ENDOCRINOLOGY

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Elective reflection part I – USA land of abundant& fragmented healthcare

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The first part of my elective was spent in the endocrinology department at Harbor UCLA Medical Centre in Sunny California. This is a public hospital owned by the county of Los Angeles. Unlike theprivate hospitals in US, Harborprovide medical care to insured and uninsured alike. As a result, the hospital serves the poverished populations in the surrounding areas such as Long Beach and Harbor.

Endocrine services

Unlike endocrinology in the UK hospitals, our service was a consult service. This meant that the inpatients were referred to us if they had endocrine pathologies that the admitting team wanted us to review. We did not admit or discharge patients but followed our patients and aided the admitting team in the management of patients' endocrine conditions. This followed the notion that the endocrinology is mainly an outpatient service. My team was small with 1 attending (equivalent of consultant) Dr Ipp, one fellow Silvana (registrar) and 1 resident Luani (Senior House Officer). They were all so kind, encouraging and helpful in navigating our way through the US system. Our team was within a much larger endocrinology team consisting of about 30 doctors and specialist nurses. During the week, we also attended outpatient services where we encountered variety of interesting endocrine diseases.

Patient populations

Unlike the poverished population of South Asians that the The Royal London or other teaching hospitals in East London serve, much of our patient population consisted of Spanish speakers from South America. The rate of diabetes in Hispanics in the US is extremely high. Hispanics adults in the US are 66% more likely to be diagnosed with diabetes than white population[2]. This is second only to the non-hispanic black population. The reason behind this is multi-factorial – including diets, genetics and sedentary lifestyle.

Diseases and presentations seen during the elective period

During my stay, the most common diseases I encountered in both inpatient and outpatient settings were diabetes. Currently in USA, 25.8 million people are affected by diabetes (8.3% of the population), of which estimated 10.8 million are undiagnosed [1]. 79 million of population are in pre-diabetic state heading towards diabetes if they do not obtain better glycaemic control. This is compared with 4.45% prevalence in the UK[2]. What was interesting to me was that these diabetic patients in Harbor often presented very late with serious complications of diabetes. We were consulted on average of two diabetic ketoacidosis per week. Other common presentations were necrotic foot or foot amputations resulting from poor glycaemic control. This was heart breaking but extremely interesting for us to see as we saw presentation of diabetes we commonly do not encounter in the UK owing to the NHS and early detection of diseases. I recall my haematology consultant who had spent most of her life in acute and general medicinein London hospital telling me that she has only seen 2 DKAs during her entire 25 years career. Here at Harbor, we have seen at least 6 in the span of 3 weeks. Moreover, we were told in the medical school that DKA only occurs in type 1 diabetes, but majority of the DKA we saw were in young male with type 2 diabetics. This often was their first presentation or they had been told that they had pre-diabetes by their primary doctor long time ago, but since then they had lost their insurance and could not access a doctor for several years. Compared to the UK, there is definite reduction in health seeking behaviour owing to the lack of social health care system.

Management

I felt the main differences in the management of diabetes here and in the UK were the strong emphasis on patient education. Overall, I felt that health practitioners made stronger effort to educate the patients on their conditions. According to the health practitioners, the increased need for patient's understanding of their own condition comes from the fragmented care within the US health care system. The patient records are not easily accessible across the health care providers in the US. This is dissimilar to the UK, where the medical records are easily accessible

through general practitioner wherever the patients may access care. This forces patients to know their condition well enabling them to communicate their medical history wherever they may access care. I saw this in two settings in the management of diabetes.

1. Diabetes education and self-monitoring glucose in type 2 DM
Diabetes education classes ran every day at 10.30. The classes headed by the diabetes specialist nurses aimed to educate patients about the condition itself, management and the common emergencies such as hypoglycaemia and DKA. The classes were extremely informative and covered wide spectrum of topics. It also ran in English and Spanish to accommodate the large Spanish-speaking patients in the area. They encouraged attendance by providingmini glucose monitor to use at home after five consecutive classes. Unlike in the UK, most type 2 diabetic patients were expected to home monitor their own glucose levels.

2. Diabetic retinopathy
There were also multi disciplinary diabetic clinics that ran every Friday morning. The clinics were ran by a group of doctors, specialist nurses, ophthalmologists, podiatrists and nutritionists so when the patient came for a diabetes check, they will be able to access comprehensive care. Sitting in on the clinic, I heard Juan the diabetic nurse explaining carefully to the patient about the retinal changes and glaucoma seen in her pictures.

Summary

As I reflect on my experience of the past three weeks in Harbor, I see more the differences rather than similarities between my experiences here compared with my experiences throughout the medical school in UK hospitals. I saw variety of conditions and presentations of endocrine diseases that are rare and interesting. I have also met amazing doctors and nurses that were encouraging and patient with our lack of knowledge for the US method of clerking patients. I have never felt so incorporated as a part of the team or had more responsibilities than I have had here at Harbor. However, at the same time, I never felt as supported and linear with senior consultants as I have done here. I have learnt so much from each of the specialists here. This was an invaluable experience and possibly the best firm experience I have ever had throughout the medical school. The only thing I wish I could change about this experience is to have more time so I could have spent some time in paediatric endocrinology.

References:

1. Los Angeles County Health services 2012. Harbor-UCLA Medical Center [online] Available at: <http://www.ladhs.org> [Accessed 20 April 2012].
2. Center for Disease Control, 2011. 2011 National Diabetes fact sheet. [pdf] Atlanta. Available at: <http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf> [Accessed 20 April 2012].
3. Diabetes UK, 2011. Diabetes prevalence 2011. [online] Available at: http://www.diabetes.org.uk/Professionals [Accessed 20 April 2012].