Department of Haematology and Haemato-Oncology, Chaim Sheba Medical Centre (Tel Hashomer) / Tel Aviv University Medical School, Israel

I completed a 4-week elective in the haematology and haemato-oncology departments at the Chaim Sheba Medical Centre (Tel Hashomer) in Israel. During this time, I was fortunate to gain experience in a number of different areas, including: haemato-oncology clinics and ward, benign haematology clinics (including ambulatory care) and bone marrow transplantation clinics and ward.

Therefore I was able to participate in numerous different aspects of patient care, such as taking histories and examining patients, attending ward rounds and MDT meetings, and assisting with procedures including intrathecal chemotherapy (CNS prophylaxis) and bone marrow biopsies and aspiration. I was given teaching on the microscopy techniques used to examine aspirate slides. Additionally, I was able to participate in academic activities by attending lectures.

This elective experience allowed me to achieve many of the objectives I had set out to accomplish before my elective; namely, to gain a deeper understanding of the structure of the healthcare system in Israel, and the key differences between Israel and UK practice. Additionally, I wanted to become more confident taking a basic medical history in Hebrew and to increase my knowledge of medical terminology.

Whilst on the wards, I was particularly struck by the attitudes of both the doctors and the patients (and their families), and how they differed greatly to the mentalities I had experienced in the UK.

Overall, approaches in Israel are far more informal compared to the UK. Doctors and patients communicate in a very chatty fashion, with no time given to some of the conversational formalities that might exist in British medicine. Generally speaking, patients come across as demanding and forceful. Patients are not afraid to ask for exactly what they want, even if the doctor has made it clear that they disagree, and this can lead to conflict. Similarly, staff members in discussion (for example in an MDT setting) will all voice their opinion, raising their voices and interrupting the other participants. It is clear that no-one is intending to be rude but it makes for a very noisy and energetic meeting!

In a similar manner, it is socially acceptable for doctors to answer their mobile phones immediately, as soon as it rings, irrespective of the situation they find themselves in. For example, it is entirely normal for a 20-minute clinic consultation with a patient to be interrupted 4 or 5 times whilst the doctor takes phone calls. The doctor would simply stop mid-sentence to answer the phone, and the patients would not find this upsetting or offensive. I found myself wondering if this sort of attitude has the potential to compromise patient care, as doctors are dealing with so many patients simultaneously. It must be very difficult to practice like this without mixing up patients and constantly losing the thread of consultations.

I also found it interesting the way in which the vast majority of patients, regardless of their background, used religious terminology heavily in their conversations with doctors. Patients of both Israeli and Arab backgrounds, Jewish and non-Jewish, would pepper their discussions with phrases such as ‘God willing, I will get better’ and ‘God will help’. This applied both to patients who appeared religious and also those who appeared to be otherwise completely secular. It seems to be a pervasive cultural phenomenon that even those who probably have little or no belief in God and practice no religion outside of the hospital use the religious phraseology in this context nonetheless.

Another key difference I noted between Israeli and British medical practice were various aspects of the therapeutic approach. In Israel, drugs are invariably prescribed according to their brand name. Both patients and doctors refer to brand names in conversation and drugs are often referred to by brand name when written about in the notes (the prescriptions themselves however tend to include both brand and generic name). This applies to both older and newer drugs. I found it very difficult to follow in this regard and had to keep looking up the generic names for all the drugs that were mentioned. Most of these were drugs commonly used in UK practice, however there were a few names which were unfamiliar even in the generic form. For example, metamizole/dipyrone (marketed in Israel as Optalgin) is a popular anti-pyretic and analgesic drug, which in Israel is prescribed freely in much the same way as paracetamol is given in the UK. In the UK (and a number of other countries) it was banned in the 1970s due to the significant risk of agranulocytosis. Interestingly, despite this it was heavily used throughout the haemato-oncology ward. I also noted that there were some classes of drugs where specific drugs commonly used in the UK do not seem to be used in Israel, and the reverse. This may due to both differences in approaches to risk profiles as well as costs of some drugs. For example, UK doctors tend to prescribe benzodiazepines such as midazolam, lorazepam, temazepam and diazepam. In Israel, brotizolam is used much more commonly. Broitozolam does not have a UK licence due to safety concerns. There are also new drugs such

as daratumumab, an anti-CD38 monoclonal antibody used to treat myeloma, which has not received NICE approval as it was deemed not sufficiently cost effective. In Israel, daratumumab has already provided an effective treatment to a number of myeloma patients since January 2017.

When based in clinics, I quickly realised that the follow-up consultations took a very different format to those I had observed in other specialities. Patients rarely complained of any symptoms when asked, and very little time during the consultation was dedicated to actually discussing how the patient was feeling. Instead, the patients and their relatives were desperate to know the results of their most recent blood counts. The patients generally knew exactly what their previous counts had been, and were very aware of the significance of these numbers, to the extent that they appeared to care significantly more about the precise trend of the blood tests rather than how they themselves felt. Although it seemed positive that the patients were very keen to be well-informed, I felt that sometimes the holistic approach was lost. Equally, decisions on whether to treat or change a drug regimen were generally based on blood results rather than symptomatology, which I found surprising.

Although I thoroughly enjoyed my elective experience, I had not anticipated some of the things I saw and heard during my time in haematology and haemato-oncology. I quickly noticed that it was very difficult to tell how well a patient would appear in person, based solely on their blood counts (although this was invariably the aspect the patients were most interested in discussing). Patients who were young with no prior medical history, but acutely very sick would sometimes have the same platelet or neutrophil counts as older patients with multiple co-morbidities who appeared to be very well, and the reverse. It made me appreciate how critical it is to always consider the bigger picture; not just the most recent blood counts but also the trends over time, and of course the patient themselves and how they feel.

I was also lucky enough to have the chance to spend time sitting with some patients, to hear their stories in more detail. Some patients had chronic disease, such as Immune Thrombocytopenic Purpura, with numerous relapses leading to prolonged admissions. Although on the surface they currently appeared to be healthy, many had been very unwell in the past with disease resistant to conventional therapies, and had spent time in intensive care. Many of the patients I spoke to in ambulatory care seemed well, and outside of the hospital were going about their daily lives as normal. However, they were in fact being monitored extremely closely and still required regular hospital attendances for blood tests and for ambulatory therapies such as intravenous immunoglobulin. This made me realise the impact of diseases which can be almost ‘invisible’. Most patients had been asymptomatic except for a purpuric rash, but in fact in physiological terms had severe pathology and still required intensive specialist follow up.

Overall, I am very grateful to have had the opportunity to experience medical practice in Israel. I was surprised by the number of differences I found between Israeli and British medicine, despite both being developed countries. On the other hand I was also surprised by how familiar much of it felt to me. This elective also allowed me to learn more about myself and what is important to me in my choice of speciality and career. I enjoyed the variety of being able to integrate both ward and clinic based care, but I also felt frustrated by the way in which the speciality is driven so heavily by test results rather than patient symptomatology. Most importantly I feel that this elective caused me to challenge my preconceptions regarding what it is that patients value from their interactions with healthcare professionals and to understand that the real picture may be more complex than it initially seems.

Liora Wittner
UCL