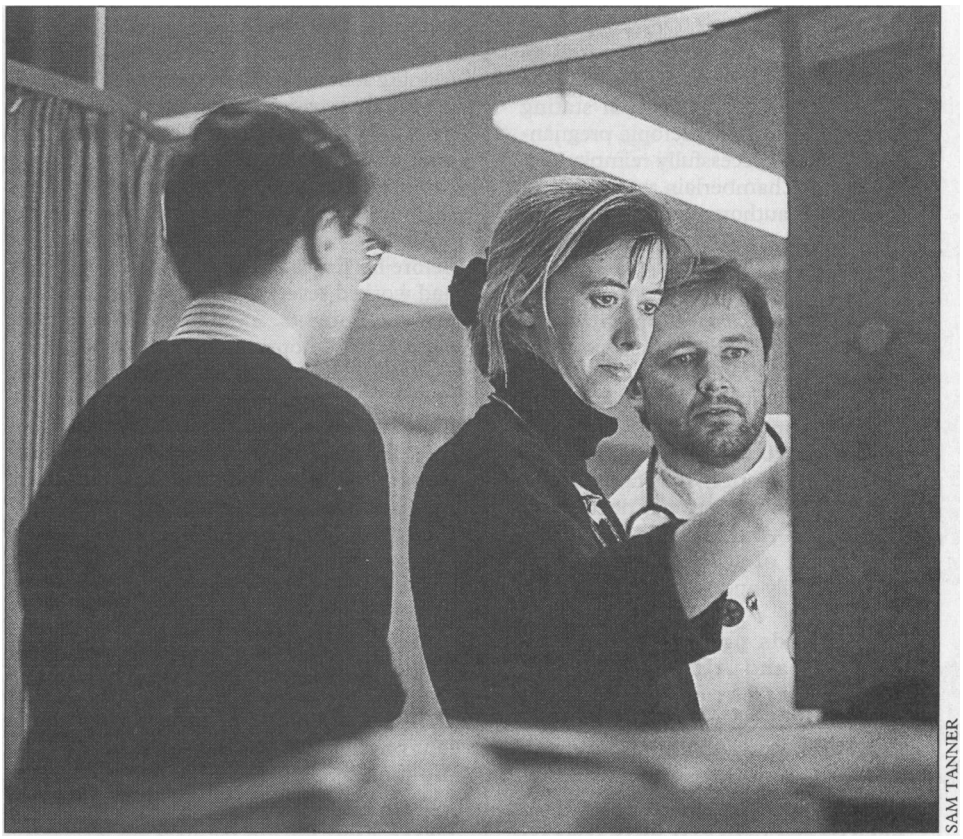
Doctors are more miserable than ever, says report


SAM TANNER

"The near universal support for women doctors to keep working was rather unexpected", said the report

Doctors in Britain are becoming increasingly isolated and dissatisfied with their careers, says a report this week funded by the Department of Health. "The disillusionment and disenchantment with medicine disclosed in this report among young doctors of both sexes gives serious cause for concern," it says (see also editorial on p 1524). Two thirds of women doctors and over half the men said that they had regretted studying medicine.

The independent Policy Studies Institute interviewed over 200 doctors five years after they qualified in 1986 about their career experiences. The sample was stratified by sex and medical school, and the response rate was over 80%. The research follows on from a previous study published in 1988, which looked at the careers of 640 doctors who qualified in 1966, 1976, and 1981.

One of this study's main findings is that the career progress of women in the 1986 cohort had already fallen behind that of the men. They were doing less well than women who had qualified five years earlier and were less likely to enter hospital medicine. This was despite the fact that 1 in 4 women had achieved three or more A grades in their A levels, compared with 1 in 9 men.

"Certain things in this report were more depressing than the previous one," said Isobel Allen, author of both reports. "More doctors had lost their way and were now seeing themselves as failures. Women especially were saying, 'I'm not good enough to do hospital medicine.' Why weren't they? There is a very pervasive competitive atmosphere in medicine, which is made worse by the process of teaching by humiliation and the pressure to get good jobs. Half of the workforce are now women, and we have to allow for flexibility otherwise we will only allow half the workforce to pursue a career path that seems set in stone."

Men also expressed discontent with medicine. Although 60% of women had thought of leaving medicine, so had 40% of men. But only 2% of the cohort had already left medicine and less than 1 in 10 thought that it was even fairly likely that they would seek other careers. "A substantial minority of others...were unclear of what else they might do," says the report. Careers counselling was criticised as inadequate: one third of doctors had not received advice.

