MEDICAL PRACTICE

Where Shall John Go?

Holland

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There are several options open to doctors wanting to work in Holland for a year or two. Although many of the Dutch speak English, language remains the main bar to clinical medicine; this is less of a disadvantage in such specialties as radiology, pathology, and anaesthetics, and vacancies are fairly frequently advertised in the *BMJ*. The main opportunities lie in academic or industrial medicine. The choice of academic centre for the doctor who has funds from England will depend on individual interests and training requirements. Most Dutch medical research is funded centrally through Government agencies, though contributions do come from industry and charitable foundations. There is strong competition for research posts (which are regarded as an important phase of medical training) and the English doctor may find it difficult to obtain support from this source, although occasional vacancies are advertised in English journals. An alternative often practised by American university staff is an exchange, either concurrently or sequentially over two years. The former may have advantages, as houses and cars can often be exchanged as well as jobs. This sometimes leads to disappointment but the proximity of Holland to Britain allows both parties to assess the desirability of an exchange before being irrevocably committed.

Research depending heavily upon doctor-patient relationships suffers from the same disadvantages as clinical medicine. An American psychologist friend of mine found the small nuances of meaning difficult to convey and was disappointed with the clinical aspect of his visit. On the other hand, it is surprising how much a little newly learned Dutch, a patient's half-forgotten English, and much goodwill can achieve in terms of a simple clinical history. Areas of incomprehension can at least be defined

and resolved with the help of an interpreter, and it should not be difficult for the visitor to function effectively in this way, given that most of his colleagues (as well as the laboratory technicians) will speak very good English.

Several large British and American companies have quite sizable operations in Holland, mainly in petrochemicals. Most of these companies are based in the Hague or Rotterdam in the south of the country and advertise in medical journals. Schooling and housing are usually arranged by the company and such posts may have attractions for the doctor with a young family, particularly since several of the English schools are situated in this area.

Dutch medical regulations

To practise clinical medicine the visiting doctor must show that he is appropriately qualified. The Ministry of Health will need to see originals of university and higher medical qualifications together with evidence of registration by the GMC. It does not seem to be essential for this to be done in advance and can most conveniently be arranged after arrival. These documents will also be needed for registration with a university as a post-graduate student. If contact with patients is to be continued a subscription to a medical defence society should be maintained.

Dutch medicine

Dutch medicine offers sufficient contrasts to our own to be continually stimulating while retaining enough of a basic identity to prevent dissociation. University education is considered a right and there is no entrance selection provided that the student has passed the diploma of secondary education, which must include some science subjects. There are eight medical schools: two in Amsterdam, and one each in Leiden, Rotterdam, Groningen, Utrecht, Maastricht, and Nijmegen. The yearly entry is about 1800 with a 30-40% dropout rate, mainly in the first year.

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The composition of degree courses varies between the different centres, but there is a general trend towards integrated teaching over five to six years culminating in the examinations for a university medical degree. To obtain the "arts" certificate with its entitlement to practise general medicine, this is followed by a final year of rotating internship (two months each of internal medicine and surgery, and eight months in an approved general practice). Those wishing to stay in hospital medicine pass directly into the training programme of their chosen specialty.

About one-third of Dutch doctors work in general practice, an equivalent proportion are hospital specialists, while the remainder are employed in public health, hospitals (as junior staff), insurance, and administration. In the universities and larger centres senior and junior staffing has a similar structure to that in England. The specialist (consultant) is the senior member of the team supported by the internist (senior registrar/registrar), who has completed his specialist training but who does not have a permanent appointment, and the assistant (registrar/SHO), who is still in training. In the remaining hospitals specialists will be responsible for the total care of their patients and do not have junior staff. The transition from assistant to internist follows a period of approved specialist training but does not include examinations equivalent to our own MRCP or FRCS. Specialist medical training and designation of training posts are supervised by a committee drawn equally from the medical faculties of the universities and the Royal Dutch Medical Society. At the end of his training the doctor becomes a registered specialist. Although the "arts" certificate entitles the doctor to practise medicine without restriction, in practice insurance companies will refund only the costs of hospital treatment prescribed by registered specialists.

The Dutch health service is based on a mixed compulsory and voluntary insurance system administered by private insurance companies and based on government regulations. Insurance is compulsory for those with an annual income of less than Dfl 32 000 (about £6000), premiums being payable at a rate of about 10% of total income, divided equally between employer and employee. About 70% of the population is covered by the scheme—as are the elderly, who pay reduced premiums. Most of the rest are insured through private schemes, although this is not compulsory; medical expenses, however, are very high and few are uninsured. Cover usually includes all fees for general practitioners, hospital specialists, medication, transport, and hospital admissions for the first year of illness; thereafter hospital costs are born by the State. Maternity expenses are not included and are an important, and very expensive, factor to be taken into account by the visiting doctor whose family is likely to expand during his stay in Holland.

