SOPHER

PAEDIATRICS

Elective Report

Elective Location: Hadassah HarHaTzofim, Jerusalem, Israel

Department: Paediatrics

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My elective took place in the paediatric department of Hadassah Hospital on HarHaTzofim (Mount Scopus). The Hospital is situated in Jerusalem on the border between Arab East Jerusalem and Jewish West Jerusalem. Because of this there is a wide range of different patients, from diverse demographic groups. The department has around 40 inpatient beds as well as a busy outpatient department and a day hospital for children with chronic diseases such as CF or diabetes. The hospital is connected with Jerusalem's much larger HaddassahEinKerem hospital and so it mainly deals with specialised tertiary referrals.

What are the prevalent paediatric diseases in Jerusalem? How does this compare to within the UK. Do these differ within the different demographic groups?

One of the doctors told me that the Hospital is situated on the border between the first world and the third world. The majority of the patients coming to the hospital are from Arab East Jerusalem and especially the adjacent village of Isawiya. The East of Jerusalem is made up mainly of different villages which are oftenover-populated and quite rural. There is also a very high percentage of consanguinity within these villages, with it being the cultural norm for first cousins to marry and even when people do not marry direct family, it is rare to marry outside of the village. Due to these two factors, there are a large amount of both infectious and congenital diseases that are very rare, if not unheard of, in the UK. Also, due to the isolation of many of these villages there are a number of congenital disorders that only exist in this area. Examples of infectious diseases include brucellosis, almost never come across in the UK, however relatively common in the Palestinian population, due to consumption of unpasteurised milk and living in close proximity to livestock, such as goats. Rheumatic fever is also prevalent within the population.

As far as congenital disorders, there are a large number of different diseases that are extremely rare in the UK, but were commonplace within the department. For example there were three patients on the ward with Primary CiliaryDyskinesia, a disorder which is very rare in the general UK population. There were also a host of metabolic disorders, including Glycogen Storage Disease and galactosemia that were prevalent.

In contrast, Jewish West Jerusalem is regular western city, albeit with its own personality,and so the prevalence of rare infective diseases is much lower. Consanguinity is also seen as societally inappropriate and as such there were less genetic disorders. One of the things the hospital is world renowned for is the Cystic Fibrosis centre, led by Prof.Kerem who discovered the CFTR gene. The carrier rates of CF are known to be higher in the Ashkenazi Haredi society, so I was very surprised during my session sitting in on the CF clinic that there were very few young Haredi patients, the Haredi patents who were there were mainly adult (as there is no provision for adult CF treatment in Israel, so they remain with their paediatrician). When I asked about this I was informed that due to the high risk of diseases such as CF, Tay-sachs and Gauchers almost all of the Haredi population was performing genetic testing with organisations such as DorYeshorim before even beginning to date one another, this has led to a drastic reduction in genetic disorders within this population.

Familial Mediterranean Fever was a common disorder in all of the demographic groups. Arab, Sephardi and even (although much rarer) Ashkenazi populations suffer from this and it was very high up the list of differentials for fever of unknown origin.

How are the Paediatric services run in Jerusalem? How does this differ from in the UK?

The Israeli health system is run by four different private health insurance companies called *Kupot*. Everyone has to pay for one of the Kupot; however the amount that is paid is based on a proportion of a person's income, which becomes in effect a separate healthcare tax. People are also able to opt into a better coverage deal to include things such as dental care and some forms of integrated medicine. On paper none of the Kupot are better than any other and the one that someone decides to belong to will usually be dictated by proximity to the closest medical centre or historical association.

Within the primary health care system provided by these Kupot there is not only family medicine (the equivalent of General Practice in the UK), but also there are a number of specialists who work in the community. So a child who has a sore throat will not visit the local family doctor, but rather the community paediatrician. I sat in with a Family Doctor one morning and saw no paediatric cases at all. There are also what would be tertiary referrals in the UK, for example to a paediatric neurologist, which can also be seen within the community setting in Israel.

This can often cause some conflict, where the patient wants to be treated in the hospital setting, the Kupa may have their own community service which they run and so they refuse to give permission for the patient to go to the hospital service. One example of this was in the paediatric diabetes clinic, where a lot of the patients were Arabs from East Jerusalem, who were with a certain Kupa that provide their own diabetes service in the centre of Jerusalem. The problem is that many of the Arab patients do not speak good Hebrew and are also afraid of needing to go through many checkpoints into what is in effect a foreign country to them. They much rather go to a local hospital to them, where most of the doctors speak Arabic, and the ones that don't have 24 hour access to medical interpreters. This fight between the hospitals and the health insurance companies and the need to get permission from the Kupot for all hospital visits, is something that I found strange.

One other major difference is that whilst most prescriptions are subsidised, there is no concept of free medication for children. This leads to chronic disease being a financial burden for families with their only help in the charitable sector.

To think if I want to be a paediatrician.

I certainly took a lot from my time in Hadassah, working with people who were world experts in their fields, with a range of different patients form a variety of backgrounds with a plethora of different diseases. I loved the way in which Arab doctors treated Jewish patents and vice-versa with no prejudice about colour or religion, how children were children no matter where they were from and as such required the best possible health care. I am still not sure what I would like to do long term, however I very much enjoyed paediatrics, from working with small children and their parents to dealing with adolescents who are struggling to adapt to life with disease. I also realise that within Israel where many paediatricians are super-specialised, the decision to become a paediatrician is only the beginning.

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