EEC doctors meet in Dublin

Support urged for transnational training schemes

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Patience is the first requirement for anyone contemplating a future in European medicopolitics. This is certainly true of the Standing Committee of Doctors of the EEC, where the wheels grind slowly and occasionally painfully. An example is the transnational exchanges for doctors in training, plans for which were first discussed in Copenhagen in 1979 and which were still being discussed at the standing committee's third plenary assembly in Dublin last week. Even so, tangible results are achieved, the most important of which has been the free movement of doctors, agreed in 1975.

The committee now represents over 600 000 doctors and is regarded as one of the most important medical representative organisations in Europe. Regular contacts are maintained with officials of the European Commission and with the Advisory Committee on Medical Training. The latter committee, which advises the commission on all matters of basic and continuing education, has representatives from the profession, government, universities, and competent authorities—in the United Kingdom this is the General Medical Council. The outgoing president of the standing committee, Dr Tony Farrelly, has also been chairman of the advisory committee.

The standing committee also has close ties, often with common membership, with the European Union of General Practitioners (UEMO), the European Association of Senior Hospital Physicians (UEMS), the Permanent Working Group of European Junior Hospital Doctors, and the European Federation of Salaried Doctors. All these organisations report regularly to the standing committee.

It is impossible in a committee of 60—particularly when the members represent 10 different countries—to draft policy statements, and much of the preliminary work is done in the subcommittees. Some of the important decisions that the committee took at its meeting in Dublin last month are reported here. This was the final meeting of Eire's three year stint of running the standing committee: next year the French take over and the annual meetings will be held in Paris.

In his final introductory address to the committee after three years as president, Dr Farrelly summarised the accomplishments during this time, some of which had been started before the Irish took over.

The committee was, he declared, on the brink of achieving its long awaited general practice directives; it had completed an occupational health charter and was near to achieving its objectives for occupational health training and specialisation in the EEC; it had evolved three declarations on continuing medical education, numerous clauses (limiting the right of access to a university education), and computerised medical records; and it had initiated or continued with studies on professional liability, third country credentials, preventive medicine, doctors' strikes, human rights, organ transplants, and "unexplained death."

All this and more besides had taken over 50 meetings and cost about £85 000 a year. Dr Farrelly reported that he had also visited all the member States except Luxembourg—he goes there next May. He had also attended meetings of all the medical organisations with special links with the standing committee, an exercise

which, he claimed, had increased the insight and trust between these bodies and the standing committee.

Pilot schemes for transnational training

The Hospital Doctors Subcommittee has been disappointed with the response to the proposal for a pilot project for transnational training. The scheme for several posts in each member State for training doctors from other States had been given the "go ahead" a year ago. It had been envisaged that to provide the maximum educational benefit the doctors concerned would have already started their specialist training and that the posts would be full time, include training and service elements, and be of six to 12 months' duration. Where a tradition of exchange programmes already existed the subcommittee had asked for information.

The British Medical Association's response had been as follows: "We have sought the advice of the various bodies concerned, including the councils for postgraduate medical education and the DHSS, on possible mechanisms for implementing the scheme and identifying suitable posts and trainees for participation. All those consulted have viewed the objectives of the scheme with favour, but have acknowledged the practical difficulties which might be encountered in implementing it due to the conditions of employment of specialist trainees in the UK. We are now in the process of compiling a list, through our regional consultants' committees, of heads of units who would be prepared to accept EEC trainees from time to time, or who already do so. Once such a list has been established it can be made available to other member States so that interested trainees may consult directly with the trainers concerned."

Comité Permanent

The standing committee was founded in 1959 with the following objectives: (a) to study and promote the highest standard of medical training, medical practice, and health care within the European Community; (b) to study and promote the free movement of doctors within the European Community; and (c) to represent the medical profession of the EEC member States at the level of the European Community.

The secretariat of the committee rotates among the members, and the Irish Medical Association has provided this service for three years, with Dr Tony Farrelly serving as president. The retiring secretary of the IMA, Dr Noel Reilly, has been the secretary general. From 1 January 1983 the secretariat will be in the hands of the French Medical Association and the president will be Dr Jacques Monier.

The plenary assembly of the standing committee met for the third time in Dublin on 26 and 27 November. Dr Alan Rowe led the UK delegation, which contained representatives from the General Medical Council and the Royal College of General Practitioners.

It had been suggested that the larger States would allocate 10 posts and the smaller ones five. Seven countries had said that they would try to take part in the scheme but with the increased unemployment among doctors and several applicants for each vacant post the Hospital Doctors Subcommittee had proposed modifications to the original scheme. The scheme would be limited to a few member States and would be available to doctors who had almost completed their training—in the last or penultimate year—so that they could be gainfully employed in their host country. The Danish Medical Association had offered to set up a central bureau to gather information on suitable posts and departments.

