Travelling fellowship to the USA – September/October 2013

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On Saturday 21st September 2013 at a quarter past midnight I started my journey to the USA to undertake a 3 week travelling fellowship with generous sponsorship from the British Society for Surgery of the Hand. A bus took me from Nottingham to terminal 3 of Heathrow airport, arriving at around 4 o'clock in the morning, a time when even Heathrow seems to shut down. About an hour later, desks began to be staffed and I was able to check in, go through security relatively painlessly and get some breakfast pending my flight, which left on time.

After an 8 hour flight I landed in Chicago and had to navigate through immigration. The queue moved impossibly slowly, and I calculated that there was no way I would make my connecting flight if I stayed in it. A little guile and a lot of luck resulted in a queue-jump and I was able to catch my connection to Rochester, Minnesota, home of the Mayo Clinic. A shuttle bus took me to my basic but comfortable hotel which I am delighted to report set the trend for free Wi-Fi in all hotels and hospitals for my entire trip, allowing me to keep in touch with my young family back home using Apple's FaceTime.

Mayo Clinic, Rochester (23-27 Sept)

I spent the remainder of the weekend exploring the city of Rochester. It struck me that city comprised the enormous Mayo Clinic and little else. The skyline is dominated by several large tower blocks, most of which are part of the clinic and some of which are hotels. Surprisingly, the majority of this organisation shuts down at the weekend. Emergencies continue to be treated at the large, acute St. Mary's hospital towards the edge of town. I explored the extensive walkways around the perimeter of the city centre and beyond for several miles. I reached an area called Foster's Arend where there is a lake and a man-made beach which is popular in the summer but sadly closed after Labor Day. The weather at this point was typical of an English summer and I wouldn't have minded a dip! Apparently, in the summer it become unbearably hot, and in the long winter it gets unusually cold for the latitude due to cold winds from Canada. The city is generally under snow from November to March and there are raised, enclosed skywalks and subways for getting around in comfort and safety.

On Monday I presented myself to the admin office towards the top of one of the tower blocks and my passport was photocopied. I was given maps of the campus, an ID badge and a password for the computers and was let loose. I went straight to the hand clinic via the super-fast lifts to the 15th floor of the Gonda Building to meet Dr Kakar, who had kindly facilitated my visit. The buildings were even more impressive on the inside, with grand entrance halls, high ceilings, and even a live pianist!

I had organised the whole trip myself and this had been relatively easy. I e-mailed contacts listed on the websites of the Kleinert Kutz Hand Center in Louisville, the Indiana Hand to Shoulder Centre and the Mayo Clinic. The first two readily accepted my request and simply asked for dates and a TB certificate. The Mayo contact

initially responded to say that they too were happy to have me visit. However, nearer the time it seemed that they had no-one for me to shadow. A British colleague and friend of Dr Sanjeev Kakar in the Mayo e-mailed him on my behalf and Dr Kakar kindly offered to let me shadow him. As an ex-pat, he was keen to help other British doctors experience medicine in a different country. I then booked flights, hotels, and annual leave and applied for funding which was later granted.

The grandeur and scale of the Mayo clinic led me to expect a completely different experience from UK orthopaedic practice. In fact, I found far more similarities than differences. The case mix is strikingly similar to that which we see at home. Aside from the occasional complex case, the clinic was awash with carpal and cubital tunnel syndrome, trigger finger and thumb CMCJ arthritis. I expected all of the patients to be among the rich and famous and to have travelled from far and wide to be treated at this prestigious unit. A few of them were: a couple had flown in their private jet from Florida for hand surgery, and King Juan-Carlos of Spain was in town having a hip replacement (don't worry about confidentiality; it was on the local news). The vast majority of patients however were ordinary Minnesota folk from within driving distance and across the social spectrum.

I expected the pace of work to be rapid and highly efficient in a country where healthcare was predominantly privately funded. Again I was wrong. We see many more patients in a UK clinic than they do at the Mayo. It is usual to have around 100 patients in a hand fracture clinic at Queen's Medical Centre in Nottingham, and they would all be seen and treated by lunchtime. Consultants in the Mayo would see between 12 and 40 patients in a full day clinic, depending on the consultant, although admittedly all patients were seen by the Consultant. It was explained to me that patients come to the Mayo expecting to get the "red carpet" treatment. They want to spend a decent chunk of time in clinic and be fussed over. The Mayo works on an Academic model, which means that the consultants are salaried, so it doesn't matter how fast they work. They have very little interference from management and have lots of autonomy. I was told to expect a different experience at the other units as they would be based on a Private model, but this was not borne out as you shall read later.

