Around Europe

Clinical Medicine and Research in the Netherlands

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In November 1973 we undertook, on behalf of the British Council, a week's visit in the Netherlands to several medical schools, research establishments, and funding and health care organizations, including the Netherlands Ministry of Health and Environmental Hygiene. The medical schools visited were those of Amsterdam, Leiden, Rotterdam, and Groningen—at all of which we had most cordial and informative meetings.

An Englishman immediately feels at home in Holland. There was no language problem as everybody we met spoke excellent English. The Dutch seem to have a wealth of good will for the British left over from the war: one of the most popular television programmes is "Dad's Army."

Health Services

The Dutch appear well pleased with their health services which have developed in a rather haphazard but practical way. Everyone who earns less than Dfl. 23,200 (£3,800) a year—and this includes about 70% of the population—is insured under a national scheme; they have to pay 4.75% of their salary and the employer contributes a similar amount. The 30% of the population who either earn more than this or are self-employed are for the greater part covered by private insurance policies. Even those who are covered by the compulsory national scheme are able, and often do, take out additional private insurance to qualify them for a better class of accommodation in hospital—for example, a private room.

The Netherlands is second only to Sweden in the amount it spends on its health care. In 1972 the figure was 7% of the gross national product and the cost continues to rise.

Doctors' Pay

General practitioners tend to work alone and not in group practices. They are paid on the basis of a capitation fee; if they do not charge more than the scale fees their salary is about Dfl. 50,000 (£8,000), but some earn up to double this amount.

Specialists work as entrepreneurs; they are paid on a fee-for-service basis. Patients have to be referred to them by a general practitioner, as in the British system. Most of the 6,000 specialists are attached to hospitals, but about 400 operate without hospital appointments. Specialist pay is high. Surgeons can

earn up to Dfl. 500,000 (£80,000) a year and it is not at all unusual for them to earn Dfl. 250,000 (£40,000) a year. A regional bacteriologist of about 30 will be on an income range of Dfl. 100,000—Dfl. 200,000 (£16-32,000) a year. Full-time faculty members earn considerably less.

Medical Organizations

The Royal Netherlands Medical Association combines some of the functions of the British Medical Association, the royal colleges, and the General Medical Council. Through the various councils and committees within its organization it recognizes specialist qualifications, controls hospitals and training, and also deals with medical disciplinary matters. In the latter field the attitudes are different from those of the General Medical Council in that a much more serious view is taken of medical malpractice that results in disability and death than in affairs of morality and the heart.

Undergraduate Medical Training

Any student who succeeds in the final school examinations (equivalent to A-level) in the Netherlands has the right to university education and until recently could select medicine if he or she so wished. As a result of this policy the number of medical students starting first year preclinical training was so large that it was really impossible to train them. The medical schools protested that some form of selection was necessary and so the following system was introduced.

A student who obtains 75% or more of the marks in the final school examination is automatically accepted for undergraduate medical training. This is a very high standard and accounts for only a very small proportion of the medical school entry. Of those students who obtain a pass mark (50%) but less than 75%, all are entitled to enter a lottery for medical education. Their names are simply selected at random and those who succeed in the lottery start preclinical medical undergraduate training. This method of selection is chosen because it is felt that everybody should have a fair chance irrespective of his industry, intelligence, and enthusiasm. The students and others who are in favour of this method of selection argue that high marks in the final school examinations have never been shown to relate to superior performance as a doctor and it is felt that the lottery is just as likely to select the best doctors—and perhaps they are right.

Even with this selection procedure the number of students is well above requirements and there is a 20% drop-out rate in the first year alone. Despite this and subsequent drop-out in later years, all deans thought that they were producing too many doctors.

Many students are financed by a system of government loans, which are repaid during the first five years of practice. Apparently it is most unusual for loans not to be repaid even in the case of married women doctors who are not practising; in these circumstances the husband pays.

The system of medical school administration is different from the hierarchical system that we know in Great Britain. The medical school deans are themselves elected by councils made up of various proportions of faculty members, students, and

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technological staff (laboratory technicians and secretaries etc.) This same council is concerned with many of the policy decisions of the medical school and can influence the type of research carried out by faculty members. The proportion of faculty members on the council varies between universities but is never more than half of the total membership.

