Postgraduate Training Around the World

Internal medicine in the Netherlands

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Summary: In this overview various aspects concerning internal medicine in the Netherlands are discussed. Special attention is given to training, which is likely to be increased from 5 to 6 years in the near future. Current problems in internal medicine are mostly related to under-funding of health care and include unemployment (which necessitates reduction of training facilities), disagreement with the government about finances and an argument with the sickness funds concerning professional responsibility and the termination of free enterprise. Also the issue of task definition of the general internist is reviewed. Funding of research used to be mainly the task of the government. Problems with the national economy, however, have resulted in a reduction of the governmental contribution. Private research foundations related to patients' associations, (pharmaceutical) companies and non-university hospitals have increased in importance.

Introduction

The major preoccupation at present of general internists in the Netherlands include such divergent aspects as training and research, and the resolution of social problems, including disagreement about financial matters. In this respect the situation in the Netherlands does not differ from many other European countries.

In this overview various aspects of training, current problems in the Netherlands and funding in research will be discussed. At first some general information is presented.

General information

In the Netherlands, a country with 14 million inhabitants, there are 1792 internists (299 female) and 347 physicians in training to become internists. Approximately 1500 (75%) of them are members of the Netherlands Association of Internal Medicine (Nederlandsche Internisten Vereeniging – NIV). Physicians in training are associated members; they have their own board and are represented by one

member on the NIV board. The NIV also runs its own journal (*The Netherlands Journal of Medicine*), which is published monthly.

Training

At present training to become an internist takes 5 years; physicians in training usually receive their education in 1 or 2 hospitals. The system is that of a decentralized master-apprenticeship¹ and the responsibility for teaching rests entirely with the training unit. Three years are spent in general internal medicine and 2 years in sub-specialties and research (1 free year is optional). There are no examinations, but there is national curricular teaching and (until now anonymous) testing in the first 2 years. National teaching (conducted by a committee appointed by the NIV) is mainly focused on basic pathophysiological, pharmacotherapeutic and clinical knowledge and local teaching is more directed to clinical skills.

The committee for Registration of Specialists (SRC) responsible for the quality of training is advised by Visitation Committees, which inspect training units. Therefore the quality of both trainer and training unit is assessed whilst the trainer assesses the quality of the resident.¹ Also testing after basic teaching is intended to test training units rather than individual residents.

Training is given in 3 different kinds of hospitals (Figure 1): the two first years may be given in a so-

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Figure 1 Training schemes. a. *At present*: A₂ = non-university hospital with 2 years of training. A₅ = non-university hospital with 5 years of training. U = university hospital; usually in 1–2 hospitals; 3 years for general internal medicine, 2 years for sub-specialties and research (1 free year is optional). b. *Near future*: B = basic training for 2 years (general internal medicine) with curricular training. C₂ = continued training with obligatory periods on departments of cardiology, respiratory medicine, out-patients and surgery. C₄ = additional continued training:

- 2 year — several departments (→ general internist)
- 1 year — 1 sub-specialty (→ internist with special interest)

called A₂ non-university hospital. Full training may be given either in an A₅ non-university or in one of the 8 university hospitals (U). In addition, combined training in an A₂ and A₅ or A₂ and U, or even A₅ and U hospital is possible. There are 21 A₅ and 28 A₂ hospitals (Table I).

In the near future the training period will be increased to 6 years (Figure 1): basic training (B) for 2 years in general internal medicine with curricular training and testing as described above.

After the initial 2 years there will be continued training (C₂) for another 2 years with obligatory periods in the departments of cardiology, respiratory medicine and surgery (4–8 months each) as well as in the out-patients clinics (8–12 months). The 6 year training period is to be completed either by spending 2 years in several departments (to become a general internist) or by spending the entire 2 years in a sub-specialized department (to become an internist with special interest, such as endocrinology, haematology, nephrology).

For the future there is a distinct preference for combined training to be spent both in a non-university and in a university hospital in 1 of 8 regions. The responsibility for the organization of training will rest with one of the 8 regional educational boards which

together form a central (national) educational board. This 'regionalization', the division of the country into 8 regions according to their university hospitals, in which both non-university and university hospitals will cooperate to educate residents, has already started.

For the most part, former A₂ hospitals will continue to teach as B hospitals. Former A₅ hospitals will become either BC₂ hospitals (4 years of training) or BC₄ hospitals (6 years of training; this will seldom occur). The U hospitals will usually apply to be BC₄ hospitals; however, a limited number of residents will receive full training there, the majority spending only the last 4 years of more specialized training (C₄) in a U hospital. This new division of teaching hospitals has been planned by a special committee of the NIV and has not yet been approved by all authorities involved.