Patients arrive for their appointment in a spacious, opulent reception where there is a well-equipped education area containing hand models and several computers with educational applications regarding hand and upper limb. They are given a pager, which buzzes when the patient is due to come through and start filling out their questionnaires. All Dr Kakar's patients fill out a DASH (disabilities of the arm, shoulder and hand), a PRWE (patient-rated wrist evaluation) and a Michigan hand questionnaire.

The patient is then seen by a medical student (if present) and then a fellow/resident or Physician's Assistant (PA). A PA is similar to a nurse practitioner in the UK. They study a specific PA degree, which seems to be quite similar to a medical degree. Their role is clinical, clerical and surgical. They see patients in clinic, they organise appointments/kit/operating lists, and they assist in theatre and close wounds independently. The sub-consultant staff will spend a substantial amount of time taking a full history and examining the patient thoroughly, measuring joint range of movement and grip strength. One PA told me that part of his job was to "shoot the breeze" with the patients. After all of this, the patient would always be seen by the

Attending (Consultant). He would chat to the patient at length, carry out a focused history and examination and formulate a management plan.

I found that there was greater use of investigations such as MRI and nerve conduction studies compared to the UK. This is partly due to availability, but also for medico-legal reasons, and because even local patients have travelled hours by car and want their visit to be a one-stop shop. Investigations are often on the same or next day.

The Mayo hand surgeons are allocated to one of two groups, orange or blue, which would determine their position on a two week rolling rota. One group would operate on Tuesday and Thursday and see patients in clinic on Monday/Wednesday/Friday whilst the other group did the opposite. The following week, the teams would swap over. I was spending time with the orange team which included Dr Kakar, Dr Elhassan, Dr Bishop, Dr Shin and a young man called Karim Bakri, whom I recognised as a plastics trainee from Nottingham! I had previously met Dr Shin at a BSSH instructional course in Manchester.

Some consultants dictate at the end of clinic or after seeing a batch of patients. Most dictate immediately after seeing each patient. Either way, dictation is carried out by telephone to a recording service which will later be typed up. I noted that the dictated letter was generally quite comprehensive, including a statement about the patient's mood. This is because billing is based on assessment of different systems and stratified as to the depth of enquiry. Thus, the physician will charge for a mental state assessment at the basic level simply for determining that the patient is in an appropriate mood!

Outside each room is a panel of lights controlled by buttons inside the room. These will indicate which member of staff is due to see the patient next. Despite having the luxury of solid walls between consultation rooms, doors were rarely closed during consultations. White coats were not worn in clinic in the Mayo except over scrubs when nipping out of theatre, although they were used more extensively in the other units I visited.

I talked to the resident on the team, Dr Ben Wilke, about training in the USA. He confirmed my belief that they work extra-ordinary hours. Ben would arrive at work between 5 and 6 in the morning. We would usually leave sometime between 6 and 10, plus on-calls. He admitted that he could probably get away sooner if he worked more efficiently. It was not immediately obvious what the juniors do when clinic or theatre finish, which is generally before 5pm. As in the UK hand practice, there are very few inpatients. Apparently a number of administrative tasks accumulate throughout the day and are logged on the computer. This involves many calls from patients which must be returned by the resident. This may be for medical issues, but frequently these are for rescheduling outpatient appointments, a job entrusted to the resident rather than a secretary based on the "red carpet" principle. These hours are only for the duration of resident training, which is 5 years. Thereafter there is a similarly onerous year of fellowship followed by independent practice, the hours of which are much more sociable and, to a large extent, dictated by the surgeon. There is much variability, and some residents are worked harder than others depending on the unit and the supervising consultant.

