ORTHOPAEDICS

Hartford, CT, USA – Orthopaedic Associates of Hartford and Connecticut Joint Replacement Institute

Objectives, to be met through experience not research:

- *Contrast the population in East London with those seen in Hartford, CT.*
  - *How does this change the health needs of the population?*
  - *How does this change the way they present?*
  - *Does it change the pathologies seen?*
- *The NHS vs. private health care in the USA:*
  - *Can you notice the difference in management?*
  - *Is the spending gap noticeable?*
  - *Is money spent correlated with better patient care?*
  - *Are there more options for both the doctor and the patient with respect to diagnosis and treatment?*
  - *Does this reflect in a better prognosis?*
- *Develop my understanding and interpretation of basic imaging techniques including plain radiographs, CTs, MRIs and bone scans.*
- *Develop my understanding of key orthopaedic pathologies and how they are managed.*
- *How can my experience of healthcare in the USA help me when working in the NHS?*

Having completed a trans-Atlantic flight and catching a coach from Boston to Hartford, bleary eyed I was picked up from the bus station in downtown Hartford and made our way to the house where I was staying in West Hartford. On this short journey, I was struck by the difference between Hartford and West Hartford. West Hartford is an affluent, safe neighbourhood with large detached houses with an all American friendly feel. A quarter of a mile down the road is Hartford, which is an inner-city melting pot of various different cultures – unemployment is high, as is criminality. This mix of wealth with poor is, of course, present in East London. However contrast in safety of the neighbourhoods is not the same – when leaving the house every morning, I was advised to keep the door on the latch as it was safe and would be easy for us to get in and out. In downtown Hartford there were large gangs all of which carried guns. I think the poverty and danger of Downtown Hartford is reflected well in parts of East London, especially Newham, Hackney and Whitechapel, however this is not as juxtaposed with wealth in quite the same way.

The cultural mix in East London is mainly Bengali, Turkish and Eastern European. None of these groups are represented in Hartford, which had a large Hispanic community as well as afro-Caribbean contingent. Although the populations are very different – It seems that their complaints are largely the same. However, the size of patients I saw in Hartford is significantly larger that those I have seen in an average orthopaedic clinic in the UK. I think this may reflect the need for total knee and total hip arthroplasty at a younger age in the US.

Although the pathologies seen in the Hartford were not particularly different from those seen in East London, there were a couple of memorable cases which I have not seen before (or certainly not as commonly). Firstly, I saw a few patients who really responded badly to total joint replacements having

inflection after infection eventually requiring a hinged device then an arthrodesis. I have seen this on one occasion in the UK but saw a large handful of these patients in The States. This may merely be a reflection of the large volumes of patients seen, or could be due to the pay for service nature of the system in the USA. I have seen a number of patients in the UK be denied total joint arthroplasty as the surgeon believed that they would fail the rehab. The system in the USA is geared for doing as many total joints as possible perhaps.

Away from total joint replacement I saw a number of cases of avascular necrosis of the femoral head as well as bony infarcts due to steroid use. This may be a reflection of higher steroid use in the American health care system, as many patients seemed to be on poly-pharmacy with steroids included in their regime.

There are many differences between the NHS and insurance based scheme in the US – there is certainly a tiered system is the US depending on whether the patient is insured or not and what type of insurance it is (i.e. how comprehensive it is, is it Medicare?). In almost every consultation there is a mention of cost or money. Most insurers require some co-payment for drugs – this results in doctors' hands being forced as to what they can prescribe or leads to patients choosing which drug they can afford. Conversely for procedures and consultations different companies decide how much a certain encounter costs so for the same operations, by the same surgeon in the same locations he will be paid significantly less by Medicare patients than other insurers. This was never discussed in front of patients but can create an atmosphere within some consultations. Similarly, a saw some uninsured patients who were in desperate need for operations but who were never going to have one.

The Connecticut Joint Replacement Institute, which performed total hip and total knee replacements, is a phenomenal place. It is a section of the general hospital solely for orthopaedic conditions, as a result the infection rate and other complication rate is significantly lower than all quoted statistics. Patient satisfaction is higher, hospital stay is shorter and outcome is better, as well as being more efficient with between 8 and 10 total joints being replaced by a single surgeon everyday. Nothing I have seen in the UK can compete with that service. I feel that in this respect the UK has a lot to learn about setting up of facilities and creating specialised centres, which can run efficiently.

Although I have mainly written about arthroplasty, I saw a myriad of orthopaedic conditions from spine or hand disease to highly specialised surgeons who specialise in the patellofemoral joint. The overall experience has taught me many aspects of basic orthopaedics such as examinations and management as well as interpretation of many imaging modalities including plain radiographs, CTs, MRIs and bone scans as well as studies such as EMGs and nerve conductions studies.

There are many lessons to be learned including streamlining of facilities and the importance of specialist input but there is also much to be appreciated within the NHS as I have alluded to above. As a doctor working within the National Health Service I will be mindful to keep the patient at the centre of all consultations and decisions, while trying to balance practicality any the agenda of the hospital (not letting either interfere in delivering the best care for my patients).