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General Practitioners

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Participant report

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I chose to complete my Erasmus program in the vibrant cities of Amsterdam and Den Haag. Both these experiences were very different and I intended for them to be, with a focus on wealthy city living professional demographic in one and urban, mixed background and working class population in the other.

I felt this would best reflect my current place of work which is in Birmingham where there is a similar stark contrast in its wider demographic.

In Amsterdam, the practice was based in the area of Oude Turfmarkt. Local attractions and canal front tourism was absent during the covid lockdown which set in within days of my arrival. I was warned I would have a stranger than expected experience by the doctors but I was excited nevertheless. It was early days we were none the wiser of what was going to come ahead. By the time I moved to den Haag things had become drastically different and the lockdown set in fully in the UK after advisory precautions were not taken on board. I cut my trip short to return to UK on government and professional advice.

Prior to that from what I could see restrictions were placed and followed well by the locals in Netherlands and the surgery did not need to struggle to manage patients as the ambulance services, out of hours services and GP services were doing a fantastic job of triaging, testing and directing patients well.

I learned from the two GP trainees what their structured training was like. Technically it is possible to be a qualified GP within 3 years of graduating medical school. They were able to apply straight out of medical school for GP training but not many would do this. Once you have experienced a few different specialities and have decided which one suits you most, you can apply and there is random allocation on a non merit based system. Everyone is given fair opportunity and this avoids elitism culture in healthcare. GP training is conducted by the universities but licenses are issued by the State board of health once completed.





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The training is split into hospital based, community based acute and chronic disease management. There is serial testing – written and osce style, periodically throughout rather than lump examinations.

The service provision need pressure of junior doctors is not there, but I appreciated the value in having fixed varied foundation training as I did note a significant experience gap between myself and another trainee which was purely down to this. I definitely felt for GP training, foundation training in the UK has been very useful in exposing you to specialties and giving you the confidence needed in managing simple and slightly complicated cases.

Healthcare is insurance based similar to neighbouring countries and the cost of appointments depends on intervention, time allocated to the review and in the case of Den Haag there was a difference in cost between face to face and telephone but this was not the case with Amsterdam. This seemed to be decided by the local GP practice and insurance company arrangements.

Considering we were in the covid lockdown- I enquired from the GP's about whether funding would be impacted by reduced attendance in places like Den Haag where the income of the practice is dependant on traffic. I was informed that whilst smaller GP practices would likely take a knock and then be subsidised by the state, the larger practices tend to have a slight buffer.

It was interesting in this case to note that in the NHS the role of healthcare staff there is no risk of insecurity during a crisis unless you are a locum doctor whereas this seemed to not be the case in Netherlands where real discussions about workforce reduction were having to take place as redeployment was not an option for some of the doctors and nurses who had limited training elsewhere.

The approach to working together in Netherlands is fantastic. There is a very low threshold for working on first name basis irrespective of grade and seniority and I felt this egalitarian approach in the workplace directly impacted my mood and comfort.

Unfortunately in the NHS we often suffer with lack of respect from patients and sometimes even government officials which has been an issue during my training period when there were junior doctor strikes and backlash for vocalising concerns about working health conditions.





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I find that as much as we try to maintain openness in dialogue during working as a GP, we often create a professional barrier – be it through clothing such as suits as well as insisting on using titles. This is to be firm on our position in the conversation before it is dismissed- as almost a defence mechanism from fears of being weathered down I imagine. It had not really occurred to me before but seeing the doctors attend work in casual clothing on first name basis talking about daily living was really refreshing. They even visited patients at home on bikes which just would not be an option for me personally in inner city Birmingham for safety and timing constraints.

We held daily debriefs in the morning and lunchtime for coffee social and work lunches together once a week.

The respect is mirrored with the interaction between patients also. I understand that risk of litigation is lower, job satisfaction is higher, employment and opportunities are more equally distributed.

I noted that in the small things – such as medical fitness notes for working. These are removed from the job requirement of a GP in the Netherlands because the board of health identifies this as a topic that can create conflict and therefore damage patient-doctor relationship. Instead an external independent body arranges these through the occupational health dept. This is very fair and very considerate approach to improving dynamics in healthcare.

There is also the question of insurance and less so guidance being the barrier to access. Most patients with an idea of referral desired or required are able to proceed with gateway opened by GP but where there is clinical question the GP can refer to insurance company rejections as the reason for not proceeding and again the GP is then not seen as representative of a healthcare system that is failing but the insurers become the obstacle instead as opposed to what can happen in the UK where depending on location, services available can be different CCG to CCG. This is of course a much simplified way of seeing things from a patient perspective but it remains remarkable to see how relaxed and friendly the interaction is between GP and patient with no concern about being pushed either way into an unnecessary plan of action and no need to create any further professional barrier than the one that is naturally in place.

I could describe the beautiful building in which the clinic in Amsterdam was held endlessly due to its classic historic traditional dutch design with steep staircase, tall narrow rooms, lots of light and character. This however was in stark contrast to the





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purpose built building surrounded by multipurpose businesses and shops in Den Haag, in Schilderswijk area of regeneration and growth. Here I was still able to see the same approach to working and friendship as I was in Amsterdam. I cycled for my commute with my supervisor guiding me along the streets of the fast paced city. I suspect this is Dutch work life balance is something I will aspire to for a long time coming.