At the end of clinic, I was given a brief tour of some key Mayo locations. I visited an anatomy lab where there appears to be an endless supply of limbs to dissect. I was also shown a very impressive building that was built for the Mayo by the founder of Slimfast, Dan Abraham. During a stay at the Mayo he noted that the staff were unhealthy so spent an enormous amount of money building a Healthy Living Centre. This houses a vast and well equipped gym, a walkway for exercising in the winter, and kitchens which not only serve healthy food, but also where staff are taught how to cook healthy meals (and presumably mix milkshakes). The already large building is currently undergoing an extension…upwards. I was also shown the consultants mess, which is a bit like our junior doctors' mess crossed with an expensive hotel lobby.

The following day was a theatre day in the Gonda building, although if you call it "theatre" nobody has a clue what you are on about. Same goes for "A&E". The operating rooms are much the same as in the UK, but slightly bigger, have 3-4 ceiling mounted operating lights instead of the usual two, and also have ceiling mounted monitors for such things as displaying imaging or live arthroscopy video. The PA or nurse will prep the patient and the PA will close the wound at the end. In all the units I visited, the patient was prepped by someone other than the doctor.

Knife to skin was 8am and the list was finished by about 4, which was fairly typical. This list was quite light and I felt the last case could probably have been done quicker. There was a removal of spanning ex-fix across a wrist and EUA, a carpal tunnel and trigger thumb release, another small case that I cannot recall, and a distal radius malunion osteotomy and iliac crest bone grafting which took about 4 hours! A plastic model of the radius had been made using CT and bespoke cutting jigs had been made to cut the radius. There was even a small chunk of plastic representing the shape and size of iliac crest graft required. In the adjacent theatre I watched Dr Berger doing a wrist arthroscopy and open DRUJ exploration. The "stop" moment is routinely used.

In the little downtime between cases, as the turnaround was quite rapid, the doctors went to the nearby plaster room where such things as removal of k-wires were performed. Patients in plaster were reviewed here, with their x-rays. There is also a nice staff lounge where free food and drink is available.

On Wednesday I was nominally allocated to follow Dr Elhassan. The day began with a journal club at St Mary's hospital across town at 6.15am. It was a very business like meeting, with rapid and confident presentation of papers by fellows which were then discussed by the assembled 9 or so fellows and 3 consultants. They got through about 6 papers in 45 minutes and it struck me that the fellows really knew their stuff, and the consultants even more so. They all had a grasp on the literature to a level that I would consider unusually high at home. Dr Kakar said that, in his experience, American trainees were better read, but less operatively capable than their British counterparts due to differences in the training systems.

After this I went back to the Gonda Building for Dr Elhassan's clinic. Dr Elhassan is a very interesting Lebanese character with a flamboyant personality and dress sense! The day's clinic proceeded much the same as my previous clinic day with Dr Kakar, only a little quicker. Patients seen included:

- snapping scapula listed for arthroscopic debridement
- a shoulder arthrodesis for post-traumatic paralysis
- habitual shoulder dislocation listed for cuff tightening by anchoring the cuff more lateral on the humeral head
- biceps tendinosis
- cuff tear
- ACJ injection, blind but with ethyl chloride anaesthetic
- Shoulder injection for arthritis, blind via anterior approach
- Non-union of proximal humerus plating, listed for reverse total shoulder replacement – patient physiologically 70+
- Arthroscopic carpal tunnel decompression

I found that Dr Elhassan was a fairly aggressive surgeon but not unduly so, and not to the extent that I was expecting when I came to the USA. At lunchtime, Dr Elhassan took the team and me to lunch. Every day they went to the same Italian restaurant over the road. Such was the regularity of the visits that the restaurant had named a dish after Dr Elhassan. I was compelled to try the "Salati di Elhassan", a salmon based salad, and it was delicious!

In the afternoon we saw a few more patients, and when Dr Elhassan's clinic was finished, I drifted next door to where Dr Shin and Dr Bishop were holding their clinics. Patients I saw that afternoon included:

- a fragment specific fixation of a distal radius fracture
- an undisplaced radial styloid fixed with a plate – Dr Shin was adamant that such fractures were unstable and must be treated aggressively
- a C5/6/7 root avulsion following a low speed scooter injury. Five months down the line, the patient was showing remarkable signs of recovery and therefore the planned nerve grafting surgery was cancelled in favour of waiting longer.
- Open carpal tunnel
- Central slip rupture – proposed intrinsic transfer from same or adjacent finger
- An intra-osseous ganglion of the distal phalanx listed for excision via the nailed
- A scleroderma patient with multiple auto-amputations of the fingers

I also witnessed Dr Bishop inject the flexor sheath at the level of the proximal phalanx for triggering. When faced with a mucous cyst which had settled somewhat, he proposed watching and waiting, and aspirating if it recurred. He feels that such cases often resolve with conservative treatment. We also saw a patient with bilateral UCL thumb ruptures 10 weeks previously. She was listed for repair +/- fusion, as it was felt that reconstruction does not work well.

