Institutes for general practice have been set up in all Netherlands universities. Their work is divided into teaching (both theoretical and applied), research, and care of patients. I shall confine myself to the teaching programme.

Students have a course in general practice training before their final examination at the end of the sixth year, though in some universities students are under the guidance of general practitioners in their first three years. In some cases students take care of one or more families and make reports. At Rotterdam in the fourth year 15 hours of lectures are given on general practice, and include, for instance, the place of the family doctor in health care; group practice and relations with social workers, district nurses, psychologists, and pharmacists; infectious diseases; and contraception. In addition, the Institute of General Practice in Rotterdam provides a programme of practical work for groups of about 30 students for five half days, covering general practice topics.

We think that it is particularly important to always bear in mind the kind of work the doctor will be doing as a general practitioner. We particularly want to turn out a doctor who can co-operate with workers in other disciplines. Practice work groups have been started with the university departments of social and preventive psychiatry and social health care. This practical work is done in the fourth year. In the sixth year students spend four weeks with a family doctor, becoming familiar with general practice. Since it takes place just before their qualifying medical examination, most of the students think highly of this course; in fact, some of them who had originally decided to specialize have opted to become general practitioners after this course.

We are also discussing changes in medical teaching which will give the student three choices—namely, general practice, social and mental health care, and clinical medicine; the basic curriculum is common to all.

Vocational Training for General Practice

Vocational training for general practitioners lasts for one year. The prospective general practitioner spends at least six months with a general practice tutor, followed by a period in hospital. He attends the institute of general practice for one day a week, when he can discuss the problems he has encountered in his tutor's practice. A short course in group relations is included in the training programme and the institutes for general practice have psychologists on their staff to run this course.

In Rotterdam the tutor general practitioners have formed a teachers' workshop, to discuss the problems that arise in training general practitioners and to give the tutor-practitioners the opportunity of becoming more proficient. The workshop meets once a fortnight under the guidance of a member of the staff of the institute for general practice.

After completing his vocational training, a prospective general practitioner may be registered as a general practitioner. He can then enter into a contract with one of the insurance schemes, which cover about 70% of the population. The registration commission, which includes representatives of the general practice institutes and of the medical professional organizations, supervises general-practitioner registration, and it also approves the general practitioner tutors. A general practitioners' council, which fixes the training standards, includes representatives of tutors, professional organizations, and the government.

Apart from caring for his maternity cases in the Netherlands the general practitioner takes no part in the work of the hospital, though he may, of course, visit his patients and consult with the specialists. Several general practitioners have full- or part-time jobs in nursing homes.

Though vocational training for general practitioners is virtually obligatory, ensuring that most students have a good knowledge of general practice before taking the qualifying examination, the training period is very short and it would be ideal if it could be extended to at least two years.

Germany

S. HAUSSLER

The Federal Republic of Germany has 125,300 doctors; nearly 52,000 are salaried doctors working in hospitals and 51,000 are specialists or practitioners working in their own practices—though in the last few years the number of general practitioners has been declining.

Undergraduate training is the same at every university and specialization occurs after university training has been completed. Specialist courses in general medicine are conducted at several universities and lectures given by general practitioners. There are no chairs in general medicine, departments of general medicine, or institutions for general medicine, so it is not surprising that only 10% of students wish to become general practitioners. Since 1971 students have been allowed to do their practical work in institutions belonging to the social health insurance. It covers the public health service, supervised by occupational health doctors or general practitioners, and not just in hospitals.

After completing his undergraduate training, the doctor has to decide whether to specialize as a general practitioner.

Rules for the vocational training for general practitioners are laid down in the "Regulations for Vocational Training." If a doctor wishes to obtain the legally protected professional designation of general practitioner he has to complete a four-year period of vocational training after his university course. This consists of: one year internal medicine; one year surgery and/or gynaecology (both sections must be done in hospitals); at least three months as an assistant to a general practitioner; and the rest of the time in hospital or general practice according to his choice. Efforts are being made to improve this period of vocational training by establishing special seminars and extending the time spent with the general practitioner. Nevertheless, there is a lack of suitable training practices and funds for vocational training.

After this four years and another 18 months' probation a doctor can set up as a general practitioner. He receives a licence and becomes a member of the "Kassenärztliche Vereinigung." This has disciplinary functions, supervises professional activity, and enters into collective agreements with the various health insurance schemes about the remuneration of doctors. There is no direct relation between these health insurances and the doctor; he deals only with his Kassenärztliche Vereinigung.

Fees for Service

German doctors are paid according to the amount of work they do, for instance: medical advice with simple examination D.M. 3.50; house visit D.M. 9; intramuscular injection D.M. 2.; intravenous injection D.M. 4.; thorough medical examination D.M. 5. The payments cease if the doctor is ill or on holiday, but he can insure himself for these occasions. Most general practitioners own their own x-ray equipment, and have an E.C.G. machine, but they also have direct access to hospital x-ray departments.

