Present position of gastroenterology in the Netherlands

Although the subspecialty of gastroenterology was recognised as an independent specialty in the Netherlands as long ago as 1913, most of the gastroenterology services in this country are still provided by general internists. Some two million of the country’s 15 million citizens experience digestive complaints annually. Thirteen per cent of the total mortality, 12% of the hospital admissions, and 17% of total hospital days result from diseases of the digestive system. Most complaints are handled by primary care or general practitioners who really have a gatekeeper function before patients go on to second or third line specialised centres. In general this system is to a great extent comparable with that in the United Kingdom.

Gastroenterology hospital practice

Similar to all European countries and the USA the specialty of gastroenterology has undergone enormous development in the past 20 years, mainly because of the development of new drug treatments, diagnostic and therapeutic endoscopy, specialised hepatology services, and consultation for nutritional support.

In the Netherlands there is a somewhat unorthodox situation because patients with digestive tract related diseases can be treated by four different kinds of specialists:

1. By a board certified gastroenterologist, who is performing full time gastroenterology and endoscopy services.
2. By a general physician (or general internist) who has completed a course of gastroenterology training. They perform gastroenterology services 80% or more of their working time and general internal medical services 20% or less. Although this specialist still has a role as general physician it is for some reason not allowed, or the person is not willing, to have the title of consultant gastroenterologist.
3. By a general physician with a limited interest and also limited training in gastroenterology (usually less than 12 months of specialised gastroenterology training), who is performing 50% or less of working time of gastroenterology.
4. By a general physician without special training in gastroenterology.

A recent report by the Dutch College of Hospital Services states that ideally one in five internists (average number in each hospital) should be specialised in gastroenterology.1 As the government recognises one full time equivalent in internal medicine for 14,000 inhabitants (>15 years), from this it can be derived that ideally one full time equivalent gastroenterologist for an adult population of 70,000 should be available. At the moment, however, there is no more than one gastroenterologist per 125,000 inhabitants. According to a report, this figure is comparable with that in England and Wales, but lower than in Denmark or the USA.2 Of the above categories (1) and (2), a total of 90 full time equivalents are currently in practice in the Netherlands. About 55 are practising in one of the 128 general hospitals while the remaining 35 are mainly working in the eight academic hospitals, who all have an established gastroenterology department and related services available.

Although the subspecialty of gastroenterology is a recognised speciality with board certification, similar to cardiology, thoracic medicine, and rheumatology, these numbers show that the clinical practice of gastroenterology in the Netherlands is still not fully developed. This is mainly due to the leading position of the general internists at the academic hospitals and in the larger teaching hospitals. They keep the facilities for patient care and training at a limited scale. In general, a doctor is not allowed to follow training for more than one year in a particular subspecialty.

Although this system guarantees a broad support for day and night services in general hospitals, it ignores the need for expert knowledge in certain subspecialties. This is especially true for gastroenterology, where not only is it necessary to obtain specialised knowledge to deal, for example, with difficult clinical problems, but also to obtain proficiency in endoscopic treatment. One area where our specialism has expanded enormously has been the cooperation with the surgical departments. Several hospitals now have combined gastroenterology units.

Because there is not more than one gastroenterologist per 125,000 of the population, most of the work in gastroenterology is done by physicians in categories (3) and (4). They perform 75% of the routine gastroenterology consultation in general hospitals and 75% of the routine gastroscopies and sigmoidoscopies. The remainder of the 25% more difficult cases are referred to specialists of categories (1) and (2) at general and academic hospitals.3

In almost all academic hospitals specialised hepatology services are also provided by the gastroenterology department and not by the department of general internal medicine. This guarantees an optimal training in hepatology for future gastroenterologists.

Specialty training

The training of the subspecialty of gastroenterology is mainly performed in the eight academic hospitals in the Netherlands, who all have a board certified programme for training. It consists of three years of general internal medicine and three years of specialty training in gastroenterology, hepatology, and endoscopy services. There is a regular external assessment by on site inspections by three members of the gastroenterology board. The gastroenterology board (Concilium Gastroenterologicum), consists of all the heads of academic gastroenterology departments with supervision by the government. These on site inspections are routinely done once every two to five years and they are the most powerful aid to the establishment and maintenance of quality training.4 They also provide an important aid to quality control of gastroenterology services in the teaching hospitals. The training usually entails a schedule such that a third of the time is spent in outpatients’ clinics, a third in clinical ward consultation, and a third in endoscopy services.

