Letter from . . . Holland

Arts and afgekeurd

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One way in which English visitors to the Netherlands may easily be intimidated at the expense of their hosts is by offering them a "groene haring" from one of the market stalls. A "green" or fresh herring is a whole filleted raw herring, dipped in chopped onion. Held aloft by the tail fins it is lowered steadily into the gullet of the recipient, whose head is thrown well back. The special bemused and triumphant facial expression which follows the final act of engulfment is unique to the Dutch. The "groene haring," like the smoked eel, is an important part of Dutch social history. With the present embargo on trawling for herring in the North Sea this fragrant delicacy had become more sought after than any other endangered species. At present the herring is imported from elsewhere, but it is not quite the same thing. The problem is that the herring has to be specially prepared soon after the catch by a technique of gutting which leaves some of the digestive glands within the fish. After subsequent filleting and salting, the flesh has a very soft texture. The continuation of this old tradition depends on the future of Dutch fishing in the North Sea. There are prospects that herring fishing may be permitted again next year—cheering news for raw herring connoisseurs planning their holidays.

Ins and outs of training

A medical practitioner in the Netherlands is an "arts." A career as "arts" is a popular choice, but the number of places available in the eight university medical schools is considerably exceeded by the number of applicants. Success in gaining a place depends on a weighted lottery system, which means that, in general, school assessments and performance in school final examinations are decisive. A central bureau then appoints successful candidates to a particular university, complying with the candidate's preference as far as possible. The costs of the teaching course are nominal and various grants are available to cover these and living expenses where necessary. There is a high fallout rate from the medical schools, especially in the first year—when as many as a quarter of the students may leave on the basis of their own or the medical school's assessment. The reason for this wastage is not clear, but several factors have been cited. The subjects studied at school do not have to be appropriate to the medical course, and existing school assessments and examinations are perhaps not always relevant to the demands of a career in medicine. The medical schools, however, might be reluctant to define a better selection procedure than the present school assessment.

The medical course varies in different universities, but the

standards are similar. Evaluation of the candidates is based on in-training assessment and examinations rather than on a single final examination. In comparison with the British system, teaching differs in that during training the student has less contact with or responsibility for patients. In my experience, the recently qualified "arts" who takes a junior hospital post as trainee for a specialty, or before entering general practice, finds it difficult to use his knowledge clinically and is hesitant about taking decisions. This insecurity is not helped by the nursing staff, whose greater practical experience inevitably gives them a commanding role in patient management.

Further training for the specialties recognised by the European Economic Community is difficult to compare with the curious and undeveloped system in the United Kingdom. Training takes place only in licensed hospitals, which are university or larger peripheral hospitals. These training schemes last from four to six years, depending on the specialty, and are often well organised.

Trainees who complete the course to the satisfaction of their teachers can obtain specialist registration. Obtaining a place in such a training scheme is not always easy, particularly in popular subjects such as general medicine or surgery. Unlike the pyramidal training structure for junior staff in the United Kingdom, there is a more realistic balance between the numbers of juniors in training and the eventual availability of consultant posts. While this means that specialists in smaller hospitals often work with little or no junior assistance, it has the advantage that a young doctor accepted for a specialist training can look forward to a good income as a specialist in his early 30s.

"Afkeuring" is a medical assessment of a patient which results in his being declared permanently unfit for further work. An afgekeurd patient continues to collect about 80% of his usual salary until he receives his retirement pension at the age of 60 or 65. While there are just over 200 000 workless at present, there are 600 000 who cannot work for health reasons. Unfortunately, chronic subjective disability—such as nervousness and low back pain—accounts for too large a proportion of the afgekeurd workers. There is a real problem of neurosis, which is apparently worse in the heavily populated urban area in the west of the country. With the relative ease with which afkeuring has been obtained at the hands of some medical advisers and with the good social welfare, however, perhaps not surprisingly unimportant symptoms are sometimes overemphasised and the system abused. With the present difficulties for the young and fit in finding jobs, one cannot help feeling sympathy for the attitude of the less fit and the less motivated.

Partial afkeuring is also a common occurrence. A patient might, for example, be declared fit for half-time work, receive the appropriate level of sickness payment, and be presumed able to work for the other half of his time. Although I find it strange for a patient's invalidity to be assessed on the basis of the hours he can be expected to work in the week, in practice the system

has advantages. Some patients who might otherwise be retired from work do manage to cope with a part-time job, thus providing a useful contribution and preserving their role in the community.

