EUROPEAN MEDICAL EXCHANGES: LONDON/UTRECHT

SIR—I have spent a year in the Netherlands under the auspices of the European Society for Clinical Investigation (ESCI) exchange programme described by Professor Dickinson and Professor van Ypersele (Dec 20/27, p 1446).

A potential problem with the scheme (especially for the British) is language. I have met five participants visiting London, and their English on arrival was good to excellent. When I went to the Academisch Ziekenhuis, Utrecht, my Dutch hosts, recognising that Dutch-speaking visitors would be nigh impossible to find, made a special effort to teach me their language. Newly married, I spent a week under intensive language tuition in a convent! My German proved to be a mixed blessing, for as my Dutch improved the two languages fused until I became a standing joke in the department—the Scotsman who spoke Dutch with a German accent. It is a fallacy, by the way, that all Dutch people speak English, but with the help of medical students and the patience of nurses, I struggled through.

Language apart, the greatest adjustments for me were not in patient management but in hospital structure. The Dutch have fixed periods of training before accreditation as physician (five years) or surgeon (six). A trainee in internal medicine is appointed for five years to one major centre, though he may spend the first two years in a district general hospital. Utrecht had 23 trainees at different stages. There are statutory requirements (so many months in cardiology and chest medicine, for example) but flexibility allows for the development of special interests and for research. After five years one becomes an "internist" and can apply for consultant posts. The Dutch manage very well with two tiers of consultants, an arrangement much feared in the UK. They have in university hospitals junior members of staff who take turns managing a ward and its trainees but themselves are answerable to senior staff.

I was the only junior doctor on the ward and directly answerable to a consultant. In Britain no doctor would run a ward singlehanded, but the Dutch use medical time more economically. A ward secretary notes what samples have to be taken, which patients require appointments and investigations, and which results need chasing. Nurses set up infusions, take blood out-of-hours, and deliver specimens to laboratories, leaving the doctor free to devote more time to patient management.

At night, on a rota basis one trainee covers all inpatients and admissions—ie, one doctor covers about 110 patients in varied specialties, an arrangement made possible only because consultants expect to be telephoned. In fact I never had more than four admissions in a night and often they were patients already known to the hospital; furthermore, the night duty rotation was only one in fifteen.

Besides the economic advantage of having only one doctor per ward there is the benefit that the prospects of becoming a consultant are better—and improved even further by the number of doctors entering specialist training being related to the vacancies envisaged in that specialty. This means that competition for training places is fierce, and young doctors often have to do non-accredited jobs while searching for a training post. There is no in-training assessment and it is very exceptional for anyone starting a training programme not to finish it.

The medicine I saw was excellent but specialised and academic, to a large extent to the exclusion of true general medicine. The distinction between teaching and district general hospitals is greater in the Netherlands and much of what is general medicine in the UK falls under different specialties there. My three attachments were in general medicine with oncology, nephrology, and haematology with bone marrow transplantation. Cardiology, neurology, and chest medicine are independent specialties, and in my year in Utrecht I never saw a Dutchman with a stroke, chest pain, or tuberculosis.

The ESCI exchange programme offers an excellent opportunity to would-be physicians to learn about other nations' health care structure and medical training. The differences in patient management in crossing the North Sea from St Bartholomew's Hospital are probably not much greater than those one might experience crossing the Thames. However, I learned that there is an alternative to the British career structure and postgraduate training arrangements need not be so repressive. The pity is that the scheme has not spread its wings wider. France, one of the three largest countries in Europe, has never taken part, and in Britain all five participating hospitals are in London.

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SIR,—Before giving my personal view, as a Dutch doctor working in a large hospital in north-west London as part of an EEC exchange programme (Dec 20/27, p 1446), I must stress this is not an unbiased double-blind, crossover, case-controlled study.

Since starting work as a senior house-officer (SHO) in the UK, I have been struck by several differences between medicine in hospitals in the two countries. One has been the influence of the hospital's budget on medical practice. I found myself being contacted by people wanting to know why I had asked for such and such an investigation. They were asking: "Will this test affect future management of the patient?". I recognise the advantages of thinking about the relevance of investigations but this approach can also lead to problems. For instance it is virtually impossible to obtain an erythrocyte sedimentation rate, liver function tests or a computerised tomographic (CT) scan after 1800 hours because of the expense. Referring a patient with possible intracranial disease to another hospital for an urgent CT scan may save expense at my hospital, but surely not in the NHS as a whole. On the other hand, if I want to admit a patient with a myocardial infarction to the coronary care unit, he has to be seen by the casualty officer, the medical SHO and registrar, and the cardiology registrar, which is not only wearing for the patient and his family but also, I feel, not cost effective.

The role of nurses differs a lot. In the Netherlands nurses take blood, set up intravenous infusions, and generally do many of the procedures I am asked to do in London. By contrast much of the work of nurses in the UK appears to consist of perhaps less rewarding tasks such as washing patients and handing out meals.

Neurology is far more a routine part of general medicine in the UK than it is in the Netherlands. In my country large numbers of neurologists have ready access to beds. This had tended to result in them doing their own acute and chronic admissions and generally creating a subspecialty quite separate from that of other physicians. My recent experience suggests that the quality of general internal medicine is devaluated if neurology is largely removed.

In the Netherlands undergraduate medical studies consist of four years of theoretical training followed by two years of clinical experience, the equivalent of house jobs in the UK. After this you can become a general practitioner or undertake specialised training as an assistant internist (eg, SHO). To become an internist (consultant) takes six years on average, during which time all subspecialties of internal medicine are experienced. In the UK the route to consultant status seems slower and less predictable: passing the membership examination of the Royal College of Physicians, for example, merely enables the successful candidate to get a medical registrar's job but it does not inevitably lead to a consultant post. We often feel the grass is greener elsewhere but in this instance I do not think it is.

At 3 o'clock one morning I am called to casualty to see a 76-year-old woman with probable heart failure. The casualty officer has taken blood samples and arranged for a chest X-ray and an electrocardiogram. "You merely have to find a bed", he tells me. However, I am not optimistic about finding one at that hour. The 45 minutes spent checking in the patient will be the least of my problems. It will take at least another hour to unearth an empty bed after trying to convince unenthusiastic night nurses to accept the patient on their ward. I remind myself to write her up for night sedation, an antiemetic drug, and a laxative or my colleague covering the wards may well be telephoned. This all seems far removed from the undergraduate teaching I received at Utrecht University. In two hours we found a bed for her and she responded well to frusemide. "Could you please repeat your name, doctor?" she asked. "Dr Bravenboer," I replied. "Oh," she said, "you must be foreign with a name like that, but they have taught you very well here".

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