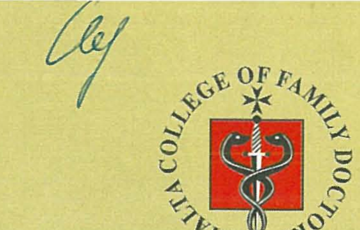
MALTESE FAMILY DOCTOR VOLUME 14 - ISSUE 02 DECEMBER 2005

Maltese Family Doctor

It-Tabib tal-Familja

A peer-reviewed journal of the Malta College of Family Doctors



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The mission of the Maltese Family Doctor is to deliver accurate, relevant and inspiring research, continued medical education and debate in family medicine with the aim of encouraging improved patient care through academic development of the discipline. As the main official publication of the Malta College of Family Doctors, the Maltese Family Doctor strives to achieve its role to disseminate information on the objectives and activities of the College.

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Family Medicine Quo Vadis?

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Family Medicine Quo vadis?

Dr Noel CARUANA

We are witnessing great changes around us. In preparation to Malta's accession into Europe the Department of Health has set up the Specialist Accreditation Committee (SAC) to organize a system of registers in which to classify medical practitioners. This is a long awaited wish come true for many of us, as it has placed Family Medicine at par with its sister specialties..... on paper! But let us take a closer look to see if there have been indeed any changes at the roots.

As in many things in life, change is a constant thing and is usually best taken in small doses. This is definitely the case with the SAC administration which is now well over one and a half years late in issuing the Specialist certificates!

Change needs to occur within and without, and a certificate hanging on your clinic wall does not make you a better doctor than you were pre May 2004. It may be held by many that being listed in the specialist register necessarily implies that things will fall into place. This is indeed a gross misconception, and the College is doing its part to ensure that through its Continued Medical Education programme, Family Doctors indeed keep a standard which befits them as specialists of Family Medicine.

The college council has been working on the set up of Vocational Training for new prospective Family Doctors. The MCFD has organized Courses to prepare a number of Teachers of Family Medicine so that it could deliver a professional Vocational Training Programme. Following interviews to select the prospective Trainers (Teachers) last year, one was expecting the result of such interviews so that the selected doctors could start, together with the National coordinator, to implement the New Curriculum for Vocational Training programme. Now over a year on, not only have the results not been issued, but we are informed that the Health Department is stating that it will be the Trainees to select the Trainers rather than both Trainee and Trainers being involved in the training post allocation! This is a most irregular and unprofessional way of doing things and is jeopardizing the image of Family Medicine which the College is trying to develop and project to our society, in order to bring about a more meaningful and respected role of Family Medicine in our midst.

If we now peep out of our small Mediterranean niche, and look beyond our politicians' controlled reality, we realize that our present society is under the restructuring effects of three mutually reinforcing tendencies; Health care industrialization, medicalization of life and politicization of medicine are actively promoting fear of disease and concurrently eroding the theory and practice of medicine.

Industrialization of Healthcare

Reorganization in the delivery of healthcare services has transformed doctors and their patients into simple cogs in the big machinery of a mega-pharmaceutical industry. This fact is more alarming when "treatment" is used for prevention rather than curing. We must stop and think on the effects of recent and not so recent guidelines issued which are transforming the way we are delivering "healing" to our patients. A case to illustrate such a point is the effect the guidelines issued in 2003 by the European Society of Cardiology have had on our management of blood pressure and hypercholesterolemia. According to these guidelines, the threshold for intervention have been lowered than ever before, with a blood pressure of 140/90mmHg and serum cholesterol of 5mmol/l, selected to lower the risk of ischaemic heart disease. Getz et al[1] argue that if these values are applied to the Norwegian population (which has one of the highest life expectancies in the world) half the population would be at risk by age 24. By age 49 this proportion would rise to 90% and thus over 75% would be a potential consumer for the pharmaceutical population. Thus we can see that a shadow of fear about one's health is being "forced" on an otherwise healthy population. We need to ask, who is benefiting from these developments?

Medicalization of life

This can be depicted by the old phrase by GK Chesterton "an obsession with health is destructive of it"[2]. The supply-demand relationship is industrially led and people in industrialized countries are healthier than ever before, so the profit for selling treatment to the sick is limited. "There is much more money to be made by convincing the healthy majority of the immediacy of threats to their health"[3], but do we know the effects of being labelled as at increased risk on our lives?

Politicization of Medicine

Currently, both internationally and locally, we are witnessing a clamping-down phenomenon, as governments are trying to increase control over the behaviour of both patients and professionals. It is

laudable that politicians need to put the interests of the population above those of the individual however doctors must necessarily to the opposite. Politicians are reasonable fearful of the independence held at heart by members of the traditional professions of religion, law, teaching and medicine. These professionals are in daily contact with the man in the street and know very well how far society can go wrong. This daily interaction is an opportunity and a duty of the professional to intercede with the power holders on behalf of the ordinary citizen. If the independence of these professionals is eroded, as we are seeing happen even in our country, as our society is transforming itself more and more into a market-driven society, important elements of social justice and citizen power are more and more suppressed.

So what is our role as Family Medicine Specialists, amidst such a changing scenario? How can we resist and even revert such trends?

Iona Heath a GP in London[3] argues that there are three factors which give general practice the potential to resist such influences: the challenge and freedom of uncertainty, secondly, the consultation process and thirdly, the persistence of pluralism.

Uncertainty in daily living

Family Doctors have to come to terms with the limitations of biomedical knowledge in their daily dealings with illness and suffering of their patients. They learn to develop a better understanding of the element of uncertainty in daily life and acquire that "6th sense" which may not be so necessary in other specialities who deal with a more selected population where the incidence of a particular disease is selectively higher. In the realm of general practice illness is a human experience which touches all corners of the existence of an individual. The doctor-patient relationship allows them both to explore the best ways to deal with this suffering, for the benefit of the patient.

The consultation model

The nature of the conversation between the patient and his family doctor has a profound bearing on the outcome of the consultation process. If the interaction is a genuine one, and the doctor managed to create a conversation where all the assumptions of biomedical knowledge can be questioned and where all the assumptions can be of benefit to the particular patient, then one would be successfully resisting the industrialisation of healthcare. In this scenario it is the healthcare systems which adapt to the person and not the other way round.

Social context

Both globally and definitely on the locally scene, General Practice is deeply rooted in a social and cultural context of the town and village life. If GP's have meaning for their community, then family medicine will prove an effective resistance to the forces of standardisation and globalisation.

It was once thought that with the expansion of western medicine, traditional forms of medicine would die out. However, this has not happened and in recent times we are witnessing a revival of alternative forms of medicine which continue to thrive alongside modern medicine. The experienced GP will master the skills to use both knowledge found in textbooks and other sensible, though seemingly unorthodox, biomedical knowledge.

Contrary to what has been expected, "pluralism and complementarily have become the norm across the world, which give us good reason to be hopeful"[3] that family medicine will retain its relevance in the modern society both globally and on the local scene.

References

1. Getz L., Kirkengen AL, Hetlevik I, Romundstad S, Sigurdsson JA. Ethical dilemmas arising from implementation of the European guidelines on cardiovascular disease prevention in clinical practice. A descriptive epidemiological study. Scand. J Prim Health Care 2004;22:202-8.
2. Chesterton GK. Illustrated London news, August 10,1929.
3. Iona Heath. Promotion of disease and the corrosion of medicine. Canadian FP Vol. 51: October 2005

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Editor's Note

This journal is intended to offer a forum for discussion on different areas of family medicine, ranging from epidemiology, research and statistics, to ethical issues and moral dilemmas.

Contributions (both from the national sector and by our colleagues abroad) to this journal are welcome. Review papers, research articles and relevant news items should be sent to the editor by email to: journalmfd@yahoo.com or on floppy/ CD in Microsoft Word format to: The Editor, Maltese Family Doctor, PO Box 69, Gzira, GZR 01 Malta.

Falls in the older person

Ms Mary Lou GRECH

Falls are the most common cause of injury in the Older Person (OP) and become more frequent with advancing age. There is a higher chance that a fall in an OP leads to trauma due to decreased protective reflexes and saving mechanism.

Introduction

It has been estimated that thirty-three per cent of people over 65 years and 50% of women over 85 fall at least once a year. As well as the cost of hospital treatment, the ensuing loss of confidence and decreased functional abilities will make increased demands on long-term health services, both community and institutional. In the over 80s the incidence of death increases within one year of a fall. The number of falls increases in the final year of the Older Person's life. Falls cause 17% of deaths in people over 75.

Who falls?

- Very active Older People fall more often. However, they hardly ever sustain injuries.
- Women fall more than men because they live longer and remain active for a longer period of time. They have more postural sway which renders them unstable in later life.
- Caucasian and Oriental women have a higher falls rate. As these races have a higher prevalence of osteoporosis, these women suffer higher incidences of fractures.