In the more distant future, individual testing of residents might become non-anonymous and testing might even be extended to graduated internists.

Current problems

Most of the current problems are based on the present difficult financial situation in the Netherlands and are

Table I Number and kind of hospitals; number of consultants in relation to the number of physicians in training

	No. of hospitals	Consultants	Physicians in training
Teaching hospitals			
University	8	251	170
Non - university A ₅	21	146	128
Non - university A ₂	28	129	49
Non-teaching hospitals	128	—	—
Specialist hospitals	48	—	—

related to the consequent constraints on the funding of health care.

Unemployment and reduction of training facilities

Although only 12 internists (7 men, 5 women) are registered for unemployment within the Royal Netherlands Society of Medicine (KNMG), hidden unemployment must be considerable.

A recent questionnaire conducted by the NIV among A₁ teaching hospitals revealed 146 internists holding temporary positions (not always in internal medicine). Already in 1979 the NIV decided to have a report prepared by the National Hospital Institute (NIZI) concerning the expected supply and appointment of internists.² From 1980 the problem of unemployment received more attention and measures were taken to reduce oversupply. It was decided to request internal medicine programmes to retain residents for an additional year after their formal training of 5 years. Also the consultant to resident ratio was reduced to 1:1 (and might be further reduced in the future). This resulted in reduced numbers of physicians in training to become internists: 397 on January 1st 1984 and 335 on January 1st 1986.

Finding a consultant position is increasingly difficult for Dutch specialists. Specialty practice in the Netherlands is essentially a 'closed shop'. Prospective candidates must be invited to join a hospital by the specialists already there. The number of internists from abroad is negligible. Recently a comprehensive review article concerning physician oversupply in Europe, including the Netherlands, has been published.³

Problems with the government

Major problems did (and do) exist with regard to the government, all based on decreasing funds for health care. In 1984 an agreement was made between the Specialists Association (LSV) and the government to decrease excessive incomes, but also to decrease excessive working hours. It was decided to couple a 'standard income' with a 'standard working-week'. Since then many arguments have taken place concerning this issue. Recently disagreement arose because of abrupt reduction of fees, eventually leading to protest meetings and advertisements from specialists in local and national newspapers.

Moreover, decreasing funds for health care also caused decreased budgets for hospitals, decreased numbers of hospital beds and decreased funds for research (see below) and education (see above).

Problems with health insurance companies

In the Netherlands 70% of the patients are insured

through sickness funds, 30% pay a fee for service and have their costs insured with various health insurance companies. A sickness fund is a compulsory health insurance for the people with a lower income. Part of the contribution for the sickness fund is paid by the insured individual and part by his or her employer. Medical specialists have contracts with the sickness funds, receive their fee directly from the sickness funds and are paid per visit and/or intervention.

Problems, especially with the sickness funds, arose because these funds wanted both to decrease specialist incomes and to cut free enterprise and change it into a tenure with fixed salaries for all medical specialists. Professional responsibility would then rest entirely with the hospital management.

Problems with regard to task definition

Because general internal medicine covers a large field and has many marginal areas, conflicts with general practitioners and other specialists may arise. This was the reason why the NIV installed a committee to define the task of the general internist, especially with regard to marginal areas, which might also be claimed by general practitioners, paediatricians, geriatricians and subspecialists in internal medicine (endocrinologists, nephrologists, haematologists, etc.). Obviously this is a matter of division of labour, but also it is the opinion of the NIV that the general internist might have the best overall picture.

Funding of research

Funding of research used to be mainly derived from the government, but increasingly private funds are becoming important. The 8 medical faculties and university hospitals receive their budgets through the Ministry of Education; these budgets have decreased markedly in the past few years. In addition, the government makes grants available for specific projects concerning stimulating research (Ministry of Education) and for the prevention of disease and epidemiological studies (Ministry of Health). Public health research concerning preventive medicine and medical biology is sponsored by the Ministry of Economic Affairs, as are special institutes (for instance studying atherosclerosis). These funds have not changed substantially.

Private funds, mostly given as grants, have become more important in recent years. These funds are raised by foundations related to patients' associations; they usually have scientific advisory boards consisting of well-known scientists. Increasingly, also, funds for research are being made available by industry, particularly the pharmaceutical industry, and by non-university hospitals.

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