The situation in the Common Market countries

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Summary
The training of undergraduates and postgraduates in the original member countries of the European Community (Belgium, Federal Republic of Germany, France, Italy, Luxemburg, and the Netherlands) is outlined and compared with training in the U.K. and Ireland. It is noted that, in the European Community, training is inadequate and should be improved. Harmonizing with the U.K. will require concessions to be made on both sides.

Introduction
During its first stage, the European Community consisted of six countries: Belgium, the Federal Republic of Germany, France, Italy, the Grand Duchy of Luxemburg, and the Netherlands. In 1973 three new members joined the Common Market: Denmark, Ireland, and the United Kingdom.

This paper concentrates on the situation prevailing in the six original countries. The Council of Ministers of the European Community decided to institute the free movement of doctors between the nine EEC countries, and for that purpose, directives have been issued, specifying that the specialty of dermatology-venereology is recognized in Germany, Belgium, Denmark, France, Italy, Luxemburg, and the Netherlands. The minimum duration of training for this specialization is 3 years. In the United Kingdom and in Ireland, however, venereology is independent of dermatology and in each of these disciplines it takes 4 years to become a specialist. This means that 'continental' dermato-venereologists will be allowed to migrate between their six countries in order to practise the full scope of their specialty, but will not be able to cross the channel to apply for a post of venereologist in a hospital in the U.K. or Ireland.

On the other hand, British venereologists as such will not be able to migrate to the other countries of the Community.

The monospecialized section of dermato-venereology of the European Union of Medical Specialists defined the scope of its discipline as follows: 'Diagnosis, treatment, and prevention of diseases of the epidermis, the skin, and the hypodermis and their appendants of venereal diseases and sexually transmitted diseases'.

This definition of dermato-venereology will certainly be defended before the High Consultative Committee set up by the Council of Ministers of the Community. It will be the task of the Consultative Committee to see to it that the training of doctors is at a high comparable level and to harmonize the curriculum of the qualified doctor and the specialist.

It is clear that, at the present time, concepts are diametrically opposed between the U.K. and the other Community countries as regards the teaching of venereal diseases, both as a basic training and as a specialty.

Training
1. Training of the future doctor
In Belgium, we have at the present time six faculties of medicine and two new faculties will soon become operational.

In 1972 there were 36 faculties in France, 23 in the German Federal Republic, 22 in Italy, and 7 in the Netherlands.

There is no university in the Grand Duchy of Luxemburg, and its nationals, after having been authorized to study in neighbouring countries, must come before a Governmental Committee in order to be able to practise either general medicine or a specialty in their country. In the five countries equipped with a faculty of medicine, there are chairs of dermato-venereology, urology, and gynaecology. Although venereology is linked to dermatology, it must be stressed that the teaching of sexually transmitted diseases is spread over three disciplines and is considered as a minor subject falling within the framework of other specialties, such as general pathology, bacteriology, pediatrics, and psychiatry.

The future doctor therefore receives a heterogeneous theoretical and clinical training; the diagnosis and treatment of syphilis is taught by the professor of dermatology and the diagnosis and treatment of...
gonorrhoea in men by the professor of urology, and the professor of gynaecology is left to teach female pathology including the sexually transmitted diseases. This is an unsatisfactory situation and the newly qualified doctor is ill-equipped to make an accurate diagnosis and start appropriate treatment. On the other hand, in the 29 medical schools of the U.K. and Ireland, the complete teaching of venereology is the responsibility of one specialist.

II. Training of the future specialist

The problem remains the same in the five countries mentioned above. Here again, theoretical and practical courses in sexually transmitted diseases are given within the framework of various disciplines. The studies of a specialist in dermatology-venereology cover the theoretical and practical aspects of syphilis. In most countries there are theoretical and practical courses in the pathology of gonococcal infections, and the other sexually transmitted diseases also fall within the curriculum of the future dermatologist.

This does not mean that the future specialists of other disciplines receive no specific training in sexually transmitted diseases. The curriculum of urology and gynaecology covers to a great extent the study of these conditions.

