Interview with Dr. Kajetan von Eckardstein

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Dr. Kajetan von Eckardstein.

In the August 2014 issue of AANS Neurosurgeon*, we take on "Neurosurgery Around the World." While we have seen a multitude of reports from developing countries in the international forum on things such as pediatric neurosurgery and so forth, given the breadth of*

neurosurgery around the world, I found it prudent to interview an international personality who is both on the forefront of leadership and up-and-coming. Dr. Kajetan von Eckardstein is a superb surgeon working in an advanced neurosurgical unit in Germany. He is on the forefront of neurosurgery and has received fellowship training in the United States, providing him a unique perspective on German neurosurgery and its differences to American practice. Here we go:

Jamie J. Van Gompel (JVG): Dr. Von Eckardstein, can you describe your practice for us?

Kajetan von Eckardstein (KVE): I work in the neurosurgical department of Göttingen University in central Germany. Göttingen University was founded in the beginning of the 18th century and offers more than 80 programs to more than 23,000 students, of which more than 3,500 students are currently enrolled in Göttingen Medical School. With more than 2,600 neurosurgical procedures per year and 66 neurosurgical regular beds, as well as six intermediate care beds and up to 11 beds on the interdisciplinary intensive care unit, we are one of the largest neurosurgical centers in Germany. With a team of eight staff surgeons and 11 residents, we perform procedures from all areas of the neurosurgical spectrum, including functional and complex vascular neurosurgery, pediatric neurosurgery and spine instrumentations. For the past several years, I have functioned as a senior surgeon among the staff surgeons with a variety of administrative and clinical duties and next in line to the head of the department (Prof. Veit Rohde) in the hierarchy; my surgical interests are, among others, functional neurosurgery, skull base including posterior fossa, and complex spine instrumentation.

JVG: What attracted you to a neurosurgical practice?

KVE: It was very early in medical school in Berlin that I developed an interest in neuroanatomy. Through additional courses in neuropathology, my medical thesis on neuropathological aspects of gene transfer in the treatment for gliomas, and an internship in neurosurgery as a visiting student at the department of neurosurgery at the University of Texas at Houston, I decided on a career in neurosurgery. For me, the combination of an intellectually challenging area of medicine and hands-on, yet delicate and precise procedures, as well as a beautiful anatomy, that every time is breathtaking again, is the reason I am in neurosurgery today.

The University Medical Center Göttingen.

JVG: Describe what you believe is the typical practice of neurosurgery in your country: Is neurosurgery all cranial, is all spine being done by neurosurgery, or is orthopedics involved?
KVE: Probably, the typical practice of a neurosurgeon in Germany is not that different from the practice of a colleague in the U.S. Neurosurgeons in private practice will do a lot of smaller spine cases and peripheral neurosurgery, as well as initial evaluation of referred patients with more complex pathologies; only a minority will perform craniotomies. Colleagues in smaller and mid-size centers, some of them privately operated, will cover most of the cases, and only larger centers, such as university centers, most of them run by the state, will feature the full spectrum. We have an overlap with neuroradiology regarding aneurysms but still will clip about 60 percent of the cases evaluated, and with orthopedic and trauma surgery regarding spine instrumentation. Cervical spine is neurosurgery-dominated, while lumbar spine is claimed by both neurosurgeons and orthopedics. Usually, with involvement of the spinal canal or with neurological deficits, the patient will be treated by neurosurgeons.
JVG: What is a typical day in practice for you?
KVE: The German hospital system is organized profoundly different from the U.S. system, and this is reflected in the way we practice medicine in larger institutions. Patients admitted to our hospital are not patients on my service, where I have the sole responsibility, but are rather patients assigned to the department, with the head of the department being formally responsible. Therefore, we have a morning conference where we discuss all planned operative cases of the day

and confirm indication and surgeon selection before the procedure will take place. Afterwards, the patient will postoperatively be seen and treated by the residents on the floor, which are supervised by one of the staff surgeons, which is not the surgeon performing the surgery. After a day in the OR, I will round on the patients on my ward. Once a week, I will see patients in the outpatient clinic, again, not necessarily only those on whom I personally will operate or have operated.

JVG: Describe how you believe your practice differs from neurosurgery in the Americas.

KVE: As stated in the previous answer, there are advantages and disadvantages to this system. The indication for surgery is being double-checked by a group of experienced surgeons prior to surgery, possible perioperative complications are promptly discussed and unmasked and not a month later in M&M conferences. Due to clinic hierarchy, the head of the department can quickly react, when a member of the team is having difficulties with a certain procedure and can provide or arrange for support. By doing so, also staff neurosurgeons can grow and develop operative and judgment skills as they go on. Although this is great for teaching and training, patients sometimes complain of being followed by a variety of different surgeons and not only “their” neurosurgeon.

JVG: Describe the biggest issue you see challenging your practice.

KVE: The practice of neurosurgery in a university hospital setting as of today is challenged by an ever-growing level of administrative tasks, including proper medico-legal, fiscal documentation and aggressive growth of private hospital companies running mid- to large size hospitals, picking lucrative patients. As we are legally obligated to admit all patients referred to us, the ratio of cost-intensive patients with co-morbidities increases. The lack of less complex cases, such as standard microdiskectomies, is endangering profound resident training, which is also compromised by strictly enforced work-hour regulations.

JVG: Describe the biggest issue you see challenging neurosurgery in your country.

KVE: One of the biggest challenges of neurosurgery in Germany is whether we will be able to maintain – on the long run — a high level of patient-centered surgical care with a budget currently at $4,650 USD per capita. The other challenge, pertinent especially to neurosurgery, is a high number of neurosurgical residents who will

seek a job possibility in the years to come. There currently is a mismatch between staff positions and residents in training. The increased number of residents employed is due to work-hour restrictions, increased administrative non-surgical workload, but also due to the residents' request for a better work-life-balance.

JVG: What is the biggest opportunity for neurosurgery in your country moving forward?

KVE: If we manage to overcome these challenges, I think neurosurgery in Germany will prosper and grow and will attract patients and neurosurgeons from other European countries, as well as from Eastern Europe.

JVG: Please share with us a unique aspect of neurosurgery in your country that may not be practiced in the Americas as much given your unique perspective of prior training in the U.S.?

KVE: In my fellowship training, I did not observe or perform a single hemicraniectomy. I think, the U.S. colleagues are more reluctant to perform this simple procedure than European neurosurgeons and despite its proven effectiveness.

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