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Erasmus+ Hippokrates Exchange Programme Participant Report
Dr Emilie Couchman
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I would first like to express my gratitude to every patient and professional at the 'de Poort van Borne' practice for making me feel so welcome. Thank you to those who took the time and effort to translate their daily work into English so that I could fully participate with each experience. A particular thanks to Dr Herman van Enter for devising such a varied and interesting schedule, and for ensuring my experience was both informative and enjoyable.

I am currently an academic GP ST4 trainee based at West Hampstead Medical Centre (on the Royal Free VTS Scheme) in North London, England. Between the 28th April and the 10th May 2019, I completed an exchange to a practice called 'de Poort van Borne' in the rural village of Borne, east Netherlands. Borne has a population of around 23,000, and the practice provides care to around 7500 patients.

I intended to learn about the Dutch healthcare system, specifically: its structure and funding; the interface between a small rural practice and secondary care; primary care service provision both in and out-of-hours; the balance between accessibility and continuity within Dutch primary care; the clinician training pathway; and palliative care delivery in the context of legalised euthanasia (in specific cases, under specific circumstances).

Dutch healthcare system

Structure and funding





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Health insurance is mandatory in the Netherlands in order to consult with a doctor, receive prescriptions and undergo investigations. There are a range of companies that provide insurance, each offering varying levels of policy cover. Many Dutch people who are rarely unwell opt for a 'basic' package, which includes cover for healthcare aspects such as: GP care; pharmaceuticals; medical specialist input (at certain hospitals only depending on the package); patient transport; and maternity care. For example, a large insurance company called '*Zilveren Kruis*' provide basic packages ranging from €114.95 per month to €133.75 per month. Patients can choose to add additional services to their insurance as they wish, for example physiotherapy. If a patient is unable to afford insurance, the government support them to pay for a basic level of insurance (similar to what we know as receiving benefits).

A patient's insurance company pay anywhere between €65 to €100 annually to their GP practice (a proportion of which is paid at each quarter). The specific amount depends on a patient's demographic characteristics. For example, if they are elderly and have multiple comorbid conditions, the insurance company pay the practice a higher amount. In addition, the insurance company pays the GP practice €9.95 for each patient consultation on average (this fee increases or decreases depending on the length of the appointment time), and further payments are made for procedures such as coil fittings. These two payment streams are a significant source of income of each GP practice. For example, in the case of '*de Poort van Borne*', if each patient's insurance company pays the practice a minimum of €65 each year, this would yield an annual income of €487,500. This of course needs to pay for the running of the practice, including aspects such as the building, staff salaries and equipment.

Further, Dutch people pay tax, of which the government allocates a subset to the healthcare system. The government also provide practices with financial incentives for undertaking certain health checks (for example discussions about diabetes management) called 'Vital Health' checks. They are recorded on a separate electronic system to the patient records and are similar to payments made through the 'Quality Outcomes Framework' system in the UK.

Each patient has to pay an 'own risk' (excess) annual fee of €385 before receiving/claiming for any secondary care services. Payment thereafter depends on the specific healthcare needs of the patient, and whether or not the patient must pay depends on the details of their particular insurance policy. For example, some insurance companies only have contracts with certain hospitals, and if a patient is referred to a hospital not covered by their policy, they will have to pay independently or ask for a referral to a hospital that is included in their policy.

Children (up to the age of 18) do not need their own insurance policy and are insured for free with a basic package. However, they may also be covered by the insurance company of their parent with the 'best', most comprehensive, policy.





During my observation of general practice, it did not appear that the clinical decision-making of GPs was influenced by their patient's economic status. However, conversations about money did frequently arise. For instance, patients would ask whether what the doctor was suggesting would be covered in their insurance policy, and if not, they would sometimes decline the treatment or investigation despite this being against medical advice. GPs and GP trainees reported feeling that by patients having to contribute to their insurance in order to receive healthcare, the population seem more aware of the cost of certain services, and thus often use them more appropriately.

