Risks of malignancy for the undescended testis

	Increased risk
Unilateral	5.1-fold
Bilateral	11.7-fold
Royal Marsden study ²	

One boy in 120 with an undescended testis will develop malignancy²

- 1 John Radcliffe Cryptorchidism Study Group. Cryptorchidism: an apparent substantial increase since 1960. *BMJ* 1986;293:1401-4.
- 2 Chilvers C, Pike MC. Epidemiology of undescended testis. In: Oliver RTD, Blandy JP, Hope-Stone HF, eds. *Urological and genital cancer*. Oxford: Blackwell, 1989:306-21.
- 3 Woodhouse CRJ. Late malignancy risk in urology. *Br J Urol* 1992;70:345-51.

Malignancy—Undescended testes have a higher incidence of histological abnormalities, and presumably the increased risk of malignant change is related to this. Originally, a 35-fold increase in risk of malignancy was quoted for a unilateral undescended testis, but more recent work has calculated this to be about a fivefold increase in risk. It used to be thought that all an orchidopexy did was to make the testis palpable and hence improve earlier detection, while the risk itself remained unchanged. However, recently published evidence from a large British study has suggested that an early orchidopexy actually reduces the risk of subsequent malignancy.³

Prostheses—Absence of a testis (either inherent or iatrogenic) should probably be treated by placement of a testicular prosthesis. The prostheses are filled with silicone gel and are available in various sizes to match the other side (which has often hypertrophied). They should be implanted during adolescence since earlier surgery merely has to be repeated as the contralateral testis increases in size.

Professor Lewis Spitz, Institute of Child Health, London, provided the pictures of obstructed inguinoscrotal hernia and empty hemiscrotum.

The ABC of Paediatric Surgery is edited by Mark Davenport, consultant paediatric surgeon, department of paediatric surgery, King's College Hospital, London.

How To Do It

Work in the European Union

Frances Klemperer

Continental Europe is now only 20 minutes away by train from mainland Britain, and moving ever closer politically. Mutual recognition of medical qualifications within the European Union is well established: working in other parts of Europe is, in principle, straightforward. Working in different health care systems can offer new perspectives on British medical practice and the NHS. But the cultural differences and practical difficulties are not always easy to overcome.

Registration

Working in Europe has never been easier. Mutual recognition of medical qualifications applies throughout the European Union and its partners in the European Economic Area (Norway, Iceland, and Liechtenstein). Any doctor who is a citizen of, and who trained in, a member state is free to work as a doctor in the other member states.^{1,2}

The first step is to register as a medical practitioner in the country where you want to work. There is no centralised registration system. You will have to go through the procedures unique to each member state. This is likely to cost several hundred pounds, take several months, and require a good deal of determination.

The British Medical Association can provide addresses of sister organisations and registering bodies equivalent to the General Medical Council. As in the United Kingdom, registration requires a large number of documents, both originals and notarised translations; these can be arranged through any reputable translator—try *Yellow Pages*. Allow time to collect them all. They may have to be sent, or even taken in person, to myriad different official departments. You may have to relinquish originals of the most important documents for a long period of time. Some countries require documents that do not exist in the British system—for example, the “national proof of good character or good

repute” (required in Belgium), the “certificate of good conduct” issued by the police (required in Germany), or the “testimonial of morality and honesty” (required in Greece). An imaginative response, perhaps a letter from your head of department, will probably be more effective than seeking further advice from either the country's registering body or its London embassy.

European Community law requires that the registration process be completed by the authorities of the country concerned within three months of submission of your application.¹ There have been reports of suspected illegal discrimination against incoming doctors^{2,3}: the European Public Health Alliance, an association of non-governmental organisations in the health sector, is looking into these problems. Directorate-General XV of the European Commission has responsibility for this area. The Maastricht Treaty gives a citizen of the European Union the right to petition the European Parliament if his or her rights under European law are being infringed. (The parliament will, if it sees fit, then forward the complaint to the commission for further investigation.)

