# Elective in the Emergency Room, Sinai Hospital of Baltimore, Baltimore, Maryland, USA

Going into my elective, I had the following learning objectives:

1. To consolidate clinical skills needed for practical procedures such as cannulation and venepuncture, using equipment that may initially be unfamiliar.

2. To gain an understanding of the fundamental similarities and differences between America and Britain with respect to the delivery of acute healthcare.

Introduction

Sinai Hospital of Baltimore is a 600-bed community hospital serving the 600,000-strong population of the city of Baltimore, in the State of Maryland. Sinai is a teaching hospital for medical students from the Schools of Medicine at Johns Hopkins University and the University of Maryland, with all full-time faculty staff holding academic positions at one or other of these two institutions. The vast majority of patients seen are African-American or African-Caribbean, and there is a high burden of cardiovascular morbidity.

The Emergency Room (ER) at Sinai is known as ER-7 because it is divided into seven departments, each catering for various acute presentations. It accommodates a total of 30 beds. Much as in the UK, the ER has a triaging system, an urgent care centre for minor complaints, a paediatric unit and an observation centre. However, as opposed to having one unified majors area as I have been used to in UK hospitals, Sinai ER has a dedicated chest pain centre and an emergent care centre. The purpose of the latter is to provide high-intensity care for critically ill patients. Like St George's Hospital in London, where I trained, Sinai is also a trauma centre, accepting victims of gun crime amongst other presentations.

In my time at Sinai, I worked 8- to 10-hour shifts (including 4 nights) with multiple emergency physicians, nurses and physician assistants in all areas of the ER except paediatrics. This exposed me to chronic, subacute and acute presentations covering all body systems, including those with which I had perhaps been less familiar, such as dental problems and wound management.

I chose America because I wanted to experience medicine at its most advanced. Additionally, having relatives in Baltimore was a good reason to spend my elective in Maryland. Lastly, NICE recommends that all junior doctors be familiar with its guidance on managing acutely unwell patients in hospital.[1] I chose emergency medicine because I reasoned that since it deals primarily with acute disease management, it would be a valuable experience at my junior stage irrespective of my eventual chosen specialty.

Discussion of learning objectives

Prior to starting my elective rotation at Sinai, though I was knowledgeable in the theory of suturing and gluing wounds – including the requirement to maintain sterility, irrigate and anaesthetise the wound and provide wound care advice to the patient following closure – and though I had practised on synthetic skin, I had not actually sutured a real wound in a live patient. The ER was a perfect setting to increase my proficiency in managing real wounds. I sutured, glued or stapled several patients' wounds, all in different anatomical areas and resulting from various mechanisms of injury. I thus became comfortable at performing these skills.

Additionally, I had the opportunity to further my skills in venepuncture and cannulation, since nearly all patients seen in the ER required basic blood panels and/or intravenous access. I occasionally also had the opportunity to practise taking an arterial blood gas (ABG) sample. Being cognisant of the fundamental technical principles of venepuncture, cannulation and ABG-taking was vital in allowing me to successfully complete these skills despite using equipment that differed slightly from what I had been used to back in the UK. Finally, I continued to develop my skills in recording and interpreting ECGs (EKGs) as well interpreting radiographs and CT scans in the acute setting.

From my time experiencing healthcare in the UK and now America, I have realised that the fundamental difference between the two health systems is the extent to which they are publicly or privately funded. Whereas the UK subscribes to a public, tax-funded system, the US employs a private, insurance-driven system. Simply speaking (and this is perhaps overly simplistic), whilst the UK has adopted a socialist healthcare system since

1948 with the setting up of the National Health Service (NHS), the US continues to operate by the capitalist principles of competition and ability to pay. Indeed, many Americans with whom I spoke whilst on elective referred to the UK system as delivering “socialised medicine”. In political terms, you might say that the UK NHS is rooted in left-wing ideology (it was the Labour party who established it in 1948), whereas the US system adheres to right-wing thinking.

