NEUROSURGERY

Elective Report 2011

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Contents

SSC 5c (Elective) Assessment

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Subject: Neurological Surgery

Location: New York Presbyterian Hospital

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Objectives:

1. How does a large city centre teaching hospital provide healthcare in a system based mainly on private insurance?
2. What are the main neurosurgical conditions in the NYPH patient population and how do they compare to those of the Royal London Hospital?
3. Learn about the health system in the US and how the new laws will affect it, especially regarding the patients of NYPH.
4. To explore clinical experiences unavailable in the UK and reflect on how they can help me in my foundation years and beyond.

Background:

There are some broad similarities between Barts and the London (BLT) and New York Presbyterian (NYP). St Bartholomew's merged with The London and The London Chest in 1992, allowing the oldest hospital in the England (Barts, founded 1123) to join the oldest English medical school (The London, 1785). Similarly, The NewYork-Presbyterian Hospital (NYP) was formed by the merger in 1996 of the New York Hospital (1771 – second oldest in the US) and the Presbyterian Hospital (and associated medical school Columbia University College of Physicians and Surgeons – 1767, the oldest in the US). This created the largest hospital in New York with currently over 17,000 employees; almost double that of Barts and The London. Although NYP sees almost 3 times as many outpatients and has double the inpatient capacity as Barts and The London, they see roughly the same number of emergency visits a year (approx. 500,000). BLT covers 2 million people encompassing the most diverse patient population in Europe. As the healthcare system is different in the US it is hard to directly compare patient populations given the less well-demarcated catchment areas, but NYP covers large chunks of New York City and neighbouring New Jersey.

Report: (1107 words)

How does a large city centre teaching hospital provide healthcare in a system based mainly on private insurance?

Unlike the UK, the United States does not have a universal healthcare system free at the point of care. However the US spends more on healthcare than any other nation. 44.7% of the total expenditure is government financed, mainly through state-run Medicare (for the over 65s) and Medicaid (for those on low income). 200 million individuals have private health insurance plans provided by employers or unions, or purchased individually; Medicare and Medicaid cover 80 million. Leaving the number of uninsured persons in the United States is roughly 50 million[i]. Medical costs for the uninsured are a considerable burden; almost 50% of personal bankruptcies are due to medical debt[ii]. It is easy to see why when you consider what an inpatient stay costs the patient accrues: The basic daily rate, which includes room, meals, nursing care, housekeeping, procedures such as operating room, recovery room, and/or items doctor ordered investigations, such as X-rays or laboratory tests. On top of that there is usually separate bills from physicians who bill independently for their services.

Under the Emergency Medical Treatment and Active Labor Act (EMTALA) 1986, hospital emergency departments must treat emergency conditions of all patients regardless of their ability to pay. However there is not a direct form of compensation for the hospitals, which has been blamed for the decline in the number of emergency departments[iii] in the US. NYP has a large emergency department (200,000 attendances annually) and covers a wide population mix. As such it has a broad mix of patients. 30% of its patients are covered by Medicare, and almost as many by Medicaid. Just over 40% are covered by personal insurance leaving just under 2% who pay themselves or have workers compensation. NYP has dedicated insurance specialists that help all patients, insured, underinsured and uninsured with the details of how their care will be funded. NYP also has a charity and financial aid program for those who cannot meet their costs. The insurance specialists are very important, as many people will not be familiar with their policies or those of Medicare or Medicaid. For example different insurers have different networks of specialists, who may not be at the hospital the patient presents to. Also, some insurers require prior authorization for some services.

As a large metropolitan hospital, NYP has a wide range of income streams and its size, in theory, allows it to be more efficient than smaller hospitals. As such it is able to provide a very high standard of healthcare to its patients, being awarded 'Best Hospital in New York' and one of the best nationally in the most recent annual US News rankings[iv].

What are the main neurosurgical conditions in the NYPH patient population and how do they compare to those of the Royal London Hospital?

