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Elective report - Clinical Neurology

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Introduction

I write this report after a three week placement at the Ronald Reagan UCLA medical centre and a further three week in Bangalore, India.
This report is required to be read along with my piece of reflective writing.

The American Health care system

One of my objectives was to study a few important aspects of the health care system in the USA as I intent to specialise there.

Funding

There are four major sources of funding for healthcare in the USA: patients' own resources, private insurance, federally funded Medicare insurance for the elderly and disabled, and Medicaid insurance for low-income people, funded equally by the state and federal governments.
Primary-care physicians (PCPs) - general internists, family physicians and paediatricians - are frequently used, but many patients seek specialist care directly. Doctors in the USA are generally well paid and have access to some of the most sophisticated and up-to-date treatments in the world. However, the threat of litigation is omnipresent. I have discussed this below.

Training system

Most American students complete an undergraduate (baccalaureate) degree of four years' length before starting their medical education, which takes an additional four years and leads to a Doctor of Medicine Degree (MD). When they have attained their medical degree, graduates apply for residency programmes, which comprise their graduate medical education (GME).
These programmes, which are accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, typically last between three and seven years, depending on the specialty or subspecialty. Completion of one to three years of GME is required to obtain a license to practice medicine in any state or jurisdiction in the US. Some overseas specialist training may be considered equivalent and reduce the overall length of the residency programme. Doctors wishing to sub-specialise can undertake a fellowship programme, which involves an additional one to three years training, after completing the initial residency programme.

My experience of the Health care system

My main aim for the elective period was to experience two very different health care systems. The system in India and the USA had their own approach to patient care. They were both very different from NHS. I feel a number of different factors contribute to the difference. Broadly I list the following as major contributory factors - funding (insurance companies), privatisation of health care, physician liability and technology.

The aim of a model health system would be to provide the safest and best possible care to patients. Accountability is something that I felt physicians in the USA had constantly at the back of the mind, in contrast to India and to some extent the UK.

ACCOUNTABILITY IN HEALTHCARE

Historically two approaches to policing care have been noted - the ‘no blame’ and the accountability models. Over time there seems to be a shift towards liability. Emphasis on a particular system varies between countries and I feel the reasons for this are multifactorial.

Medicine is a profession where doctors are socialised to be collegial and non-confrontational. It is so specialised that it requires doctors to review their peers. Regulating watchdogs in the form the GMC in the UK help keep a check on the quality of care in the NHS. This is a powerful professional third party organisation helping doctors to provide a consistent and universal quality of care. Right from medical school we are bred to report malpractice around us.

In the past most physicians in the USA were self employed. This is currently the case in India too. With the development of resource rich multi-speciality centres, this attracted a number of doctors to move into bigger institutions. Hospitals attract physicians as they bring with them their patients and in a privatised system - this is the obvious strategy. This raises the question - do these extra institutional benefits bias internal policing?

It is reasonable to think that a ‘no blame’ culture presumably solely relying on the self motivation and respect for the medical profession would camouflage errors by incompetent careless clinicians unwilling to follow safety rules and standards. In the USA patients with the help of lawyers are more vigilant towards the quality of care they receive. Lawyers are a huge political force who have hypertrophied malpractice to the extent of lowering trust in the medical system. Are lawyers legal enough to deal with a profession so specialised as medicine where decisions are based experience taking into account human error? The other downside of this system of liability is that it induces a culture of trying to avoid confrontations rather than a thoughtful strategy to attack the root cause of the problem.

The Indian healthcare system is also open to litigation to some extent. But, the situation there is slightly different. Doctors hold a very privileged position in society people accept their intention to heal and treat. Poverty and illiteracy are two factors affect the situation in terms of awareness and financial support. But, this might leave room for preferential treatment - i.e. more caution around certain patients compared to others leading to inequality in the delivery of care.

An entirely ‘no blame’ culture is not feasible either. There are a number of cases of malpractice of which Shipman’s is the most popular. I propose that an atmosphere of trust in which people are encouraged and rewarded for essential safety related information will work well. I believe that doctors undergo intensive prolonged periods of training where stereotypical characteristics of hard work, humanity, knowledge and good intentions are continuously rewarded. But exceptions always exist.

Experience of Neurology

Neurology seems to vary considerably depending on the grade of the institution and the geographical location.

Geographical location is a broad word with a number of factors to it. Culture, environments, genetics are some of them. Infections in neurology are more endemic in India compared to the West. TB, neurocystisarcosis, HIV were the commonly seen. My observation is that autoimmune conditions seem to be more common in the West. I guess the evolution has rendered the body’s immune system to attack one thing or the other - if not external infections in extremely hygienic and infection free west, it would have to be the body itself.

Consanguinity is common in India and seems to results in very interesting patterns of inheritance of neurological conditions.

The grade and resources at an institution massively influence the influx of presentations. The Ronald Reagan is a tertiary centre for Neurology along the west coast of America to where a number of complicated cases get referred to. It was natural for a number of cases to not have a diagnosis. Every patient was extensively investigated with good quality MRIs, regular discussions with a multidisciplinary team (involving pathologists, electrophysiologists, neruoradiologists). I particularly enjoyed thinking from first principles in such cases and the ongoing research into literature for case reports to help with the management although it was overwhelmingly complicated at times.

The centre at Bangalore had a great diversity of neurological pathologies. From bread and butter neurology to the rarest of the rare conditions, it was simply outstanding. Diversity in neurology was what I enjoyed the most. It is natural for indians to leave a problem until it is unbearable. A number of patients had text book presentation and the high influx of patients from all over india made it useful to practice my examinations. Decision making had to be very fast. The hospital had income assessed subsidised care. Hence people from all parts of the country from different social classes came there. It was truly the most florid experience of clinical medicine I have had thus far.