Thursday was another theatre day. It began with the weekly upper limb meeting, where some interesting and difficult problems were presented. This included a case of recurrent elbow dislocations. Drs Morrey (of the Coonrad-Morrey elbow replacement and O'Driscoll (of elbow fame) were among the assembled consultants. After the meeting, the medical student and I took the link bus to St Mary's hospital for theatre.

The theatre complex at St Mary's is incredible. There are 60 theatres all on one level in one complex. It reminded me of an airport concourse, or perhaps a shopping centre. There are 110 operating theatres across both sites. The cases I witnessed that day were:

- extended carpal tunnel release in a patient with an old proximal row carpectomy
- reverse total shoulder replacement in the patient with the humerus non-union seen the previous day
- another reverse total shoulder with a latissimus dorsi transfer to achieve external rotation

The highlight of the day, and indeed of the week, was witnessing a free vascularised bone graft from the medial femoral condyle to the wrist for stage 4 Kienbock's disease. Drs Shin and Bishop always operate together. On this particular occasion, Dr Bishop harvested the graft via a medial approach to the distal femur. He identified the descending branch of the superior geniculate and traced it to the medial trochlea where he excised a segment of bone on the vascular pedicle. Dr Shin meanwhile prepared the wrist by excising the completely destroyed lunate and proximal pole of capitate and scaphoid from a dorsal approach. He then fused the graft to the capitate and scaphoid, tunnelled the pedicle round to the volar radial wrist and anastomosed the artery with the radial artery and the vein with a superficial vein under microscopy. Aside from the anastomosis, the whole operation was done under loupe magnification, something I noted was ubiquitous during my stay in the USA.
In the evening, I was invited to a meal that was being held in honour of two visiting consultants from Japan, Dr Oshi and Dr Kato. Local consultants Dr Bishop, Dr Shin, Dr Dennison, Dr Amadio, and Dr Rizzo were also present. I discovered that the Japanese consultant surgeons work even harder than those in the USA, starting at a sensible 7.30am, but regularly finishing at 10-11pm!

On my final day I met Dr Dennison at 6am and was escorted to the weekly hand meeting in the Methodist hospital. There was a teaching session and an interesting talk from Dr Oshi regarding spontaneous PIN degeneration. I then spent the day in clinic before returning to the hotel to prepare for an early flight to Louisville.

Kleinert Kutz Hand Care Center, Louisville (30 Sept – 4 Oct)

I arrived in Louisville airport and went straight to my hotel, which was only yards from the Interstate. Although a little early, I was permitted to check in. I was very disappointed with the quality of the hotel. I had booked it myself online and, as it was a Days Inn, I expected a basic level of quality and cleanliness, but it was not clean and looked like the sort of place that charged by the hour! I felt quite dejected actually, but settled in nonetheless and gave the place a bit of a clean myself with a flannel that started out white. I then took a nervous walk to a nearby Taco Bell for some food and hunkered down for the evening. There were a lot of late night comings and goings which I put down to it being a Saturday. My room was directly off the car park on the ground floor. There seemed to be an unreasonable amount of use of car horns, but I later realised that many American cars pip the horn as they lock to indicate that the alarm has been set.

Having survived the night I set off to walk into town to pick out a possible commuting route for the week ahead. I met a few interesting folk en route including a lady of indeterminate age with few teeth who boldly asked if I was "looking for a date." I politely declined and quickened my pace! I spent the day exploring on foot, getting rained on, buying souvenirs and avoiding the locals. The following morning I got a cab to work!

I arrived on Monday morning to the news that the much loved and respected Harold Kleinert had passed away on the Saturday of my arrival, aged 92. There was therefore a sombre mood to the unit. Nonetheless, teaching took place as normal at 6.30 as it did every morning. At the end of teaching, Dr Kutz (still operating at 83) announced that there would likely be a hand transplant on the list that week. This only happens once every year or two and I could not believe my luck. However, the operation did not go ahead as the recipient changed his mind! The Kleinert Kutz hand center carried out the first 5 hand transplants in the USA. The first in the world was in France in 1998 and there have now been 72 worldwide. Eighteen have survived beyond 5 years and seven of eight transplants over 10 years old have survived.

