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LETTER TO THE EDITOR

Northern European manpower in Otorhinolaryngology-Head and Neck Surgery

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The manpower in Otorhinolaryngology-Head and Neck Surgery (ORL-HNS) among European countries is highly variable [1]. However, it is rather obvious that great differences still do exist in training, availability and even in clinical practice for this specialty in Europe. Furthermore, there are no existing generally accepted treatment guidelines for the majority of conditions taken care of by ORL-Head and Neck Surgeons. It thus seems that for quality assurance purposes, further efforts are needed to harmonize and standardize these issues.

There are altogether approximately 23500 ORL-Head and Neck Surgeons in the member states of the EU. The European Union of Medical Specialists (UEMS, The Union Européenne des Médecins Spécialistes) currently has memberships from 37 countries, and forms the representative organization for the National Associations of Medical Specialists in the European Union and its associated countries. One of its main aims is to work towards a standard setting for training and practice in individual medical specialities. Further, the efforts of this organization focus on the development of unified models for the training of the next generation of medical specialists. This is supposed to contribute to high standards of clinical practice, and hence to improved care for patients throughout Europe.

To harmonize the concept of training and availability of ORL-HNS practice in Europe, the UEMS ORL Section has recently started an initiative to explore and discuss the manpower of this specialty in various parts of Europe. The primary aim of this effort is first to document and present the current status of the relevant items in each country and to highlight principles regarding both clinical and theoretical education that could be distributed among other member states. The secondary aim is to distribute information on the current status on European migration of ORL-Head and Neck Surgeons. Northern Europe was chosen as the first region to be surveyed and presented for general discussion and the main parameters of this issue are

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Table 1 Facts on ORL-HNS manpower in Northern European countries (https://www.laakariliitto.fi/site/assets/files/27039/physicians_in_the_nordic_countries_2016.pdf, http://www.orlforum.se/images/pdf/enkat/PP_Tjansteenkat_2015.pdf)

	Popul. (*M*)	Specialists (active)	Specialists/inhab.	Medical faculties	Length (years) of basic/ORL-HNS training	Exit exam
Denmark	5.70	382	1/15,000	4	6/5	No
Finland	5.49	345	1/16,000	5	6/5	Yes
Iceland	0.34	22	1/15,000	1	6	No
Norway	5.17	331	1/16,000	4	6/5	No
Sweden	9.85	654*	1/15,000	6	5.5/5	Yes**

* Only members of the Swedish Medical Association

** Not compulsory for a certificate from the National Board of Health and Welfare

listed in Table 1. This area (Denmark, Finland, Iceland, Norway and Sweden) forms a culturally homogenous area with a population of 26 M people and with rather similar health care organizations. The current density of ORL-Head and Neck Surgeons (1/16,000 to 1/15,000) in this geographical region compares well with the recently published mean (1/18,000) of 27 EU countries [1].

In the present survey, it appears that in Northern Europe the basic medical education is rather similar in terms of its length and structure. In addition, the training for ORL-HNS specialty is typically 5 years in all these countries. Medical doctors from Iceland will be trained abroad for various specialties in other Northern European countries.

Doctors who have completed their medical qualification in an EU/EEA member state and who are EU/EEA citizens are licensed in accordance with the European directive 2005/36/EC but migration rate of medical doctors has been minimal. In Denmark, currently only approximately 10 (3 %) out of the 382 ORL-HNS specialists have foreign education. Finland is officially a bilingual country and all doctors must be able to speak either Finnish or Swedish to obtain a position for clinical practice. In 2015, there were only five (1.5 %) out of the 345 ORL-Head and Neck Surgeons with non-Finnish background. Also in Norway, a specialist training from an EU or a non-EU country is accepted, but an 18-month supervised training system is mandatory to be authorized as a medical doctor and all non-citizen doctors are required to pass a language test. Sweden has the same regulations as Finland regarding EU/EEA-educated medical doctors, with the addition that an estimation is made regarding the length and contents of education with a possible adaption and/or adequacy period or test. Additionally, knowledge in Swedish is mandatory. Iceland has the same regulations as Sweden regarding EU/EEA-educated medical doctors. Furthermore, an estimation is made regarding the length and contents of education with a possible adaption and/or adequacy period or test. However, currently all the 22 ORL-Head and Neck Surgeons are of Icelandic ancestry.

In Denmark, 47 % of the ORL-Head and Neck Surgeons work mainly in private sector and they are all financed by the public health care system. Sixty-five percent of the Finnish ORL-Head and Neck Surgeons work in hospitals, but 58 % have a secondary occupation in private sector. Twenty-five percent have their main occupation in private sector and 10 % are in university or administration positions. In Sweden 20 % and in Norway 46 % of ORL-Head and Neck Surgeons work in the private sector. In Iceland, 80 % out of the 22 ORL-Head and Neck Surgeons work in hospitals, but 90 % of them have a secondary occupation in the private sector. Further, 20 % work only in the private sector, which is still financed by the public health care system in Iceland.

Prediction of future manpower varies a little in Northern Europe. During the past three years the increase in the number of ORL-Head and Neck Surgeons in these countries has varied between 2.3 and 10.4 %. However, there seems to be a clear need for more ORL-Head and Neck Surgeons in Sweden, i.e., approximately 180 new specialists in 2020–2024 and the number of residents during this period might not cover the loss of specialists due to retirement rate and other factors. In Finland, the expected manpower is stable and in balance with the annual number of new ORL-Head and Neck Surgeons trained at the five universities until 2030. The same can be stated for Denmark where there is a sufficient number of doctors in training during the period 2013–2017 according to the National Board of Health. Norway has a large volume of residents in this specialty, i.e., currently 103 in total. However, many hospitals have difficulties in recruiting ORL-Head and Neck Surgeons as many of them stay in the biggest cities and even prefer to work as a general practitioner instead of moving. In Iceland, the expected manpower is stable and has been estimated to be in balance with the annual number of new specialists trained until 2025.

Our conclusion is that the Northern European ORL-HNS manpower concept presents as a rather homogenous field in

terms of training and number of available specialists. Migration has been fairly minimal in this field except for Sweden, where the forecast for open positions and training volume for the coming years might not be in balance. Evaluations for manpower items in other parts of Europe will contribute to the harmonization process of our specialty.

Reference

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