Working on a Different 'Footing': A British Perspective on American Medicine

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INTRODUCTION

It was with some anxiety that I arrived, with family in tow, to Boston for my year's fellowship at Harvard - and what a year it has been! The Red Sox World Series victory, ending the 86-year curse, rolled into the mesmerizing presidential debates and subsequent election. These dramatic events have been a backdrop to a wonderful time spent training under two excellent physicians at one of the leading teaching hospitals in the USA. It has been fascinating to see the American healthcare system at work, and how it differs from the British model. In Britain healthcare is dominated by the National Health Service – the "NHS". Not a day goes by without some headline or other with those three capital letters standing out. The NHS is funded by taxation, and provides free healthcare to all citizens regardless of station in life. It is an enormous and unwieldy beast, being the largest employer in Europe. Conceived in 1948, in post war Britain, it was a radical and groundbreaking solution to a nation's health needs – a system that other nations envied. Now, over fifty years old, it groans under the strain of chronic inadequate investment, spiraling healthcare costs, excessive political involvement and poor workforce morale.

One of the most striking differences between Britain and America that I have noticed is the work ethic. I find Americans to be very positive in their attitude to work. Residents appear to ooze enthusiasm - regularly using words like "fascinating" and "awesome". In contrast, British doctors often complain over tea about their work environment – the 'great British whinge'. This may well be cultural or it may reflect the strain of working in a massive government bureaucracy. To illustrate this: an English friend, who is now a resident in Philadelphia, was approached by his Chief who had misinterpreted his typically British reserve whilst being shown some interesting x-rays as a sign that he was dissatisfied with his program!

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Americans seem to work much harder with longer hours and shorter vacation times. If you arrive at a British hospital at 7:45 in the morning you'll get the best parking space, but finding an open coffee shop would be a challenge! Most surgical days start with academic or clinical activities at 8am. Internist colleagues generally start at 9am. The American early start culture offers many benefits. The volume and quality of early morning conferences available to the Harvard Orthopedic residents is impressive and promotes education without compromising clinical experience. I am still amazed at how much can be achieved by 8 O'clock in the morning!

The amount of advertising of medical services, products and medications (never using generic names) in America is astounding. In Britain it is illegal for a doctor to advertise his or her services, and direct advertising to the public of prescription drugs is not permitted. It would seem distasteful to many British doctors. I was shocked to see television advertisements which advise patients to ask their physicians about such specialist products such as mobile bearing knee replacements, erythropoietin and chemotherapy medication. Whether or not the audience actually needs a knee replacement in the first place is not an issue to the advertisers!

The outpatient clinics are run in a similar manner in both countries, with comparable numbers and mix of new and established patients. In the clinic, the level of supervision of residents is different. In Britain, although guidelines suggest that the trainee should be supernumerary, this is rarely the case and residents will often see patients on their own which is far from ideal. This typifies the unresolved struggle that exists in the NHS between service commitments and training commitments.

It seems American patients have a better insight and understanding of their conditions, being more aware of what medical problems and medications they use compared to their British counterparts. Perhaps this is a product of all the advertising. I have noticed a striking difference with pain medication. It surprised me how knowledgeable the average patient is about pain medication, and also how often narcotic based analgesia is prescribed. Although both oxycontin and hydromorphone are available in Britain, I don't think I have ever prescribed it.

Patients here seem to expect more from their health care system. The system is as a whole more interventionalist - whether it is through investigation, physical therapy, orthotics or surgery. In America patients get a better service - "Something needs to be done for everybody". In contrast, in

Britain it is still acceptable to say there is no treatment, or to adopt a wait and see policy. In the case of Orthopedics there is often a long delay to treatment or investigation as the patient sits on a waiting list lasting several months – occasionally symptoms resolve, more often they worsen.

