There are now over 31,000 maternity beds, more than half of them in public hospitals, and the rest private. Only about 3% of babies are born at home. Maternity care is supervised by the "Society for the Protection of the Mother and the Infant," an organization which itself comes under the auspices of the Ministry of Health, and supervises prenatal and postnatal maternity care, neonatal and infant care, and family planning. The State provides 83% of its budget. French working mothers are entitled to six weeks off before the confinement and eight weeks after delivery, and can claim several kinds of maternity allowances. Almost all of the French population belong to the social security system, which covers all maternity expenses. This includes four antenatal visits, a 12-day stay in hospital, a postnatal examination, and three compulsory examinations of the baby at 8 days, 9 months, and 2 years.

Some Inadequacies

Until 1968 there were several inadequacies in our maternity care—for example, insufficient equipment in the public hospitals, too many small private institutions, lack of interest by most paediatricians and anaesthetists, a shortage of obstetricians, and lack of financial support for perinatal research. These inadequacies began to be commented on in the medical and lay press and eventually the government appointed a secretariat of state whose primary interest was the prevention of perinatal mortality and morbidity. The sheer economic cost to the community of children and adults with disabilities thought to be due to perinatal causes was enormous (2·5% of the gross national product) and a national survey of the problem was obviously needed.

The report recommended aiming at a perinatal mortality rate of 18 per 1,000 by 1980. The measures taken included increasing the number of teachers in perinatal specialties, using private institutions for clinical teaching, reorganizing specialist training in obstetrics and gynaecology, and instituting postgraduate teaching. Despite the difficulties a large programme of postgraduate training has been started throughout France, and films (on prenatal and neonatal care) are to be distributed free of charge to all doctors and midwives.

A programme of vaccination against rubella of all girls aged 13 years and over and women at risk was started in 1971 with 50,000 vaccinations a year. The following year a law introduced minimal requirements for private institutions so far as the number of beds, surgical and resuscitation equipment, and availability of medical care were concerned. Since then 84 institutions have closed and 476 are expected to close soon.

In 1971 9.4 m. francs were spent on this improvement programme and the budget for the next five years is 258 m. francs, 74 m. coming from the State. At the same time a big effort has been made by the doctors themselves: private institutions have been reorganized on a larger basis; a Society of Perinatal Medicine was established in 1971; and perinatal research teams have been organized.

One of the results of these measures has been that the reduction in the perinatal mortality rate which should have been reached in 1980 has already been achieved, owing partly to the fact that even before the government's action the medical profession had begun to improve the quality of care and there had been technical improvements. Of course, in some fields improvements still have to be made—particularly in the organization of obstetric and paediatric departments and of putting research on a permanent basis.

Université René Descartes, Paris
CLAUDE SUREAU, M.D., Professor of Obstetrics and Gynaecology

The General Practitioner in Europe

Chairman's Introduction

R. de SMET

Today our programme centres on the general practitioner. The patient hopes to find a man in whom he can confide, someone who will help him find his way in the increasingly complicated labyrinth of specialist medicine; administrators expect him to carry out the task of primary physician; and the sociologist hopes the general practitioner will give medical care a more human face and make our society healthier.

Though the general practitioner is confident that he can fulfil this task, everywhere he is trying to define his functions more accurately. Inevitably this ends up by confirming that general practice rests on three pillars: frontline care, integral approach, and continuous medical assistance. By these three essential characteristics, general practice clearly stands apart from specialist medicine, and the necessity for specific vocational training is obvious.

If we wish to steer western Europe's medicine in the right tracks then we should start trying to understand each other. We must focus our attention on our common interests rather than on the differences that may seem to separate us.

Heverlee, Belgium
R. DE SMET, M.D., President of the Scientific Society of Flemish General Practitioners

Great Britain

JOHN FRY

There is no single "best-buy" system of medical care that can be applied to all countries. The National Health Service is certainly not exportable across the English Channel because of the nature of its evolution—from the friendly societies and sick clubs of the last century, Lloyd George's National Health Insurance Act of 1911, and the Emergency Medical Service of World War II. Even in 1948 it was not a radically new system that was introduced into my practice: the only difference was the form of payment, and this was merely an extension of the previous capitation system of the National Health Insurance to cover the whole population.

We must accept as inevitable that even though we have a Common Market there will always be different forms of general practice in the member countries. It is quite wrong to work for, or expect, the development of a common form of medical care system and general practice in the E.E.C. What we should strive to achieve are common approaches to our problems. We should try and learn from one another through regular discussions, and an E.E.C. general practice group should be set up to study common problems. Political clashes with governments over remuneration, conversely, must be left to local professional associations.

More important for improvements in the quality and status of general practice are the education of undergraduates in general practice and the continuing education of established doctors; research into the common clinical conditions seen in practice; studies into the best methods of care in general practice using techniques for early diagnosis, long-term care of chronic conditions, preventive methods, and health education. There are also the respective roles of hospital doctors and general practitioners.

Despite the depression and demoralization in the 1950s and early 1960s (which resulted in the emigration of many British

doctors), in the last ten years there has been a resurgence of general practice, with a mood of confidence in the future.