When do they fall?

Tis the season

There are increased numbers of falls in:

- March: because of deconditioning after winter inactivities;
- October: because of decreased light which leads to increased confusion and increased rates of depression.

In Malta we may also have post-summer inactivity deconditioning.

During the day

Most falls occur:

- during the early morning hours, when going to the toilet;
- in mid-mornings, because of increased activity;
- in the evenings, when there is decreasing light and a tendency for increased confusion.

Where do they fall?

Thirty-two to forty per cent of falls occur in hospitals / residential homes. Of these, 45% - 61% occur on visits to the toilet at night owing to disorientation and medication/sleepiness while 22% of falls occur when the OP is getting out of bed. 28% - 45% of falls occur in the home, mainly while rushing to the toilet or tripping both inside and outside the home.

How do they fall?

People under 75 years tend to trip namely because of poor dorsiflexion of the ankles, while those over 75 years tend to fall when turning because of slow reactions. They also tend to fall sideways not backwards. (Bottomley 2004)

Causes of falls

Intrinsic factors include:

- Chemical restraints
- Poor vision
- Muscle weakness of trunk and lower limbs
- Deconditioning: interaction between 'ageing' – disuse – disease
- Inattentiveness/confusion/poor judgement
- Gait abnormality (due to various pathologies and 'ageing' changes)
- Orthostatic hypotension
- Polypharmacy
- Self medication
- Dehydration and malnutrition
- Poor balance control due to somato-sensory dysfunction/ vestibular dysfunction.

In May 2004, Dr Jon Marsden noted that carotid sinus syndrome with drop attacks are often accompanied by syncope, especially when precipitated by certain head and neck movements, namely rotation with lateral flexion. Many Older People have amnesia of the fainting episode and approximately

60% of these falls are unwitnessed. This makes detection of the problem difficult and the condition is frequently undiagnosed and therefore not treated

Extrinsic factors include:

- Physical restraints
- Environmental hazards:
  - Poor light including reflection and glare
  - Poor colour contrast in different floor surfaces
  - Poor visual cues especially for OPs with dementia
  - Loose carpets and small furniture
  - Pets
  - Bad footwear
  - Slippery / uneven floors inside and outside the home
  - Sudden noises
  - Stairs with poor banister support, both in private and public places
  - Inappropriate seating
  - Inappropriate mobility aids

Tracing the cause of a fall is very important. Extrinsic causes should be dealt with immediately together with the OP/carers, while appropriate diagnosis and treatment of intrinsic causes must be a priority in the team's clinical management of the Older Person.

Prevention through physiotherapy

It is said that most falls are unavoidable. Although this may be so, studies have shown that a good percentage of them can be prevented and physiotherapy has a major role in this aspect by:

1. Prescribing exercise programmes to improve balance and muscle power
2. Re-educating gait
3. Prescribing appropriate mobility aids and orthosis
4. Advice on the Older Person's environment to obtain and maintain maximal safety and functional mobility
5. Work on falls programme together with the Older Person and the carers
6. Health promotion

1. Exercise programmes

When prescribing exercise programmes to improve balance and muscle power, the physiotherapist ensures that:

- Most of the exercise programme is composed of extension exercises to emphasis strengthening of the anti-gravity muscles which are the extensor muscles of the trunk and lower limbs. Increased muscle bulk helps to lessen the impact of a fall owing to increased padding.
- If the cause for the fall is a vestibular problem, a progressive exercise programme to precipitate head movements should be started as early as possible.
- Balance exercises must include correction of adjustment of the person's centre of gravity especially in activities like sitting to standing and turning. Better balance not only prevents falls but lessens the Older Person's fear of falls.

2. Gait re-education

This includes correction/improvement of the Older Person's gait techniques. Here the physio must take special care to keep the gait pattern as normal as possible and to maintain two-legged mobility (i.e. without a walking aid) for as long as possible, as normality of gait patterns will confuse an Older Person less and ensure greater compliance.

3. Appropriate mobility aids

When and if a walking-aid is needed, it must be professionally prescribed and not bought off the shelf as a birthday or (more recently) a Christmas present. Some points on mobility aids viz walking-aids include:

- Use of mobility aids radically changes the person's centre of gravity, weight transference, balance, gait pattern and speed. The Older Person must learn to adjust to these changes.
- High walking aids DO NOT correct posture but increase strain on the shoulder joints and throw the centre of gravity backwards, thus precipitating the risk of falls.
- Many homes and public establishments do not have access to certain walking aids, and lack of manoeuvrable space can cause falls. Importance is usually given to wheelchair access but in fact only 1 in 40 disabled Older People use them. The greater majority use walking aids.
- Many Older People prefer to 'furniture walk' in their home than use a walking aid, especially if there is limited space.
- Quite a few Older People inherit a walking aid from a neighbour, relative, etc. and are not keen to change to a more appropriate one.
- In Malta we also have a phenomenon where people especially women are embarrassed to use these aids in public.

The physiotherapist must take all these points into consideration before prescribing an aid. It is very important to see that the person can and will use the aid functionally.

4. Environmental advice

Proper advice on the OP's environment cannot be given from a clinic. The assessment of the actual home, both inside and outside is very important. The individual's manoeuvrability must be seen within his environment. The physio, usually together with the occupational therapist (OT), visit the Older Person's home and together with him/her and the carers work on any safety issues required.

Here it is very important for the clinicians NOT to institutionalise the people's homes. We must listen to the Older Person and keep our advice within his perspectives of needs and priorities. As clinicians we must make people aware of risks and hazards but we must not put them off activities.

5. Falls programme

Generally speaking, few Older People will be willing to change attitudes to prevent falls. It is therefore wiser to make them the prime movers in this area. One good way of doing this is to actually make the individual identify hazards for falls himself and suggest methods of prevention.

Another method is to have a Falls Diary where he notes any fall he may sustain. This will help him and his carers to identify the reasons, times and frequency of his falls.

The health professional must also break down the barrier of fear of the Older Person being on the floor. S/he must be able to teach him/her/the carer to get up from the floor. This is especially important in cases with a history of frequent falls and/or if the OP lives alone.

6. Health promotion

Health promotion on falls prevention and management should mainly be targeted to three different groups:

1. To people within the 40-60yr (pre-retirement) cohort who should have promotion for healthy ageing. This is especially important for women who would benefit from an exercise programme that stimulates vestibular input and maintain bone mineral density.
2. To well-elderly who would benefit from participation in Falls Prevention and Management Programmes.
3. To the carers of Older People with a history, or are at risk, of falls.

The real picture

In Malta, services in the community are still lagging far behind. The established government physiotherapy services for Older Persons available are those in institutional systems in acute, rehabilitation and long-term care. However institutionalisation of people suffering from falls is not the solution. It actually increases their number of falls.

The only physiotherapy services for Older Persons living at home are:

1. Health Promotion Programmes held at government Day Centres (and occasionally parish centres);
2. A miniscule Domiciliary Service targeting OPs who cannot leave their home owing to frailty or severe architectural problems.

Health professionals must be pro-active in establishing Falls Prevention and Management Programmes outside institutional settings. Progressive therapy practice advocates the need of making the OP's home 'a tailored ecological niche for the individual' (Rowe 2004)

GPs must have quick and easy access to rehabilitation therapists to help their case management within the home environment. This should not only lead to a higher primary level of care provision but decrease hospitalisations and institutionalisation of the Older People. It is appreciated that GPs have limited direct access to Physiotherapy Services. However the Physiotherapy Department at St Vincent De Paule Residence is always available to give advice and can be contacted on 22912219 from Monday to Friday, from 7.30 a.m. to 3.30 p.m.

References

Bottomley, J. M. (2004) *Safety and Fall Prevention and Management in the Elderly Population*. Paper presented at the conference entitled 'Advances in Balance and Falls Management in the Older Person', organised by the International Association of Physical Therapists working with Older Persons (IPTOP) in association with the Irish Association of Physiotherapists in Neurology and Gerontology (Ireland), May 6th - 8th at the Trinity Centre for Health Sciences, St James Hospital, Dublin, Ireland.

Rowe, J. (2004) *Falls Prevention – Recent advances in Therapeutic Ignorance*. Paper presented at the conference entitled 'Advances in Balance and Falls Management in the Older Person', organised by the International Association of Physical Therapists working with Older Persons (IPTOP) in association with the Irish Association of Physiotherapists in Neurology and Gerontology (Ireland), May 6th - 8th at the Trinity Centre for Health Sciences, St James Hospital, Dublin, Ireland.

