GENERAL MEDICINE

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Elective Report

Al Makkassed Hospital, Jerusalem

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Introduction:

This report is based on a 5 week placement in Al Makkassed Hospital in Jerusalem. The Hospital was founded in 1968, it consists of 250 beds and over 750 employees. It is a privately funded hospital and contains an emergency department along with departments for all specialties.

We have structured this report around four objectives as follows:

1. What are the most common emergency presentations in a busy Jerusalem hospital? How do they differ from a typical London hospital?

2. How is the health system organised and delivered in Palestine? How does it differ from the UK?

3. Gain experience in the evaluation and treatment of various acute medical and surgical disorders.

4. Attain a rudimentary understanding of the Arabic language. Attempt to clerk a patient in the Arabic medium.

Objective 1:

What are the most common emergency presentations in a busy Jerusalem hospital? How do they differ from a typical London hospital?

Al Makkased hospital has a 20 bed emergency department which like the hospitals in the UK is open 24 hours a day, 7 days a week to serve the local population. Similar to the UK, the department is led by the team consultant, with additional doctors and nursing staff also being present. On arrival of patients in to A&E, they are first assessed by either the nurse or doctor and the course of their management planned. Once patients are seen, they are then triaged in order to determine the priority of their treatment based on the severity of their condition. In the UK, the minor cases are treated in either minors or referred to walk in centre's (a complimentary service usually managed by nurses), to help ease the congestion in A&E departments. Al Makkassed however was currently in the process of establishing a service of a similar nature.

Within the UK 5,230,624 cases were seen in 2010, with the busiest day being on Monday morning, contrary to the expected Friday night. The majority of attendances in 2007-8 were found to be self referred (66%), with referrals from GP's remaining relatively low at 6.1%.
The table below displays A&E attendances by primary diagnosis in 2008-9.

Primary diagnosis	Attendance in 2008-9 (%)
Diagnosis not classified	16.2
Laceration	8.5
Dislocation/fracture/joint injury	8.3
Sprain/ligament injury	6.8
Soft tissue inflammation	6.1
Confusion/abrasion	5.7
GI condition	5.3
Cardiac	3.6
Total valid records	56.6

The vast majority of admissions into A&E have been shown to be related to lacerations, dislocations and fractures, with sports injuries and road traffic accidents being the primary reason. It is important to note, what these results do not show is the effect of alcohol on the number of admissions. The total impact of alcohol on the NHS amounts to £2.7 billion every year. A large proportion of these admissions are related to excessive alcohol intake, particularly in the under 25's.

When comparing this to emergency department admissions in Jerusalem, a number of problems arise. The primary difficulty being the absence in any significant corresponding data. In order to therefore get an idea of the most common admissions, a number of senior doctors working at the hospital were consulted. What we found was, unlike the UK the number of alcohol related injuries were close to none. The most common admissions however, like the UK were related to fractures and lacerations due to primarily road traffic accidents and sports injuries. While injuries incurred during conflict were normally common, a ceasefire meant such injuries over the past few years were relatively uncommon. Cardiac related admissions were also found to be relatively common.
A significant difference between the UK and Jerusalem was the absence of any organised and coordinated primary care within Jerusalem. This meant that many patients with chronic illnesses were only identified and treated by A&E doctors at the very late stages of their illness. Two such examples were firstly a patient presenting with gangrene of her foot, due to uncontrolled diabetes. Another case was a patient presenting with bilateral claudication of his legs, he was found to have significant arterial disease and had not been seen by any doctor regarding this until his A&E admission.

Objective 2:

How is the health system organised and delivered in Palestine? How does it differ from the UK?

The current Palestinian health system is made up of fragmented services that have grown and developed over generations and across different regimes. At present there are four main health care providers within Palestine; The Palestinian Ministry of Health, UN Relief and Work Agency, Non-governmental organisations and the private medical sector. Numerous attempts have been made to establish a health plan for the occupied Palestinian territory, which would serve to integrate the activities of the four main health care providers. This has, however not proved successful, primarily due to the continual restrictions enforced by the Israeli military, which has inhibited the Palestinian authority in making any steps towards a partnership. Any attempts to develop and renew the health system by the Ministry of health have been met with the same obstacles. The restrictions placed by Israel on the free movement of Palestinian goods and labour across borders have resulted in damaging consequences to not only the health care system but also the economy and society. The lack of sovereignty, control over land, water and the environment, all of which are relevant for the protection and promotion of health have been denied.

Within the UK, the National Health Service (NHS) provides health care for all UK citizens free of charge. Since being established in 1948 it has grown to become the largest publicly funded health service, serving over 60 million people. The NHS is directly funded from taxation, and its current budget for 2011 is marked at £110 billion. The NHS employs over 1.7 million people, with over half being clinically qualified. The NHS is divided into parts; primary and secondary care (see figure 1). Primary care is usually the first port of call for the majority people; it includes general practioners, optometrists, pharmacists etc. Secondary care includes planned specialist care or surgery and is usually following referral from primary care. The NHS is controlled by the Department of Health, headed by the secretary of health, who reports to the prime minister. The Department of Health controls 10 Strategic Health Authorities (SHA), which oversees all the NHS trusts within each area. An illustration of this structure can be seen in Figure 1 (below).

