"Apart from 'surviving' cycling on the 'wrong' side of the road, Dutch general practice is an excellent example of an alternative primary care model in Europe ..."

A new meaning for 'going Dutch'

I was fortunate enough to spend 2 weeks at a practice in Veghel, a small town situated in the southern Netherlands, on exchange through an EU Leonardo Grant Scheme for AiT's (GPs in training) and First5 GPs (those within 5 years after qualification). I had chosen the Netherlands on the basis of my command of the Dutch language and in recognition of the subtle cultural and language nuances within every general practice consultation.

The Leonardo da Vinci Programme is part of the European Commission's Lifelong Learning Programme which funds organisations in the vocational education sector to work with partners from across Europe. As part of this, the RCGP Junior International Committee had been awarded funding for up to 30 young GP participants.

Apart from 'surviving' cycling on the 'wrong' side of the road, Dutch general practice is an excellent example of an alternative primary care model in Europe: professional, coordinated, and integrated. The same problems exist: how to deal with ever-increasing complex patients in a 10-minute consultation.

My host practice was run by two GPs and had one practice nurse, two administrative assistants, and an in–house psychologist, and served a practice population of about 3200 people. A normal working day started at 8:30 am and ended at approximately 6 pm (paperwork dependent). The practice itself did not offer extended hours.

Dutch general practice is rooted in the community; my host GP continues to both live and work in Veghel and has done so for the past 25 years. The daily routine was similar to the UK: 10-minute consultations, home visits, minor surgery, reviewing lab results, and correspondence. The practice used very similar (QOF-type) parameters to guide medical care when assessing a patient with a chronic illness, although there was not specific indicator remuneration. There was shared-care between primary and secondary care for chronic illnesses, but also between GPs and practice nurses in chronic disease management.

Patients were encouraged to 'pre-inform' the GP or assistant the reason for the consultation by use of a simple term, such as cough or shoulder pain, when booking an appointment. This was optional for patients but had distinct advantages since GPs could 'prepare' before the patient walked in the door. Indirectly it also curbed patients' problem 'lists'. The consultation style was very similar to that in the UK, providing comprehensive care and using a person-centred care approach.

One of the striking features of Dutch general practice is its efficiency. For example, all the local diabetic services for the region are arranged as a cooperative where there is a central recall system for annual blood investigations. Results are forwarded to the GP before the annual diabetic check. It seemed that Dutch GPs were not 'swamped' with QOF parameters but instead used those same parameters as a guide to providing good medical care when assessing a patient with a chronic illness. They were more likely to utilise technology more effectively. GPs also had access to their local hospital's website and had early electronic communication of any patient admissions, although only had access to their own practice's patients. Dutch GPs do not issue fit-for-work certificates. All Dutch GPs are required to do a certain number of out-of-hours sessions per month, of which the scope and practice is similar to the UK.

I was privileged to have an honest discussion about euthanasia in the Dutch context, and the inherent caveats. This is perhaps a discussion that still needs to be had in the UK without the political/religious agenda. It also seems that chaperones are seldom used in the Netherlands; indeed there is no obligation to offer a chaperone.

One of the striking differences is the attitude of Dutch patients to health care. They do not pay directly for medical care, however, personal medical insurance is mandatory and allows for unlimited basic medical care. And yet, given this 'unlimited' access to healthcare, Dutch patients seem very sensible when utilising this finite resource. When I raised this issue, my Dutch host suggested that the main difference might be a concerted drive by the Dutch government and Dutch GPs to improve patient health education and highlight their responsibility towards personal health and health care. Now, if we could try to do the same here, it would put a 21st century spin on the meaning of 'going Dutch'?

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