One of the most important constraints on the careers of women was the need for constant geographical mobility. "There should be recognition that dual career families are now the norm rather than the exception... there must be increasing acceptance that the nomadic style of life traditionally expected of junior doctors is not suited to the demands of young people today," says the report.

But the biggest constraint on the careers of doctors of both sexes was on call responsibilities. Although the report notes that the interviews were carried out before the reduction in junior doctors' hours, it warns that most doctors peppered their comments on the questions of hours with such remarks as "it wrecks the best years of your life." The report says, "There were many examples of interview with doctors who were quite literally at the end of their tether."

Almost all of the doctors interviewed thought that part time training should be more readily available. Nearly all of the women and over 80% of the men thought that more should be done to help women to reach senior positions after they returned to medicine after a break. "The near universal support for more help for women doctors to keep working was rather unexpected," says the report.

Many of the doctors resented being used as "work horses" and "dogsbodies" and wanted structured training programmes with geographical stability. "This generation of doctors is less inclined to accept things than their predecessors," said Ms Allen. "They want to be treated as professionals, but they feel that they are like ants at the bottom of the heap." The report argues that senior managers in the NHS and the profession itself have failed to recognise the cultural change among younger doctors.

The report makes over 30 recommendations. One is that the number of hours worked by junior doctors should not exceed the 48 hours a week set out in the European Union directive on the organisation of working time. It calls for men and women to be allowed to apply for less than full time posts without restriction and for the royal colleges to accord such posts equal status with full time posts. Such posts should no longer be supernumerary.

The report recommends that strong consideration should be given to the setting up of a national careers counselling service. It suggests that school students should be given realistic advice about a career in medicine. While it recommends that counselling services are needed to prevent stress and regrets among doctors, it concludes that only changes in the career structure and the culture of the medical hierarchy will provide solutions.—LUISA DILLNER, *BMJ*

Doctors and their Careers: A New Generation is available from bookshops, price £19.95.

Headlines

President of royal college resigns: Professor Geoffrey Chamberlain has resigned as president of the Royal College of Obstetricians and Gynaecologists and editor of the *British Journal of Obstetrics and Gynaecology*. He resigned after an inquiry found no evidence to support a case report in the journal stating that a fetus from an ectopic pregnancy had been successfully reimplanted. Professor Chamberlain was listed as one of the authors of the paper with Mr Malcolm Pearce, who has been suspended (3 December, p 1459).

Minister reaffirms opposition to euthanasia: The British minister for health, Mr Gerald Malone, has told an annual conference for hospices that the consequences of legalising euthanasia would be serious. He said, "It would endanger that critical relationship of trust between doctor and the patient. And it would encourage the neglect of symptom control for the terminally and seriously ill."

More funds promised for HIV infection and AIDS: The British government has announced that £230m will be allocated to HIV infection and AIDS services in 1995-6; £49m will be spent on prevention. The government will commit a further £2m over three years for international research into HIV infection and AIDS.

Antiabortionists gain seats in US Congress: Opponents of abortion gained at least 39 seats in the United States House of Representatives and five in the Senate in the November elections. This gives them a majority or near majority in Congress on abortion issues.

French committee proposes drug reappraisal: The French national consultative ethics committee has asked the minister of social affairs and health, Mme Simone Veil, to look at reclassifying drugs. It argues that while opiates and alcohol cause strong physical dependency cannabis and cocaine do not and that current laws do not take this into account.

Masons decide to sell their hospital: British masons have voted to sell the Royal Masonic Hospital, which has lost £9m in five years. It is expected to fetch up to £20m. Some masons who believe that the hospital could make a profit if run properly will appeal to the High Court to stop the sale.

Junior doctor died of natural causes, says coroner

A young doctor in Britain died of the sudden adult death syndrome after working an 86 hour week, an inquest heard at Warrington last week. Dr Alan Massie, aged 27, of Macclesfield, Cheshire, was on a general practice training scheme at Warrington General Hospital, during which he had complained to his parents about long hours of work and had appeared pale and tired.

He had worked a 56 hour week immediately followed by one of 86 hours in the obstetrics and gynaecology department before his death on 31 January this year. He had worked seven of the eight previous days and three nights, including two unbroken periods of 27 hours and one of 24 hours.

But Professor Michael Davies, principal of the cardiovascular pathology research group at St George's Medical School, London, said that there was no scientific way to show that stress or long hours of work could have caused the doctor's death. He said that there were 50-100 sudden deaths in Britain every year that could be categorised as due to the sudden adult death syndrome and for which there was no specific explanation.