Mary Lou GRECH Dip PT, Dip Ger, MWCPT

Principal Physiotherapist in the Department for the Elderly and Community Services

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President: Dr Pierre Mallia, **Vice-President:** Dr. Andrew P Zammit, **Hon Secretary:** Dr Noel Caruana, **Hon Treasurer:** Dr Michael Cordina, **Quality Assurance Secretary:** Dr Adrian Micallef*, **Educational Activities Secretary:** Dr Mario R Sammut, **Research Secretary:** Dr Jean Karl Soler, **Communication Secretary:** Dr Saviour Cilia, **College Registrar:** Dr Michael A Borg, **International Affairs Secretary:** Dr Tonio Xuereb, **Members:** Dr Jürgen Abela*, Dr Renzo Degabriele*, Dr Mario Grixti, Dr Philip Sciortino. (*Co-opted members)

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Secretary's Report of College Activities 2004-5

Dr Noel CARUANA

Council and its meetings

There were 14 meetings since the last AGM of 10th August 2004.

Council posts during 2004/2005 were assigned as follows:

- Dr.Pierre. Mallia – President and Secretary for Ethics
- Dr. Andrew P Zammit – Vice President
- Dr. Noel Caruana – Honorary Secretary
- Dr. Michael Cordina – Honorary Treasurer
- Dr Michael Borg – College Registrar
- Dr. J.K. Soler – Secretary for Research and Publications
- Dr. Mario R. Sammut – Secretary for Education
- Dr. Savior Cilia – Secretary for Information and Communications
- Dr Adrian Micallef – Secretary for Quality control and audit
- Dr. Anthony Xuereb – Member
- Dr. Jurgen Abela – Member
- Dr Renzo Degabriele – Webmaster
- Dr Philip Sciortino – Member
- Dr Mario Grixti – Chairman of SAC subcommittee

It was also decided that the following subcommittees would be set up to facilitate the working of the Council. It was stressed that the aim of the council would be to involve the college members as much as possible. The subcommittees set up were:

1. Statute subcommittee
2. Research subcommittee
3. Ethics subcommittee
4. SAC subcommittee
5. Education Subcommittee

During the council meeting of 30th August 2005 the president suggested some alterations in the responsibilities for certain posts on council, as follows:

Dr Anthony Xuereb was asked to perform duties of International Secretary a post previously held by Dr J K Soler. Dr Jean Karl Soler was asked to act as College Registrar, while Dr Mario Grixti was asked to act as Secretary on SAC subcommittee. These changes were approved by the majority of councillors present at the meeting.

MCFD-RCGP Teachers' Course

The second Teachers Course. There were 19 applicants of which 14 eventually accepted to participate in the two-modules, each of five days, Teachers' Course. The first module was held in May 2004 with the second module being held in October 2004.

Following approval by members at the EGM in April 2004, the College paid part of the expenses, with the rest of the cost being paid by the participants.

The Education subcommittee has been having contacts with he RCGP discussing the possibility of organizing the fourth and fifth modules during 2005/2006.

The College had submitted a proposal for funding of these advanced courses to the European Social Fund Project.

MMCFD – MRCGP (INT.)

- The College has been studying the issue of developing a locally based Membership, for a number of years. During the last EGM, members approved the process of applying for the introduction of the MRCGP(Int) in Malta. Since then the College President has been discussing the issue with Dr. John Howard - Chairman of the International Committee.

  In January 2005 five members from the Council attended to a three day international membership workshop organized by the RCGP in London. Fees incurred for this attendance were borne entirely by the attendants with the help of sponsors.
- Membership Board

  Following approval at the EGM and at AGM of 2004, the College started to work on the development of the MMCFD and to explore the development of the MRCGP(Int) in Malta. In April 2005 the Council proposed the setup of a Membership Board and the Curriculum Committee. The Council had asked its members to participate in the formation of these two bodies. Members who volunteered and were later approved by council were as follows:

  Dr. Mario Grixti as chairman of Membership Board, Dr Jurgen Abela, Dr Michael Borg, Dr Frank P Calleja, Dr Jean Karl Soler, Dr Mario R. Sammut, Dr Michael Cordina and Dr Noel Caruana as members.

- Curriculum Development Secretariat
  In order to develop a curriculum for the eventual assessment to be introduced for conferment of the MMCFD title, a Curriculum committee was set up, after a call for interest and participation was made through the Colleges media. The following members volunteered to contribute;
  Dr Philip Sciortino as Chairman of curriculum Committee, Dr Ron Borg, Dr Anton Bugeja, Dr Noel Caruana, Dr Doreen Cassar, Dr Sandra Falzon Camilleri, Dr Adrian Micallef and Dr Mario Sammut as members. The Secretariat has prepared and submitted a Proposal for funding of a "Curriculum Development Project For Membership Assessment", to the European social Fund Project.

FAMILY MEDICINE AS A SPECIALTY IN THE HEALTH CARE PROFESSIONS ACT

A Specialist Accreditation Subcommittee was set up in October 2003 and was asked to draw up a document about the Specialty of Family Medicine in Malta, which was subsequently presented and approved, at the EGM in April 2004. These criteria were further discussed during last year's AGM, as can be seen in the minutes. The Specialist Accreditation Subcommittee continued its work during the past year and was always present during a number of SAC meetings. Despite the fact that more than a year has elapsed we are still waiting for the certificates to be issued to our members by the SAC.

CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMME 2004-2005

2004 (news of events for 2004 after AGM of same year)

- The Autumn CPD meeting was co-organized with the Association of Dermatologists and Venerologists, entitled DERMAFEST ON 30th October
- The European General Practice Research Network hosted by the MCFD organized its meeting on 8-10th October 2004

2005

- The Winter CPD meeting. Community Care of the Elderly and Managing Domestic Violence –(February 12).
- The Spring CPD meeting. Coeliac Disease in Family Practice, was a CPD evening organized in association with the Malta College of Pathologists and the Coeliac Association Malta. (March 4)
- The Summer CPD meeting Tackling Acute Musculoskeletal Problems in Family Practice.(July 18)
- ThenAutumn CPD in set to include a one day venue on October 29th - Respiratory update

The college organised another two activities as part of its ongoing CME

- MCFD-DSU A series of CPD meetings on Public Health issues relevant to Family Doctors.
  (March to June and September to December)

2. MCFD and Emergency Response Team organised a one day Seminar on Pre-hospital Emergency Care on 23rd April. There were 30 participants who could take part at this hands-on style seminar. As this event was overbooked, the symposium was re-organised in June 2005 for a second group of participants who received hands-on training.
3. In collaboration with the St James administration, the college is accrediting a series of "Lunch and Learn" seminars open to all Family Doctors.

The College is in the process of setting up a number of CPD initiatives, which include:

1. A Diploma in Family Practice (a call for applications was issued and closing date was end of August 2005)
2. Membership of the Malta College of Family Doctors.
3. International Membership of the Royal College of General Practitioners.
4. Specialist/ Vocational Training Programme in Family Medicine.

LOCAL NEWS

23-26th September 2004

The College was participant at a three day conference being organised in Malta by Pfizer. The seminal was aimed principally for French doctors and was entitled: "The Universities of Depression" Maltese Family Doctors were invited to attend for a Saturday meeting to discuss with French Gps on areas of common interest.

The College requested a meeting with the APFD to clarify any issues that were arising after the setup of this new Association. The meeting, in September 2005, was a cordial one, and the APFD president explained that the main aim of the association was to promote the interests of Private Family doctors. It did not seek to interfere in the academic work of the college.

International News

26th November 2004

Dr Mario R Sammut as Europrev representative of of the College attended a meeting in Barcelona, Spain .The Europrev is the European Network for Prevention and Health Promotion in Family Medicine.

January 2005. In January 2005 five members from the Council attended to a three day international membership workshop organized by the RCGP in London. This meeting hosted by the RCGP, was organised to familiarise prospective countries with the concept of an international Membership of the Royal College of General Practitioners(MRCGP(Int)). It was attended by representatives from Lebanon, Dubai, Malaysia, and Rumania.