In terms of consultation the 10 minute model remains the standard. In house psychologists take 30 minutes and dieticians and physiotherapists between 10-30 minutes depending on intervention. A clinic can hold between 10-20 patients face to face, more when telephone consultations are held.

I was amazed to see junior GP colleagues trained in minor surgery, ultrasound, sports therapy. Trainees were able to independently perform minor surgery and even supervise each other! I also think that the PREP for HIV programme was excellent and very relevant in the population of Amsterdam and I think it would be a great addition to the UK services when it rolls out also.

I did note that the safeguarding services that are integrated between community and GP child and vulnerable adult services in the UK is not reflected similarly in the Netherlands. Neither of the practices had Safeguarding leads and when prompted they stated the rate of abuse as not high enough to warrant it but it would seem also that there is no database for children that is at hand to assess if situation did arise. I wonder if this is something that may one day cause a serious missed opportunity to present itself. Antenatal and post natal checks and baby checks are all externally organised also. It could be possible a child would be known to be abused in one service and the services don't communicate this with each other and so multiple presentation and escalation of behaviour can be missed. It certainly worried me but upon reflection that was more because of the involvement I have had personally in other cases in my own practice.

I obviously had a different experience during the lockdown with majority online e consult, video consult or telephone consult.

This telephone consult was newer concept there and in my practice in the UK we hold telephone triages regularly and draw clinics from these also. I was surprised at how useful they found it because it dawned on me that there had been no need prior to the lockdown for them to need to reduce their workload or become more efficient as demand and supply were matched and patients were generally able to get appointments when needed. The doctors commented on how it made them realise





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what a significant portion of their clinical work can be carried out through history alone. The databases used for electronic note recording was similar to emis and within 48 hours of the lockdown we were given two new codes related to coronavirus-suspected infection and anxiety about coronavirus. This was very fast and very helpful in maintaining good record keeping for future analysis of patterns of infectious spread. The code was used 58 times in the practice by the end of the first week as it was disseminated well through the team via the Crisis team ladder.

My OOH experience was reduced to make it safer for me through avoiding exposure. I understand the OOH GP work from the hospital in Amsterdam alongside a team of paramedics, nurses and technicians to help deliver home visits, co ordinate admission and management and triage. Mask fitting and PPE was available to these OOH GP easily. Priority was again given to doctors with no need for supervision to work here, as to avoid wasting valuable PPE during the crisis.

My supervisor in Amsterdam was Dr Peter Vonk, the lead and the longest working GP at the centre having been there for over 35 years. He was calm, easygoing and approachable. He was very keen to help me learn from my exchange but given the circumstances this was difficult. I enjoyed getting to know more about his work from a business perspective as this was a new concept to me. He had innovative ideas and plans. He did seem to take the lead on projects and the autonomy to make decisions about direction of healthcare with the support of his team. One afternoon we sat and researched whether there would be any evidence to support chronic monoxide poisoning as a cause of headaches which may help manage a lot of the patients that we see on a weekly basis. It was an interesting topic that had crossed his mind and he was able to elicit support easily.

During my placement in Den Haag I had the privilege of working with Dr Martin Baardman a former military GP with a great deal of experience on and off the field. My father was an ex military man and as a second generation British Asian doctor in the UK I have often struggled with the idea of nationality and identity which has become more complicated in the aftermath of recent wars, migrant crisis and Brexit planning. I have not always found it easy to explain that advocating or caring for one group more than another based on 'roots' was something I struggled with since I am always a degree closer to those who have sought refuge or asylum in the UK whereas my colleagues are often a few degrees of separation away. This can be tricky to talk about purely because it not something everyone can relate to and it invites debate and doubt from people who feel your identity is now up for discussion.





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Of course in some settings your dual heritage is an advantage but at the same time it can be disadvantageous in how it separates you if you are unfortunate enough to work in an environment where such is the case. The Hippocratic oath we took means we care for all life equally and we do not discriminate.

In the UK I am very lucky that I have not had to face situation yet where we turn away patients although I have no doubt this has happened to many of my colleagues due to newer restrictions on access to healthcare services and in the situation of military service this would have been a very relevant issue also. Not for lack of trying but for lack of resources and support to co ordinate any efforts to help those during a time of war who are not on your 'side'. A sad concept but a very real one for military doctors who may often face the dilemma and approach it in different ways due to compromises that must be made. This is a real test of the oath.

Working with a former military doctor in an urban setting, I was extremely impressed with how integrated, involved and dedicated he was at improving the living situation for those he cared for. The above reflections I have described all relate to the way he challenged me but also the way I challenged myself to think deeper about his experiences. The work doesn't stop for Dr Baardman who not only understood his powerful position in a patient doctor dynamic but he challenged it also by making himself more approachable, relatable and breaking barriers that may be perceived by his patients who are from the backgrounds of those directly or indirectly affected by his life's work. He was humble and kind, caring and motivated. He made his patients feel valued and respected. He took time to ask about their families and explore holistic approaches to caring for them. I could feel his passion for teaching and sharing his knowledge and I would definitely recommend him to any exchange participants going forward. Unfortunately, my time at his practice was cut short due to the covid crisis but it has left a lasting impact and for that I am grateful.

I returned to work in the UK for the COVID measures and I think my time in the Netherlands has significantly changes both my attitude to my working relationship with my patients and my approach to teamworking also. In a situation where we are all facing the same pandemic, I see how important a unified structured approach and open communication is key to success. I do hope to return to the Netherlands again to complete this opportunity, but I made the most out of it nonetheless.