Tests on Dr Massie failed to show any specific cause of death, but the inquest heard that the most likely possibility was a cardiac arrhythmia. Dr Stephen Bentley, a consultant physician at Warrington Hospital, told the inquest that every possible effort had been made to revive Dr Massie after he collapsed while having tea with his girlfriend, Sharon Allison, at his hospital flat. Resuscitation attempts went on for an hour. Asked if long hours of work could be ruled out as a contributory cause of death, he replied: "I never rule anything out, but my own opinion is that is very unlikely." He said that Dr Massie did not work harder, or less hard, than any of his colleagues at the hospital.

The inquest was told that the national target for junior doctors' hours was 72 hours a week by the end of this year. But Warrington Hospital had achieved this figure last year. The rotas worked by Dr Massie were in accordance with Department of Health guidelines.

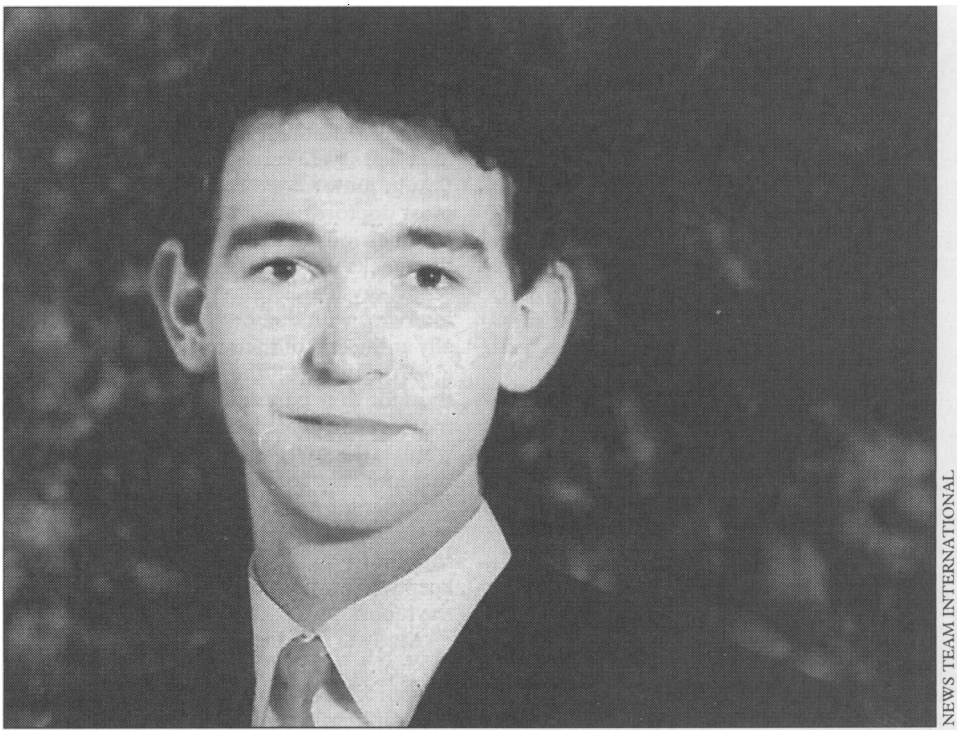
George Massie told the inquest that his son had always looked tired and pale when coming home from work. "I feel the high level of stress had a bearing on my son's death. There is a fault in the system. Everyone has a human right to be able to have eight hours' sleep a day."

Coroner Mr John Hibbert said that research was going on into the effect of stress and long hours, but at this stage there was no evidence to suggest that it could cause death. He could only record a verdict of natural causes. But he would be writing to the Department of Health to report the details of the case and suggest that the whole issue should be looked at immediately.

Gerald Malone, minister for health, issued a statement pointing out that the coroner made no link between Dr Massie's death and his hours of work.

"The grim days when some junior doctors were contracted for over 100 hours a week are a thing of the past," he said. "Our commitment to reducing junior doctors' hours is not negotiable."

But Dr Andrew Carney, chairman of the BMA's Junior Doctors Committee, said, "There are several thousand junior doctors working excessive hours under similar conditions to Dr Massie... We know already that many hospitals will not reach the 72 hour target set for the end of this year."—DAVID SKENTELBERY, Orbit News Service



NEWS TEAM INTERNATIONAL

Dr Alan Massie died suddenly after working an 86 hour week

Italian doctors plan protest action

Doctors working in Italy's public hospitals plan fresh industrial action to protest at cuts in the health service outlined in next year's budget. The action will include a ban on overtime and a four hour strike later this month.