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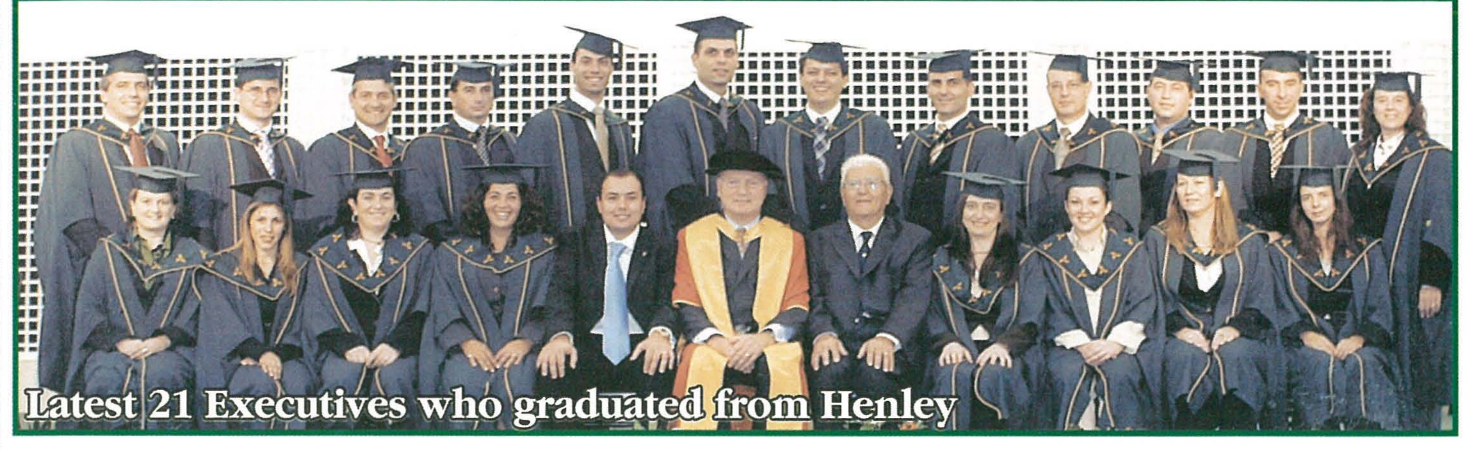

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Henley Management College is the oldest independent management college in Europe, established in 1945.

For sixty years Henley Management College has been at the forefront of management education and development. It offers a portfolio of open executive programmes and a range of tailored programmes to suit the needs of organisations worldwide. It is one of the world's largest international Graduate Business Schools, working with approximately 6,000 managers from 80 countries. It does this through a network of Local Offices and Associate Organisations. The College will continue its development both at Greenlands and worldwide. Through new technologies the College is reaching new audiences and providing new services in support of management education and development.

Since 1972, the College has offered a range of Master's and Doctoral programmes in partnership with Brunel University. Until seven years ago, students were registered for MBA degrees of the University on programmes delivered by staff of the College. In March 1997 the College was granted powers, by the Privy Council, to award its own degrees for taught programmes.

Since early 1997 all new Master's students have registered for the College's own awards, and degrees of Henley Management College were conferred for the first time in 1998. Today the College rather than the University will award the majority of degrees conferred at the ceremonies. The two institutions continue to collaborate in both teaching and research and the University remains the awarding body for research degrees.

Both the college and the University are committed to continuous improvement in the quality of education and services they provide. Our staff and students are the key to our success and we hope that all will feel justifiably proud of their achievements.

During these years, the College has worked closely with individuals and organisations to establish a worldwide network of relationships with people who have grown as a result of 'The Henley Experience'.

From its launch in 1974, The Henley MBA programme has been continuously developed and improved in response to the changing needs of managers worldwide. The College has led the development of alternative modes of study that fit into the changing lifestyles, as well as designing specialist MBA's to meet the subject needs of different business sectors.

The programme is the first Distance Learning MBA programme to be available in Europe and in the past twenty years it has been continually re-designed and updated to meet the changing needs of management development and training. All coursework, assignments, projects, examinations and dissertations are set and assessed at Henley. E-learning facilities are available to all students.

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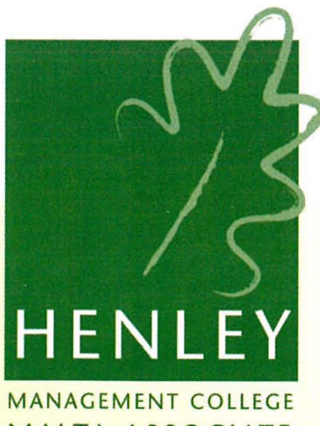
The Henley MBA programme was launched in Malta in 1991, this was run through the Malta University Services Ltd and directed by Prof Reno J Sammut who was at that time Head of the Department of management at the University of Malta. By the mid-nineties the University of Malta has established its own MBA programmes and from 1998 the Henley Programmes were organized through Management Development Services Co Ltd (MDS) in collaboration with the Malta Chamber of Commerce and Enterprise.

In Malta this Distance learning programme has been changed to a part-time evening course. Lectures, tutorials are provided by local professionals who are also MBA Graduates. Local feedback is given on assignments and individual supervision is provided for projects and dissertations.

During the past fifteen years over 450 Maltese executives have registered on the Henley Programmes. Of these 210 have graduated with the Henley Executive MBA and another 50 have obtained the Post Graduate Diploma in Management. At present there are 140 who are on various stages of the programme. As can be seen from these figures, the completion rate is extremely high. Over the years six Maltese participants have been awarded the prestigious Henley Prize. The Dissertation is the culmination of the participants work on the Henley MBA programme it requires the participant to demonstrate a critical approach to management problems and a capacity to relate specific issues to broader Management literature.



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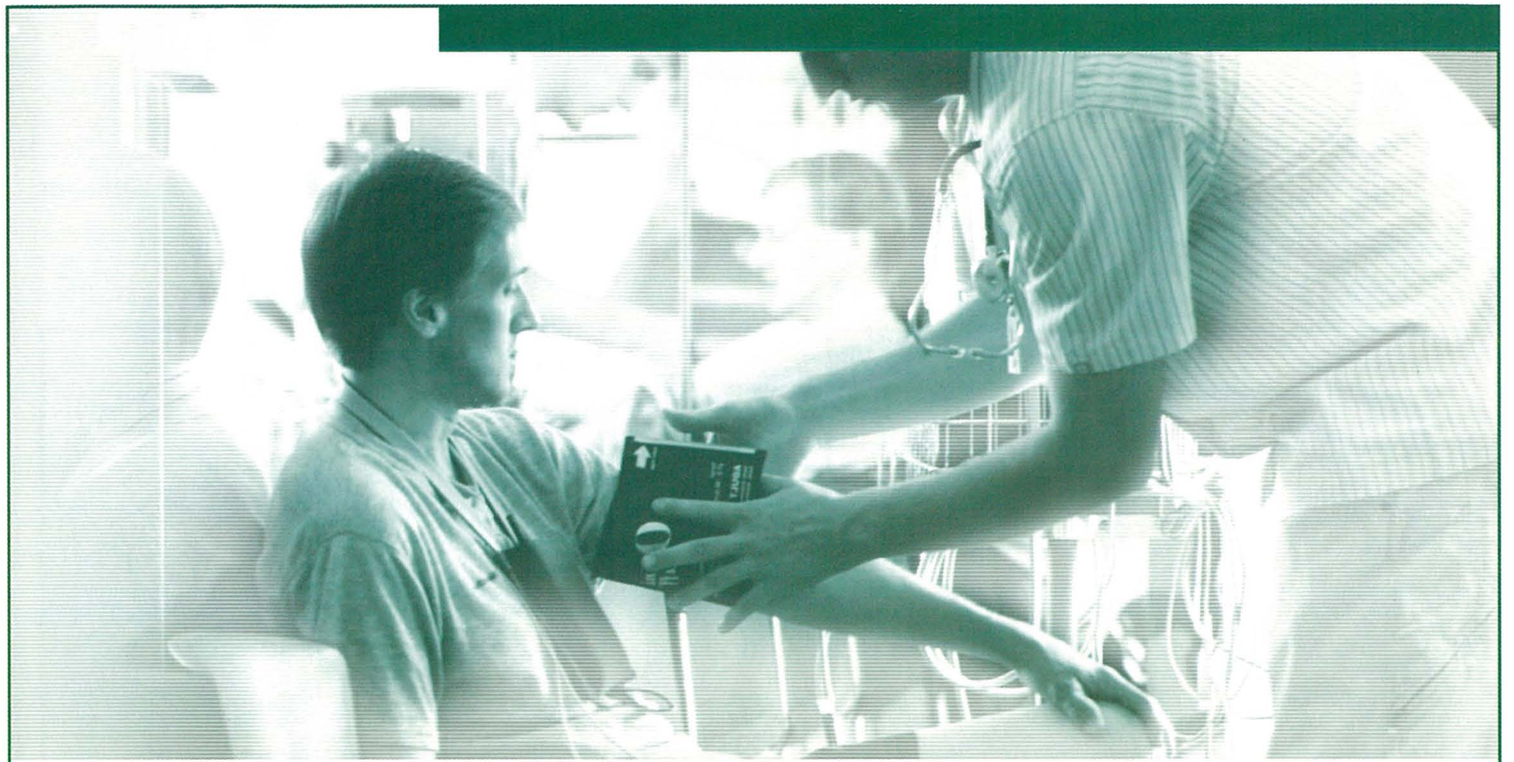

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20-24th April 2005: Dr M Sammut attended a meeting of the European Academy of Teachers in General Practice (EURACT) in Budapest as Malta's representative.

September 2005: Dr JK Soler and Dr M Sammut attended the European WONCA meeting in KOS, Greece. They represented the college at this meeting. Expenses for the attendance were borne by the two attendees personally or through sponsorships.

MEMBERSHIP

College membership at presently stands at 220. I urge those members who have not paid their membership for 2005 to do so at their earliest.

