ORTHOPAEDICS

Year 5 Elective report

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1) Describe the pattern of orthopaedic conditions prevalent in Taiwan and how they are managed
2) Describe the pattern of orthopaedic services and healthcare in Taiwan. Be able to list the differences between the NHS and the National Health Insurance (NHI)
3) Gain further exposure to orthopaedics and understand the role of an physician in treating orthopaedic conditions

Taipei is the Capital of Taiwan/Republic of China with a population of 23 million habitants. The life expectancy is 78.53 years, longer than the United States but on par with Germany and the main ethnic group are Han Chinese (98%). The hospitals in Taipei have merged into one unit, known as Taipei City Hospital. A single hospital is referred to as a branch i.e. Yang Ming branch of the central organisation. Yang Ming branch covers the Shilin district, a wealthy district of Taipei. The majority of orthopaedics cases seen were therefore mainly related to geriatric conditions i.e. complications from osteoarthritis, osteoporosis or lumbar and cervical degenerative disc diseases. A frequent presentation is a fall, where the patient commonly sustains a fracture to the neck of the femur. The management is dependent on the type of fracture and the patient's age, but commonly involves a total hip replacement, a hemiarthroplasty or a dynamic hip screw.
Back pain due to vertebral disc degeneration is another common presentation in the United Kingdom as well as in Taiwan. However in terms of management there are differences. In the UK, often a holistic approach is taken, "wait and see", analgesics and the pain ladder, physiotherapy or even acupuncture is recommended. In Taiwan the degree of disc degeneration is assessed directly by X-rays and MRI, in most cases an artificial disc replacement is recommended. Both management options are offered in both countries, however the proportions are inverted, a conservative/medical approach is the main step of treatment compared to a surgical intervention in Taiwan.
Trauma cases, often due to road traffic accidents with scooters in Taipei, are less common in this district. This is different to the pattern seen at the Royal London Hospital, where patients are admitted for road traffic accidents or penetrative trauma and occupational injuries.

I spent most of my time in theatre, with only two afternoons in the general orthopaedic clinic per week. The clinic had patients with a variety of conditions and the lists were therefore enormous with approximately 70 patients per clinic. Nevertheless he had two nurses with him, one was writing the notes of the consultation and the other nurse was preparing injections, forms etc. Even though a consultation was shorter compared to the UK, he was still able to spend an adequate amount of time with the patient due to the nurses assisting him.

The overall spectrum of patients I saw in orthopaedics in Taipei was much broader due to differences in the healthcare system structure. Primary care as a gate keeper to secondary care has not been implemented in Taiwan as in the UK. Patients have the choice to see a GP first but the majority decide to see a specialist straight away without the necessity of a referral. As a result common conditions i.e. osteoarthritis that can be normally seen and managed in primary care in the UK would present to secondary care. In terms of management, there is not much difference,

however from speaking to patients, they prefer to see someone who is a specialist in their condition rather than a general practitioner believing their knowledge is inadequate.

A wide range of health care workers were involved in orthopaedic care. Orthopaedic consultants held daily ward rounds to assess the progress. Nurses on the ward provided the care for the patient on the ward. The head nurse had the role of his secretary, writing notes and answering his phone calls, but also was his primary assistant in surgery. She would also stay on ward rounds and relay the management plans of the consultant to the ward nurses. Lastly physiotherapists as well as occupational health workers were also involved.

Taiwan's healthcare system is known as the National Health Insurance (NHI) and was instituted in 1995. It is a single payer healthcare system like the NHS and the revenue is financed by payroll based premiums from employers (76.8%) as well as the government (23.2% from i.e. tobacco excise tax). The government and employers share the contribution for the insured and their dependents. Every service requires a copayment in form of a small fee, except health check ups of patients older than 65 or cancer screening programs. This is different to the NHS where funding is entirely tax based. The NHS is more socialised as the government provides and also pays for health services. As single payer systems, both systems have a high coverage rate and both systems avoid a selection of young and healthy patients over older less healthy patients, often seen in private health care systems. The NHI has a better accessibility than the NHS as it provides direct access to secondary care, but at the same time the weakness is the limited role of GPs as a gatekeeper system. In Taiwan there seems to be a strong health seeking behaviour embedded in the culture, taking medicine and seeking medical help frequently. Nevertheless the system works efficiently despite shorter consultation times without a decline in quality of the consultation. The NHS is famous for long waiting times, which is almost a non-existing problem in Taiwan. Patients can get a same day appointment and be seen by a secondary care specialist or a GP. Elective surgical interventions have a waiting time of less than 2 weeks. The NHI is in fact considered by experts as one of the best healthcare systems along Sweden and Japan, however it is almost always disregarded because of the country's political conflict with China, which left Taiwan isolated from the World Health Organisation.

Because of the high turnover of patients in clinics as well as different dialects spoken in Taiwan, I was not able to take many histories. I don't feel that I have benefited as much from clinics and meetings compared to the time I spent in theatre. I have assisted every day in theatre and was allowed to suture many patients. I felt it was an excellent opportunity to improve my surgical skills, such as suturing, casting/splinting or drilling, as well as learning anatomy in situ. I found it particularly useful that the list for a theatre on one day contained patients with similar operations. This allowed the knowledge to sink in gradually/repetitively over the day.

The most common surgeries I have observed and could assist were hip and knee replacement surgeries. Vertebral disc replacement surgeries were quite common too, however it was difficult to assist as the surgical field was small and not large enough to accommodate more than two people.