My experience of the Dutch healthcare system left me feeling privileged to have the NHS healthcare service that is free to all at the point of access. However, I also reflected on the potential lack of sustainability of such a service; a concept that has become more apparent over recent years. For example, it led me to consider the limitations within the NHS given how progressively thin the limited funding is spread. For instance, long waiting lists for mental health service appointments, or lack of continuity given an emphasis on increasing accessibility and service provision in terms of quantity. Further, I have been aware of recent privatisation within the UK system, as patient choice is diversifying via 'any willing provider' contracts, facilitating competition with independent sectors. On a daily basis, I encounter an increasing number of patients who choose to seek private medical care; particularly in the West Hampstead area, and am wholly unsure of how the system will look in 5-10 years' time.

'de Poort van Borne' practice team

- Five '*huisarts*'
- One trainee '*huisart in opleiding*'
- Three psychosocial therapists (adult/child psychiatric nurse/social worker)
- Five practice assistants (reception/administration/healthcare assistant)
- Two practice nurses
- One practice manager

The '*huisarts*' (GPs; translates literally to mean 'home-doctor') in the Netherlands are the first port of call for all healthcare needs. They link patients to secondary care specialists and alternative services such as physiotherapy. Most work independently, but medical centres employing multiple GPs are increasingly common.

Practice assistants are responsible for:

- administration tasks such as managing the daily agenda and greeting patients at the front desk
- triaging requests for face-to-face, telephone and home visit consultations (they can request further support with this from doctors as required)
- carrying out multiple practical procedures, such as ear syringing, suture removal, blood pressure monitoring, administered injections and performing cervical smears, and they also undertake blood tests for point-of-care testing as





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requested by GPs throughout the working day, for example, the practice has a D-dimer and CRP machine

The two practice nurses are responsible for undertaking required reviews for diabetic and elderly patients. The two psychosocial therapists have training in mental health and provide psychological therapies to adults, children/adolescent patients and families.

In- and out-of-hours service provision

Practice hours consist of 0800 to 1700. Most appointments are scheduled a few days in advance, and the practice have a rule that each patient requesting an appointment has to be seen within three days. Around 4-5 same-day appointments are available each day. Ten-minute appointments are offered (for single complaints). Telephone consultations are undertaken as required, and an email consultation system is soon to be implemented in the practice.

There is no electronic call system in the practice linked to the waiting room, because doctors feel that they gain valuable information from going to call patients themselves and observing how they walk to their consultation room.

The practice uses an electronic health records system called 'Medicom'. Other departments, such as the hospital pharmacy and laboratory reports are also linked to the system. It is projected that by 2020, each patient will have access to their Medicom records, including their last five consultations and their medication list.

'Medicom' is connected to the out-of-hours system after 1700 each day, so that on-call doctors can review each patient's medical notes (providing they have consented to this data sharing). The out-of-hours service is provided by a central GP station called the '*huisartsenpost*' in Hengelo, a nearby town around 20 minutes from Borne. Doctors have to undertake around 2-3 shifts per month, and provide either home visits, telephone appointments or appointments at the station. I shadowed Dr Herman van Enter during an on-call evening shift at the '*huisartsenpost*' in Hengelo. Doctors must undertake telephone triage, face-to-face appointments and home visits (with a designated driver and car). The system runs exactly as does the out-of-hours system in the UK, with the added advantage of having access to each patient's medical records.

Primary and secondary care interface

GPs are able to contact secondary care doctors for phone advice through the hospital switchboard, as in the UK. Referrals to secondary care are made via an electronic, paperless system. The link with secondary care specialists appears strong, for example, GPs are able to request that a specialist visits the practice to see a patient that they have particular concerns about. However, Dutch GPs often face the familiar challenge of having to wait several weeks for clinic/procedure outcome letters, which can hinder their ability to help patients in a timely, supportive





way. This is a common experience of many British GPs.

Continuity

Providing comfort and continuity is of the utmost importance within the ethos of the practice. Dr Herman van Enter, a senior GP, strongly advocates the need to treat patients as equals and ensure that they are comfortable in his consulting room by encouraging the approach of 'my room is also their room'. He associates continuity with an increased ability to provide comfort to patients, as one is able to better address their needs if one knows them, and their biopsychosocial background, well.