COLLEGE JOURNAL AND NEWSLETTER and WEBSITE

The previous editor of the college journal expressed his wish to resign from his post in September 2004. Following a call for application for this post, Dr Noel Caruana was approved by Council in December 2004, to be the next Journal Editor. Following the change in editor, the journal's name was adjusted to "Maltese Family doctor"/It Tabib tal- Familja. The first issue was published in June 2005, being Volume 14: Issue 01 June 2005. The College Journal It-Tabib tal- Familja is being issued twice yearly in June and December. For the first time the College's Journal is available online.

The MCFD Newsletter compiled by Dr S Cilia, continues to be sent monthly exclusively to college members, and includes local and international news for the benefit of the Family Doctor. Important and urgent notices to members are available on the college's website which is updated regularly by our webmaster, Dr R Degabriele.

Contributions to both the Journal and Newsletter are welcome and are to be addressed to the Editor and College secretary respectively.

Dr Noel CARUANA MD MSc
Honorary Secretary MCFD
Email: noelcaruana@gmail.com

Thiazide diuretics may still be the preferred first-line drugs for essential hypertension:

What should be the first-line antihypertensive for most patients with essential hypertension? The answer to this simple yet intriguing question has remained elusive. A three-year study published in JAMA 2002 shows that thiazide diuretics may still be the preferred first-line drugs for hypertension. The study looked at 33,357 patients with hypertension and at least one coronary heart disease (CHD) risk factor. The study examined whether an angiotensin-converting enzyme inhibitor or a calcium-channel blocker would lower the incidence of CHD compared with a diuretic. The mean follow-up was three years, during which time 2956 had fatal CHD or non-fatal MI. The relative risks (RR) for the patients from each treatment group were similar. Basing their argument partly on cost-effectiveness, the researchers concluded that thiazide-type diuretics should be preferred for first-line anti-hypertensive treatment.

Reference: Antihypertensive and lipid lowering Treatment to prevent Heart Attack (ALLHAT) authors and coordinators. Major outcomes in high-risk hypertensive patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blockers vs diuretic. JAMA 2002; 288:2981-2997.

Colorectal Cancer: Family history is under-reported

Family history is often used to estimate risk of colorectal cancer and to decide which patients warrant colonoscopy, however there is a considerable degree of recall bias and inaccuracies.

A study by Mitchell RJ et al reported their study of 199 colorectal cancer patients and 133 controls selected from the community. Using face to face interviews the researchers assessed the accuracy of family history as given during consultation with actual cancer morbidity data from cancer registers.

The study showed that there s much underreporting of colorectal cancer in both first degree and second degree relatives. Thus the researchers conclude that family history though a useful indicator should be interpreted with considerable caution. Mitchell RJ, Brewster D, Campbell H et al. Gut 2004; 53:291- 295.

Tuberculosis in Malta – Some historical facets

Dr Charles J. BOFFA

The dark chronicle: In 1841, Dr Charles Galland, professor of anatomy at the Malta University carried out post-mortems on 615 unselected cases who had died from various diseases and he found clear indications of tubercular lung disease in 13% of them. This shows that the number of TB cases with lung involvement at that time was high.

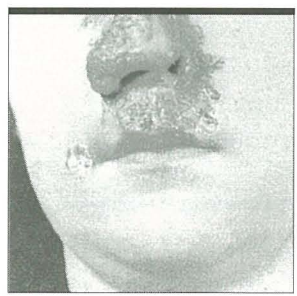
The famous Sir Temi Zammit in his paper "Tuberculosis in the Maltese Islands" (1900) also shows that quite a number of Maltese in various towns and villages succumbed to TB.

The following mean population figures for some localities for the years 1890-1899 throw some light on the sad situation regarding deaths from TB - mostly of the lungs, compiled for Sir T. Zammit. Figures were perhaps approximate.

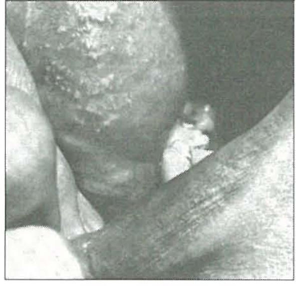
Out of a population of 24,136 in Valletta - Floriana, 659 died
Out of 3,349 in Tarxien - Paola, 112
Out of 12,601 in Cospicua, 324
Out of 7,288 in Vittoriosa, 131
Out of 8,179 in Senglea, 205
Out of 7,900 in Qormi, 168

The number of cases seems to have very gradually decreased slightly during the 20th century, probably due in general terms to better nutrition and sanitation.

On the 22nd April 1909, while on a visit to Malta, King Edward VII, inaugurated a 60 bed sanatorium at Palazzo Vilhena, Mdina. He named it after his brother the Duke of Connaught who at that time was the British Commander in Chief in the Mediterranean – who as a noble gesture donated eight hundred pounds sterling for the purchase of new equipment. Other items were financed by the Maltese administration.



Lesions of Tuberculosis: Nose,



Lupus vulgaris: tongue

In later years structural changes were made at the 'Connaught' to accommodate around one hundred patients and the number of staff was increased. For many years, Gozitan patients were accommodated in a building known as St Theresa hospital at Tal Ibrag.

During the Second World War there was a slight rise in TB cases

And now to a later time horizon. The Second World War was responsible for a large number of deaths. Besides other factors, an ill nourished population has little resistance to various diseases. Furthermore certain social disruptions tend to trigger diseases. There was an increase of TB cases; very poor nutrition and overcrowding in the shelters, refugee cntres and homes all contributed to this rise. However I do not want to give the impression that there was rampant tuberculosis. During Malta's second great siege, the officials running the Medical and Health Department ably led by Professor A.V. Bernard – the Chief Government Medical Officer and doctors were concerned because the number continued to increase with the worsening food situation. During mid 1942, Malta was on the verge of starvation. The food supplies which arrived in mid August on the five merchantships of the Santa Marija convoy acted like a blood transfusion at a most critical time. Nine other merchantships, besides some warships had been sunk, with appalling losses in human lives. Another four merchantships with food, medical supplies etc. arrived in November 1942.

It is relevant to mention that during late November – December 1942 and during the first months of 1943, all of us at the Lyceum and other secondary schools, were given a small teaspoon of cod liver oil, twice a week to boost up our resistance. In 1942, one of our very knowledgeable masters and one of my schoolmates succumbed to TB and died.

The incidence of TB was as follows:

1939	–	154 cases
1940	–	183
1941	–	239
1942	–	344
1943	–	263

Besides these, there were also some other unreported cases (because of the stigma associated with TB) in out-of-the-way farmhouses, who somehow escaped the attention of health inspectors who were performing much more work than normal, so much so that they were exempted from military service.

During 1955 and 1956, one of my duties entailed performing a half-day session once a fortnight at the 'Connaught' to cater for the dental-oral needs of TB patients, at that time around 90. Several of these were in an advanced stage and coughed up blood (haemoptysis) of a bright red colour. Some had persistant mouth ulcers probably due to secondary infection from the lungs. A few other patients had 'lupus vulgaris' on their noses. (see photos)

There was a rather high incidence of dental-peridontal disease and inflamed sulcus. Efforts were made to improve their mouth hygiene. The oral tuberculous lesions particularly those of the lips developed as small pimples which gradually broke down to form painful ulcers at the corners of the mouth. Tuberculous ulcers are characterized by an irregular undermined border, while the base is usually covered with an ugly yellow exudate or mucus.

Some ulcers developed on the tongue, in certain cases where irregular edges of teeth existed. Streptomycin therapy was used for tubercular lesions of the tongue. Marked sialorrhea was common.

When intravenous therapy with arsphenamine or Mapharsen was periodically administered, the oral tuberculous lesions tended to aggravate.

I used to be deeply concerned while carrying out treatment, because of the risk involved, more so when Dr Emanuel Agius confirmed that the ulcers were infected with the TB bacillus.

Among the very dedicated specialists and doctors at the 'Connaught', I remember the Noble Dr Felix Apap Bologna, Dr Joseph Micallef and Dr Anthony Lanfranco. Dr Lanfranco was later appointed physician in charge of the TB ward (women) at S.L.H. Mr Anthony Darmanin – the Wardmaster (equivalent to present-day S/Administrative Nurse) was indeed a very efficient and humane personality. The nurses carried on under dangerous conditions and were also unsung heroes. Last but not least there was an admirable chaplain – Rev. Francis Catania who did so much spiritual and social good for so many.

Dr Anthony Lanfanco had mentioned to me an interesting historical fact. About 1910 to 1920, a new medicine 'Umckaloabo' based on this plant which grew in South Africa and the Gold Coast was used for some time by some doctors in Switzerland, England and also tried in Malta. This consisted of teaspoonfuls – the dose depended on the severity of the disease, of a liquid extract made from the root and fortified by alcohol and glycerine for preservative purposes. Lozenges were also used.