The action is in response to the first budget to be drawn up by Prime Minister Silvio Berlusconi's right wing coalition, which will set out to cut £2.5bn from the funds available to the health service. Hospital doctors feel that they in particular are being penalised. On 16 December members of Anaao Assomed, the main association for hospital doctors, plan a four hour strike and a demonstration in Rome, though essential services will be maintained. From 15 December there will be a ban on overtime and standby duties.

In Italy doctors who work at least 38 hours a week in a state run hospital can receive a special "full time allowance." One of the budget proposals is to reduce this payment from the start of 1996 for those who undertake additional private work—originally a cut of 25%, now reduced to 15%. "If they want to cut the allowance they should cut the hours," said Dr Donato Antonellis of Anaao Assomed. The budget also blocks a planned upgrading for the most junior category of hospital doctors and orders a ban on new recruitment until next June.

Other cuts will be at the expense of the public. In the Italian system patients contribute to health care costs through purchasing special low cost "tickets" for tests, specialist consultations, and certain drugs. Some patients are exempt, including young children, elderly people, those suffering from cancer, and unemployed people.

The new proposals raise the age for exemption for elderly people from 60 to 65 and make patients from families with an income of over 70 million lire (£28 000) ineligible.

The initial proposals also suggested introducing a "ticket" for non-urgent treatment in a casualty unit (an idea shelved for the time being) and the closure of hospitals with under 120 beds (decisions are now being left to regional authorities). The budget has passed through the Chamber of Deputies, the lower house of the Italian parliament, and is now awaiting review by the Senate.

Morale among hospital doctors is low in Italy. Their contracts expired in 1990 and have not been renewed; there has been no negotiated pay rise for eight years. "There is a big problem at the personal level," said a doctor in Rome. "The system offers little incentive to work harder and better."

There is also serious unemployment. Italy has more doctors than any other country in Europe—350 000 at the last count, of whom 20 000 are unemployed and 30 000 underemployed. The newly qualified can find themselves jobless or underused for years.

Over the next three years Mr Berlusconi's free marketeers plan sweeping changes. Hospitals are to be funded on the basis of conditions treated. There are plans to make them more businesslike. A new breed of manager is being trained to take over, replacing decision makers who traditionally came from political backgrounds.

But a parliamentary commission has also been set up to report on all aspects of health care in Italy. The chairman is Senator Valentino Martelli, a heart surgeon and member of the hard right National Alliance. —LUCINDA EVANS, freelance journalist, Rome

ASSOCIATED PRESS

Italians protest against health service cuts

Court upholds force feeding for mental illness

The British Court of Appeal last week upheld the decision of a High Court judge to allow a psychiatric patient detained under the Mental Health Act to be fed through a nasogastric tube against her will. The ruling, which may go on appeal to the House of Lords, confirms that force feeding can count as medical treatment for a mental disorder. Such treatment may be imposed on patients compulsorily detained under the act.

Lords Justices Hoffmann, Neill, and Henry dismissed an appeal by a 24 year old detained patient, named only as Ms B, over Mr Justice Thorpe's decision last July that doctors at Warlingham Park Hospital near Croydon, Surrey, could lawfully force feed her by nasogastric tube.

Ms B was sexually abused from the ages of 6 to 20 by her grandfather and later by a lodger in her house. At the age of 20 she began compulsively harming herself. She was admitted to hospital, where she was constantly watched to stop her from cutting or burning herself and instead virtually stopped eating. She was diagnosed as suffering from a borderline personality disorder coupled with post-traumatic stress disorder.

When her weight dropped to 32 kg (5 stone) doctors proposed to force feed her by nasogastric tube, but her lawyers won an injunction preventing the move pending a full hearing. Mr Justice Thorpe held that force feeding was treatment for mental disorder and that the act allowed her to be fed against her will even though she had the mental capacity to make up her own mind. The judge said it was "disquieting" that the act allowed what the common law would not—the treatment of a competent patient against her will.

The Appeal Court judges held that treatment for a mental disorder included treatment for the consequences and symptoms of such a disorder. The ruling made it unnecessary for them to consider whether Ms B was capable of taking her own decisions. But they had doubts about Mr Justice Thorpe's conclusion that she was competent at the time.