There may be problems in arranging medical insurance for someone going to Holland as a postgraduate student. Under reciprocal agreements among members of the EEC an employed person and his family, insured in the UK, are entitled to urgent medical attention on presentation of a certificate from the DHSS, who will reimburse 80% of the cost. Nevertheless, doctors going to Holland on visiting fellowships may find that they are classified as being "self-employed," not being in the regular employment of the grant-giving body, or employed by the university or hospital in Holland, while their regional health authority or other permanent employers may not pay insurance premiums during a sabbatical year. Usually grant-giving bodies will agree to reimburse fees for urgent medical attention but failing this the doctor will need to join a private insurance scheme on his arrival in Holland.

Dutch life

A compassion for refugees fleeing persecution has been a consistent feature of Dutch society for many centuries. Perhaps for this reason, more than any other, few countries can claim to have played such a significant part in the upheavals and

evolutions of European culture. For the English and Americans the links are particularly close. In 1608 the Pilgrim Fathers arrived in Amsterdam but after a few years moved to the quieter town of Leiden under the guidance of pastor John Robinson and William Brewster, his principal elder. The house which they purchased in 1611 from Brewster's earnings as a teacher of English at the university became the centre of the English colony's life in Leiden. The university itself also had its origins in persecution, having been founded to commemorate the stubborn resistance and great hardship endured by the townspeople in successfully resisting the Spanish siege of 1574.

The 400th anniversary celebrations last year emphasised the close inter-relationship between this particular town and its university, but also illustrated the pride which the Dutch as a nation have in their scholastic heritage. For the visiting doctor there are many centres of academic excellence together with good hospital facilities and scope for a widening of experience. It is also a country of great charm where his family will enjoy being permanent tourists.

The Dutch are among the most home-loving nations in Europe, even though few are owner-occupiers. Enchanting or downright infuriating contrasts become apparent during the first few days. This will be a busy time finding one's way about the new town and shops, arranging children's schooling and bank accounts, and is a time when the overwhelming helpfulness and kindness of the Dutch will leave a permanent impression. All the family will rapidly become converted to the use of the bicycle, a sadly underused form of transport here, but one for which the Dutch make special provision by way of cycle tracks ("fietspad"), segregating the cyclists from cars and lorries. Dutch habits at home soon become accepted: potted plants on every square centimetre of window ledge, and curtains which are never drawn at night—a tradition which we found rather disconcerting as recluses, but quite fascinating as voyeurs. There are a few frustrations: the Dutch never queue, and, although this is a continual outrage to the English sense of fair play, it at least introduces a competitive spirit into everyday shopping, similar to that of the first day of the January sales in a large London store.

Language

It is important to learn to speak Dutch even though English is spoken much more commonly than is any foreign language in England. The universities run a language course based on an excellent programme devised in Utrecht. This is usually available in a language laboratory or through conventional teaching sessions, often at nominal cost. In Leiden, as in other universities, this was organised by the International Centre, a voluntary organisation predominantly drawn from the wives of university staff, who help in a practical way with the introduction and integration of the visitor into his new surroundings. Information is available about houses for rent, schools, household furniture, and utensils for sale (usually by departing visitors and often quite cheap); and where to obtain, and how to complete, forms necessary to satisfy local regulations—for example, registration as a foreign visitor. This latter is important and originals of birth and marriage certificates are required for presentation at the local town hall.

Housing

Houses are extremely expensive to buy and rented accommodation is the only practical choice for those who are visiting for a year or two. In a university town the International Centre is likely to have the best selection of rented flats or houses, though hospital administrators may also have similar lists. Some hospitals and universities have their own rented accommodation: since this is usually cheaper than average it is much in demand and difficult to obtain. Most of the large American or British firms based in Holland own or rent accommodation

for the use of their staff. This is usually on one of the newer housing estates and most of one's neighbours will be English or American. Whether this is considered an advantage or a disadvantage depends on one's viewpoint; certainly it will inhibit one from learning to speak Dutch.

Schools

Primary education begins at 6, but may be preceded, if parents wish, by a crèche (age 2-4) or "kleuterschool" (age 4-6), both of which are fee-paying and much the same as our own nursery or play school. My own children, aged 3 and 5, benefited enormously from attending these Dutch-speaking schools. For the older children on a relatively short visit parents may prefer the English schools which begin at age 5 and follow a system similar to that at home. There are English schools in the Hague, Rotterdam, and Amsterdam, but fees are quite expensive. Transport to the schools is often arranged by a special bus or by a parents' rota.

Finance

Visitors paid from England are exempt from any Dutch taxation, although liability to UK income tax depends upon several factors, not least the length of absence from England. Since quite large sums of money may be at stake it is important to define one's individual tax position as precisely as possible before leaving England. This will be time well spent. English banks will arrange an account in Holland but it is probably more convenient to make arrangements at a local bank soon after arrival. All that is required is a letter of introduction from one's English bank and a passport as proof of identity. An English Eurocard is very convenient as it permits up to the equivalent of £30 sterling to be drawn in any continental bank.

