

Radiology, Beilinson Hospital, Rabin Medical Centre / Tel Aviv University Medical School, Petach Tikva; General Practice, Maccabi, Tel Aviv

My elective was split between three weeks in the Radiology department of Beilinson Hospital, and three weeks in the GP HaShla clinic in Tel Aviv.

As part of the radiology elective, my time spent at Beilinson was divided between sitting in on various reporting rooms, getting group and one-to-one teaching, and witnessing clinical encounters with patients for ultrasound scans.

Common scan modalities included CXRs on which Pulmonary Embolism and pneumothoraxes needed to be excluded acutely, and CXRs requested pre or post-operatively by other departments. Abdominally, XRs and CTs were commonly used to rule out abdominal obstruction and following trauma. These were then followed by other imaging modalities such as CTs and MRIs when indicated, to better evaluate soft-tissue pathology. Within the UK's National Healthcare System (NHS), relatively less invasive and less expensive investigations are ordered first, only then followed by more specialist scans and this was also the case in Israel. Another similarity between the UK and Israeli medical systems is the fact that multidisciplinary (MDT) meetings in both countries occur frequently and are an essential part of care provision.

Another imaging modality I learnt is commonly requested at this hospital is cardiac MRI. This is the gold standard, preferred to echo in terms of precision, for estimating left ventricular cardiac function by measuring EDV and ESV, and thus monitoring cardiac failure longitudinally.

Overall, the hospital had more paediatric imaging than perhaps other hospitals I have been to in London. The Schneider Paediatric Hospital attached to the Beilinson campus is the biggest paediatric hospital in Israel. Moreover, in comparison to radiology departments in the UK, the breast imaging field seemed to be more advanced in Israel, potentially owing to the higher percentage of population carrying BRCA1 and BRCA2 genes, predisposing to breast – among other- cancers.

In terms of management of the radiology departments in the UK, most of the work-load is reported by consultants, with trainees giving their input. With regards to service provision in Beilinson, reports are written by both consultants and trainees. If the trainees are junior, the reports are checked by one of the consultant radiologists.

While sitting in with radiologists reporting on scans, we would discuss imaging modalities and imaging findings and their significance, such as the importance of windowing in CTs, or the presence of intraabdominal fat stranding on CT scans of patients with transitional cell carcinoma and other less serious pathologies, a sensitive sign representing inflammation, infection or cancer.

I was given the opportunity to look at CXRs of common pathologies, write reports in my own notes and systematically present my findings to one of the physicians. Moreover, individually or in groups, students were given lists of patients with either common or interesting findings on imaging, and were able to review the scans and discuss our findings with one of the radiologists, which proved an excellent and engaging learning tool. I became able to appreciate the importance of clear, well-structured radiology reports. In particular, I learned to appreciate that often there is a level of uncertainty in radiology and that this, too, needs to be openly communicated and discussed in the reports.

These three weeks enhanced my knowledge of anatomy, served as revision in diagnosis of acute conditions and gave me an overview on writing radiology reports and the width and breath of a career in this specialty, which includes among other things reporting, providing invaluable input at MDT meetings, scanning of patients such as in ultrasound and fluoroscopy and performing procedures such as biopsies.

My second three weeks were spent in a GP clinic belonging to the Maccabi Health Medical Organisation (HMO) in Tel Aviv. As GP clinics operate within HMO buildings, this means that they can include an array of services such as specialist clinics, blood and urine test labs, nursing and emergency assessment areas, as well as physiotherapy departments with gyms. 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 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. 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 four 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. Another difference is that here patients can directly book appointments to be seen by specialists, such as paediatricians and gynaecologists. This means – at least in the centre of the country where services are readily accessible – slightly less variety in the range of conditions that GPs deal with routinely.

In terms of similarities between the medical systems of Israel and the UK, both allocate considerable to preventive medicine. Each day GPs receive a list of patients which includes preventive measures that need to be addressed. 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, 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 and neurovascular damage caused by uncontrolled diabetes.

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 only need over the counter medication such as certain viral infections, from illnesses that required more urgent attention.

I am grateful to the JMA for their contribution in funding these six weeks, as the time spent in these two specialties enabled me to be able to make a more informed choice with regards to what career pathway to pursue after my internship year in Israel.

(Dr) Luisa Peress (QMUL)