Her solicitor, Lucy Scott-Moncrieff, said that her client was disappointed at the ruling and wanted to appeal. "She's in a different hospital where they have no immediate plans to force feed her. She's not at all well, but she feels much safer than before. She is still completely obsessed with the idea of eating or not eating and still weighs only 5 stone, the weight at which it was thought necessary to force feed her to save her life."—CLARE DYER, legal correspondent, *BMJ*

New inquiry launched into cot death

An expert group of scientists and clinicians has been set up by the government's chief medical officer, Dr Kenneth Calman, to investigate a theory linking cot deaths to chemical poisoning. The inquiry follows a programme on the subject that, when shown on British television, prompted 60 000 calls to a special helpline and the widespread withdrawal of cot mattresses from sale.

Dr Calman has criticised the programme, ITV's *The Cook Report,* as irresponsible and its findings as "limited, inadequate, and flawed." It sought to establish a link between cot deaths and toxic fumes from antimony, which is used as a fire retardant in mattresses. In 1991 an official investigation rejected the mattress theory. Research for the television programme claimed to show high concentrations of antimony in babies who died suddenly and unexpectedly.

Dr Calman, while criticising the methodology, said that he took seriously the claims linking chemicals with cot deaths. Lady Limerick, chair of the British Red Cross Society and vice chair of the Foundation for the Study of Infant Deaths, will head the 11 strong expert group. Its terms of reference are to review the findings of the 1991 Turner report on sudden infant death syndrome and any subsequent data on hypoth-eses linking antimony with unexplained deaths in infants. The group is to advise on what further studies should be undertaken to investigate postulated causal relations between chemicals and cot deaths.

A follow up television programme reported that samples of hair from well babies sleeping on cot mattresses contained average levels of antimony 20 times greater than in hair taken from their mothers. A total of 49 babies in Oxford and Derby were tested. In view of the public concern over the issue, Dr Calman has asked for a report as soon as possible.—JOHN WARDEN, parliamentary correspondent, *BMJ*

Canberra legalises cannabis for patients in trials

The use of cannabis for medical purposes has been legalised for the first time in Australia in the federal capital, Canberra, under controversial circumstances. Under a law passed by the Australian Capital Territory's assembly, patients suffering physical and psychological illnesses can smoke marijuana with the written authorisation of a doctor. Possession of up to 25 g and cultivation of up to five plants will no longer attract a penalty. Police have warned that Canberra will turn into a haven of drug abuse.

Under the new law, doctors can issue certificates of therapeutic use of cannabis only as part of research programmes. The law was passed despite opposition from the minority Labor government.

The law's chief sponsor, independent member Michael Moore, said that medical science backed the therapeutic use of the drug to relieve suffering in people with cancer, AIDS, and glaucoma. "I suspect the police will be comfortable with the law over time. After all, this is not a police issue, it's a health issue," he said. "This is good news for those suffering nausea from chemotherapy, muscle spasm from muscular disorders, and those suffering from the symptoms of AIDS."

But the assembly has come under national pressure to amend the laws from the federal health minister, Carmen Lawrence, the Australian Medical Association, and the Australian federal police. Federal Attorney General Michael Lavarch said that the assembly had "acted prematurely" and "in disregard of a cohesive national approach." He called on the members who passed the law to "move quickly to repeal the amendments and repair the damage done to the territory's reputation for responsible law making."

Terry Connolly, the health minister for the Australian Capital Territory, criticised the law as being a radical drug experiment. "With no consultation with either the medical profession or the police, the Liberals and Independents have now made it legal for a doctor to prescribe cannabis for treatment of anything from cancer to the common cold, provided the doctor keeps research notes," he said.

The leader of the Australian Capital Territory's opposition, Ms Kate Carnell, has indicated that in the wake of the row the Liberal party will move to amend part of the new legislation.

She said that cannabis should be prescribed only to those taking part in clinical trials with the approval of the minister of health. "Liberals are of the view that medical research into the benefits or otherwise of any drug, be it cannabis or some other substance, should be permitted to go ahead under strict controls," said Ms Carnell. —CHRISTOPHER ZINN, Australian correspondent, *Guardian*

KELLY/SIPA/REX

Cannabis is becoming more respectable

British patients demand to use cannabis

A delegation of patients, doctors, and members of parliament in Britain has urged the Department of Health and the Home Office to make it legal for British doctors to be able to prescribe cannabis. They argue that cannabis should be awarded ordinary schedule 2 status, which would allow patients to obtain it from general practitioners instead of facing arrest when buying it from drug dealers. The delegation told the Department of Health and the Home Office that cannabis can relieve symptoms for patients with multiple sclerosis, AIDS, some cancers, and glaucoma.