Certificate of specialist training

Once registered as a doctor, you may also be eligible to register (and practise) as a specialist. Until recently, if trained in the United Kingdom you would have needed the certificate of specialist training, issued by the General Medical Council. To get it you had to have spent three to five years in recognised training posts and have obtained membership or fellowship of a royal college. It was not necessary to have reached consultant status, or to be “fully trained” by British standards—that is, qualified to apply for a consultant post. These arrangements are now changing with the implementation of the Calman proposals on specialist training. The certificate of specialist training will be replaced by a certificate of specialist training that will apply equally to the United Kingdom and the rest of Europe and will

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replace accreditation. Each royal college is publishing exact requirements for every specialty, and during the transitional period the General Medical Council can provide detailed information. The current and future certificates denote entitlement to charge fees on a specialist's scale, rather than suitability for any particular post or grade.⁴

Finding work

The BMA can give advice on where job adverts are published. The European Medical Association has information on international job opportunities, and it gives members access to its membership database, a potential source of contacts. Your royal college membership list may also provide a list of colleagues working in your host country. International conferences can be a source of opportunities, too. You could try writing to chief clinicians asking for advice. Consider research or drug company posts, which may be less daunting in terms of language requirements.

Find out the local style for both a curriculum vitae and a covering letter. Some places will expect to see your handwriting, which might even be analysed by a graphologist; others will expect a typewritten letter. When going to a job interview, consider taking open references with you: use of references and referees does not always follow practice in the United Kingdom.

Attend seminars in your chosen country. The medical registration body may be able to provide information or addresses: continuing medical education may be compulsory for continued registration. You may find local contacts through doctors who work for the English speaking community, particularly if you have an introduction from one of their patients. Ask the United Kingdom consulate or embassy, whose addresses can be obtained from the Foreign Office in London, if they can let you have a list of English speaking doctors. Follow up letters with a phone call and then a thank you note. Small gifts for helpful secretaries may also be a worthwhile investment. Check on what is local practice.

If you are in a training scheme in the United Kingdom discuss with the scheme organiser the possibility of arranging an exchange with a doctor of the same grade. The United Kingdom is a popular destination for foreign trainees; this may be a way to find a job without entering the open market. Bear in mind that postgraduate training may not be structured; some countries have no postgraduate exams. If you want to gain accreditation for your post abroad agree this well in advance with your royal college.

Finding patients

What if there is no suitable job available? (Medical unemployment continues to be high in many European countries.⁵) What if you still want more work?

Then look for patients: in most of Europe it is less common than it is in the United Kingdom for specialists to be in full time salaried posts. Many conduct a largely, or exclusively, outpatient practice from their own premises. A common, cheap, and convenient option in many countries is to use part of your home as an office. Remember that you will need to allow space for a waiting room, too, and that there may be tax implications. For general practitioners and psychiatrists this is a natural choice. Expatriates of all nationalities will be clients. Most, for whom English, rather than the local language, is their first or second tongue, may prefer a doctor who is a native English speaker and from the same or similar cultural background. Make yourself known to the expatriate community: visit their doctors; make contacts with English speaking embassies; write articles in their newsletters; give talks

at the international clubs, schools, and churches; become associated with helplines and voluntary organisations. Make sure your office address is convenient for the expatriate community—for example, near an international school—and don't go anywhere without your business card. But be wary of advertising: many European countries are less liberal than Britain about advertising or even providing information for patients.

Language

The 1993 council directive 93/16 (article 20) states: "Member States shall see to it, that, where appropriate, the persons concerned acquire, in their interest and in that of their patients, the linguistic knowledge necessary to the exercise of their profession in the host country."⁶ This is interpreted, and implemented, in different ways: only a few countries impose language requirements other than the informal hurdle posed by the need to negotiate the bureaucracy. Even if you choose to practise medicine only with expatriate patients, however, you need to be able to liaise with colleagues, hospitals, and pharmacies, not to mention patients' insurance companies.

