Continental doctors take leadership in British medicine

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Within living memory it would have been unthinkable for the manager of the England football team to be a continental European. Not only has that happened, but also every football team in the country has players from across the Channel. In the Middle Ages, the Archbishop of Canterbury spoke with a foreign accent on more than one occasion. In the future will the Presidents of the Royal Colleges do the same?

Recently, cardiovascular medicine and surgery in the United Kingdom have seen the recruitment of many senior consultants and professors from Italy, France and Germany. There has been no equivalent movement in the opposite direction, and this movement of medical staff towards the United Kingdom will probably grow. These changes are the effects of negative aspects of continental medicine and indicate both good and bad news for British medicine. The negative aspects of European continental medicine, which make a career in the United Kingdom seem attractive, vary from country to country. In Germany, the professorial structure is very strong with rigid control from the top, including the disbursement of monies from private practice. When the chief retires, there is often complete replacement of the whole pyramid by the new chief. In Italy, the appointment of professorial chairs is made in an arcane and archaic fashion, which engenders both filial respect from junior doctors towards their chiefs and also uncertainty about whether the chief can pull off a deal related to the junior’s future. In addition, Italian surgeons are often not allowed to operate independently before they are 40 or even 50 years old.

In France, in the state Assistance Publique hospital system, pay is low and relations between doctors and administrators poor, with doctors feeling they do not have the power to change the environment in which they work. Furthermore, in Germany and Italy there are too many doctors (in contrast with too few doctors in the United Kingdom). There is also a feeling in some countries on the continent, particularly among academics, that merit goes unrewarded and that other events, not the quality of the individual or what they produce, will determine their career path. However, on the continent there is a wide perception that merit is rewarded in the United Kingdom. There is certainly less funding available for research in the cardiovascular system in continental Europe and, in particular, the existence of the British Heart Foundation in the United Kingdom is seen by Europeans as an attractive part of academic life.

The positive aspects of British medicine and particularly British academic medicine that attract continental doctors include, importantly, the fact that they will all have learned English to a high standard during their schooling and medical training. Secondly, there is space in British academia. In cardiovascular medicine and surgery, there are fewer and fewer natives wishing to pursue academic careers. There is funding for research, particularly from the British Heart Foundation, and new doctors take responsibility at an earlier age. Continental doctors are often successful in the United Kingdom because they are well motivated to take part in change (which is demonstrated by the fact that they have come to the United Kingdom), and also because they do not know, or accept, the conservative constraints of the system.

0195-668X/5 - see front matter © 2004 Published by Elsevier Ltd on behalf of The European Society of Cardiology.
Several medical and cultural changes are influencing British doctors against pursuing a career in academic medicine. Calman training has produced uniformity, which tends towards mediocrity. In the past, flexibility of training allowed academics to experience and enjoy research and build a training that was suited to their own career needs. This gave a diversity of skills and ways of thinking. The pursuit of private practice, which generates enormous incomes among NHS physicians and surgeons, produces role models for junior doctors who aspire to material wealth as opposed to intellectual advance. Many specialist registrars expect a consultant post immediately after their training ends and a private practice associated with it. On the continent, especially in Germany and France, although private practice does occur the proceeds are often used for the good of the department as a whole and not for individual gain. British doctors choose private practice partly because they see their contemporaries, for example in financial services, earn more money than they do and partly because of the failure of academics to act as role models. However, wider anti-intellectual movements might also be responsible. Furthermore, once junior doctors have achieved their training number, they know they are almost certain to be appointed as consultants. This removes incentive for initiative and differentiation.

Most of the forces described here are not going to change within the next 10 years. Continental countries will continue to produce more doctors than they need. The negative aspects of continental academic hierarchy will persist and Calman training will tend to produce homogenous trainees with an inclination towards mediocrity and private practice and away from the excitement of discovery. However, a system where many of the leaders of academia are continental and the foot soldiers of the health service are natives, is not necessarily a bad thing. It may produce a new flowering of British research led by a mixture of continental ideas and flair, which is combined with the unique British system of funding research, particularly in the cardiovascular system. Seen from a pan-European point of view, perhaps the European Union ideal is best achieved when the best of Europe is being shared.