

Towards a healthy Europe

HISTORIC changes continue in both eastern and western Europe. These changes have important implications for the practice of medicine throughout the region. They present new problems and there is a need to have an understanding of possible future developments. Developments within the 12 countries of the European Community are focused upon here. However, given the current debate regarding the deepening and widening of the European Community, it is impossible not to consider the medical developments within the European Free Trade Association countries and those in central and eastern Europe. The most important considerations at the moment are those of medical education, medical manpower and the role of the European Commission in health matters.

In many of the countries of the European Community, concern is increasingly expressed regarding the quality of both undergraduate and postgraduate medical training. The 'doctors' directives' lay down the basis for comparable training throughout the European Community.^{1,3} The nature of undergraduate training varies considerably, particularly with regard to the degree of clinical teaching and experience that students receive, and doctors seeking postgraduate training in European Community countries other than their own may require short periods of instruction to obtain new clinical skills.

Regarding vocational training for general practice, the 1986 directive has now been adopted by all countries in the European Community.³ In spite of this, there remain some difficulties over its practical adoption in three of the new German Lander (regions). Implementation of the directive, which has to be complete by 1995, remains patchy because of problems of inadequate government funding of training schemes, insufficient hospital posts for trainees, the slow development of criteria for trainers and the payment of trainers. Two examples demonstrate these difficulties. When the directive was adopted in Italy, training schemes were set up but there was no funding available from government to resource the training and pay the trainee doctors. In Belgium there are two types of training, one which complies with the directive but is largely taken up by non-Belgian European Community graduates, and another which is two years in duration but only part-time and therefore does not properly fulfil the criteria in the directive.

Since the initiation of the directive, the Royal College of General Practitioners, the British Medical Association and the Department of Health have been concerned that until 1995 it is possible for a European Community medical graduate to apply for the post of general practitioner in the United Kingdom, not having received training in general practice equivalent to a general practitioner trained in the UK. The minimum training required under the directive is two years. There is no real possibility of change until 1995 when the directive requires the European Commission to review its working and make proposals to achieve further harmonization of the training of general medical practitioners. The official policy of the European Union of General Practitioners (representing the interests of general practitioners in the European Community to the Standing Committee of European Doctors and the European Commission) is that the minimum period of training should be increased to three years. It is important that full implementation of the directive is achieved as quickly as possible throughout the European Community and that improvements are obtained during the review process in 1995.

Concern has also been expressed regarding the quality and length of specialist training in the European Community and

a new initiative is being developed through the foundation of 'European boards' for each specialty in order to improve and maintain the standard of training.

Under the 1975 directive (75/362/EEC)¹ the Advisory Committee of Medical Training is the body responsible for ensuring that a comparably high level of medical training exists throughout the European Community. Unfortunately, as stated recently by its past president, the advisory committee is marking time as the European Commission has become firmly convinced that medical training in the 12 member states has reached an equally high level and is using the excuse of budget and staff restrictions for postponing action. No plenary meeting of the Advisory Committee of Medical Training took place between June 1990 and November 1991. This situation is unacceptable. The European Commission has a responsibility to enable the committee to carry out its remit fully. Appropriate representations have been made by both the College and the British Medical Association to the Department of Health and to the Standing Committee of European Doctors.

With regard to medical manpower in the European Community, an important study has recently been concluded by the Permanent Working Group of European Junior Hospital Doctors. The report is due to be published in the near future but was commented on recently in the *British Medical Journal*.⁴ The study related to 15 European countries (nine in the European Community) and the results show that at present over 60 000 doctors are unemployed in western Europe, two thirds of these doctors in Italy. By the mid 1990s the problem is likely to have eased and by the turn of the century, because of the changing age structure of the medical profession and significant numbers of doctors retiring, a balance should be achieved. It is important to look at figures for each country in more detail and have regard to the possibility of increasing movement of doctors within the European Community, and also possible future migration of doctors from eastern Europe. The problems of medical demography today are serious and require careful monitoring and attention, both by governments and by the Advisory Committee of Medical Training.

Political and economic changes within the European Community in 1992 are not likely to affect doctors immediately, but in recent years the European Community has had an increasing interest in health matters. Health related issues have been the concern of a number of different directorate generals within the European Commission. The intergovernmental conference on political union has examined the possibility of extending the provisions of the Treaty of Rome to health matters. The commissioner in charge of Directorate General 5, responsible for social affairs and education, is in the process of setting up an informal health committee to assist in developing action in this area. There are plans to launch a European public health alliance,⁵ and one of its aims will be to press for the appointment of a senior commissioner to coordinate European Community health policy. It is important that bodies in the UK, particularly the royal colleges, the British Medical Association, other health professions and the Department of Health, develop a view on whether a separate European Community directorate general for health would be desirable, and if so, what its areas of responsibility should be. With regard to the increasing involvement of the European Community in health matters, it is encouraging to note that the Standing Committee of European Doctors has taken the important step of establishing a permanent secretariat in Brussels in order to represent the interests of the profession more effectively.