Each full-time doctor has a list of around 2500 patients for whom they are responsible. (If a doctor works part-time, they are responsible for 500 patients for each day that they work). The practice website clearly states that if a patient's own GP were to be unavailable (for example due to illness, holiday or after a night shift), patients would be seen by an alternative GP in the practice. There is a 'duo' system, which means that GPs work in pairs within the practice in terms of managing lists of patients, ensuring that one doctor in the pair is available for patients at all times. The potential for relational discontinuity at times is therefore acknowledged and a pre-emptive plan is made with each patient if their doctor is due to be away. This approach manages patient expectation and provides comfort.

Given my particular interest in primary care continuity, (I am currently working on my PhD proposal entitled 'Rethinking continuity in primary palliative care'), I was impressed to feel on a daily basis that continuity was at the forefront of the mind of each member of the practice team. The assistants tried to maximise GP-patient continuity when booking patients in to appointments, and doctors clearly relished seeing their own patients because of the relationship they were able to build and comfort they were able to provide. This is not my experience of NHS general practice, and I felt even more strongly that my proposed PhD exploring why we are unable to provide continuity in UK primary care is essential if we are to make sustainable changes that will provide benefit at both individual and organisational levels.

Training pathway for clinicians

Medical school

There are eight medical schools in the Netherlands: Universiteit van Amsterdam; VU University Medical Centre Amsterdam; University of Groningen; University of Leiden; Universiteit Maastricht; Radboud University Nijmegen; Erasmus Universiteit Rotterdam; and Universiteit Utrecht.

To qualify as a doctor in the Netherlands, three phases must be completed:

- BSc in Medicine (3 years)
- MSc in Medicine (3 years)
- General training in a Dutch hospital (optional 1 year)

Dutch GP training





GP training in the Netherlands is a 3-year programme. The first and third years of training are undertaken in a GP practice. First-year trainees generally have 30 mins per patient, and final/third-year trainees have 15 minutes per patient. The second year involves hospital-based training, and includes a 6-month emergency medicine placement, a 3-month nursing home placement and a 3-month psychiatric placement. GP trainees have to complete a multiple-choice question (MCQ) assessment (160 questions) on a bi-annual basis and complete a certain number of video consultations and case-based discussions (recorded on their e-portfolio) throughout. Similarly, trainers also have to complete the MCQ assessment every six months and undertake a minimum of 40 hours of training each year in order to be allowed to continue as a trainer.

The GP trainee in the practice, Dr Esmée Ellenbrook, is in regular contact with her supervisor. She has at least one hour of case-based discussion each week, and one hour of consultation observation and feedback each day. She attends a once-weekly training day with her GP trainee colleagues. I attended the weekly teaching day for local GP trainees. The format was very similar to the UK GP trainees' VTS sessions. It started with one of the trainees delivering a short presentation on a recent health-related issue in the media; then one trainee showed the group a video-recorded consultation and received feedback on her performance; and then followed a 'Balint-style' reflection group discussion, based on a case that a trainee had found particularly difficult that week. I was given an hour of time to present a PowerPoint presentation on UK general practice. (I also delivered this presentation to the 'de Poort van Borne' practice team). I discussed the NHS in general, and my personal career path and experience as an academic GP trainee. We had a very interesting and lengthy discussion thereafter about comparisons between our systems.

Palliative care and euthanasia

Given my research interest in palliative and end of life care, I was particularly keen to explore how palliative care is delivered within primary care given the Dutch law regarding euthanasia and assisted suicide. GPs in the Netherlands appear to take the lead in managing their patients' palliative care needs, and only rarely need to request support from the palliative care team.