To learn the language, consider an intensive residential course: this is expensive, but a good investment to facilitate administrative tasks and social and professional integration. Everyday colloquial language is often harder to learn than technical medical language.⁶ For continuing studies, government sponsored courses, which are equivalent to those run in English by the British Council, may be cheaper and better regulated than private enterprises. Find conversation partners native to your new country. The ability to speak native English is greatly in demand throughout the world. Others will be keen to improve your colloquial language and teach you their culture in exchange for the opportunity to practise English with you. Try advertising for a "conversation exchange" through a local shop or library or a British Council language school.

Health care in the European Union

There are significant cross cultural differences in health care across the European Union. About half of the countries in the union finance health through insurance schemes, usually controlled by the government. Patients often have completely free choice of doctor, with direct access to specialists.^{7,9} Working as a hospital employee necessitates adaptation to local facilities and therapeutic practices; working independently requires a thorough knowledge of local social security and health insurance schemes. The European Council has suggested that countries set up "information centres" to provide migrating doctors with information on the health and social security laws and the professional ethics of the host country.¹ At the moment these are not widely available—gather information in advance.

The international section of the BMA has a wide range of health care information on the European Union. The Permanent Working Group of European Junior Hospital Doctors produces booklets giving information on training and health care systems, also available from the BMA. The European Medical Association provides a service for doctors in the union, particularly those practising outside of their home country, with access to information on all aspects of health care, including structure and regulations, doctors' associations, specialist medical centres, and medical education. The King's Fund library is also an excellent source of information on international health.

Although there is a single market in medicines, in

Europe could be your oyster

TOM VAN SANT/SPL

practice this does not seem to be the case. Drug companies have different marketing strategies and are subject to different controls in different countries. Whether a drug can be sold in a supermarket, over the counter in a pharmacy, or on prescription only varies widely. Drugs that are unknown in the United Kingdom may be in common use just across the Channel; conversely, those that are routinely used in the United Kingdom may be unavailable or may be prescribed at different doses under different names. The European Medical Association can provide information on drugs available across the union and the different proprietary names under which they are available.

Living in Europe

Medical registration is only the start of the bureaucratic slog. Everything takes twice as long if you cannot speak the language well, and 10 times as long if you are unfamiliar with the system. You will probably need to do the following:

- Find accommodation (and schools/childcare for your family)
- Acquire an identity card
- Set up a bank account
- Register with the local social security/health insurance system
- Subscribe to medical indemnity
- Organise local and central government taxes.

Consider, early on, hiring an accountant who is familiar with handling doctors' affairs. If you need a car, seek advice from a United Kingdom company specialising in export and find out what the second hand car market is like in your destination country before buying in Britain. Your car should be registered and insured in the country in which you are resident.

Consider your own and your family's health care. The E111 form, available from the Post Office, will give you access to temporary emergency care at the same level as that provided for citizens of the host country. If you forget the form, you will have to pay and seek reimbursement later. Register with the local health insurance or social security system or ensure that your employer has made the arrangements for

you. In view of prescribing differences across Europe take supplies of regular medicines. It is also worth discovering the telephone number of the emergency services and the location of the nearest English speaking general practitioner and accident and emergency department before you, or your children, need them.

Consider communications and access to library services. Depending on your destination, you may want to arrange for your home medical library to help with acquiring articles, or use the library facilities of your royal college. The BMA library also provides an excellent service to its members. With a modem and computer you can directly access remote databases. The BMA library Medline is available for the price of the (international) telephone call; other health databases are also available on line.

Culture shock

When the initial honeymoon period of excitement and novelty subsides, anticipate culture shock.¹⁰ Homesickness is a slightly different problem. Try assuaging it with the widespread availability of the BBC on cable television.