All bodies representing the interests of doctors within the European Community and throughout the whole of the continent must become more effective at ensuring, and further developing, higher educational standards and ensuring improved levels of care. Within the UK, our tradition of high quality medical education, the growing awareness of our involvement in Europe and the increasing importance being placed on primary health care should enable us to play a role in the development of European health care.

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Preventive medicine in primary care: management of hyperlipidaemia

SUCCESS in the prevention of coronary heart disease may reasonably be considered, like infant mortality rate, to be a criterion of the quality of a country's health care. The United Kingdom should have been pre-eminent in controlling coronary heart disease: its epidemiologists and medical scientists have been at the forefront of research on this subject; and the National Health Service, with public funding of care and free access for the population to general practitioners, is an optimal setting for preventive care. Yet mortality rates from coronary heart disease in the UK (except in southern England) are the world's highest, and the decline in these rates in the UK in the over 60 year olds, among whom most coronary deaths occur, is far slower than the decrease in the majority of other countries with high rates, for example the United States of America, Australia and Finland.¹

While public health measures are central to controlling the disease, there is an imperative parallel need for the detection and treatment of individuals at high risk of coronary heart disease.² The Royal College of General Practitioners' guidelines on the management of raised blood lipids, to be published as *Occasional paper 55*,³ are to be welcomed as a landmark, like the RCGP's previous recommendations on this topic.⁴ Their true recognition will be their widespread adoption by general practitioners throughout the UK. There have been several published sets of recommendations, following the original European and USA recommendations, and the striking feature has been their consistency, commonality far outweighing differences. The present guidelines, dealing specifically with lipid risk factors, are to be commended both for their simplicity and completeness. They are a valuable contribution to the control of coronary heart disease in the UK.

There is great scope for an increased role for general practitioners in the prevention of coronary heart disease, as was recognized in the recent white paper. The new contract for general practitioners will encourage preventive practice, which need be neither time-consuming nor expensive, though the main motivation will continue to be the satisfaction of practising good medicine. The practical basis for general practitioner involvement in the prevention of coronary heart disease is overwhelmingly strong. Not only does the vast majority of the population consult the general practitioner within a five year period, permitting opportunistic preventive care, but general practitioners are in a position to combine comprehensive care for the individual patient with concern for the family as a whole. The theoretical bases for risk factor reduction are now compelling, and they

References

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3. Council directive 86/457/EEC. *Official Journal of the European Communities No. L267/26*. London: HMSO, 1986.
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merit brief summary.

The case against cigarette smoking is an interesting paradigm by which other risk factor interventions may be judged.⁵ It is based almost entirely on epidemiological studies: the consistent demonstration that smoking is a strong, dose-related, independent predictor of the incidence of coronary heart disease.⁵ The case is not based upon clinical trials, though non-randomized observations on persons who have chosen to stop smoking indicate lower coronary heart disease rates and lower rates of recurrent coronary heart disease, than among comparable persons who continue to smoke. Nor is the case for action against smoking supported by evidence of high success rates in achieving long term smoking cessation. Smoking is addictive and pleasurable, and we must at present be content with moderate cessation rates. Though there are interesting hypotheses to explain the association between smoking and coronary heart disease — free radical effects, altered platelet function, lowering of high density lipoprotein cholesterol — we lack clear understanding of the basis of the association. Hence the case for smoking cessation in the prevention of cardiovascular disease, by counselling and ancillary methods, is based — and soundly so — on the convincing observational epidemiology.

The issue of hypertension management is more complex. The epidemiological association between blood pressure and several cardiovascular end points shares the same features suggesting causality as the smoking association, such as strength, consistency, independence, predictive ability and gradation of effect; and it spans the range of 'normal' blood pressure as well as hypertensive levels. Clinical trials of blood pressure lowering offer convincing evidence of reduction in strokes and cardiac failure, but evidence of reduction in coronary heart disease is inconsistent in individual trials and quite modest in a meta-analysis of these trials.⁶ Two recent trials of hypertension treatment in the elderly have achieved reductions in coronary events as well as strokes.^{7,8} The interdependence of coronary risk factors is evident from the Gothenburg hypertension trial: a substantial fall in coronary heart disease was confined to those participants in whom both blood pressure and serum cholesterol level decreased.⁹

The association between hypertension and lipid risk factors is of increasing interest. Not only are these variables synergistic in their effects on risk, but as the Gothenburg study shows, combined management is likely to yield greater benefit than selective attention to one or other risk factor. Furthermore, lipid