"We know it is safe and therapeutically valuable," said Clare Hodges, secretary of Alliance for Cannabis Therapeutics, a patients' pressure group. "We want it to be available on prescription immediately so patients don't have to wait for the results of clinical trials that could take years. Of course we need clinical trials, but they should be done in parallel with treatment. It is illogical to ban the use of cannabis when doctors are able to prescribe heroin and often do."

Patrick Wall, professor of physiology at St Thomas's Hospital, London, said that it was undignified for people to have to buy the drug illegally. "Cannabis was available on prescription until the early 1970s, when it was dropped from the *British Pharmacopoeia* for the correct reason that it was not an effective sedative," he said.

"People today want to use it against other

symptoms, not as a sedative. No one ran into trouble with it as a prescribed drug then, and there's no evidence to suggest they would now. The scientific situation has changed in the last 10 years. We now know there is a whole family of natural and synthetic substances related to cannabis. One of them, amantamine, is produced naturally by the body."

Nabilone, a synthetic drug closely related to cannabis, is available in Britain, but doctors are restricted to prescribing it for sickness after chemotherapy. A similar drug, dronabinol (Δ^9-tetrahydrocannabinol), is licensed in the US but again only for sickness after chemotherapy.

The Home Office and Department of Health have said that they will consider approving the drug for medical use. —ALISON TONKS, *BMJ*

Judge bans hepatitis C test kits

The sale of kits that are widely used throughout the NHS for testing blood for the presence of hepatitis C virus was banned by a High Court judge in Britain last week. He held that a Californian biotechnology company effectively owns the patent on hepatitis C virus, which it discovered in 1987.

The permanent ban on kits made by Murex Diagnostic Laboratories and Organon Teknika follows a ruling last May by Mr Justice Aldous that the kits infringed a patent on the virus owned by Chiron Corporation. Murex, a British company, and Organon, a Dutch group, had unsuccessfully argued that the patent was invalid.

The ruling means that only kits made by Chiron and its licensees, Ortho Diagnostic Systems and Abbott Laboratories, may be sold in Britain. Each test costs the NHS £2 compared with about 50p for each HIV test. Until the ban Murex had supplied more than one third of the hepatitis C test kits used by the NHS.

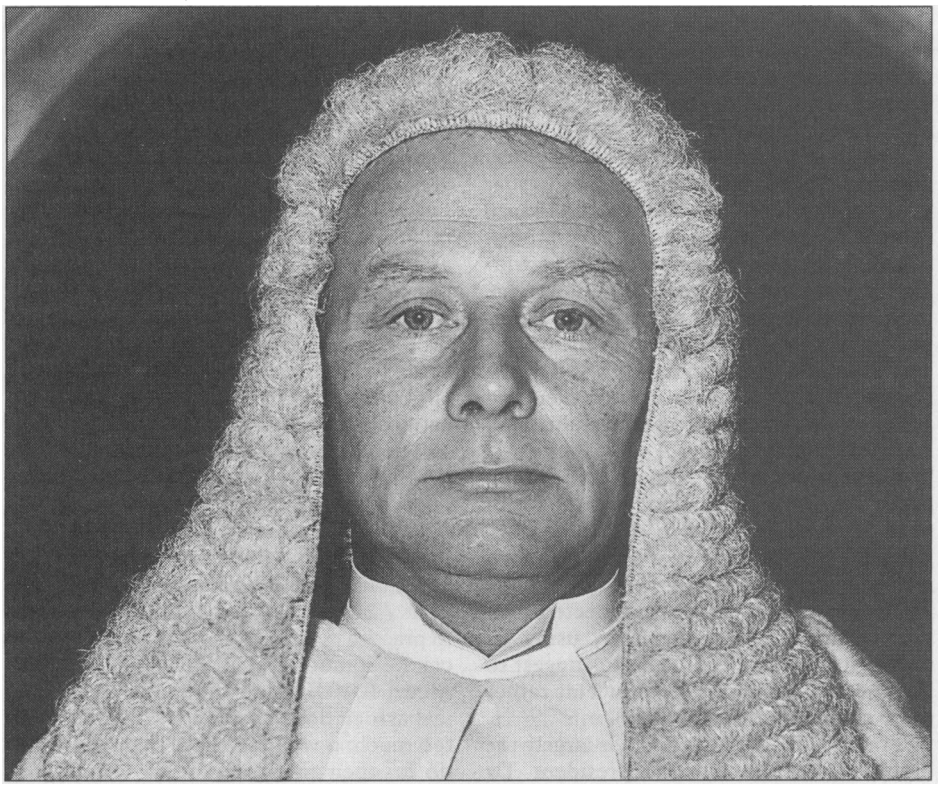
The patent gives Chiron a wide monopoly over developments dealing with hepatitis C, including vaccines, although at the time it was granted no one had worked out how to make a vaccine. "It's as if they had said we claim anything that covers malaria when they've only found quinine," said Peter Prescott QC, counsel to Murex.