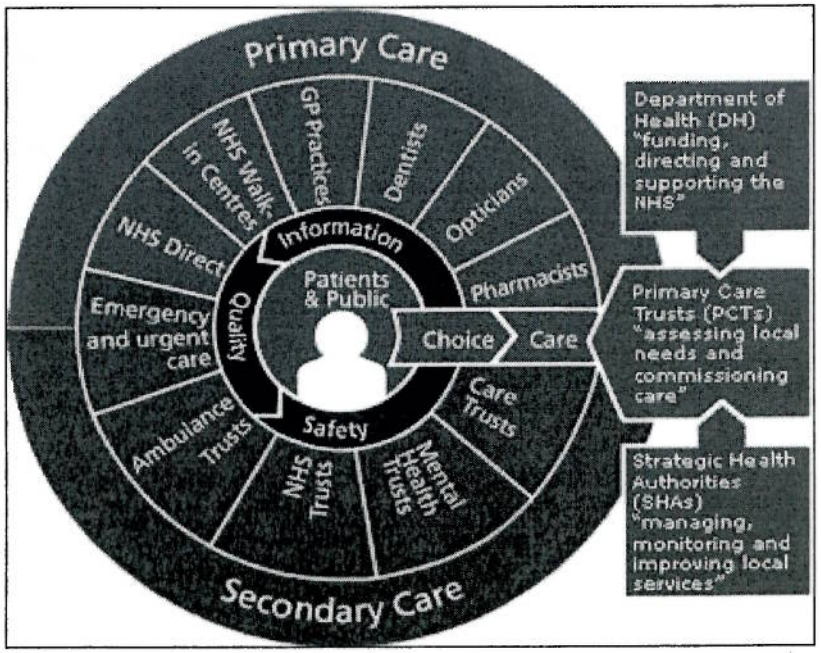

Figure 1: Structure of the NHS

Objective 3:

Gain experience in the evaluation and treatment of various acute medical and surgical disorders

Below is a list of some of the conditions that were seen during our rotations around emergency medicine, internal medicine and general surgery (collated from 2 additional students).

Emergency Medicine	Internal Medicine	General Surgery
1. 33yr old male, Follicular tonsillitis with possible rheumatic heart disease 2. 9yr old boy, Left wrist Greenstick fracture 3. 14yr old male, right first metacarpal fracture 4. 35yr old lady, 12weeks gestation with right iliac fossa pain. Dx with severe UTI 5. 7month old girl, frontal haematoma and nasal area lacerations following fall 6. 50yr old lady, epigastric pain, ECG showing IHD changes with a positive family history for IHD 7. 28yr old male, left sided flank pain, Dx with ureteric colic after Abdominal X ray 8. 19yr old male, deep laceration to left mid forearm with flexor tendon damage. 9. 72yr old lady, presented with fever and SOB, Dx with right lower lobe pneumonia 10. 19yr old male, fall from 6m, displaced fracture of right tibia and fibula, two deep lacerations to face	1 A 55 year old man who presented with severe chest pain, shortness of breath, diagnosed to be Non- ST Elevated Myocardial Infraction 2. A 67 year old women presenting with ulcers in her mouth and genitals, diagnosed to be Behcet's disease 3. 43 year old female with pulmonary hemorrhage (found on biopsy) and haematuria, possible diagnosis of Goodpasture's syndrome 4. 44 year old obese male presenting with shortness of breath and leg pain following a long flight - Deep Vein Thrombosis and Pulmonary embolism 5. A 55 year old patient with Coarctaion of aorta and Aortic regurgitation, admitted for surgical repair. 6. 57year old women, very poorly controlled Type 2 Diabetes, with peripheral vascular complications 7. 16 year old pregnant girl presented with severe shortness of breath, found to have primary Pulmonary Hypertension 8. 45 year old male with severe anemia and Massive splenomegaly myelofibrosis 9. 57 year old lifelong smoker, presents with severe chest pain and shortness of breath on exertion, admitted for elective angioplasty 10. 66 year old male, life long smoker, admitted for acute exacerbation of COPD	1. 17yr old girl presenting with appendicitis with bowel malrotation 2. 46yr old man post-AP resection following a rectal tumour. 3. 32yr old lady post-surgery, underwent stripping of long saphenous vein due to varicosities 4. 10yr old boy with 4cm*4cm haemangioma 5. 58yr old man admitted with bilateral claudication to level of buttocks. Contrast studies requested 6. 53yr old man with 5 arterial ulcers, bilateral spread. Investigations planned to assess extent of arterial disease 7. 44yr old lady, non-healing venous ulcer 8.7yr old with neurofibromatosis 9. 4yr old girl, Fallot's tetralogy correction 10. 55yr old man, diabetic, extensive gangrene of right foot, booked for amputation of first, second and 3rd toes.

Objective 4:

Attain a rudimentary understanding of the Arabic language and attempt a basic clerking in Arabic

During our time in Al Makkassed, an effort was made to clerk patients in Arabic. One such example was done under the supervision of the senior doctor. A patient had been admitted complaining of left iliac fossa pain which had started in the centre of the abdomen and consequently radiated down. The pain was described as coming in waves. Although the symptoms seemed classic of appendicitis, the fact that the pain was on the left was puzzling. Subsequent investigations revealed the patient was indeed suffering from appendicitis, with present malrotation of her bowel.

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