III. Training of medical assistants

Many paramedical professions are capable of taking care of the prevention, diagnosis, and treatment of sexually transmitted diseases, such as nurses working in antivenereal clinics, social workers, psychologists, and laboratory staff.

The variety of these professions, their own field of work, the level of their training, and their independence of the qualified doctor differ so widely between the countries of the European Community that they call for lengthy and tedious considerations which are out of place in this paper.

The free movement of holders of these various professional titles is still under consideration by the EEC officials, and I do not believe that these deliberations will bring about free movement or migration in the field we are tackling to-day.

The role of the general practitioner, the dermatologist, and the other specialists in the teaching and treatment of STD and in research

(1) The general practitioner

In the nine Common Market countries, many patients still first consult what they call their 'family doctor'. In some countries, they are even obliged to do so by social insurance legislation.

In the field of sexually transmissible diseases the role of the general practitioner remains of the foremost importance. He may, however, rarely see a patient with venereal disease and his training has not equipped him to manage the problem by making an accurate diagnosis, giving adequate treatment, and contact tracing.

According to his conscience, he may either refer his patient to a specialist without delay or try to accomplish a miracle cure by administering massive doses of wide-spectrum antibiotics.

In some countries a conscientious doctor may comply with the compulsory declaration and cooperate effectively in the detection of the causative agent. This is required by law in Belgium, but only a few doctors fulfil this formality, mostly through ignorance. Our statistics, which are the lowest of the Common Market in the field of VD, are completely erroneous and give only a partial idea of the epidemic nature of the disease. Efforts are being made, however, to intensify the study of venereal diseases during postgraduate or refresher courses attended by a great number of Belgian general practitioners.

(2) The dermatologist

Certainly, during his training period, the specialist receives detailed theoretical and practical courses in sexually transmitted diseases, but in practice only patients with clear signs and symptoms will consult him. The dermatologist is perfectly capable of diagnosing the venereal origin of a dermatosis and of starting the treatment he deems the best, but he will be completely untrained in the field of prophylaxis. The patient will usually be very reluctant to talk about the origin of the condition for which he came to see this specialist, and the doctor will seldom have the opportunity of examining the sexual partner who was the contaminating contact. He will therefore have to confine himself to treating his patient and giving him some sensible advice to avoid spreading the disease to other people.

(3) Other specialists

We have mentioned that some patients still consult their family doctor, but in countries where it is not mandatory by social security legislation to see a general practitioner first, it has become fashionable for the patient to speak proudly of his 'specialist'. He chooses his specialist according to the symptoms he feels. No modern woman will feel liberated if she does not regularly see her gynaecologist, and a man with acute gonorrhoea will consult a specialist urologist. It may also happen that a positive result from a laboratory investigation will be returned to a specialist in another discipline who will then have to deal with a patient who has contracted a venereal disease.

In hospital circles, or within a well-established medical team, the patient with VD and his infected partner(s) will be treated quickly. The prevention of venereal diseases will be greatly facilitated, especially if the hospital has a well-trained staff of medical officers.
In the United Kingdom this problem of disjointed action by various specialists does not exist. The specialist in venereal diseases treats patients of both sexes and takes any preventive measures that may be required.

Conclusions
The diagnosis, prevention, and treatment of sexually transmitted diseases are inadequately organized in the Common Market countries, except in the United Kingdom and in Ireland.

This is due to the heterogeneous teaching of general practitioners and specialists, who receive insufficient instruction or practice in this field, and also to the ignorance of patients.

The Directives of the European Community simply list the different types of training and medical practice in the nine countries. They try to coordinate them partially by establishing an average training time for the dermato-venereologist. It will now be necessary for the Consultative Committee to harmonize the quality of training in the various disciplines.

As regards venereology, the example of the United Kingdom is a good one, but allowance should also be made for the way which venereology is practised by dermatologists in seven Common Market countries. These dermatologists seem determined not to relinquish a field which has long been theirs, and concessions will have to be made on both sides. It is to be hoped that a compromise will be achieved for the benefit of our patients and to combat the epidemic of STD, of which dramatic new outbreaks are occurring in these nine countries.