Teaching was delivered by Professor Beppo who was visiting from Japan and is an alumnus of Kleinert Kutz. The topics were 2nd MC base vascularised grafting of the scaphoid and recalcitrant tennis elbow symptoms secondary to a synovial fringe. After this I was taken to the doctors' lounge where free breakfasts and lunches were provided by the hospital every day. It was a quiet week as the ASSH meeting was taking place in San Francisco, but there was still plenty happening in theatre to keep me occupied.

One of the fellows was a Brit by the name of Chris Milner. Unfortunately, Chris was working nights so I didn't see much of him. I got chatting to another fellow from Malaysia who had a wife and kids at home and had only seen them for two weeks in the last 18 months. It made my 3-week sacrifice pale into insignificance.

There were 3 hand theatres in use, each with 2 bed spaces so that cases could overlap. There was therefore no downtime between patients and the list ran very efficiently. Nurse anaesthetists were used to provide anaesthesia and these were supervised by an anaesthesiologist. The nurse anaesthetists told me that they did everything an anaesthesiologist does, but I noted that when a patient under a block required a general anaesthetic, the nurse called in the doctor who administered the GA.

As one might expect, cleanliness was taken very seriously. Masks were mandatory at all times in the operating room. Scrubbing generally involved a hand wash and dry with non-sterile hand towels followed by the application of an emollient-based chlorhexadine hand gel. Dr Manon-Matos had a short list due to being post-on-call:

- Cubital tunnel, arthroscopic-assisted
- Thumb CMC joint fusion
- Volar wrist ganglion excision
- Distal radius ORIF

Dr Tien had an all-day list comprising:

- Volar wrist ganglion excision
- Left thumb trapeziectomy and FCR suspension (half FCR through drill hole base 1st MC)
- Cubital tunnel with transposition of nerve
- Ring finger sagittal band repair
- Carpal tunnel with "Swiss" knife (like smiley knife)
- FDP repair (traumatic laceration)
- revision amputation ring finger at P2 for infected non-union P3
- 3x distal radius fracture ORIFs

I left at 5pm for dinner in the relatively safe city centre before walking home along what I hoped would be a safer route. I was only asked for money twice, and received no offers of entertainment, but still decided to get a cab in the next day.

After 6.30 teaching on Tuesday I went to Dr Kutz clinic. At age 83 he is still very mentally sharp and capable of seeing a full clinic. I met a patient with an injured hand who I got chatting to. It turned out that he used to work at the hotel I was staying at. When I told him this, he became very concerned for my welfare and was adamant that I needed to find somewhere else to stay. Among other reasons, a recent murder at my hotel prompted a panicked search for an alternative hotel, which proved very difficult as all the hotels in the Downtown area were fully booked because of a construction conference. Eventually I was able to secure a room in a Holiday Inn across the Ohio River, technically in the next State, but still within 10 minutes of the hospital.

I returned to clinic for long enough to see Dr Kutz carrying out a consultation regarding a workers compensation claim and telling the patient he was normal. I spent the afternoon packing up and moving, and breathing a sigh of relief!

Wednesday began with a comprehensive talk on carpal fractures, excluding the scaphoid and lunate, delivered by one of the fellows. I noted that these guys really put a lot of effort into their presentations, and that they were criticised by their seniors if they did not. On this occasion the fellow had done a good job and was congratulated. The presentation, as with all medical discussion in the USA, was heavily literature based.

After my free breakfast I went to theatre with Dr Kutz and Dr Thirkinnad. Dr Kutz operated relatively slowly, but deliberately and with remarkable precision. It was a pleasure to spend time with Dr Thirkinnad who was one of the best surgeons I met. He was an excellent technician in theatre, a rapid and efficient decision maker in clinic and a fantastic communicator. He had time to discuss cases with his fellows and allowed them to operate, and had a great way of dealing with patients. He told one patient his post-surgical hand looked great, but the patient was clearly alarmed at the state of it. Dr Thirkinnad told the patient, "The hand out of surgery is like a newborn baby: its mother thinks it's beautiful, everyone else thinks it looks like a monkey!"