This had been used in a series of cases by Dr Sechegaye in Geneva over a period of about 10 years. A number of patients had claimed a sense of bien être, but in due course it was found that it did not arrest the disease.

There is a fact that should not be lost sight of. It is well known that in chemical analysis; when certain substances are put together the combination may yield something different from either. It was then felt that Umckaloabo when in contact with human blood could possibly provide a chemical substance which is toxic to TB, although the drug was harmless to the hardy germs of TB by itself.

Following the extensive research and developments in Europe and the U.K., new concepts and lines of treatment improved. In 1957, 68 patients from the 'Connaught' were sent at Government expense to England and Milan for special treatment. Many of them responded well to treatment and returned healed. In the following years, the number of new cases in Malta and Gozo gradually decreased.

Around 1952, it had been generally felt that the 'Connaught' was not the ideal Sanatorium although it had served its purpose well for many years. Furthermore it was situated too close to an inhabited locality. Dr (later Sir) Paul Boffa – at that time Minister of Health and Prof. G. Galea – Chief Government Medical Officer suggested the building of a small TB hospital. In 1953, a Parliamentary Committee was appointed to study the matter and make suggestions. The Tal Virtu or some other suitable locality was mentioned. However the Government of the time was defeated soon after and the advisory commitee lapsed with the dissolution.

In 1952 (and later) mainly through the initiative of Dr Paul Boffa, a financial aid was given to families whose breadwinners suffered from TB and were exposed to infection, mainly in order to increase their resistance by better feeding.

The 'Connaught' was shut down in November 1956 and a small section for TB patients was set up at St.Vincent de Paule. (Now residence for the Elderly). Later another TB ward was set up at S.L.H. The 'Connaught' was inaugurated as a museum of Natural History on 22 June 1973.

The brightening turning point: In the spring of 1950, Mass B.C.G. vaccination was introduced by the Department of Health. This proved to be of immense value and in the following decade, the number of cases dropped a lot. There was a dramatic fall in the number of new cases and deaths from tuberculosis.

References

Dr J. Hennen. Sketches of Medical Topography of the Mediterranean (1839)

Dr T. Zammit. Tuberculosis in the Maltese Islands (1900)

Parliamentary debates (1953)

Dr C.J. Boffa. The Second Great Seige, Malta 1940-1943 (1970)

Dr Charles J BOFFA, BChD, BPharm, FICD, PhD
Formerly Consultant Dental Surgeon and Lecturer
Department of Health

International Secretary and Research Secretary Report for 2003/2004

Dr Jean Karl SOLER

This short report is intended to inform College members on the activities of the Secretary for Research and International affairs. This follows a formal request by Council to elected officials to forward formal reports on their activities on a regular basis.

This first report combines the activities of the Secretary for Research and for International Affairs. This is because there is significant overlap in these activities, certainly with regard to international activities. The report details activities from the election of Dr Jean Karl Soler to the present College Council, and his appointment to the posts of International and Research Secretary, till the end of 2004.

College representation at International Conferences

In Malta

Soon after election to Council, Dr. J. K. Soler was involved in the organisation of the World Organisation of Family Doctors (Wonca) International Classification Committee (WICC) meeting in Malta in October 2003. Dr. Soler has been a member of this committee on a personal basis since 1998. The WICC is the body that produces and maintains the International Classification of Primary Care (ICPC) that is the officially recommended classification for family medicine in Malta endorsed by the College. This prestigious international meeting was held at the Forum Hotel in October 2003, and the College Council and the Department of Family Medicine were officially invited to attend a joint session with the WICC. This session was unfortunately poorly attended, with Drs Pierre Mallia, Mario R Sammut and J. K. Soler attending and presenting the activities of the College, past and present, to our international guests. The Maltese study of the epidemiology of General Practice, Transhis, was also presented at the meeting. WICC members Prof. Dr. Henk Lamberts and Dr, Inge Okkes have been instrumental in the development of this project locally, and have given College members the excellent electronic patient record (EPR) program Transhis, which includes ICPC-2-E. In fact Maltese doctors were amongst the first in the world to use ICPC-2-E in EPR.

In October 2004, Malta was fortunate to be able to host the European General Practice Research Network again. In fact we had a Research Methods Course organised at the Forum Hotel, and then a full EGPRN meeting in Gozo immediately afterwards. This Research Methods Course was different from its sister course run in Malta in 1999 in that it was part of the first module of a Master of Sciences in Primary Care and General Practice organised in collaboration with the University of Ulster. The course ran for five full days and was attended by more than 15 doctors including three Italians and one German GP. The theme of the EGPRN workshop was "Research using Electronic Patient Records in GP". The workshop started with two pre-conference workshops on EPR, one led by Maltese GP Mario R Sammut. Dr. J. K. Soler had the honour to share the opening keynote speech with Dr. Douglas Fleming. The meeting was well attended, and four Maltese GPs and two Gozitan GPs were present. Drs. Mario R Sammut, A Mifsud and Mark Rosso also addressed the meeting. A more detailed report has been submitted for publication in this journal.

Abroad

Here follows a list of international events where the College's interests were represented by the International and Research secretariat in the person of Dr. J. K. Soler:

- A closed meeting between WICC members and World WONCA Executive at the WONCA Europe 2003 meeting in Ljubljana, Slovenia, in June 2003, dealing with ICPC
- An EGPRN workshop at the WONCA Europe 2003 meeting in Ljubljana, Slovenia, in June 2003
- The eHID expert workshop at the Scientific Institute of Public Health, Brussels, Belgium, February 2004. This workshop dealt with the collection of data from EPR.
- A Workshop on the International Study of Burnout in European Family Doctors at the EGPRN meeting in Antwerp, Belgium in May 2004
- The WONCA Europe Executive Council meetings in Ljubljana, Slovenia 2003 and Amsterdam, The Netherlands in 2004, where Dr. Soler represented the College.
- A meeting of European Medical journal editors discussing the future of the European Journal of General Practice at the

WONCA Europe Amsterdam meeting, June 2004. At this meeting Dr. Soler applied, and was eventually accepted, to the new Editorial Advisory Board of the Journal.

- A meeting of WONCA Europe Network organisation members discussing the future of the Network Organisations collaboration at the WONCA Europe Amsterdam meeting, June 2004
- The "Multilingual Mapping of Diagnostic Concepts in ICPC-2 and ICD-10" invitational closed Spinoza workshop in collaboration with the Academic Medical Centre, University of Amsterdam and the National Library of Medicine, Washington, at the AMC in Amsterdam, June 4-7 2004. Here Dr. Soler represented Malta and announced the Maltese translation of the short titles of ICPC-2-E.
- The inaugural meeting of the working group between the WONCA International Classification Committee (WICC) and the World Health Organisation Family of Classifications network (WHO-FIC) at the Academic Medical Centre, University of Amsterdam, June 7 2004. This meeting discussed the inclusion of ICPC in the WHO Family of Classifications.
- The WONCA (World Organisation of Family Doctors) International Classification Committee (WICC) meetings in Malta in October 2003 and in Trondheim, Norway in 2004
- The EGPRN meetings in Verona –Italy, Antwerp-Belgium and Gozo-Malta

One should state that all Dr. Soler's local and international travel is at his personal expense, and is not subsidised by the College in any way. Dr. Soler does receive some support for travel to WICC workshops directly from World Wonca.

Projects

Research projects

Three important projects have been implemented with the support or collaboration of the MCFD Research Secretariat.

In November 2003, College members Drs. Tanya Melillo, Isabel Stabile, Mario R Sammut and Dr. J. K. Soler founded the Malta Family Practice Research Network. The aim of this group is "to develop research in family practice in Malta" and to change GPs' 'need for' research into 'want to' research. The group has organised a College research symposium in July 2004, and has supported the EGPRN meeting in Gozo.

The Maltese arm of the Transition project has now collected four years of data from the EPR Transhis used by Drs. Carmen Sammut, Mario R Sammut, Frank P Calleja, David Cefai, Joseph Grech Attard, David Sammut, Daniel Sammut, John Buhagiar, Jason Bonnici and Jean Karl Soler. These doctors use the program to record all their contacts with patients, recording reasons for the encounter presented by the patient, their interventions (including tests and prescriptions, with a full record of drugs prescribed and test results) and their diagnostic labels. A formal report of the project is planned for the European Journal of General Practice. However, the results of the first year of data collection are available in the publication "Sick leave certification: an unwelcome administrative burden for the family doctor? The role of sickness certification in Maltese family practice" published in the June 2004 edition of the journal with the co-authorship of Dr. Jean Karl Soler and Dr. Inge Okkes, and the invaluable support of Prof. Dr. Henk Lamberts. [1]

The International study of burnout in GP has been funded by the European Society of GP and the EGPRN (it was in fact the first project to be joint funded in this way). The study has been coordinated by Hakan Yaman from Turkey and Dr. J. K. Soler, and involved the development of a tool to study burnout, which included both the Maslach Burnout Inventory [2] and a questionnaire on doctor characteristics and job satisfaction. This large study required two study arms, and in fact one can proudly state that both the pilot study and the main study were performed in more than 14 European Countries, including Malta. The results of the main study have been discussed at an EGPRN workshop in Antwerp in May 2004 and should be published soon, whilst the pilot study results have been published in Australia. [3] The pilot study indicated that 50% of respondents had high emotional exhaustion (EE) scores, 30% high depersonalisation (DP), and 41% low feelings of personal accomplishment (PA). Preliminary results from the main study seem to confirm this, with 50% high EE, 35% high DP, and 37% low PA.