One of the great contrasts between American healthcare and her European counterparts is the culture of litigation, despite claims by Senator Kerry in the second presidential debate that stated litigation accounted for less than 1% of the total cost of healthcare. The true cost of litigation can only be assessed if one accounts for the cost of practicing defensive medicine. It is easier for a visiting surgeon to observe ingrained differences in practice that can be attributed to defensive medicine. Many self-limiting conditions are over investigated to exclude any rare differential causes of pain. Even if surgery appears to be the most appropriate treatment, fears about potential litigation means other treatment modalities are pursued first, fruitlessly. Young and fit patients are often prescribed home therapy assessments after surgery – merely to avoid any potential lawsuit should they fall at home. Such assessments are generally only deemed necessary with elderly patients in Britain. This is only one example amongst many of the practice of defensive medicine - and surely this approach, as well as litigation itself, has raised the cost of insurance premiums.

Unfortunately in Britain the double-edged sword of medical litigation is on a dramatic increase. This changing culture also brings positive aspects with it - risk management and clinical governance are top of the agenda, leading to changes such as more vigorous consent processes and safety procedures.

Another difference between our systems is the number of people found in the operating room. In Britain, each and every anesthetic must be administered by an MD, with a technician assisting. Most operating rooms have an attached anesthetic room which allows for more rapid turnover. The scrub nurse is always a registered nurse, and there are always one and sometimes two runners. Recruitment and retention of nurses in the NHS is a real problem in Britain. Despite the demand very few of the younger generation wish to train to join a profession which is grossly underpaid and overworked. It is not uncommon for a senior OR nurse to make $45 an hour in Massachusetts while in Britain they would be lucky to make half of this – add to this the higher cost of living in Britain. As a result, many of the better floor and OR nurses are lured towards better paid administrative roles. The OR is often run by large numbers of temporary staff, though this is improving because the NHS has recruited large numbers of overseas nurses, notably from the Philippines. Some feel that this is a form of skills poaching from more needy countries.

There are fundamental differences in medical and orthopedic training between the USA and Britain. We start medical school at the age of 18, fresh from high school, and complete the basic MD by the age of 23 or 24. Then starts the 'houseman' year – this is equivalent to an internship and comprises six months in medicine and six months in surgery. Then a 2 (or more) year programme in "basic surgical training" is undertaken. During this the trainee rotates at six month intervals between different surgical specialties. During this time the trainee sits the Royal College of Surgeons membership examination. Once this hurdle has been jumped, the trainee can then apply for a six year specialist registrar training program in Orthopedics which incorporates a 1-year fellowship. In the fifth year of this, candidates sit for their comprehensive exit exam in Trauma in Orthopedics which awards them the title of FRCS (Orth).

There are changes happening: a new training scheme to be launched this year aims to shorten the journey of specialization. This has been combined with new European law which forbids doctors to work longer than 58 hours a week. Many are concerned that these changes will reduce the quantity of training experience to which trainees are being exposed, potentially leading to inadequately skilled surgical consultants.

In comparison to the USA; medical school fees in Britain are substantially less, meaning resident debt is less of a problem. Furthermore, resident salaries are almost double that in the USA. However, training is much longer and there is a bottleneck at the start of specialist registrar training which can often be cleared only by taking extra time out to undertake clinical research.

After completion of training, surgeons can work as a consultant in the NHS. They are contracted to work a 40 hour week which includes allowances for administrative duties, teaching, on call commitments and furthering education. Sub specialization is also on an increase but almost all consultants will be expected to participate in general trauma on-call and will have a weekly half-day trauma list and fracture clinic. At completion of training, most orthopedic surgeons can confidently manage trauma and need to as there are very few dedicated trauma surgeons. The more complex fractures such as pelvic, shoulder or calcaneal fractures are often referred to an appropriate specialist after initial management.

The basic consultant salary starts at a minimum of £65,000 per annum ($117,000). This figure is the same for all hospital specialties. There are no office expenses and 30 vacation days are allowed per year. On top of this there is an allowance for time spent attending activities of further education, such as conferences. This salary can be boosted by private practice, which is worked outside of the NHS hours. Relatively few people in Britain have private health insurance as the NHS is free for all. Many companies offer private health insurance as a perk to their employees, and occasionally some private individuals choose extra health insurance to access speedier medical treatment and to afford more choices.

Offset against this is the higher cost of living in Britain – houses, cars and ice cream are all more expensive. With gas costing $8 per gallon, I am amused when Bostonians vociferously complain that prices have gone above $2 a gallon!