ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

I spent 3 weeks of my GP/Family medicine elective in a clinic belonging to the Maccabi Health Medical Organisation (HMO) in Tel Aviv. As GP clinics operate within HMO buildings, this means that the HMO building includes an array of services, namely; specialist clinics such as endocrinology, paediatrics and nephrology, a blood and urine tests lab, a floor for nursing and emergency assessment, as well as a floor belonging to the physiotherapy department with a gym.

My time was spent between sitting in two GP clinics, outpatient specialist clinics, as well as physiotherapy sessions for a range of conditions from orthopaedic to respiratory, and finally shadowing the GP on-call responsible for the nursing assessment centre.
In terms of most common conditions people present with, this is similar to other Western countries, with chronic conditions needing long-term follow-up such as hypertension, hypercholesterolemia, diabetes as well as depression and anxiety being very common complaints. Appointments booked by patients feeling generally unwell due to infections are also common. A difference from the UK is in the rates of liver disease which are lower in Israel. The rates are likely influenced by different cultural norms with regards to alcohol consumption and albeit there seems to be an increase of it in Israel, it is too early to see the clinical effect this change will have on liver disease in the population in the future. With regards to data on mortality from alcohol-related liver disease, in Israel this was 2.2 for men and 0.1 for women per 100,000. In the UK, the rates were 12.5 for men and 6.1 for women per 100,000 respectively. This represents a 5-fold higher mortality rate in men and a 60-fold higher mortality rate in women in the UK compared to Israel (Blachier et al).

With regards to delivery of healthcare, a difference is that while in the UK the only healthcare provider is the NHS (National Healthcare System), in Israel there are 4 HMOs with varying services. Maccabi patients – like in the UK – can switch between GPs reducing waiting times, but this can affect continuity of care if patients keep switching physicians. Sitting in clinic however, I observed that many of the patients came back to the same doctor, with whom they had built a rapport over time, and who knew their medical history. Another difference is that here patients can directly book appointments to be seen by some specialists, such as paediatricians and gynaecologists. In the UK, GPs are often the gate-keepers of secondary care, seeing every patient and then deciding whether they can be treated in primary care, or referred onto specialist services in secondary care. Here, at least in the centre of the country where secondary care is more readily available, there is slightly less variety in the range of conditions that GPs deal with. It still needs to be said that regardless, GPs can still choose to see all types of patients.

In terms of similarities between the medical systems of Israel and the UK, in both considerable time is allocated to preventive medicine. Each day GPs receive a list of patients which includes preventive measures that need to be addressed. These vary according to the patients' age and history and include: vaccinations, folic acid supplements to be taken before and during pregnancy, occult stool blood testing in the relevant population, measurement of blood pressure, cholesterol levels, glucose levels, for advanced diabetes referral to diabetic foot clinics and ophthalmology. Standardised protocols and cut-off measurements which are similar

across countries and follow WHO or similar international medical organisation's guidelines are used for many conditions, such as HbA1c monitoring in diabetic patients.
Like in the UK, primary prevention focuses on minimising risk factors such as for cardiovascular disease, by periodically asking about them and checking in clinic. Furthermore, measures such as life-style modifications (weight loss, exercise, healthy eating), smoking cessation and pharmacologic treatments are started early, to prevent disease development. Once a disease has already developed, the aim of secondary prevention is to optimise treatment, in order to avoid serious disease complications such as myocardial infarctions, strokes, neurovascular damage caused by uncontrolled diabetes, development of cancer. Another area of preventive medicine consists of advocating simple public health promotion strategies, a very common one being smoking cessation. Patients here in Israel, like in the UK, can be referred to a wide range of services to help them quit smoking, and there are a variety of products that can be used as nicotine-replacement therapy.

This experience served as a revision and opportunity to enhance my knowledge in a variety of medical fields including cardiac, respiratory, gastroenterology, renal medicine, as well as emergency management of acute conditions. Sitting in clinic and being the one often examining patients, increased my confidence in reporting findings, and discerning illnesses that would need pain relief and medication only such as viral infections, from illnesses that required more urgent attention. This is also relevant in the context of GP clinics within HMOs that serve as walk-in clinics as well. Being able to distinguish between urgent and non-urgent becomes crucial for resource and time management. My time in clinic also reminded me of the importance to document findings that are not pertinent to the current presenting complaint, such as any skin rashes or tenderness, so that these are present in the patient's documentation and can be used in the future to make other diagnoses easier, or for follow-up purposes.
While shadowing the GP on-call responsible for the nursing assessment area, I was once more reminded of the importance of effective A-E assessment. There was an instance of systemic mastocytosis causing the patient to frequently experience both anaphylaxis and angioedema. They presented with a rash spread all over the body, slight skin swelling and reduced consciousness level but no neck, mouth or tongue swelling or respiratory compromise. It was a hard call to make, whether they would need IV antihistamines and corticosteroids, or urgent administration of IM adrenaline and referral to an emergency department. The patient's opinion also guided management, they said they had been through both anaphylaxis and angioedema several times before, and this felt like angioedema. They were administered IV antihistamines and IV hydrocortisone and kept under observation, they slowly felt better and were discharged that day. This situation also reminded me about the importance of effective and concise communication between the various healthcare professionals about a patient's status, to coordinate their care. With regards to communication, albeit my understanding of Hebrew is very limited, I was still able to appreciate how doctors managed to built rapport with their patients both with verbal and non-verbal clues such as posture, and by opening their consultations calmly, with open questions such as "what brings you here" or "what's new", letting the patient express their problem and worries, and then asking more specific questions pertinent to their complaint.

I am grateful for the experience I have had during these 3 weeks, and it enabled me to be able to make a more informed choice with regards to pursuing a career in this specialty after my internship year.