The difficulties caused by culture shock are rarely acknowledged in the success oriented worlds of expatriate medical and business staff. It can be all the more disconcerting when the new culture is geographically close and superficially similar to the one you have left behind. If you are the main breadwinner remember that culture shock is usually worse for a spouse who has not got a job and for children (with a new school culture and educational system to negotiate), because the loss of social networks and the environmental change are greater.

Familiarising yourself with the new culture and language and making social contacts within the host country will help to reduce culture shock.¹¹ Handbooks on expatriate living will complement tourist guides: there are now increasing numbers of books on living and working on the continent as the European markets have become more accessible.⁸⁻¹⁵ If you can, and particularly if you are taking your family, visit your destination for a weekend reconnaissance trip before you move. Take a camera with you.

Coming home

Before you leave, think about coming home again. Appointments to posts are rarely made a long time in advance, but you may be able to take leave of absence for a specified period of time. This offers job security for the future and continuing pension rights. It may allow you time abroad to learn the language before starting work in a job exchange or provide a safety net if your job abroad does not work out. Being on leave of absence can also give extra credibility to your curriculum vitae.

On your return, prepare for reverse culture shock. Coming back is notoriously harder than the move away from home—and harder than most people anticipate. The shock will be greater if you have not had access to British media: some aspects of life back home will have been forgotten, others will have changed.

I acknowledge the advice received from Sallie Nicholas, secretary, European Medical Committee, and from the BMA.

Appendix

Sources of information and useful addresses

European Commission, DG XV/E2,
Rue de la Loi 200, 1049 Brussels, Belgium
Tel: +32 2 295 9061

This is the section of the commission concerned with the free movement of doctors.

European Medical Association,
Place de Jamblinne de Meux 12, 1040 Brussels, Belgium
Tel: +32 2 734 21 35
Fax: +32 2 734 21 35
Internet: EMA @spl1.y-net.be

European Public Health Alliance,
1 Place du Luxembourg, 1040 Brussels, Belgium
Tel: +32 2 512 93 60
Fax: +32 2 512 66 73

Gunn E, ed. *Vacher's European companion*. London: Vacher's Publications, 1995.

Useful for finding institutions in the European Union and your member of the European parliament

King's Fund Library,
11-13 Cavendish Square, London W1M 0AN
Tel: 0171 307 2400

Standing Committee of Doctors of the EC (CP),
66 Avenue de Cortenbergh, Bte 2, 1040 Brussels, Belgium
Tel: +32 2 732 7202
Fax: +32 2 732 7344

Coordinates the views of other European medical groupings and represents the medical profession as a whole to the institutions of the European Union. One of its aims is to promote the free movement of doctors within the union.

Unit for Social Security for Migrant Workers, DGV,
Rue de la Loi 200, 1049 Brussels, Belgium
Publishes a free summary of both social security and health care schemes of the member states.

European Commission. *Your social security rights when moving within the European Union: a practical guide*. Luxembourg:

Office for Official Publications of the European Communities, 1995. (Also available from HMSO Books.)

HMSO Books (Agency Section),
HMSO Publications Centre, 51 Nine Elms Lane, London SW8 5DR
Tel: 0171 873 8372

