

PERSPECTIVE: PART II

MY EUROPEAN SABBATICAL— HOW YOU CAN DO ONE, TOO!

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Introduction

I have been an academic clinician-teacher-administrator at the University of Washington since 1991. My most recent role as the medical director of our health system's accountable care programs led me to want to better understand how other countries work to improve care coordination and chronic disease management to improve the value of health care. Although I knew that barriers would abound, I started thinking about taking a first-ever sabbatical. My wife and I had always wanted to live in Europe, so we began thinking about where we could live that would provide the right professional and personal opportunities. I studied German in college and was eager to resurrect that. Some Expedia searches confirmed that almost all European capitals are less than two hours by plane from Berlin. That settled it—Berlin became our destination!

Planning

With an idea of what we wanted, we now turned our attention to how to get it. Questions at this point included how long of a sabbatical would I take and when? Would I receive any salary support? What would I actually do? Who would take care of our house and dog?

Our daughter was willing and able to house and dog sit. Her “hard stop” at the end of June 2018 defined our end date. My job responsibilities determined possible starting dates. Ultimately, we chose December 1, 2017, to June 30, 2018, as my sabbatical start and end dates. Because we decided against pursuing a work or study visa, we had the 90 days allowed for tourists to be in the Schengen zone of Europe, which includes Germany and most of Continental Europe.

Initially, my boss was supportive of the time away, though noncommittal on whether any funding would be available. My institution classifies most medical school faculty as “without tenure for reasons of funding” which means that one must find internal or external funding to have an income and benefits. The conversation about funding repeated itself several times. Over the same time, I assumed a leadership role in our

health system's work to improve the care of people with hypertension. As I dug into that, I became aware of many knowledge gaps about these patients, as well as the need to develop a series of system-wide initiatives to support this work. Ultimately, our health system leadership agreed to fund me at 20% for 7 months to do this. Fortunately, I have great clinical partners, so coverage of my patients was not difficult to arrange.

Coincidentally with these preparations, I began searching for collaborators in Europe. I identified leaders in medical organizations or academic institutions who were doing work that seemed likely to advance my goals. I sent many e-mails to people in Europe. Ultimately, I identified two people in Berlin (who subsequently connected me with others), two people in Heidelberg, and three people in the Netherlands. English is the common language for medical science in Europe so there were no substantive language barriers to developing collaborations.

Arrival and Early Work

Ultimately, we left Seattle on December 31 with a plan for me to examine a data set of our hypertension patients; to develop and carry out plans for quality improvement activities via participation remotely; and, a list of meetings with Europeans in the areas of hypertension, diabetes, and care management. We rented an apartment in the Friedenau district of Berlin and arrived New Year's night with an enthusiasm for many discoveries and new experiences to come. We were not disappointed!

Within a week, I had my first meeting with an internal medicine physician who works with the Kassenärztliche Vereinigungen (KBV), also known as the National Association of Statutory Health Insurance Physicians. This organization manages the nationwide approach to contracts and quality assurance for work in primary care practices in Germany. Subsequently, I met with two other people working at KBV who helped me understand the German approach to organization

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of care and chronic disease quality improvement. The most well-developed chronic disease program is for people with type-2 diabetes, which supports quarterly visits with primary care physicians to collect standard data and manage care according to a standard practice guideline. This has existed since 2003 and has more than 4 million patients enrolled. Metrics such as HBA1c control, blood pressure control, and metformin and statin use have all improved during this time. However, I was surprised to learn that the blood pressure control rate for diabetics is lower in Germany than in the United States.

Germany has universal health insurance coverage, but significant gaps and variations in care remain. For example, there is no universal electronic medical record in Germany and information sharing is more difficult in the United States due to differences in privacy laws. Patients tend to switch doctors more often than I expected. In addition, patients have direct access to specialists, which increases the risk of communication gaps among the doctors who are taking care of a given patient. I was surprised that there is minimal development of mid-level providers in the German healthcare system and care teams tend to be very small.

Later Work

In early February, we travelled to the Netherlands. I met with a family physician who leads clinical practice guideline development for the Nederlands Huisartsen Genootschap, or the Dutch General Practitioners Association. These widely used guidelines include an approach to cardiovascular disease prevention that integrates lifestyle changes including smoking cessa-

tion, as well as control of blood pressure and lipids. In general, Dutch family practitioners are less likely to use medications and more likely to recommend lifestyle management. This makes their overall treatment approach more conservative than most of the Eurozone. The Dutch patient-physician primary care relationship is very strong, with patients valuing continuity in a way that seemed different from Germany.

In late February, we travelled to Heidelberg, Germany, where I visited a University-based health services research group. Among other things, this group has organized and evaluated several different care management models in the state of Baden Württemberg in which Heidelberg is located. In general, care management work in Germany uses practice assistants—approximately equivalent to medical assistants in the United States. In both Germany and the Netherlands, registered nurses are employed very little, if at all, for these functions.

Conclusions

I found the working groups in Germany and the Netherlands similar to the United States. There was evidence of strong collaboration, but also evidence of siloing, especially in Germany. I found some interest in creating a Europe-wide approach to some problems, such as cardiovascular risk reduction, but that had challenges as well. In the United States, large-scale approaches seem easier since most medical societies that develop clinical guidelines are national, for example, the American College of Physicians or of Cardiology. Undoubtedly, there are local variations in implementation that may impede or improve quality depending on the specifics,

and that seemed to occur in both countries I visited.

From becoming much more adept in the German language to conducting a lot of work to better understand hypertension management, I accomplished all of the goals of my sabbatical. It influenced the work I had begun remotely about hypertension management in my healthcare organization. Aside from providing me a different and more global population perspective, the time away from my usual duties did allow for developing a more thoughtful, less hurried approach to change in our system. For many readers, this may be an important lesson—you do not have to leave town to have a productive sabbatical experience, although it makes it easier to do so.

Our time abroad did fulfill personal goals beyond expectations. To live in a non-tourist area of a large foreign city for a block of time and to get to know it very well were incomparable experiences. I attended several German conversation groups and through Facebook met a German rock-climbing partner who told me fascinating stories about the night the Berlin Wall “came down.” My wife and I also easily travelled to Amsterdam, Athens, Barcelona, Prague, Riga, and Warsaw.

For SGIM members who are eligible for a sabbatical (usually based on specified years of service), I urge you to strongly consider it. You may believe that there are insurmountable barriers, but ultimately, they are probably not as large as you think. It takes planning, and requires some trade-offs, but the experience is incomparable. Doing a sabbatical out of the United States will bring you even greater rewards—and offers a lot for your family, too!

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