International projects

One major international project involved the recent translation of the ICPC-2-E into Maltese. This translation is available free on the web for personal use. [4] Thanks go to Mrs. Ritianne Schembri for her crucial input helping Dr. J. K. Soler produce this translation.

Finally, since October 2004 we are fortunate to have the first local MSc in Primary Care and General Practice running in collaboration with the University of Ulster, Northern Ireland, UK. Fifteen participants have completed the first module by January 2005. This is the first MSc in General Practice which is running between two countries, and it involved the EGPRN research methods course which was the first to comply with the Brisbane Initiative for teaching research methods. Twelve Maltese, two Italian and one German GP have participated to date, and the second module has started in February 2005. More details are included in another article that has been submitted to this journal.

Conculsion

In summary, the College International and Research Secretariat has been very active in 2003/4, with numerous activities that promise direct and indirect benefits for college members.

Jean Karl SOLER MD
International Secretary MCFD 2003/04
Research Secretary MCFD 2003/04

Email: jksoler@synapse.net.mt

References

1 JK Soler, IM Okkes. "Sick leave certification: an unwelcome administrative burden for the family doctor? The role of sickness certification in Maltese family practice" European Journal of General Practice 2004; 10:2: 50-55 (June 2004)

2 Maslach C, Jackson S E. Maslach burnout inventory. 2nd edn. Pal Alto: Consulting Psychologists Press, 1986.

3 H Yaman, JK Soler. "The Job Related Burnout Questionnaire A multinational pilot study." Australian Family Physician 2002: Vol. 31, No. 11: 1055-6. (November 2002)

4 International Classification of Primary Care, Version 2 Electronic (ICPC-2-E) Maltese translation. http:/ www.globalfamilydoctor.com/wicc/ pagers.html

Malta College of Family Doctors

CPD Programme January - June 2006

Forthcoming Events

January 2006	Winter CPD Meeting Community Child Health Update Date 28th January 2006 Venue: Westin Dragonara Resort St Julians 9:30-16:30
February-March 2006	Membership Development Day A day workshop/seminar with the participation of British/Irish Colleges, to explore path to introduction of MRCGP(Int) to Maltese family doctors
Spring 2006	Social event- gala dinner - presentation of Accreditation certificates. Event still to be confirmed

European General Practice Research Network National Representative Report 2003/4

Dr Jean Karl SOLER

A major part of this report is paraphrased from a shorter report published by the author in the 'EGPRN News' section of the European Journal of General Practice of October 2004.

The activities of the local European General Practice Research Network (EGPRN) National representative in 2003/4 included, in reverse chronological order, the organisation of the EGPRN October 2004 meeting in Malta, the organisation of an EGPRN Research Methods Course also in October, the foundation of the Maltese Family Practice Research Network and the production of the 2003 Maltese EGPRN National Report.

EGPRN Gozo meeting

The European General Practice Research Network is the European network organisation of Wonca Europe. Its members include European Primary Care researchers, and meetings are organised twice a year in various European countries. The most recent EGPRN workshop, the 59th, took place from the 7th to the 10th October 2004, blessed by beautiful weather at the Ta' Cenc Hotel on the island of Gozo, Republic of Malta.

The theme was "Research using Electronic Patient Records in General Practice". The meeting was opened by EGPRN Chairman, Prof Dr Paul van Royen, and Malta College of Family Doctors President, Dr Pierre Mallia.

On the eve of the meeting the theme was developed during two pre-conference workshops, on research using EPR and on the International Classification of Primary Care, led by Dr Douglas Fleming and Dr Mario R Sammut respectively. The theme was introduced by keynote lectures delivered by Dr Douglas Fleming and Dr Jean K Soler. Forty-one abstracts were accepted, and most were presented successfully. However some participants suffered abrupt flight cancellations when the radar net in Milan failed, resulting in a few presentations being dropped. There were more than 70 participants from all over Europe. Drs. Mario R Sammut, Anthony Mifsud and Mark Rosso were amongst the presenters, and other Maltese and Gozitan GPs also attended the meeting. The presentations and discussions over the two days took a broad approach. Many quality data collection projects were presented, and participants shared their experiences of barriers and opportunities with regards to research using EPR. This workshop was particularly rich in its content and lively in its interactions. On Saturday the participants had the pleasure of being addressed by Minister for Gozo, The Hon. Mrs. Giovanna Debono, on closure of the meeting.

One outcome of the meeting was the resolution to form a special interest group in research using EPR, within the EGPRN but accepting outside members.

For more details of past and future EGPRN meetings, please visit the EGPRN website at http://www.egprn.org . An on-line database of all abstracts presented at recent EGPRN/EGPRW meetings is available.

EGPRN Research Methods Course

Additionally a group of motivated Maltese, Italian and German doctors attended an EGPRN International Course in Research in Primary Care. The course ran from the 2nd to the 6th October and was linked to an optional twelve-week on-line research methods module provided by the University of Ulster in Northern Ireland. This course is part of an MSc in Primary Care and General Practice with the University, and is the first Brisbane Initiative event to take place. The course tutors were Prof Frank Dobbs, Prof Hagen Sandholzer and Dr Lieve Peremans. More details are available in an article on the MSc in Primary Care and General Practice submitted to this journal.

Malta Family Practice Research Network

In November 2003, College members Drs. Tanya Melillo, Isabel Stabile, Mario R Sammut and Jean Karl Soler founded the Malta Family Practice Research Network. The aim of this group is "to develop research in family practice in Malta" and to change GPs' 'need for' research into 'want to' research.

The group has organised a research symposium in July 2004, which was well attended by College members. Previously

completed research projects were presented, including members MSc theses, projects for Irish College of GPs Diplomas, and others. Projects presented included research on smoking cessation, burnout, sickness certification, influenza surveillance and others. Some of the presentations were eventually presented at the EGPRN meeting in Gozo.

Future plans of the group include the further development of research in GP in Malta, such as stimulating the availability of more funding for local research, and support of local researchers.

EGPRN National Report for 2003

The Maltese EGPRN National Representative report for 2003 is included in its entirety for reference.

COUNTRY: Malta
RAPPORTEUR: Dr. Jean Karl Soler
DATE 20/09/2004

- (NEW) MAIN RESEARCH PROJECTS FOR GENERAL PRACTICE GOING ON IN YOUR COUNTRY
  - The Maltese Transition Project (year 4 – closure of database end 2004)

- (NEW) MAJOR PUBLICATIONS FROM GENERAL PRACTICE RESEARCH IN YOUR COUNTRY (IF POSSIBLE, PROVIDE REFERENCES)
  - JK Soler, IM Okkes. "Sick leave certification: an unwelcome administrative burden for the family physician?" First Author. European Journal of General Practice 2004; 10:2: Pages 50-55 (June 2004)
  - C Lionis, F Carelli, JK Soler. "Towards an academic career in general practice/family medicine within the Mediterranean setting: An important priority for the development of the discipline". Co-author. Editorial in Family Practice 2004. (October 2004)
  - M Esteva, C Larraz, JK Soler, H Yaman. "Desgaste profesional en los mÈdicos de familia espaÒoles". Atencion Primaria 2004 (in press).

  None other identified with Mesh search of Pub Med ("Family Practice"[MeSH] AND "Malta"[MeSH])

- (NEW) INSTITUTIONS, ORGANISATIONS, RESEARCH CLUBS ETC? (IF POSSIBLE, PROVIDE CONTACT INFORMATION)
  - Malta Family Practice Research Network (First meeting July 2004)

- (NEW) BRIGHT STARS, EXPERTS WHOM WE WOULD LIKE TO KNOW (IF POSSIBLE, PROVIDE ADDRESS)
  - Dr. Isabel Stabile - Stabile, Isabel E-mail Address: istabile@maltanet.net

- (NEW) EGPRN MEMBERS FROM YOUR COUNTRY
  - Tanya van Avendonk

- (CHANGES IN) FINANCING AND ORGANISATION OF RESEARCH ON LEGISLATIVE LEVEL
  - None to report

- (CHANGES IN) TEACHING GENERAL PRACTICE RESEARCH
  - EGPRN Research Methods Course October 2004 (Brisbane Initiative)
  - MSc General Practice Primary Care from University of Ulster

- FUTURE MEETINGS OF RELEVANCE TO EGPRN AND WHY
  - EGPRN October 2004, Gozo
  - Research Methods Course, Malta, October 2004

- HOW HAVE I PROMOTED EGPRN IN MY COUNTRY AFTER THE LAST REPORT
  - This is my second report. In the interim I have organised an EGPRN meeting, a Research Methods Course, and a MFPRN network research meeting.