Travel

It is not necessary to obtain Dutch registration for a car if you stay in Holland for less than one year; nor is the equivalent of a road fund licence required. Although public transport is fairly expensive, it is very efficient; main bus depots are almost always adjacent to the railway stations and are amply provided with route guides. Bicycles can often be hired at stations for

short or long periods and the scope of the combined bus and train tours of the countryside, which are available in the spring and summer months, can be extended by hiring a bicycle at the end of one's journey. For a family spending a fair proportion of their free time sightseeing, however, a car will prove much more economical in the long run.

Tourism

It would be a pity to consider a visit to Holland solely on professional grounds: it is equally important to be sure that all of one's family will settle down and be happy. Traditionally the Dutch eat out in the country on a Sunday and consequently most of the larger towns are deserted. This is the very best time for a visit, cycling en famille through the empty cobbled streets and along the canal banks. In many of these towns there are small picturesque squares entered by a narrow gate or archway and flanked on all sides by houses. These are the Hofjes, a unique feature of Dutch life and living reminders of a movement begun in the seventeenth century by some of the wealthiest families in Holland, who built and endowed homes for the elderly so that they could live in independence and dignity. Tourism is well organised and based upon the ubiquitous offices of the VVV, which provides street plans and lists of places of interest either free or at nominal charge. The centres of the older Dutch towns have been carefully preserved and are quite beautiful, particularly if viewed to the accompaniment of the traditional street barrel organs. Despite the urban splendour it would be wrong to dismiss the countryside as flat and uninteresting. Hills and valleys are of course absent, but woods and fields flanked by straight canals with a huge backdrop of sky have their own charm.

Even though a working visit to Holland may be for only a short time it is so near that contacts, both professional and social, can be maintained. In the last year many of the friends who gave such hospitality during our stay are now in England and we are seeing our own country through tourists' eyes as we show them round.

It is a pleasure to acknowledge the support of the Medical Research Council who made my visit to Holland possible by awarding me a travelling fellowship. My thanks are due to Professor D Smeenk and Dr Olav Bijvoet for their hospitality during my stay in the department of endocrinology, University of Leiden.

A patient who has taken D-phendimetrazine bitartrate as an appetite suppressant for one course only has some months later asked for a repeat. She says that half a tablet (17 mg $\pm$) relieves all the aches and pains in her muscles and joints that she has been plagued with for a long time. Does this have any diagnostic significance as she has been fully investigated by a general physician for arthritis, etc?

Phendimetrazine bitartrate has amphetamine-like properties, so that it is likely to produce an elevation of mood and a general feeling of well-being. Obesity is often associated with muscle and joint pains, and these may be relieved by weight reduction. Either of these mechanisms could be present in this patient, but it is as well to remember that these are drugs of habituation, and the relief she claims could lead to a dangerous demand for further prescriptions.

Would continuous alkali perfusion of the stomach in haemorrhagic gastritis be more effective than the customary antacid regimens in raising the pH of the gastric contents, diminishing the back diffusion of H^+ ions, and hence stopping mucosal haemorrhage earlier? What is the effect of pH changes on whole-blood clotting time, and are in vivo bleeding times affected by surface pH differences?

Experimental haemorrhagic gastritis does not occur in the absence of gastric acid and if achlorhydria is found during a bleeding episode it is due to back diffusion of hydrogen ions.¹ In man, antacids or a

milk drip are ineffective methods of raising intragastric pH, and, while bicarbonate infusion may be more successful, there is a risk of alkalosis. The recent introduction of potent histamine H_2 -receptor antagonists,² which effectively inhibit acid and pepsin secretion, provides a new and potentially more valuable approach. The gastric juice from patients with erosive haemorrhagic gastroduodenitis shows high fibrinolytic activity,³ which may contribute to continued bleeding, and fibrinolytic inhibition may therefore be a useful alternative approach. Platelets become non-functional and whole blood fails to clot at pH values below 6.0. The very low gastric pH is, however, unlikely to be relevant to the haemostatic action of platelets and coagulation proteins within the blood vessels of the afferent supply to the stomach wall.

¹ Skillman, J, et al, *Annals of Surgery*, 1970, **172**, 564.

² *British Medical Journal*, 1976, **2**, 789.

³ Nilsson, I M, et al, *Thrombosis et Diathesis Haemorrhagica*, 1975, **34**, 409.

Is eating less animal fat beneficial?

Much has been published on animal fats in the diet causing disease, especially coronary disease. It is possible to produce a plausible hypothesis that a high consumption of animal fat plays a part in causing coronary disease, but an unbiased observer would have to say that this falls short of conclusive evidence. Even less is there certain evidence that reducing animal fat in the diet produces any benefits in terms of human health.