Western Galilee Medical Centre, Nahariya, Israel

Overview

I spent four weeks at the Western Galilee Medical Centre (WGMC), mostly in the Emergency Department (ED) but also in paediatric emergency, oncology, internal medicine and theatre. The elective allowed me to improve on basic skills of history-taking, examining in a focused way and presenting patients, and gave me a chance to think about what the responsibilites of an emergency physician are. I spent a lot of time learning medical and general Hebrew vocabulary and tried to speak to patients and staff. There were also a few totally new experiences, which I highlight below. Outside of the hospital, I explored the coastal area and reunited with friends and relatives.

Patients

Despite knowing that the population served by the hospital was varied I nonethless found my preconceptions challenged. Most of patients that I saw did not speak Hebrew as a first language, but rather Arabic or Russian. In many cases Hebrew was poor or absent. This did make me even more hesitant to take patient histories, although thankfully Fadi, my excellent *stagaire* partner, was encouraging and made sure to involve me in any clerking he did by translating and discussing. He would often ask me to examine the patient after he had taken the history. Typical cases I saw included road-traffic accidents, COPD exacerbations or chest infections, cerebrovascular accidents, coronary heart disease and elderly 'off-legs' patients. I would judge the patient mix to be similar to the mix seen in London, with the notable relative paucity of alcohol-related admissions, such as acute intoxication, alcohol-related injuries and alcoholic liver disease.

Rarer cases that I saw included a case of a young American visitor with gastrointestinal and possibly biliary tapeworm infection and a young Syrian woman with shrapnel wounds, of which more later. I also had the opportunity to observe or participate in common procedures that I had never seen done before, such as coronary catheterisation, fixation of mid-shaft ulna and radius fractures in a child, and resection of a lung mass.

The staff

Perhaps even more than was the case with the patients, I was surprised by the diversity of the ED team. Doctors of Russian descent, Druze, and Muslim or Christian Arab accounted for the majority, reflecting the diverse population in the region. The team seemed very friendly and cohesive. It was of course gratifying to see this and deepened my understanding of Israeli culture and society.

In comparing it with my experience of London a number of things stand out. Overall, there seemed to be more harmonious interaction between the different types of medical practitioner. The medical staff seemed to have a sense of ownership of the ED: often in the UK there is a sense of being a shift-worker managed by a non-medical line manager. The 'perks' are also much greater – kitchens stocked with simple food, where staff can take a few minutes to relax, refreshments brought round twice a day, meals provided free to those who stay late, free parking. The nursing staff seemed generally more competent than I had experienced, and I observed with interest the role played by physician assistants, who are highly experienced first-responders working in the ED. There is perhaps less referal to guidelines of management which are central to ED practice for all grades of British doctors, and which are a useful learning tool for newer doctors. Overall, the workload seemed rather less here than a typical London A&E, though I was told that Nahariya has a relatively high rate of ED attendance. This discrepancy may be explained by a better staff:patient ratio and/or by the observation that the the role of the ED doctor at WGMC involves less management (patients requiring treatment are often referred quickly to the wards).

Mass Casualty

I was lucky enough to observe a mass-casualty drill, something I had never seen in London. As the 'event' was announced, the ED was quickly cleared with all patients wheeled or walked into the paediatrics department. Numbered jackets were quickly distributed assigning a nurse, clerk and doctor to numbered bays. The doctors were from all parts of the hospital and the clerks were administrative staff who had been trained for this role. Equipment trolleys appeared by each bay. Then the 'patients' – soldiers with fake blood and stories around their necks – entered. There were not as many patients as I expected, but I suppose that the point is to test the adminstrative management and coordination between sections during such an event, rather than the skills of any particular team (who in a real event may become overwhelmed by a volume of patients assigned to their bay). Indeed, no patient ended up coming to our bay at all. Nonetheless it gave us an opportunity to remind ourselves of basic trauma management and to have a small sense of the adrenalin and confusion that would occur at such a time.

The hospital is also prepared for a direct strike by missile. The ED is reinforced with extremely thick walls and there is a huge basement warehouse where ward patients can be quickly moved if necessary.

Syrian patients

I was attracted to apply to the hospital in part because I had heard that Syrians were being treated here. It sounded exciting. I was curious as to how they reached this hospital, about 40 kilometres from the Syrian border, and what happened to them once they were here. I was told that up to 4 Syrians reached the hospital each day, brought to the hopsital from the border by Israeli army ambulance, across the border by the UN, and who knows what on the Syrian side. In the past they recovered on the open ward, but they now are largely confined to the basement hospital after a number of threats to their safety. I myself assisted in the treatment of one Syrian patient, a 25 year old woman with a one year old child who suffered shrapnel damage to her right leg from a bomb or grenade explosion. She had a large, open, putrid wound on her left lateral shin, as well as sprinklings of wounds up the front of that leg and on the medial aspect of her right leg. It was the first such injury that I have seen. From the distribution of the wounds on her leg it was possible to plot where the bomb exploded and possibly even how far away – which led the surgeon to wonder how she had got away so lightly. I wondered what it was like for her to be in Israel, in an Israeli hospital, with an over-eager, oversized medical student from England trying to ask her questions with Google translate. But that is a question I never asked.

Gabriel Doctor
Barts and the London