At present over 80% of general practitioners work in partnerships or groups. Almost 10% now work from purpose-built, public health centres, and as many, if not more, work from their own private group practice premises, with excellent facilities. Most practices have secretaries, about one-third have health visitors seconded to them, and one-quarter have nurses. The concept of the health team has developed, each member knowing their respective responsibilities and thus sharing and improving primary care. Slowly, general practitioners are re-entering hospitals to care for their own patients and to work as members of hospital units.

In the past decade departments of general practice have been established in many of our medical schools and students are coming into contact with general practitioners. But there is still much to be done in the undergraduate teaching of general practice. Vocational training for general practice has become a reality, a three-year period has been accepted as appropriate by the Royal College of General Practitioners and the B.M.A., and it is hoped that, from 1977, it will be compulsory for all principals to have undergone vocational training. The growth of postgraduate medical centres, and special incentives for those attending recognized courses, has meant that over 90% of general practitioners are now annually involved in formal educational exercises.

Even so, there are weaknesses. Probably there is a 25-30% annual deficit of new entrants into general practice from British graduates, and the numbers are maintained only because of the influx of graduates from overseas countries.

The changing pattern of general practice, with more emphasis on efficiency and effectiveness, has led to some friction between the public and the profession. The introduction of appointment systems, the decline in home visiting, the growth of large partnerships and group practices, the employment of deputizing services to cover the practitioners at nights and weekends, the development of health teams (with receptionists creating barriers between the patient and the doctor), and the employment of nurses to deal with some of the routine work have all created some unease and disturbance among our patients. As a result the number of complaints about general practitioners, both formal and informal, has increased. The profession must be aware of these dissatisfactions and take steps to remedy them.

Undoubtedly the E.E.C. offers us a wonderful opportunity to set up collaborative exercises in the field of general practice, which will be examples to the rest of the world.

Beckenham, Kent
JOHN FRY, F.R.C.S., F.R.C.G.P., General Practitioner

Belgium

R. MAES

The faculties of medicine in Ghent, Brussels, Lèige, and the French section of Louvain have a long-established medical curriculum, laid down by law. This entails three preclinical years and four clinical years. But since 1965 the Flemish section of the Louvain faculty of medicine has introduced changes in the curriculum, which has enabled students in their fourth clinical year to study general practice, a specialty, research, or social medicine.

For some time it was felt that there should be more training for general practice and in 1968 the Academic Centre for Family Medicine was founded, with one full-time professor and a part-time lecturer. To free the last year of clinical studies for vocational training the 12-month internship in an academic or equivalent hospital was brought forward to the sixth year of studies. Students taking the course in general practice receive a month's intensive preparatory training on subjects related to general practice, including a two-month residential period spent with a general practitioner who has been approved by the faculty. After this the trainee is required to submit a report. This programme has resulted in an increase in the number of general practitioners, but the one disadvantage is that after graduation a doctor needs no further training to enter general practice.

At Antwerp a group of 12 general practitioners has started teaching students in their first clinical year, giving 10 seminars on general practice. Together with the students, other general practitioners, sociologists, specialists and, professors have all been discussing specific problems of general practice; the subject of the last of the seminars is chosen and organized by the students themselves. In the second clinical year 30 case clinics are held in general practice problems and their psychosomatic aspects. From this year onwards students may if they wish be attached to a family.

Subsequent Training

There is no formal postgraduate training for general practice in Belgium; some think there should be a kind of "specialist general practitioner"; others see no benefit in further years of training. There is a great variety of continuing education which is uncoordinated—organized by the universities, scientific societies, or the pharmaceutical industry—but not many general practitioners attend these courses.

The average Belgian practitioner works on his own and is responsible for his own maternity cases in hospital. Recently general practitioners have tended to co-operate in emergencies, provide weekend services, and cover holidays, but there are still very few partnerships or group practices.

The patient does not have to be registered with a particular family doctor and so may choose a physician at random; when he requires specialist treatment he can choose a specialist without reference to his general practitioner. The specialist does not have to tell the general practitioner that he is treating the patient and in large towns, particularly, patients have, for instance, their own gynaecologist or cardiologist. Naturally, this system does not help relations between specialists and general practitioners. Nevertheless, team-work is growing slowly, as people become aware of its benefits.

Clearly in Belgium the patient is rather spoilt, as he profits from the competition between physicians; on the other hand, he frequently loses his way while looking for help. Another drawback is the difficulty any doctor has of keeping a complete medical record of his patients and that of obtaining accurate statistics.

Are our patients going to benefit from the enlarged European Economic Community? Certainly, if we all copy those arrangements across our borders which seem to give patients better care, then things should improve.

Berchem, Belgium
REMY MAES, M.D., General Practitioner

Netherlands

H. J. DOKTOR

Medical training in the Netherlands is entirely in the hands of the universities, and every medical faculty has an academic hospital attached to it. The academic hospitals and the universities are the responsibility of the Minister of Education and Science, while public health comes under the Minister of Public Health and Environmental Hygiene; hence difficulties of communication may occur.