In the Netherlands there are three centres for liver transplantation with a liver unit always in conjunction with the gastroenterology departments in these academic hospitals (Groningen, Leiden, and Rotterdam). In view of the current incidence of serious liver disease there is a need for
one such liver unit with liver transplantation facilities per five million inhabitants. In these units specialised procedures for diagnosis and treatment of both adult and paediatric patients is provided. Recently it was proposed that one gastroenterologist with a specialised training in hepatology per region of 0.5 million inhabitants was needed.

Current training programmes for gastroenterology in theory also include training in hepatology. Benefits for a separate subspecialty of hepatology are – under the present conditions in the Netherlands – insufficiently clear to warrant separation from the established specialty of gastroenterology.

One disadvantage in the current training programmes is that the weekly working time for residents in training recently has been limited to 48 hours (including duties and academic studies). Although most of the specialty boards were opposed to it, this was established by a ruling from the government last year.

One year of the total education time (six years) can be reserved for biomedical research. Therefore some residents go on during or after their training for a PhD thesis. There is a strong tradition in the Netherlands to obtain a PhD degree, especially, if a career in academic medicine is desired.

Almost 65% of clinically working gastroenterologists in the Netherlands also obtained a PhD degree, which is much higher than for general physicians (<20%) or other specialties like cardiology (<20%), thoracic medicine (<20%), and rheumatology (<30%).

Research in gastroenterology
Research in gastroenterology in the Netherlands has gained in importance during the past 15 years. This has mainly resulted from an improvement in the organisation of the academic departments in gastroenterology with a rise in the number of staff members with protected time allocated for research. But it also resulted from an increase in research funding. Although first line research funds by the universities and the government have declined steadily during the past 10 years and second line research funds by special government agencies have remained strongly competitive and limited, research funds by third line parties (mainly pharmaceutical industries) and fourth line routes (mainly private foundations) have risen considerably.

Traditionally, the pharmaceutical industry in the Netherlands has always made a healthy profit and probably the highest in comparison with other European countries. This is one reason why funds for medical research available from this source have been comparatively high. Furthermore, several private foundations like the National Cancer Foundation, the Digestive Diseases Foundation, and the Foundation for Preventive Medicine have been strong suppliers of funding for clinical research in gastroenterology. The result of this policy is the steady rise of scientific output in all areas of gastroenterology.

At the 1994 Digestive Disease Week in New Orleans 110 of the accepted abstracts for presentation were of Dutch origin. Each year the Netherlands Society of Gastroenterology organises two meetings, where about 120 original papers are presented with an attendance of 500–600. In recent years successful international meetings such as the European Digestive Disease Week and the Holland Digestive Disease Week have been organised.

Future needs for the subspecialty of gastroenterology
Recently the councils of the Dutch Society for Internal Medicine and the Society of Specialists in Digestive Diseases have expressed the view that for the future a better stratification of gastroenterology practice by general physicians and gastroenterologists is needed. A separation should be made in those performing general internal medicine and more ‘basic gastroenterology’ (and routine endoscopic services) and those practising the real subspecialty of gastroenterology such as taking care of patients with colitis and performing the therapeutic endoscopic procedures (‘specialised gastroenterology’).1

‘Basic gastroenterology’ should be available in every hospital, and should be performed by internists with special training in gastroenterology or by a gastroenterologist (category 1, 2, or 3). Because of the large number of patients with complaints and diseases of the digestive tract, a clinical service in gastroenterology should be present in every hospital – but not necessarily with a complete package of all the technological facilities. An integrated approach of performing gastroenterology in cooperation with the hospital group practice of general physicians is also desirable.

‘Specialised gastroenterology’ should be practised only in a limited number of centres by specialists with complete training in gastroenterology (category 1 or 2) and a concentration of such expertise is needed. This is especially true for the difficult diagnostic and therapeutic endoscopic procedures like endoscopic retrograde cholangiopancre-atography (ERCP). For cost effectiveness only centres with a minimal number of at least 200 ERCPs per year should be qualified to perform this procedure as well as have special training facilities available. It is estimated that 40–50 hospitals could qualify for this ‘specialised gastroenterology’ function. It is clear that in these centres at least two consultant gastroenterologists should be available to guarantee optimal services.

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