Mr Justice Aldous acknowledged that a patent creating a monopoly inhibited competition and enabled the patentee to put up or at least maintain prices. That was contrary to the public interest, but it was the price accepted to achieve the advantages of the system: encouraging research, discouraging secrecy, and offering a reward to an inventor and an inducement to investors.

Jeffrey Almond, professor of microbiology at Reading University and an expert witness for Murex at the trial, said that the patent prevented other companies from developing more advanced diagnostic tests. "It's good to have alternative types of tests. You can see where there are holes in your diagnosis. Murex's kit is a bit more sophisticated. It can not only detect antibodies but also the genotype, which could have prognostic implications."

Murex and Organon are appealing to the Appeal Court. Their hopes have been boosted by a decision in the Appeal Court in October breaking the patent held by the American company Biogen on genetic engineering of material extracted from hepatitis B virus. Biogen took infringement proceedings against Medeva plc, which was developing an enhanced vaccine against hepatitis B. In the High Court Mr Justice Aldous had ruled in Biogen's favour, but the Appeal Court held that the patent's claims were too wide. To be valid a patent must describe the invention so that a person skilled in the art can reproduce it.

The Appeal Court held that this was not satisfied by showing how to make only one "embodiment" of the product.—CLARE DYER, legal correspondent, *BMJ*



UPPA

Mr Justice Aldous

Paediatrician found guilty of misconduct

A hospital paediatrician in Britain who gave excessive doses of drugs, including sedatives, to at least 12 babies has been found guilty of serious professional misconduct. A hearing of the General Medical Council's professional conduct committee directed Dr Joyce Inyang not to practise for a year except in an NHS hospital under close supervision. The committee also ordered Dr Inyang to undergo a structured programme of retraining in pharmacology and therapeutics "to address the major deficiencies in [his] clinical knowledge and skills revealed during these proceedings."

Dr Inyang had been charged with prescribing and giving excessive doses of drugs, including diazepam, chlorpromazine, and metoclopramide, to various babies. The charge related to his work as a staff grade paediatrician at Stepping Hill Hospital in Stockport between August 1992 and April 1993.

The committee heard that one 23 month old baby had been given almost seven times the maximum dose of diazepam within a short time. A second baby had been given nearly six times the maximum dose of diazepam, and other babies had been given "excessive" doses of chlorpromazine and metaclopramide. The drugs had been given when jejunal biopsies were performed on the babies.

Three of the patients to whom Dr Inyang gave the excessive drug doses were said to have received these doses on two separate occasions. The hearing was told that none of the babies in question seemed to have suffered any permanent damage as a result of their treatment.

The committee told Dr Inyang that it took "a very serious view of the evidence which [it had] heard of [his] practice when administering potentially harmful drugs to young patients." Dr Inyang was ordered to inform any prospective employer of the conditions imposed on his registration. These also included sending the General Medical Council, at intervals during the year, a report from those supervising his work. A resumed hearing towards the end of the period of conditional registration will consider his case.—CLAUDIA COURT, *BMJ*

French doctors criticise new bioethics law

The French medical association the Conseil de l'Ordre des Médecins has issued a statement criticising bioethics legislation adopted last July for not recognising the legal status of the embryo. The association claims that under the new law an embryo could be regarded as an object that could be disposed of and subjected to manipulations.

Dr Olivier Dubois, secretary general of the association, said that the decision to issue a statement reflected a concern that the legislation had not given a satisfactory answer to a problem that preoccupied many physicians who may be involved in abortion, embryo reduction, and in vitro manipulation of embryos. The unborn child, he said, had a legal status when it became a fetus, but parliamentarians, in spite of many months of discussions, had failed to define its status at an earlier stage.

The association noted that "the embryo, whatever its stage of evolution, cannot be reduced to simple material. There is no possible comparison between the human embryo and the embryo of another species. Entering as of its conception into a collective and singular history, the embryo... belongs to our humanity." Dr Dubois added that French doctors who objected to abortion or assisted medical procreation could avail themselves of the conscience clause to abstain from these procedures but that clear guidelines were lacking. He said that the association would set up a group to study this problem, before addressing the government.