Jumping between theatres I managed to see:

- Carpal tunnel decompression, cubital tunnel decompression and transposition of the nerve, ulna shortening and contralateral carpal tunnel injection

- Scaphoid fracture debridement and screw
- Neurofibroma median nerve
- A1 pulley release in Parkinson's disease which became an FDS division and FDP lengthening
- EIP to EPL transfer and carpal tunnel decompression
- Stage 1 of 2-stage FDP reconstruction with silastic rod
- Radial head ORIF

On Thursday and Friday there was no teaching due to many staff being at the ASSH. I went to clinic on Thursday morning with Dr Thirkinnad and also spent some time in the splint workshop watching an OT make a thermoplastic wrist splint, which looked much like a futura splint but took a whole hour to make! I then went to theatre where I met Dr Tuna Özyurekoglu, known to all as "Dr Tuna." I witnessed:

- Little finger P1 ORIF with wires
- Debridement and semi-closure of dorsal hand wound
- Removal humeral plate
- Carpal tunnel release

A thumb replant was planned but cancelled as deemed too tatty to repair. This surprised me as the thumb is such an important digit and I thought they would have tried to save it.

I also met a fellow whom I shall not name, but in whom I noticed significant unilateral congenital hand abnormalities. I did not want to ask him about this hand but found it remarkable that he could carry out his job so well with such a disability. He used a Tegaderm dressing to stick excess glove fingers out of the way and carried on without apparent handicap. It made me think that if I suffered a permanent hand injury, it may be possible to continue working as a surgeon.

On Friday I returned to theatre, this time with the very senior Dr Tsai. As well as some uneventful cases, I witnessed an abdominal pedicle takedown following a traumatic amputation of two fingers and degloving of the remaining two. Luckily the thumb was intact. The two degloved fingers had been buried in the abdomen some weeks previously due to lack of coverage options, and on this day were extracted and grafted with Alloderm, a cadaveric based skin graft.

Indiana Hand to Shoulder Center, Indianapolis (7-11 Oct)

A bus journey on the famous Greyhound service transported me 2 hours north to Indianapolis. I explored Downtown for a few hours before catching an IndyGo bus to the northern part of the city where my hotel and the Hand to Shoulder Center (henceforth called "the Center") were situated. I was pleased to discover that, although modest, my hotel was very comfortable and extremely convenient for the Center next door. They also had a good in-house restaurant where I ate most of my meals and a gym where I could get some unaccustomed exercise.

On the Sunday I took a long bus ride to the Indianapolis motor speedway. This was the only tourist excursion I made on the trip, and I delighted in seeing all the old

racing cars and having a tour of the famous oval circuit. By the end, I almost understood why driving round and round in a circle is exciting…almost!

The next day I presented myself to reception at the Center and was given a tour of the unit. The Center was different from the other places I had visited as it was self-contained in its own stand-alone building. It was a bit like a large GP practice, I suppose. It had everything an organisation of its type would need: human resources, IT support, clinic rooms, OT splints and theatres. It was the most interesting set-up and seemed the most transferrable to the UK. It was a model that I could envisage working in the choose and book UK marketplace. For emergencies and larger cases, the Center surgeons also worked in the large acute hospital across the street, or the other large acute hospital Downtown.

There were 3 operating rooms, separated by glass panels only, so that one could see what was going on in all theatres at all times. I perceived this as a very positive thing, and generally it was, but it was pointed out that, as a junior consultant, it might be disconcerting having your senior colleagues observing you! The key to efficiency in the theatres was a 2-bed treatment room across the corridor. Small cases under local anaesthetic such as carpal tunnel decompressions and trigger finger releases could be done here while the main theatres were being turned around. Nurse anaesthetists were not used as they were deemed to be too expensive. Dr Greenberg, my sponsor for the Center, intimated that he had no doubt that a private model was the most financially efficient. He and his colleagues, all partners in the practice, were constantly watching the bottom line and cutting cost wherever they can. An organisation the size of the NHS cannot monitor practice as closely, and NHS staff do not have the potent motivator of a stake in the business. I can see his point and wonder whether our medical system may become more akin to that in the USA. I feel that things are drifting that way, but am wary that the USA are seeking to more closely emulate the UK system, as their own insurance based system has its own problems. Healthcare funding and “Obamacare” were hot topics during my visit.