Two of the junior doctors on the committee, from the Netherlands and from Italy, were distressed at some countries' reluctance to support the scheme. And Dr Farrelly said that all the hard work that had been put into achieving free movement based on high standards of training would be wasted if boundaries were now to be closed.

The committee endorsed the modifying proposals from the subcommittee and it was suggested that a request should be made for financial help from the European Commission for the scheme.

Continuing medical education

One of the United Kingdom delegates, Mr Roger Brearley, a consultant surgeon in Liverpool, chairs the Professional Training Subcommittee. He and his colleagues have worked hard to produce an acceptable declaration on continuing medical education and the standing committee approved the final draft in Dublin.

The subcommittee had concluded, said Mr Brearley, that continuing medical education was an obligation that every fully qualified doctor should discharge. He had a double ethical duty to his patient. On the one hand he had to recognise his limitations and not undertake activities of which he was insufficiently capable, and on the other he had to find ways of continually improving his competence.

The declaration referred to the Hippocratic tradition of continuing education, and because it was in the interest of patients every doctor had the right to such education. In urging that doctors should be encouraged and helped to exercise that right, the authors emphasised the leading part that the profession must play, the importance of inculcating the value of continuing education into medical students, the advanced provisions already existing in some countries, and the need for doctors to choose the most appropriate form of education. Continuing medical education, the declaration makes clear, should not be enforced by sanctions such as compulsion, penalties, or relicensure.

Computerised medical data

The Medical Ethics Subcommittee, which is chaired by Dr J Autin of France, has been considering guidelines for storing medical data on computers. It was obvious from the discussion that there were fundamental differences in national attitudes. Although there is a draft Bill in Belgium that would allow a person to see the computerised information on him, under existing law a patient could not see his medical records; there would be no point at present in asking his permission to store information if he was unaware of any data on him, Dr J Farber declared. There were similar difficulties in Denmark, Professor Holst said, although legislation on computerised information had separated medical data from other kinds of data. Another matter that would have to be examined was the medical input given to insurance companies' data banks. Dr Alan Rowe said that in the United Kingdom this information was given by informed consent but it was obviously a subject that would have to be debated.

The committee decided to adopt the following guidelines as a first statement on the storage of medical information on data banks.

"The Standing Committee of Doctors of the EEC, having taken note of the various relevant documents—particularly the motions of UEMO and UEMS, the WMA, the Hospitals Committee of the EEC, and the Council of Europe, hereby affirms that both the collection of medical information for medical data banks as well as the access of persons to these banks must be subject to certain principles of medical ethics.

"For this reason it is considered that only doctors should have ultimate responsibility for such data banks.

"Data fed into these banks must be collected, stored, and distributed in accordance with the relevant national deontological rules and more particularly the rights and freedom of the patients with respect for the human being and the right to medical confidentiality.

"The codified data, which does not permit the identification of patients and respects confidentiality, will be registered under the responsibility of the doctors, who will retain the key to the code.

UK delegation

Delegates

Dr A J Rowe, chairman, Committee on the EEC.

Mr Roger Brearley, Central Committee for Hospital Medical Services; member of Advisory Committee on Medical Training.

Mr D R Gentleman, Hospital Junior Staff Committee.

Dr J L Kearns, chairman, Occupational Health Committee.

Dr A W Macara, chairman, Central Ethical Committee.

Alternates

Dr R J Bennison, Royal College of General Practitioners.

Mr Russell Hopkins, Joint Consultants Committee.

Sir Gordon Wolstenholme, General Medical Council.

"No data can be fed into a bank without the prior knowledge and approval of the patient who can in turn request amendments or modifications by a doctor nominated by the patient.

"Everything must be done to make certain that the medical information fed in be covered by professional secrecy.

"With this aim in mind, purely statistical data wherein there are certain elements which might allow identification of the patient must be absolutely separated from data of a purely medical nature (including, for example, diagnosis or therapy) which should remain absolutely anonymous.

"Only doctors may have access to these medical data banks and solely in the interests of their patients.

"Medical data banks to be used for medical purposes must remain autonomous and should not be linked to other banks with any other objective or aim."

Training in health economics

Should a course in health economics be part of a doctor's training? With cuts in health service spending having effects in all countries the Hospital Doctors Subcommittee had suggested that the standing committee should discuss a proposal that doctors should have training in health economics and hospital management. In Denmark, apparently, "tuition" had led to doctors being more aware of health costs. In France the Government was subsidising voluntary postgraduate courses. Dr Alan Rowe argued that obligatory training in health economics was "not on." This was a specific discipline and it was a serious proposition to suggest that it should be part of the curriculum. It was quite another matter to say that doctors should be made aware of costs. Where appropriate, doctors who had management responsibilities needed proper training and courses should be available for them, he declared.