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General Medicine

Elective report

Describe the pattern of health provision in relation to the USA and contrast this with the UK.

Health care in the USA is provided by several different bodies. These include insurance companies, government funding based on eligibility criteria (Medicare and Medicaid) and the patient's own funds. If the patient does not qualify for Medicare/Medicaid and cannot afford to pay then publicly funded hospitals provide care for free. The majority of healthcare in the US is not publically funded. In comparison, in the UK the vast majority of patients are uninsured as healthcare is free at the point of use as it is funded by the tax payer, thus there are very few private hospitals. The hospital I visited, Harbor UCLA medical center, is a publicly funded hospital in LA County. The policy of public hospitals is that they will accept any patient so the majority of their patient population is uninsured or have Medicare and Medicaid, as Medicare and Medicaid are not accepted by many hospitals as they pay less than insurance companies. Insured patients are often transferred out of the facility into hospitals who offer financial incentives to insurance companies. On the other hand, uninsured and Medicare/aid patients are often transferred out of private hospitals into Harbor as the Emergency Medical and Active Labor Act requires virtually all hospitals to accept all emergency patients with regardless of ability to pay. Often, patients will be stabilized in the closest hospital to them and then sent to Harbor to complete their work up and be given more definitive management. Similarly, primary care is also largely privatized so however there are clinics that serve the uninsured population. However access to these clinics is difficult as they are burdened with a very large uninsured population so wait times are long and self-payment is relatively expensive for the uninsured.

Describe the pattern of illness seen at Harbor and compare this with your observations in the UK

The USA spends the most on healthcare out of all the WHO members at $7,164 per capita, 15.2% of GDP, but life expectancy is 78.49, ranked 50$^{th}$ in the world, below most developed nations and some developing nations. The UK's spending is ranked at 19, spending $3,222 per capita (8.7% of GDP) but its life expectancy is higher at 80.17 and is ranked 30. The causes of a difference in life expectancy is complex and will include a multitude of factors such as culture, diet, environment, health care provision, public health policies etc. From my experience at Harbor on a medical rotation, I was able to see the patterns of illness of the uninsured. The types of disease are similar to the UK (e.g. chronic renal failure, diabetes, hypertension, cardiovascular disease, cancer etc), but because of their large uninsured population, many of them are not aware of it because they do not see a primary care physician so they present with advanced manifestations of their disease to the ER which would be unusual in the UK. I have also seen a larger number of patients with infectious diseases especially HIV/AIDs and hepatitis B and C than in the UK, which again, may be reflective of the unique patient population of Harbor rather than the whole of Los Angeles.

Health related objective: To appreciate the effect of the uninsured on healthcare provision and illness

Harbor UCLA medical center is referred to as a "safety net" hospital as it serves as a place of care for the people would not be eligible to be treatment at the majority of hospitals in LA. Because many of these patients cannot pay or can only pay for part of their stay, the hospital relies on public funding to stay open. However because of the increasing numbers of uninsured people in America, there has been an increasing financial burden on these public hospitals and their numbers have been declining as they become bankrupt. Clinics are also often burdened with a large uninsured population so uninsured patients often do not use primary care which may be in part due to the long waiting times. Therefore they often present to ER with late and life threatening presentations of conditions that could have been prevented if managed earlier on in the primary health care setting. This is also problematic for the hospital because emergency treatment is far more expensive than primary prevention and also the patients have little or no medical notes and often do not speak English so it is difficult for the doctors to have a good understanding of what has happened. Late presentation of disease is obviously also problematic for the patient's health as well they may be untreatable at that stage.

Reflection of the experience and learning opportunities Harbor

My professional objectives for this elective were to gain more experience in hospital to prepare me for my FY1 job in June. This would include proficiency in history taking and examination but also there was a lot of emphasis on planning management for the patient and following their case, which I feel that a lot of medical students are not confident in despite being a major part of medicine. The residents here were very enthusiastic about teaching and encouraged students to come up with their own management strategies. Interns also have more autonomy in terms of patient management than house officers in the UK as UK

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house officers basically follow the consultant around in the morning on ward rounds and let the consultant assess the patient and come up with a plan, whilst they document the encounter in the notes- therefore their role is relatively passive. In the US, interns are expected to perform their own rounds so that they evaluate the patients themselves (therefore they arrive in hospital a lot earlier than in the UK!) and discuss their plan with the resident before meeting with the attending later in the morning. I feel like there is a greater learning opportunity in assessing patients yourself before rounds and I will try and do this in the UK when I start my job.

Doing a rotation on internal medicine provided me with a good exposure to a wide variety of conditions and the residents were helpful in giving me interesting cases that I could learn from. I saw conditions that would not have normally been seen in the UK if I were doing a similar placement as patients had presented with illnesses that are normally managed in the primary or outpatient setting in the UK. Also there are plenty of group teaching sessions such as daily morning report where residents would present interesting cases for discussion. On a practical note, I was also given my own account for the online patient charting system to access the patient's results- something that we do not get in our medical school. I found this incredibly helpful as it makes following the progress of a patient a lot easier and is good practice for my future job.

Some difficulties in this rotation are probably encountered in starting in a new place for anyone. I was unfamiliar with the patient charting system so it took me a while to work out how to find out information about the patient, however I was able to get used to it in about a week. I also found it difficult to interpret US lab values (especially hand written ones as they are displayed in a diagram format without any labels) as they are in different units and lot of the brand names are used for drugs! However, I'm sure that after spending some more time in the US it would be something that would be easy to be accustomed to. What was probably more specific to this rotation and also something that is more difficult to overcome, was that it had a large Hispanic population that only speak Spanish. Part of the reason why I chose to do my elective in America was because I wanted to be able to communicate with the patients so it was quite a shock when I found that I couldn't with a lot of them! The residents would try and give me patients who could speak English because they felt that it would give me a better learning opportunity although there were Spanish speaking patients who did have interesting cases so my experience at this hospital was limited somewhat by the fact I couldn't speak Spanish. We encounter this problem in the UK but to a lesser extent and I also feel they are easier to deal with because these patients often come with letters from their clinics and primary care physicians which is often unavailable with patients here. However, when I will be working I won't be able to pick and choose my patients so will have to make sure that I can find a way to communicate with these patients. Most of the time in Harbor, if a relative is not available to translate, a Spanish speaking member of staff (e.g. receptionist, nurse) on the ward will be asked to come over and translate although their time is limited so your time with the patient is limited.