The Netherlands became the first country to legalise these practices. The 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act' was passed in 2001 and became effective from 2002. This law suspends the prosecution of doctors who perform euthanasia as long as each of the following conditions are fulfilled:

- the patient's suffering is unbearable with no prospect of improvement
- the patient's request for euthanasia must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness or drugs)
- the patient must be fully aware of his/her condition, prospects, and options
- there must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above





- the death must be carried out in a medically appropriate fashion by the doctor or patient, and the doctor must be present
- the patient is at least 12 years old (patients between 12 and 16 years of age require the consent of their parents)

I discussed euthanasia in the Netherlands with Dr Margreeth Ooijselaar, a GP at the practice who had also trained as a 'SCEN doctor'. 'SCEN' stands for: Support and Consultation on Euthanasia in the Netherlands. She advised me that any doctor (GP or hospital specialist) can undertake this 3-day training, and that they must subsequently attend meetings (roughly 4-5 times per year) with their local 'SCEN colleagues to discuss their completed reports and learn from each others' experiences in order to maintain their registration.

When qualified as a 'SCEN doctor', doctors are able to undertake objective assessment of a patient who has been discussing euthanasia with his or her own GP. The role of the 'SCEN doctor' is to hold discussions with the patient in their own home about their wish to proceed with euthanasia. They must not know the patient or the patient's GP, and they must complete a form making recommendation about whether or not the patient is appropriate for the euthanasia process. The strict criteria above must be adhered to, and the form is submitted to the national euthanasia committee, who retrospectively review all deaths and sometimes request further information in particularly complex cases. After the process of euthanasia is complete (the actual procedure is undertaken by a patient's GP), the 'SCEN doctor' informs the forensic doctor, who reviews all the euthanasia documentation, certifies the death and contacts the coroner. If all is in order, the patient's body is released to the family.

The GP's role in euthanasia is therefore to broach discussions with the patient (and their family as appropriate) and engage with an independent 'SCEN doctor' who will objectively assess the suitability of the patient for the procedure. The GP then also administers the lethal medication. During our discussion, the importance of continuity with one's own GP was again reiterated, as complex decisions like euthanasia would be very difficult if the GP was not familiar with a patient's biopsychosocial context.

Specific learning points to take back to my practice

- The team at 'de Poort van Borne' have a coffee break together each morning at 1030 – 1100. This appears to be an important part of cohesive, team-working, and staff also feel it enables them to be refreshed and more productive for their remaining morning work. Given the differing work schedules of staff in our practice, implementing a 30-minute coffee break into our morning routine may not be feasible, but perhaps designating a specific period over the lunch/administration break would be possible. (Of course, some doctors may be out on home visits or catching up on administration tasks).
- The trainee in the practice has one hour each day with her trainer. This differs from my tutorial structure; in that I have one afternoon with my trainer each week.





Again, due to different working patterns (for example, my trainer has commitments at the Clinical Commissioning Group on certain days of the week), it may not be possible to dedicate time on a daily basis; but shorter, more frequent sessions may suit certain trainees more than others. This said, I have always felt able to approach my trainer or other senior colleagues for advice at any time if I have a particular issue to discuss.

- This experience has forced me to reflect on my professional life and the system within which I work. At times, I have fallen into the trap of being quite negative about our working environment. I feel that this is common among UK GPs at the moment and is exacerbated by the media and recent governmental changes to the NHS. GPs at 'de Poort van Borne' report feeling proud of their work and their primary care system, and this has been refreshing. I have drawn inspiration about how I could instil positivity into my local working environment, regardless of my powerlessness to effect wider-scale changes.

Hosting plans

I look forward to hosting a second-year Dutch GP trainee called Dr Robert van Kuik at West Hampstead Medical Centre from 28th May to 7th June 2019. He is currently undertaking his GP training at the University of Leiden, the Netherlands. Myself and my practice team have developed a varied timetable for him, using my experience in the Netherlands and his learning objectives to consider what may be of most value.

De Poort van Borne practice photographs

Front entrance of building:



Entrance hall of building:
practice:

(shared with other healthcare teams such as physiotherapy, psychology and pharmacy)



Front desk of GP





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Waiting room for patients:



Office behind reception:



vasco da gama movement



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Consulting room:



'Huisartsenpost' shift



doctor's car:



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