It is true, however, that in recent years we have seen both countries’ health systems veer politically more towards the centre ground. In the UK, the Conservative-Liberal Democrat coalition, by introducing the Health and Social Care Act (2012), has abolished Primary Care Trusts (PCTs) and replaced them with Clinical Commissioning Groups (CCGs), which allows newly-established consortia of GPs to commission health services from bidding providers, so as to meet the specific health needs of their respective local populations. This has strengthened competition within the NHS, aiming to increase patient choice and drive up standards of care. In the US, under the Affordable Care Act (2010), or “Obamacare” as it has come to be known, the number of Americans now able to access basic health insurance has increased by an estimated 8-9 million. This still leaves approximately 30 million Americans with no medical insurance, potentially denying them of urgently needed treatment. Notwithstanding these recent legislative reforms, which have brought both countries more towards the political centre ground, the aforementioned public-private comparison, broadly speaking, remains valid.

As a way of increasing efficiency and expediting the treatment of patients, Sinai Hospital ER employs a team of scribes working in conjunction with emergency physicians to record histories and examination findings. I have not seen such a system in UK hospitals. Many of these scribes were prospective medical school applicants, using the opportunity to gain experience of healthcare with practising emergency physicians. The partnership worked well and I thought it led to a more efficient use of the doctor’s time, with less emphasis on paperwork.

Finally, the 4-hour A&E target in the UK is non-existent in the US.

Evaluation

The most common presenting complaints I saw at Sinai mirror those I saw during my final-year Emergency Medicine placement in the UK: namely, dizziness; chest pain; shortness of breath; abdominal pain; back pain; headache and lacerations. These symptoms have wide differentials, so it is important to rule out life-threatening diagnoses early, for example, stroke, acute coronary syndrome, deep vein thrombosis, pulmonary embolism, pneumothorax, ruptured aortic aneurysm, sepsis and cauda equina syndrome. I saw well in excess of 100 cases at Sinai and had the opportunity to observe the response to trauma calls. Several patients with gunshot wounds were admitted and managed in the trauma bays in accordance with the American ATLS guidelines.

In discussions with emergency physicians and in observing their practice, the litigious culture that seems to pervade all aspects of American society, including healthcare, became apparent. The unceasing threat of litigation prompts many emergency physicians to order investigations that may not strictly be necessary, for fear of missing a diagnosis and being subject to a resulting lawsuit. This lack of monetary stewardship is often compounded by the very palpable mind-set amongst some patients that because they have medical insurance, they almost have the “right” to any and all investigations and treatments, which will duly be paid for by their insurance company. Although this probably results in a lower diagnostic miss rate than in the UK, in my opinion it detracts from the doctor’s clinical judgment. If any and all investigations are ordered every time without diagnostic indication, this reduces the importance of a prioritised differential diagnosis list. It also means patients are exposed to unnecessarily high radiation doses in CTs, radiographs, angiograms and nuclear scans.

I have inevitably considered which of the two systems I prefer. The American, privately-funded system results in shorter waiting times for referral to secondary care specialists compared with the UK – there seems to be no such difference in the delivery of acute healthcare.[2] However, about 30 million (or one tenth of) Americans still have no medical insurance even with “Obamacare” having been in full force since the beginning of 2014.2 In contrast, the publicly-funded NHS provides a universal, comprehensive service, free at the point of need that does not depend on ability to pay, but also leaves open the option of private healthcare where the individual can afford it. Funding the health service, rather than being an individual problem as it is in the US, is a national problem in the UK. It cost the government £108 billion in 2012-13 [3] and puts a heavy burden on the UK annual public spending budget. The US spends twice the amount on healthcare per capita as the UK, but this offers no health advantage over the UK.2

Having gained experience of American healthcare, I have come to appreciate the value of the NHS in providing a high standard of care to patients, free at the point of need. We have a unique health system in the UK, which it is vital to protect and sustain into the future.

I think it is worth adding that my experience of Baltimore's thriving Jewish community was very positive. I had the opportunity to attend an AIPAC regional policy meeting, which brought together under one roof hundreds of AIPAC members from several neighbouring American States. This meeting alone exuded a tremendous sense of unity in the common goal of protecting the interests of the State of Israel.

In summary, I can confidently say that my elective rotation at Sinai was a worthwhile experience, both for my personal and professional development. I would like to express my thanks to the Jewish Medical Association (UK) for supporting my elective.

References

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