Fees may change from one doctor to another at any time. Apart from chief consultants at hospitals they can see specialists directly without a reference from the general practitioner.

Over 5,500 foreign doctors are working in the Federal Republic at present. Until recently they could work only in the hospitals, but this has now changed and there are several foreign general practitioners—mostly doctors who have studied in Germany and did their vocational training there. Not only do they speak our language fluently, but they know our rules and regulations and the German way of life. As there are three million foreign workers in Germany these doctors are invaluable, for the medical care of these immigrants alone needs 4,000 doctors. One might have thought that the appropriate number of doctors would have come from these countries to look after their own nationals, but this has not been the case, and these foreign workers cause a heavy additional burden through language difficulties alone.
A recent development in the field of general medicine has been the establishment by several universities of seminars in general medicine. It is hoped that chairs in general medicine will soon follow. We have also started special vocational training seminars in general practice. Apart from general practice topics other subjects to be included are environmental problems, preventive medicine, and health education.

From 1 January 1974 general practitioners and specialists will face quality controls of their laboratory tests, X-ray examinations, and, later on, their cytological examinations; if they fail the tests they will lose the right to carry out these examinations in their own practices.

General practitioners in the Federal Republic expect several improvements from membership of the E.E.C. The international contacts should lead to agreements regarding the training of teachers, educational criteria, and standards—in fact an improvement in the quality of medical services as a whole.

*Women in Medicine*

**Great Britain**

ROSEMARY RUE

At present about one-fifth of doctors in Britain are women: they account in hospitals for 7·6% of consultants and in general practice for 11·6% of principals. Careers for women in medicine are, however, often achieved with difficulty, and women doctors frequently undertake jobs which lack the important element of job satisfaction. Lack of training has led many to accept work in assistant grades or in narrow aspects of specialties from which no advancement was possible. Some women doctors are not working at present because they cannot find employment opportunities which combine an appropriate training.

Women compete for medical school places and their applications are of high quality. Nearly a quarter of all British medical students were women in 1968, when the Royal Commission on Medical Education recommended that the main criteria for admission to a university medical school should be the applicant’s ability to profit from the course and to become a good doctor irrespective of sex. This advice has gained broad acceptance. Now one-third of medical students are women (a total of 1,052 women in the October 1972 intake for the United Kingdom) and the argument is developing that a mixture of half men and half women is not only attainable but desirable on educational grounds. The government has announced its intention to study with the universities the avoidance of discrimination on the grounds of sex in their admission policies. At present, however, the actual mix is a policy matter for individual medical schools.

Difficulties arise for women doctors as a result of the trends and structure in a modern society which must be familiar throughout the developed world. Though it is important to take into account the individual needs of women who may become mothers at an earlier stage, the essential features of schemes aimed at avoiding wastage of women doctors is the provision of planned postgraduate training to allow them time to fulfill their role as mothers in parallel over these early years. In 1970 the first 100 women doctors in each of two schemes in N.H.S. regions were compared and closely similar results were demonstrated.

Women doctors follow the same career patterns as men until they have commitments to children—or elderly relatives. Thereafter, provided she can have intermittent short breaks for maternity leave, the typical women doctor will make progress with higher qualifications and build up her experience in medicine if she can pursue a programme which allows her to share her time between motherhood and medicine over an extended period. Most women can give about half as much time as a man during this period of their lives and they achieve a sufficient level of training and experience for a career post in a specialty six to eight years later than the men with whom they studied medicine as undergraduates.

Once trained to a career level, the average woman doctor can offer three-quarters of the time offered by a man for clinical service, some time still being needed by her for her home, teenage children, and elderly dependents.

It is most important that women medical students and young women doctors should have suitable career counselling to help them understand and plan their career patterns. To help the young mother keep in touch with her profession during the critical period when she may become dispirited and is potentially at risk of “wasting” her education a retainer scheme was started by the D.H.S.S. in 1972. This scheme offers a small payment for doctors temporarily unable to practise medicine if they will remain registered and insured and undertake a minimum amount of postgraduate education and supervised practice in the course of the year. The scheme is popular and appears to fill a need—it is a little too early to evaluate its effect but it should lead women on quite easily to the fuller programmed training already described.

*If there are problems associated with women in medicine, are there any compensatory advantages? A rapidly increasing proportion of the medical profession is required competently and willingly to undertake the care of patients with chronic disease, especially those of old age, and to help the expansion of psychiatry and preventive medicine. It is therefore very interesting to note that in the regional training schemes for women doctors the specialties which among an unrestricted choice are popular to the point of being oversubscribed are psychiatry, geriatrics, care of the young disabled, and rehabilitation. This is in marked contrast to the popularity of the surgical specialties with men. The signs are that an increased entry of women to medicine and their full training and employment would result in the eventual career choice which the N.H.S. needs. It seems fortunate that men and women tend to have different, complementary gifts to bring to medicine.*

*At this session the chair was taken by the Baroness Elles, Chairman, British Section, European Union of Women*