⁶ and by adding cereal and other infant feeds it is increased still further. Davies has shown that as a result the plasma osmolality is increased to a degree where even a small water loss (through diarrhoea, vomiting, or omission of one or two fluid feeds) may precipitate a dangerous situation. Consequently the introduction of solid feeds to the diet of infants below the age of three months seems in general to lack justification, though it is not very likely that it would harm a big healthy baby.

¹ Taitz, L. S., and Byers, H. D., *Archives of Disease in Childhood*, 1972, 47, 257.

² Davies, D. P., *British Medical Journal*, 1973, 2, 340.

Recurrent Vaginal Candida

What is the best way of dealing with recurrent candida albicans infection of the vagina?

Firstly, it should be confirmed, by repeated pathological investigation, that the infection really is candidiasis and not due to some other organism or one in combination with candida. Secondly, the taking of antibiotics as a cause should be excluded. Thirdly, the presence of diabetes mellitus should be excluded. Fourthly, nystatin pessaries should be prescribed, one to be used each morning and evening for two weeks and then one at night for two weeks. Two weeks after this course of treatment its efficacy should be checked by further pathological investigations.

Only rarely does such a regimen fail. If it does it is possibly because the patient is unable to use the pessaries properly. In that case the vagina should be painted on alternate days for two weeks with 0.5% gentian violet. This treatment is messy but well worth while in cases when nystatin has apparently failed. A less messy method of applying gentian violet is to insert Genteral cream high in the vagina.

When the above treatments fail then sources of reinfection should be looked for—for example, the patient's intestinal tract, fingers, or external genitalia, and possibly the husband. The skin can be treated with nystatin cream or powder and the intestine by nystatin tablets. Very rarely admission to hospital and skilled supervision of treatment at all stages is needed for the really intractable case. Other pessaries and paints and powders may be used—especially di-iodo-hydroxyquinoline or Penotran (hydrargaphen) pessaries—but it is probably best to choose one form of therapy and to make every effort to see that it is being properly applied. The following are some examples of the kind of drugs that can also be used for vaginal infections: Candepin (candidin), Magmilor (nifuratel), and Betadine (povidone-iodine). The importance of not having intercourse for two to three weeks should also be emphasized as well as the possibility of further investigation of the husband.

¹ Eid, E. E., *British Medical Journal*, 1970, 2, 74.

² Tracey, V. V., De N. C., and Harper, J. R., *British Medical Journal*, 1971, 1, 16.

³ Beal, V. A., *Pediatrics*, 1957, 20, 448.

⁴ Guthrie, H. A., *Pediatrics*, 1966, 38, 879.