The neurosurgical department at BLT is relatively small (6 consultants) given the size of the hospital trust but it has two centres of excellence, Queens Square and Queens Romford, within a few miles where it can refer patients if necessary. However it does have particular expertise in spinal injuries, trigeminal neuralgia, neurostimulation, pituitary tumours, complex skull base surgery, neuro-oncology and gamma knife stereotactic radiosurgery. Indeed BLT is one of only 2 gamma knife units in the NHS. The main neurosurgical conditions at BLT are therefore the ones in which the department specializes, plus trauma patients as BLT is a grade 1 trauma centre.

NYP on the other-hand has 26 Attending's with diverse specialties and sub-specialties covering almost all neurosurgical conditions. The department also benefits from a world-class neuro-ICU. Together this allows NYP to treat almost all neurosurgical conditions that present to them. In addition to the areas BLT cover, NYP has well-established centres for functional, cerebro- and endovascular and paediatric neurosurgery. The gamma knife unit at HYP has recently up-graded to the Perfexion System, which has been used at BLT since 2007.

Learn about the health system in the US and how the new laws will affect it, especially regarding the patients of NYPH.

I have studied the US healthcare system before, particularly during my Medical Law and Ethics MA, but as is always the case, you don't get a real feel for something until you experience it firsthand. There appears to me to be a dichotomy in the US system, at times both more paternalistic and more patient-driven than in the NHS. Patients with comprehensive insurance and/or deep pockets demand more control over their care than I have often seen in the UK. However overall, the system appears more paternalistic than in the UK, perhaps as a result of the more competitive nature of the medical profession and how it is funded.

This brings us to the new healthcare laws in the US. The complexities of the new arrangement are obviously way beyond the scope of this short report. In brief, the Patient Protection and Affordable Care Act (PPACA) and Healthcare and Education Reconciliation Act, a combination often referred to as Obamacare in the media, were signed into law in early 2010[v,vi]. The aim being to expand healthcare insurance to the estimated 50 million US citizens who currently lack it.

I do not see much direct impact on the day-to-day experiences of the medical professionals. I suspect the insurance specialists will take a while to figure out the new rules and funding streams as and when they come into force.

To explore clinical experiences unavailable in the UK and reflect on how they can help me in my foundation years and beyond.

The clinical experiences I have had here are incomparable to those I have had at BLT. I had no official neurosurgical rotations during my studies, the only contact I have had with neurosurgery apart from lectures has been self-organised; attending clinics, theatre and shadowing juniors.

Here I have been a sub-intern, and have been able to observe and occasionally participate in a wide range of surgeries from decompressive lumbar laminectomies to awake craniotomies to brain biopsies for CJD. Observing the patient journey through gamma-knife treatment was particularly interesting as I had not been able to do that at BLT. I have also been able to shadow the junior doctors on the ward and have been given more responsibility than in the UK. This has been particularly useful for my upcoming foundation year as the roles are very similar, and it has allowed me to improve and broaden my ward based skills.

References:

[i] www.census.gov. Last accessed May 22nd 2011

[ii] *Americans at Risk: One in Three Uninsured*, Families USA, March 2009

[iii] Fact Sheet: The Future of Emergency Care: Key Findings and Recommendations, Institute of Medicine, 2006, last accessed 22nd May 2011

[iv] http://health.usnews.com/best-hospitals/new-york-presbyterian-university-hospital-of-columbia-and-cornell-6210024 last accessed 22nd May 2011

[v] Elmendorf, Douglas W. (January 22, 2010). "Additional Information on the Effect of the Patient Protection and Affordable Care Act on the Hospital Insurance Trust Fund". Congressional Budget Office. Retrieved 2010-03-31. "This letter responds to questions you posed about the Congressional Budget Office's (CBO's) analysis of the effects of H.R. 3590, the Patient Protection and Affordable Care Act (PPACA

[vi] http://www.healthcare.gov/law/introduction/index.html last accessed 22nd May 2011