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 other's 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 supra-national 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 exercise of the profession of medical practitioner and the attainment of an 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 of 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