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Participant report
Dr Katriona Graham –Netherlands– 18/01/2017 to 31/01/2017

I have complete an exchange to a GP surgery in Zevenaar, the Netherlands and hosted, alongside my trainer, a Dutch GP trainee from Amsterdam. This has been an enlightening experience which really allowed me to reflect and question why we do what we do.

Having the Dutch GP trainee in our practice meant that I had to explain the process of how Primary Care in managed and delivered in the UK. As a first-year trainee I realised how difficult it is to explain how the surgery is run or rather why it is run how it is.

The GP surgery where I train in Suffolk has approximately 14,000 patients with 5 full time GPs, 2 part-time GPs and around 50 staff in total. The GP surgery where I went in Zevenaar has approximately 2,000 patients with 2 part-time GPs and around 8 staff in total. Although the numbers are different, the appointment lengths are the same, the working hours are the same, the clinic rooms are similar and in general I found the patient presentations and expectations similar. However, given the smaller size, continuity of care is more apparent in the Netherlands.

The role of a GP in the Netherlands is similar the main different I recognised is that GPs in the Netherlands use more skills such as removing sebaceous cysts, placing coils and toenail removal all in a day’s practice. This overall meant that they saw less patients daily than GPs in the UK due to timings. This helped me recognise that I would like to develop and keep these sorts of skills as a GP which does mean working in a surgery where this would be possible. My opinion from what I saw with the two practices is that there are more demands of the GP in the UK due to the larger numbers of patients and this then impacts on care with regards to time for referring on and continuity.

General Practice training in the Netherlands is similar with training being 3 years and experiencing two different GP surgeries. However, in the UK there is 18 months of other placements compared with only 12 months in the Netherlands. Also, in the UK, trainees (for the majority of placements) become part of inpatient hospital teams whereas in the Netherlands is it more outpatient or clinic based placements. I think it is more worthwhile to experience clinics rather than being part of the inpatient team as the knowledge you would acquire would be more relevant in preparing you to work as a GP.
In the Netherlands, everyone pays insurance which is around €100 a month, there are schemes to help if you cannot afford it. The GP service is free, GPs are paid via insurance. Patients pay initially around €300 for a referral to secondary care, investigations including bloods and prescriptions. This is capped and after which is paid for by insurance. I wondered if having to pay would influence a patients’ decision to visit the doctor or access the health service. From what I saw it did not. However, waiting times are shorter and visible online. Patients can be informed of waiting times in each hospital via an electronic system. This would manage patient expectations much better in the UK, where you can wait up to 16 weeks for some services. I wonder if it would have been any different in A&E? I witnessed the OOH service which also is very like the UK.

I was interested in teenage pregnancy rates; the Netherlands has the lowest in Europe whereas the UK has one of the highest. I remembered from medical school that we were taught that this was due to ‘relationship education’. I was fortunate to be given the opportunity to discuss with a teacher who delivers sex education. On discussion, I realised that the sex education was given in secondary schools in a similar way to how I had received it at school. There was no specific relationship education given in primary schools although relationships are discussed as part of their culture. The other finding was that contraception was discussed within a family. Teenage girls presented to the GP with their mother in the Netherlands and it was also reported that the prescriptions were picked up by either parent. I think it is more of a culture difference, expectations of individuals and family attitude’s that possible equates to ‘relationship education’ and therefore influences the teenage pregnancy rates.

This has been an excellent experience and has also led to an improvement in my Dutch language skills. I think that if I were more proficient in Dutch this would have allowed me to have more insight into consultation styles etc. However, I still feel I learnt a vast amount by observing. I feel that the opportunity has allowed me to reflect on ‘The Family Doctor’ how a GP exists in the lives of individuals and how I would like to continue to deliver care throughout my career.