The critical press release of the association came as a surprise because it is well known that French legislators who adopted the sweeping bioethics legislation last July had carefully avoided legislating on the legal status of the embryo. This was for fear that it could be taken as an argument by pro-life and religious groups to oppose legalised abortion.

The bioethics law in fact states that "any experimentation on embryos is forbidden. Exceptionally, a man and a woman who form a couple can accept that studies be carried out on their embryos. Their decision is [to be] expressed in writing. Such studies must have a medical finality and cannot impair the embryo." The rule that the embryo cannot be "impaired" is seen as ambiguous because if it is taken literally it means that not much can be done with an embryo beyond looking at it.

In the past the French medical association has taken a conservative approach and stood as a defender of a "moral order" by voicing its opposition first to contraception, then to legalised abortion. Many doctors wonder whether the association will adopt a similar position with regard to medically assisted procreation and embryo research.

There are an estimated 20 000 frozen embryos in France, mostly left over from in vitro fertilisation for medically assisted procreation. The ministry of health and social affairs has still not decided on their fate or made clear whether embryos can or cannot be used for medical and basic research.

—ALEXANDER DOROZYNSKI, medical journalist, Paris

Focus: Brussels

For doctors communautaire

Whatever its faults the European Union has been a major catalyst for travel—by both people and ideas. Less red tape and the gradual erosion of national borders have made life easier for tourists, students, and professionals wanting to venture abroad. But that flexibility can bring new headaches for professionals who want to work in another country.

Doctors were among the first professionals to hammer out arrangements on mutual recognition of qualifications and freedom to practise throughout the union. But the number of doctors who now practise in a country other than the one in which they trained is surprisingly low. The United Kingdom is the most popular destination, with 956 other European Union nationals registered (including 185 from Ireland, 179 from Germany, and 160 from Greece). There are sizeable numbers too in Greece (205), Belgium (182), and France (136) but hardly any in Luxembourg (3), Denmark (10), or Portugal (26).

Despite these figures the realities of the European Union are increasingly a factor the medical profession has to take into account. How can one respond to an Italian who moves to Britain and wants to be treated by a cardiologist who speaks his native tongue? Or how can one be sure that a patient using a certain drug can obtain it in another European Union country, particularly if it is sold under a different name? It is here that the European Medical Association aims to help.

If the national medical associations of Europe worked out the framework for the free movement of doctors, then the European Medical Association aims to oil the wheels of that movement. Via its growing databank it can locate doctors with particular language skills and also provide information on drugs available in all 12 union countries. Its services include information on health care regulations and medical reference centres and the ability to refer travelling patients to colleagues.

Unlike the national medical associations, and the bodies in which they come together at European level, the European Medical Association is not a trade union or professional association. It sees its role as providing services to its individual members, particularly those who practise in a European Union country other than their own, and creating a European network of doctors. It also aims to influence developments in European health care as they affect the medical profession.

Not surprisingly, some of Europe's national medical associations view the European Medical Association with suspicion. Until recently they have not been clear what it did or who its officers were. Also some national associations have suspected it of encroaching on their territory, using its rather grand sounding name to suggest to European bureaucrats that it wields rather more clout than it actually does.

Founded in 1990 the EMA is largely the brainchild of its current president Dr Vincenzo Costigliola. Trained in Italy, Costigliola has had a suitably multinational career. A former chief of medical services in the Italian navy, he was later responsible for the outpatient department at Belgium's SHAPE (Supreme Headquarters Allied Powers in Europe) hospital and is now a general practitioner in Brussels able to converse in Italian, French, English, and Spanish.

Last month the association held its second annual meeting, attended by the European commissioner for research and development. It currently has 7000 members, and Costigliola wants more to enable it to expand its activities without relying on the pharmaceutical industry for support: "In the future we are going to develop on line information in three key areas: jobs, information, and training. To do that we need to increase our membership as that will guarantee our independence."

The association intends to develop the spread of information among its members, largely by combing through the many publications produced by the European Union and making available data on planned legislation, research programmes, and other items of direct interest to the medical profession. It is also trying to produce a detailed inventory of universities and medical centres in the union. Membership of the association costs £21 (25 ecu) a year for those entitled to practise in a European Union state, and it can be contacted at 12 Place Jamblinne de Meux, 1040 Brussels. Other European medical associations probably shouldn't worry too much: it would be hard to do what they do for their members for 25 ecus a year.

—RORY WATSON, *European*