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Vocational training for general practice in the European Community

THE need for special postgraduate training for general practice is widely accepted in the United Kingdom. But there are countries in the European Economic Community where this need is acknowledged only by a minority, whether in government, universities or the medical profession — even by a minority among general practitioners.

Last year, however, all member states in the European Community subscribed to a directive under the Treaty of Rome which will require them to start to establish training courses for intending general practitioners in 1988. By 1995 all general practitioners wishing to work in the social security systems of the member countries will need to have been trained. It is the European Union of General Practitioners which has been mainly responsible for bringing this about and it celebrated its twentieth anniversary, in collaboration with the Commission of the European Community, at a symposium in Luxembourg last year. The meeting was not just an anniversary or celebration. Its purpose was to demonstrate the present state of training to representatives of the Commission and of national governments, and to point to the many problems still unresolved.

The directive is based on the Commission's acceptance that general practice is essential to medical care in Europe and that special postgraduate training is essential for general practitioners. Its purpose, like that of the 1976 directive on basic medical training, is to encourage — and ultimately to ensure — a minimal level of postgraduate preparation so that doctors can move freely between member states of the European Community without threatening standards of care in the country they seek to enter. The standards required are a two-year period of full-time postgraduate training, of which at least six months are spent in an approved practice.

Given these agreed standards, accepted by some countries with enthusiasm, by others with reluctance, actual progress towards the aims of the directive varies widely.

Although the UK was once in the lead in Europe in the training of general practitioners, Denmark has moved steadily from one year to five years of training (of which one is equivalent to our pre-registration year). This includes two periods of six months in training practices and a theoretical course of 150 hours. The consensus in Denmark that education for general practitioners should be the same in quantity and quality as for specialists is a point of considerable importance. However, this five-year programme is not obligatory.

By contrast Italy has barely started. A postgraduate course for 200 doctors is about to be offered in Tuscany, but excessive numbers of doctors are a major impediment to rational planning of general practice training. When it is hard enough to get a practice, young doctors may see more training as an unnecessary delay. Older doctors fear competition, and specialists, to whom patients have direct access, do not wish to see the role of the general practitioner developed. There are said to be 55 000 unemployed doctors in Italy, yet the government takes no steps to control the entry to medical schools.

The French situation is particularly disappointing because it looked more favourable 10 years ago than today. Since 1979 there has been an examination at the end of

basic training, but only those who get high marks are offered the chance to specialize. Those with lower marks are left to train for general practice, along with any that have made it their first choice. This training is called 'residanat', while specialist training is called 'internat', a prestigious term from the past. Thus general practice is a devalued branch of medicine which already suffers because 30% of French patients go direct to specialists and by-pass their general practitioner. There is indeed a two-year training for intending general practitioners, but it is not available in the more prestigious hospitals, while the period of six months in general practice is inadequately organized, often curtailed and not much sought after, as excessive numbers again make competition for practices a daunting problem.

West Germany is another country with intractable difficulties with general practice training. A two-year compulsory training period is seen as inferior to the four-year voluntary training which has been available, mostly in hospital posts, for the last 15 years. The government is at present unwilling to finance both schemes and seems likely to use the directive as an excuse for paying only for the two-year programme. Thus in Germany the directive appears to be a step backwards. As in Italy and France, far too many doctors have had a basic training and 45 000 are said to be unemployed.

It would be tedious to describe the situation of each of the 12 countries. Suffice to say that Portugal and Spain, each starting from a lower baseline, have ambitious plans, which are supported by large groups of enthusiastic young doctors. They have already set up experimental training courses within reorganized health services. But they will need time and better governmental support than they have at present.

Meeting again with the European Union after a lapse of three years, I was struck by the magnitude of the problems that hold back the process of general practitioner training in most of the 12 countries. One has to go to Europe to realize the advantage we have enjoyed here through continuing efforts to relate the number of entrants to medical schools to the country's need for doctors; the contrast with Italy, France and West Germany, with their burden of unemployed doctors, is striking. One has to go to Europe to realize the importance to general practitioners of the tradition by which patients consult us in the first instance. This tradition is relatively feeble in most EEC countries, with an inevitable reduction in the value attached to general practice and in the pressure to create a proper training for this career. One has to go to France or West Germany to realize how fortunate we have been in the willingness of our universities to accept the new discipline of general practice at a relatively early stage. The rigid conventions and protectionism of French universities make a particularly sharp contrast.

Despite all the problems, the consensus view at the conference was that the specific teaching of general practitioners should last for three years.

One lesson the UK can learn from this meeting is that we cannot be complacent. Other countries, notably Denmark and the Netherlands, are now perhaps taking the lead in vocational training for general practice. We are in danger of becoming fossilized in our arrangements for training young doctors and of emphasizing the achievement of minimum standards rather than searching for excellence. We need to create and evaluate experimental approaches to education if progress is to be made.

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HIV infection in children

THE acquired immune deficiency syndrome (AIDS) was first recognized in children in 1982, and at the end of 1987, 251 cases where the patient was less than 15 years old had been reported in Europe. Although the number of paediatric AIDS cases in the United Kingdom is small, with only 20 confirmed cases reported to the British Paediatric Surveillance Unit, the actual number of children infected with the human immunodeficiency virus (HIV) is as yet unknown. With the new classification of paediatric HIV infection,[1] children with less severe manifestations of the disease should also be recognized, but infected children who remain asymptomatic will not come to medical attention.

Since 1985 the risk of transmission via blood and blood products has been reduced appreciably, with the voluntary exclusion of infected blood donors and treatment of blood products. The majority of children acquire HIV infection by vertical transmission from an infected mother. The transmission can be transplacental, intrapartum or postpartum.

Clinical spectrum

The spectrum of HIV infection in children is extensive, ranging from asymptomatic infection to end stage disease manifesting as AIDS. Studies of perinatally acquired disease[2] (Mok JYQ, *et al.* Submitted for publication) show that the initial presentation of HIV infection in children includes non-specific signs and symptoms — failure to thrive, recurrent respiratory infections, chronic diarrhoea, unexplained fever, generalized lymphadenopathy and hepatosplenomegaly. It is likely, therefore, that most of these children will present first to their general practitioner, who must be alert to a history of risk activities in the parents so that an appropriate diagnosis can be considered.

As the disease progresses, evidence of central nervous system involvement (developmental delay, microcephaly, progressive motor deficits) or chronic lung disease (lymphoid interstitial pneumonitis) become apparent. Opportunistic infections with bacteria, viruses and other atypical organisms will also be seen. Less common manifestations include nephropathy, cardiopathy and embryopathy.

Difficulties with diagnosis

In adults, laboratory evidence for HIV infection (usually an ELISA screening test confirmed by Western blot) is specific as well as sensitive. The transplacental transfer of HIV antibodies from an infected mother to her infant creates problems in interpreting a positive HIV antibody test in an infant. Clearance of maternal antibodies occurs when the infant is six to 18 months old, with a median age of 12 months. Therefore, infants under 18 months old who are antibody positive and have a history of perinatal exposure to HIV are classified as having 'indeterminate' infection, unless there is other laboratory or clinical evidence to substantiate HIV infection.