After a Subway lunch I followed Dr Greenberg around in clinic for a few hours and, again, found little difference to our practice at home. All the same pathologies presented, and the algorithms for treatment were all very similar to the UK. I saw plenty of conservative decisions made and I did not see anyone listed for what I would consider unnecessary surgery. Carpal tunnel was only operated after failed conservative treatment and usually steroid injection, when proceeding directly to surgery could be justified. It was very reassuring to see the same genuine efforts to do the best thing for the patient as at home. Patient care seemed paramount, and money did not seem to influence decision making at all.

Of course, patients were always asked for their insurance details prior to treatment, but this was discreet. I enquired about access to healthcare for the uninsured and discovered that emergency care was available to all. If you walked into A&E with a hand injury, you would be treated whether insured or not. However, if you walked in with severe carpal tunnel syndrome, your access to treatment would be limited to charity providers which are hit and miss. It seems that being uninsured will create lots of barriers to accessing healthcare but does not preclude it altogether. Perhaps that is why 15% of Americans are uninsured, despite budget insurance such as Medicare being available. Unfortunately, the cheaper policies tend to have higher

excess, or deductible, which means that the patient who can only afford a cheaper policy may have to shell out a $5000 excess before their insurance kicks in.

On Wednesday mornings they have a difficult problems meeting at 7am. On this occasion, two consultants had brought patients in for discussion. One had ongoing wrist pain post-trapeziectomy and the other also had wrist pain. I spent the day in theatre and saw:

- An Acumed distal radius plating
- Removal of k-wires from a previous hand replant after the patient put a mitre saw through his radial styloid and radiocarpal joint
- Carpal tunnel release
- Mucous cyst
- Shoulder scope and cuff repair
- Trapeziectomy and APL suspension (through the FCR tendon and back on itself)
- Pisiform excision for OA
- 4 DIPJ fusions same hand (fixed in extension with screws)
- Carpal tunnel release
- Carpal tunnel release plus dorsal wrist ganglion excision

Thursday and Friday were again theatre days where the highlights included a homodigital island flap to cover a volar oblique pulp injury (where I'm sure a terminalisation would have been done in the UK) and a distal radius osteotomy for malunion in a 6-year-old boy who would probably have remodelled but surgery was justified by Dr Bill Kleinman on the basis that the angular relationship between ulna head and sigmoid notch had been permanently altered by the fracture and would not remodel. I had the pleasure of spending time with all of the surgeons at the Center, except for the illustrious Dr Hastings who unfortunately was away that week.

Conclusion

People ask me if the surgeons were better in the USA. All the surgery I saw was high quality but no better than I see every day working with UK surgeons. I expected to see lots of novel surgery that I wouldn't see back home, but there was lots of "bread and butter" surgery and very little of the exotic. Opportunities for the juniors to operate seemed variable depending on the trainer, but as the juniors rotate so frequently and they are not stuck with any one consultant for long.

Much of the equipment used is the same as in the UK, and some of it identical. On the whole I found patients to be better educated regarding medical matters than British patients. People in America talk about health like we Brits talk about the weather and grow up with a basic medical understanding which helps them to navigate the complicated American medical system.

I had some erroneous preconceptions of America. Not all Americans are fat, however many things in America are oversize such as cars, roads and restaurant portions! Not all houses are massive, but property seems generally more affordable. The people were polite, but not excessively welcoming, although I was bought some muffins by a kindly member of theatre staff who wanted me to experience a slice of America!

People say “have a great day” an awful lot, and much of the time I suspect they don’t really mean it, but to not join in would be impolite.

Some of my prejudices were confirmed. Tipping is complicated, especially for the uninitiated. Immigration is painfully slow and a bit of luck goes a long way. In hospital and in theatre the equipment just works, the buildings are well maintained and the staff know their jobs and do them well (or they are sacked)!

There are some differences in the practice of hand surgery in the USA. Forceps are called pickups and no-one wears lead in theatre when using the mini c-arm, but my take home message is that there are far more similarities between British and American practice than differences. The pathology and the way it is treated is much the same, only the environment in which it is treated is different. I also learned that the cheapest hotel in town is cheap for a reason!