- 1 Council of the European Communities. Council Directive to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications. 93/16/EEC. *Official Journal of the European Communities* 1993;April 5. (Available from HMSO Books (Agency Section).)
- 2 Nicholas S. Mobility of doctors In Europe: vision or reality? In: Ellis N, ed. *European Union of general practitioners reference book 1994/5*. London: UEMO/Kensington Publications, 1994:156-8.
- 3 Belcher JP. Free movement of health professionals. *European Public Health Alliance briefing paper No 6*. Brussels: European Public Health Alliance, 1995.
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- 5 Christensen SM. *From surplus to deficit: medical manpower in Europe by the year 2000*. Switzerland: Permanent Working Group of European Junior Hospital Doctors Medical Manpower Study, 1991:8-9.
- 6 Veale D. Living and working abroad. *BMJ* 1992;305:482.
- 7 Hindle A, Hindle GA, Worthington DJ. *The health care systems in the European Community: a comparative analysis*. Lancaster: Management School Lancaster University, 1993.
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- 9 Mebazan A, ed. *Guide to health in Europe*. Neuilly-sur-Seine, France: Impact M decin, 1992.
- 10 Pascoe R. *Culture shock: a parent's guide*. London: Kuperard, 1994.
- 11 Bochner A, Furnham S. *Culture shock: psychological reactions to unfamiliar environments*. London: Routledge, 1986:157-8.
- 12 Golding J. *Working abroad*. Plymouth: How To Books, 1993.
- 13 Adamson-Taylor S. *Culture shock: France*. London: Kuperard, 1994.
- 14 Gozan G. *Daily Telegraph guide to working abroad*. 17th ed. London: Kogan Page, 1994.
- 15 Twinn B, Burns P. *Expatriate's handbook*. London: Kogan Page, 1993.

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Lesson of the Week

Hypovitaminosis D in immigrant women: slow to be diagnosed

Jeannine F J B Nellen, Yvo M Smulders, P H Jos Frissen, Ed H Slaats, Joseph Silberbusch

Hypovitaminosis D osteopathy should be considered in immigrant women with musculoskeletal pain

Vitamin D deficiency in adults eventually leads to the osteomalacia syndrome, with its characteristic clinical features of bone pain, muscle weakness, and difficulty in walking. Even in moderate deficiency there is both biochemical and histological evidence of secondary hyperparathyroidism and increased bone remodelling. At this stage the characteristic symptoms of classic osteomalacia may still be absent, although irreversible cortical bone loss has already occurred. This is referred to as hypovitaminosis D osteopathy stage I.¹

Hypovitaminosis D is common in western Europeans, especially in patients with malabsorption and in elderly people eating a deficient diet. An increased incidence of hypovitaminosis D osteopathy among immigrant women could be expected because of their low intake of calcium and vitamin D, minimal exposure to sunlight, skin pigmentation, and high parity.² We report symptomatic hypovitaminosis D in six immigrant women, focusing on the time between the first consultation with a doctor and the establishment of the correct diagnosis.

Patients, methods and results

We diagnosed hypovitaminosis D osteopathy as musculoskeletal pain in the presence of an increased intact parathyroid hormone concentration, a decreased concentration of 25-hydroxycholecalciferol, and a favourable clinical response to vitamin D replacement. We analysed the general practitioner's and hospital notes of all patients with this disorder who had been

referred to this department from January 1990 to December 1992. From the notes we recorded (a) the time taken to refer the patient to this department, where the hypovitaminosis D osteopathy was eventually diagnosed; (b) the symptoms reported by the patients (localised or diffuse bone pain, difficulty in walking with or without muscle weakness, neurological complaints such as paraesthesia or muscle spasms, and non-specific complaints such as fatigue and malaise); and (c) referrals to other specialties, undue diagnostic procedures, and unsuccessful therapeutic interventions.

Table 1 shows the demographic and clinical data of six patients who satisfied the above criteria. The duration of complaints before diagnosis varied from 7 to 103 months (mean 59.2 (SD 36.2)). In retrospect, the symptoms the patients complained of were typical of hypovitaminosis D osteopathy from the beginning. Symptoms were at first unrecognised or misinterpreted. Previous referrals were mostly to orthopaedic surgeons and for many x ray examinations and blood tests. All patients had been prescribed non-steroidal anti-inflammatory drugs, and four had undergone intensive physiotherapy.

In three cases misinterpretations had serious therapeutic consequences. One patient (case 2) was treated with prednisone for suspected polymyalgia rheumatica, one woman (case 1) received oestrogen because osteoporosis was suspected, and one woman (case 6) underwent cholecystectomy because of subcostal and back pains combined with a solitary gall

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