Rewards for the innocents

As likely as not I shall be accosted round about 5 December by a young lady with a black face who will present me with a handful of sweets. All this is in honour of a grey-bearded Mr Nicolaas from Turkey in the third century AD. In Holland, Saint Nicolaas arrives on 5 December by steamboat or on his horse, and is dressed in the robe of a bishop. He is always helped by Black Peter, often a girl in knave's costume, who helps to catechise the children or other innocent bystanders and rewards the goodly with *snoepjes* (sweets). The bishop and his trusty servant are widely observed—not only in the larger stores and

supermarkets, but they even penetrate into the hospitals.

Work stops on 5 December and we all assemble in the coffee room. The laity is addressed and given good advice by the venerable old man, presents are opened, and we eat flaky marzipan cakes. 25 December is a more sober occasion. A Christmas man with flowing beard and red garments is always close at hand but his pedigree is altogether more dubious.

Last winter was really cold and the small canals were frozen solid—nowadays an infrequent happening. Ice skating became acutely popular and the nurses on my ward were slipping away early in the afternoons to get in some practice. There is a popular painting by Avercamp which hangs in the Rijksmuseum in Amsterdam, called *Winter Landscape*, which portrays the scene vividly. Frosted undergrowth, snow-covered gables, and flying scarves. Last winter the Dutch were for once reliving their own picture-book history.

I hope it freezes again this year.

Scientifically Speaking

Advances on the flu front

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Washington, DC By the calendar, the influenza season is arriving in the northern hemisphere. By many other signs, it is arriving in the United States amid uncertainty about what viruses are important this season, what can be done against the viruses, and who can be convinced that it is worth doing.

In part, the uncertainty arises from the predilection of influenza viruses to put on different antigenic make-up from the styles in which they were last seen publicly. To a considerable extent, however, the difficulties of devising an effective immunisation programme against influenza this season in the US may be identified with a residue of mistrust from the badly handled nationwide campaign against "swine flu" in 1976. That debacle still hangs around the fringes of news stories about any public vaccination effort.

Influenza continues to be an important contributor to mortality rates in the US. When combined statistically with pneumonia—which is a frequent clinical progression during epidemics—influenza is the fifth-ranking cause of death. Although antibiotics have reduced the influenza/pneumonia death rate by more than 47% in the past decade, those two continue to make up the only infectious disease category among the 15 leading causes of deaths in America.

Globe-trotting viruses

The virus problem is complicated this winter by the presence of two A types, of relatively equal occurrence, instead of the

usual strong predominance of just one A. Also circulating vigorously is a B-influenza virus, B-Hong Kong. This profusion of influenza viruses circulating simultaneously is highly unusual, according to government health officials. It has been going on for the past two winters and the combination shows no indication of sorting itself out this season.

The A types, in particular, have been undergoing their guileful drifts of antigenicity, but have not always accomplished a quick dominance of the new version over the old, so that occasionally the two strains may be isolated in the same influenza outbreak. Apparently, a world record for co-circulation of A-type viruses was established in the late winter of 1978, when a severe outbreak among students at a Cheyenne, Wyoming, high school produced strains resembling A-USSR, A-Texas, and A-Victoria.

The Cheyenne event was noteworthy for several reasons. The A-Texas and A-Victoria strains, both of subtypes H3N2 by their antigenic description according to haemagglutinin and neuraminidase, are an instance of a previous strain coexisting with the changeling. A-Victoria is believed to have become A-Texas in one of nature's recombinant sprees. The appearance of A-USSR in Cheyenne simply completed a globe-trotting journey of the virus first seen in Moscow little more than two months earlier. The odd thing about A-USSR is that it is a dead ringer for a H1N1 virus that spread all over the world in about 1950, but has not been isolated from influenza cases in man since then. By the most exacting laboratory analysis, the kinship of the two viruses is so close that it has even been suggested that the 1978 A-USSR simply escaped from somebody's freezer samples of 1950 viral isolates. For it to have lurked in some animal species, or even subclinically in man, for 25 years and not have undergone antigenic change is against the nature of an influenza virus. The A-USSR of this season already is discernibly different from the A-USSR of 1977-8, and indeed this year is being called A-Brazil.

This veritable congeries of influenza viruses has led US

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