Postgraduate Education

SPECIALIST TRAINING

Postgraduate training arrangements seem to be much more haphazard than in the United Kingdom. A young man wishing to specialize has to obtain a post with a teacher of his choice. Such posts are obtained by personal contact and there is no compulsory advertisement or committee selection. This is surprising in view of the extreme democratic attitudes seen in the selection of undergraduate medical students. The postgraduate trainee is well paid: he receives a salary of about Dfl. 30,000 (£4,760) with additional marriage allowances and does not take any higher medical qualification. When his period of training has been satisfactorily completed he is registered as a specialist and then seeks a post. Again this may be achieved more by personal contact than by open competition for specific advertised posts.

IN-SERVICE TRAINING

In-service training of general practitioners and specialists has not developed to the extent that it has in the United Kingdom. Dutch medical educationalists are attempting to define the skills and decision-making abilities that they consider their doctors in different disciplines should have. Not unreasonably they think that only when they have first defined the aims of the education can they design the appropriate courses to achieve them. This seems a more studied and rational approach to the problem of in-service training than the haphazard postgraduate education explosion that has taken place in the United Kingdom in the last four years.

Research and Working Communities

Research in the Netherlands is very well organized. Universities and university hospitals come under the direction of the Ministry of Education and Science, not the Ministry of Health. Faculty members have certain sums of money allocated them for teaching and research but they may also apply to a medical council for pure research in medicine (FUNGO), which is part of the fundamental research organization ZWO, or to a medical council of applied research (GO), which is part of TNO (Council of Applied Research). Non-teaching hospitals are financed by the Ministry of Public Health and Environmental Hygiene, which supports several institutes through TNO. The whole system is complicated but seems to work satisfactorily. The two funding organizations exert considerable influence over the type of work done. A system of "working communities" has been built up, particularly by FUNGO, so that a research worker who wishes to obtain financial support must normally belong to a working community in his field of research. The task of a working community is to discuss and, if possible, improve and co-ordinate the plans of the working groups. They hold informal

workshops on the research in progress at least once and more usually two or three times a year. In theory at least, any research worker who has a project that fits into the activities of the working community and who is willing to have it discussed and criticized, and is willing and qualified to evaluate the projects of others, may join a working community, even if this leads to keener competition for funds within the community.

This system is designed to discourage poor work and duplication of effort, but it does require a considerable bureaucracy to administer and it takes at least nine months to process any request for funds and requests can be made only at one time in the year.

The critics of the system of working communities point out the danger that they can easily become mutual admiration societies which may exclude new workers with novel but good ideas, simply because they do not fit in with the goals of the working community or because they may compete for the working community's funds.

Centres of Excellence

It is the policy of the Ministry of Education, which controls teaching hospitals, to centralize more expensive research in "centres of excellence." These centres are to be known as inter-university institutes and some have already been founded, such as those in cardiology and ophthalmology based on the University of Amsterdam.

To some extent these inter-university institutes will be "paper institutes." Their function will be to enforce co-operation between faculties in specific fields. They will be administered by a board with representations from the various universities; the board will decide priorities about the purchase and location of special equipment and facilities.

Opportunities in the Netherlands

Several British radiologists and anaesthetists are working in permanent settled posts in the Netherlands; indeed, one of the most senior of the anaesthetists is an Englishwoman married to a Dutchman. There are opportunities for young doctors to work for limited periods in research and clinical posts, but for the medical and surgical specialties a knowledge of Dutch would be necessary to communicate with the average patient. Practically all the doctors and technicians, of course, speak excellent English. Though medical students would be welcomed for elective periods in Dutch medical schools, they would find their involvement with the patients less than in British schools on account of the large number of Dutch students.

The funding of British doctors working in the Netherlands would not appear to be difficult. If they were occupying service posts they could be paid generously by British standards from Dutch resources. There is also an exchange scheme for research workers administered by the Royal Society on the British side and the Royal Netherlands Academy and ZWO on the Netherlands side. For other visits there are various awards offered by the British Council.

It is hoped that in future these opportunities will be used more often because Dutch medicine and research has much to offer and any visitor can count on a welcome from a highly civilized society and people.