RHEUMATOLOGY

Rachit K Singhal
HA06194@qmul.ac.uk

Barts and The London

Columbia University Medical CenterElective 2012: Clinical Rheumatology at New York Presbyterian Hospital (NYPH)

Introduction

I chose to apply to The University of Colombia exchange as it offers a unique, exciting opportunity to spend my elective with a world renowned educational establishment. The Columbia University's Medical Center offers tremendous facilities to deliver cutting edge research, medical education and optimum patient care, which encompasses the Center's ethos. Columbia University is a private Ivy league institution with a world renowned reputation and notable alumni include President Obama, Warren Buffett and former President Roosevelt. The associated New York Presbyterian Hospital is consecutively ranked as the best hospital in New York state offering clinical excellence. My objectives were as follows:

1. Describe the pattern of disease in the population of USA
2. Describe the pattern of healthcare provision in the USA and compare it with the UK
3. Develop greater clinical exposure to clinical Rheumatology
4. To Further my personal and professional development

1. Describe the pattern of disease in the population of USA

NYPH is situated in the upper west side part of town in Washington Heights serving a principally Hispanic population and patients also frequently visit from the Dominican Republic. Diseases such as Lupus and TB appeared to be in greater prevalence as evident by the specialist weekly Lupus focused clinics and the number of inpatients admitted. This is a Spanish speaking population and particularly the majority of older patients were not fluent in English and this created a difficult barrier to communication. I could resonant with this predicament as this is comparable to the communication problems with the Bangladeshi speaking population in East London. Often a translator service was used in outpatient clinics either in person or via telephone. This is not ideal and can make consultations more challenging and time consuming. There are also implications on patient adherence to medication when they do not fully understand their treatment regimen which can affect the control of a patient's disease.

2. Describe the pattern of healthcare provision in the USA and compare it with the UK

In addition to learn how a predominantly private, insurance based healthcare care market operates, and as a result the quality of care that is delivered to all patients and be able to compare and contrast with the UK government funded NHS system.

Health care in the United States is provided by many legal entities and health care facilities are operated by the private sector. Health insurance is now primarily provided by the government in the

public sector, with 60-65% of healthcare provision and spending coming from programs such as Medicare, Medicaid, TRICARE, the Children's Health Insurance Program, and the Veterans Health Administration. Most of the population under 65 is insured by an employer, some buy health insurance on their own, and the remainder are uninsured. The U.S. Census Bureau reported that 49.9 million residents, 16.3% of the population, were uninsured in 2010. Active debate about health care reform in the United States concerns questions of a right to health care, access, fairness, efficiency, cost, choice, value, and quality. Some have argued that the system does not deliver equivalent value for the money spent. The USA pays twice as much yet lags behind other wealthy nations in such measures as infant mortality and life expectancy.

A striking difference between treating patients in the USA compared with the UK is that in some instances they can be more demanding and feel they know what is best for them. In addition it is easier for them to change doctors and the litigation culture is more widespread.

3. Develop greater clinical exposure to clinical Rheumatology

My objective was to build on my clinical experience thus far at medical school and challenge myself in the busy, unfamiliar environment of Manhattan. I particularly wanted greater exposure to clinical Rheumatology observing a range of cases and to understand and appreciate use of new therapies such as biological medication in the treatment of Rheumatoid arthritis.

The rheumatology division operates a specialist consult in patient service which involves seeing patient referrals from the internal medicine physicians that require a specialist opinion. In addition there were three weekly outpatient rheumatology clinics covering lupus, arthritis and general rheumatology. In addition there were weekly journal clubs, interstitial lung disease conferences, rheumatology conferences and case presentations scheduled. There were daily clinical rounds which incorporated seeing the inpatients and engaging in diagnostic debate and discussions in clinic reasoning which was very interesting and a very good learning experience.

The outpatient clinics were run by four Fellows each seeing their own patient list and a Preceptor, a role which is rotated by each of the Attendings, to oversee the clinic and confirm the plan for each patient once they had been seen by the Fellow. I shadowed each of the Fellows and the Preceptor to maximise the number of cases I could see. This allowed me to see a wide range of cases and practise my examination skills under supervision which was very benefitting. I was able to hone my skills on the basics such as hand and joint specific examinations identifying typical changes such as synovitis, typical joint pattern involvement and deformities in osteoarthritis, rheumatoid arthritis and Jaccoud'sarthropathy in patients with SLE. I was also able to observe and assist where appropriate in ultrasound guided knee joint aspirations and local steroid injection of rheumatic nodules over extensor surface and into the shoulder joint for pain relief. Diagnostic challenges included patients with overlap syndromes and multiple problems presenting together and the need to decipher what condition and process is responsible for what symptom. A common problem was patients presenting with fibromyalgia and chronic pain syndrome either spontaneously or with an underlying problem such as rheumatoid arthritis. This is difficult as there is no specific treatment or abnormal investigation. I was able to observe an array of patient beliefs and attitudes toward their health particularly when some embrace disability unfortunately and fail to adapt to their chronic condition.

Rachit K Singhal
HA06194@qmul.ac.uk
Barts and The London

What was interesting to note was that the knowledge I had previously accrued from textbooks does not always follow on clinically, for example a patient with osteoarthritis can have synovial thickening or raised inflammatory markers. It is also important to not just focus on 'positive' serologies but to fully 'workup' the patient and look at the all the investigative evidence in full in context with the clinical manifestations of a disease when attempting to reach a diagnosis. I also learned to appreciate the variations in laboratory techniques and assays which may give rise to false positives.

Shadowing daily the inpatient service I was able to see a vast range of many interesting cases many of which I had only merely read about or even come across in my previous studies. Such cases included lupus, Wegener's granulomatosis, scleroderma,IgG4 disease, necrotizing polyangitis and hemophagocyticlymphohistiocytosis. In a difficult case of a young patient there was an issue of how much hope should a doctor convey to the patient and family, in a setting of a realistically poor prognosis while posing the risk of being seen to be offering 'cure'.

4. To further my personal and professional development

My personal and professional goal was to use this experience to help me form a foundation for my future career path.This rotation has allowed me to further my knowledge base in rheumatology and as a result I will be more confident in teaching medical students in the future when working as a Foundation doctor. There was a strong emphasis on evidence based practice and being familiar with the medical literature and relevant studies as this provides an up to date banquet of information to assist with the best possible management of patients. This is an essential practise I endeavour to take forward with me in future.

I was able also meet many Columbia medical students at residences and in the hospital who were very keen to discuss our London approach to medical education and the NHS and exchange ideas and concepts. During my spare time I was able to enjoy and engage in American culture, visiting famous monuments in New York such as Rockefeller Center and Wallstreet, whilst also taking in entertaining games at the New York Yankee's stadium and a Knicks basketball playoff game at the world famous Madison Square Gardens.