Jean Karl SOLER MD
EGPRN Executive Board Member
EGPRN Maltese National Representative

Email: jksoler@synapse.net.mt

Continued Medical Education - Self Assessment Quiz

Type I Questions

Each question has one correct answer.

Q1. Which of the following is a risk factor for secondary Hypertension?

A. Family history of high blood pressure.
B. Stage 2 hypertension (systolic BP 160-179 or diastolic BP100-109).
C. Lack of target organ disease.
D. Onset at 30 years of age.
E. Worsening of control in a previously stable hypertensive patient.

Q2. When evaluating patients with secondary hypertension, which of the following statements is correct?

A. Diastolic hypertension and muscle weakness often are pr4esent in patients with hyperthyroidism.
B. A CT scan of the adrenals is the initial step for diagnosing phaeochromocytoma.
C. Assessing growth hormone level is useful in diagnosing hyperparathyroidism
D. About 70% of patients with hypertension of renovascular origin have an abdominal bruit.
E. Patients in whom Cushing's disease is suspected should have a dexamethasone suppression test.

Q3. In the management of influenza, which of the following statements is correct?

A. Viral culture is the most helpful test to decide whether to start antiviral treatment.
B. Oseltamivir is active against both influenza A and B viruses.
C. Amantadine is indicated for treatment of influenza B infection.
D. It is recommended to start antiviral treatment within 72 hours of onset of symptoms to minimise viral shedding.

Q4. Screening for colorectal malignancy: Which of the following policies reflects the most appropriate plan to screen an asymptomatic 54 year old lady with no relevant family history of colorectal malignancy?

A. Offer screening until she is 75 years old.
B. Do not screen until she reaches 65 years.
C. Do not offer screening as she has no predisposing risk factors.
D. Offer a diagnostic screening test since she is at high risk.
E. Screen her because she is older than 50 years.

Q5. Most allergic reactions to food result from:

A. IgG and IgM antibodies
B. Enzyme deficiencies
C. Toxins in food
D. Ig E-mediated response
E. Low Ig A levels

Type II Questions

Each question may have more than one correct answer

Q6. Which of the following strategies to improve compliance with medication for hypertension, have been shown to be effective when used individually?

A. Daily reminder charts.
B. Combined medication.
C. Simplification of dosing schedules.
D. Patient education.
E. Partner support.

Q7. Which of the following medications help reduce the risks of fractures in postmenopausal women.

A. Calcium supplements
B. Parathyroid hormone.
C. Calcium and vitamin D
D. Biphosphonates.
E. Vitamin D and Biphosphonates.

Q8. Which of the following screening methods are recommended to screen for colorectal cancer?

A. Flexible sigmoidoscopy
B. Colonoscopy
C. Double-contrast barium enema
D. Episodic faecal occult blood tests
E. All the above.

Q9. NIDDM and cardiovascular risk . Which of the following clinical targets should one aim at to reduce cardiovascular risk in type II diabetic patients?

A. Lowering HbA1c level to 8%.
B. Lowering BP to 130/80 mmHg or less.
C. Achieving an LDL level less than 2.5mmol/l.
D. Lowering BP to 140/85 or less.

Q10. In Ascites caused by cirrhosis, which of these statements is correct ?

A. Loop diuretics should be avoided.
B. Salt restriction is inappropriate in these patients.
C. Rehydration will reverse the benefits of paracentesis.
D. Metabolic acidosis and hyperkalaemia characteristically respond to stopping treatment with spironolactone.

Answers on page 75

After reviewing the answers you may claim 2 CME points by quoting MFD December 2005/CME 002 on your application for accreditation.

Statistical Terms used in Research and Evidence Based Medicine

Term	Abbreviation	Definition
Sensitivity	Sn	The percentage of patients with disease who have a positive test for the disease
Specificity	Sp	The percentage of subjects without disease who have a negative test for the disease
Absolute / Attributable risk	AR	The difference between incidence in exposed (to treatment or risk factor) and the incidence in non exposed
Relative risk	RR	The strength of a suspected cause can be expressed by its relative risk or incidence ratio; thus Incidence in exposed/Incidence in non exposed
Absolute risk reduction	ARR	The arithmetic difference in outcome or risk between treatment and control groups. For example. If mortality is 50% in patients receiving treatment and 30% in control group then ARR=50-30 =20%
Relative risk reduction	RRR	The percentage difference in outcome or risk between intervention and control group. For example. If mortality is 50% in treatment receiving group and 30% in controls, then RRR is 50-30/50=40%
Confidence interval 95%	95%CI	This indicates the level of precision for a given statistical result. Thus, if a test is repeated 100 times, the results will fall in this range 95 times.
Number needed to treat	NNT	The number of patients who need to receive a selected treatment instead of the alternative in order for one extra patient to benefit. The NNT is calculated as 1/ARR Example. If ARR=5% then NNT=1/0.05=20
Likelihood ratio	LR	A LR>1 indicates an increased likelihood of disease, LR<1 indicates a decreased likelihood of disease. Most helpful tests have a ratio of <0.2 or >5.
Predictive Value (Negative or Positive)	PPV / NPV	Percentage of patients with a positive (or negative) test for a disease who do (or do not) have the disease in question.
Systematic review		A type of review article which uses explicit methods to comprehensively analyse and synthesise information from several studies.
Meta-analysis		A form of systematic review that uses statistical methods to quantitatively synthesise the results of several similar studies

The *Domus Leprosorum* in Crusader Jerusalem

Mr C. SAVONA-VENTURA

The origins of the Military and Hospitaller Order of Saint Lazarus is shrouded in a haze of myth and legend. The problem has been further compounded by the loss of essential documents from the ravages of wars and time. The Order's presence was a definite reality after the conquest of Jerusalem on the 14th July 1099 by the Crusaders under the leadership of Godfrey of Bouillon. The re-organization initiated in the hospitaller services available in the Holy City resulted in the setting up of two hospitaller Orders, both adopting the Rule of Saint Augustine.

The first Order, assuming the patronship of St. John, became responsible for hospitaller and hospice services to pilgrims and the sick. The second Order assumed the patronship of St. Lazarus and was responsible for caring for sufferers of leprosy. Both Orders owned separate edifices – the former within the walls of the city near the Holy Sepulchre[1]; the latter just outside the walls of the city.

The Jerusalem leprosarium, or *Domus Leprosorum* as it came to be called, may have been established prior to the Crusader's conquest. In 1565, Pope Pius IV in his Bull *Inter Assiduas* acknowledged a link between the Order of Saint Lazarus of Jerusalem with Saint Basil the Great [born c.329 AD; died 379 AD] – succeeded as Bishop of Caesarea 370] who had established a leprosarium in the city of Ptolemais [now Acre]. These services were gradually expanded by assuming responsibilities for further establishments in Jerusalem, Bethlehem and Nazareth. A leper hospital had been established in Jerusalem by the Empress Eudoxia, wife of Arcadius [383-408 AD]. However a direct link between the 4th century hospital and the 11th century establishment remains doubtful.

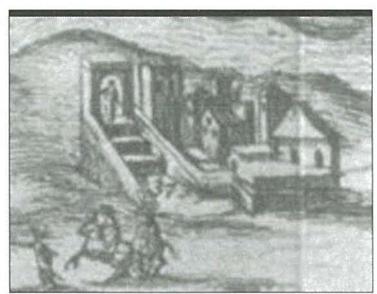
The two hospitaller Orders in Jerusalem maintained close contact and may in fact have been initially different elements of one unit, originally sharing one common Master – Blessed Gerard, le Fondateur [accession 1099 – died ~1120]. Under the Mastership of Gerald, the Order of St. John, known as *Fratres Hospitalarii*, received formal recognition by Pope Paschall II in 1113. The Act of Foundation for the Order of St. Lazarus was according to tradition set out by Paschall II in 1115. Presumably this would have been similar to that issued two years earlier setting up the Order of St. John which simply concluded "*that the House of God the Xenodochium* [or hospice] *shall always be under the guardianship of the Apostolic See and the protection of Blessed Peter*" [2]. Gerald's successor as Master of the Lazarite Order was Boyant Roger [a.1120–d.1131] who had served as Rector to the Hospital of St. John under Blessed Gerald. Raymond du Puy was appointed Master of the Hospitallers of St. John [a.1120–d.1158/60]. Boyant Roger was succeeded by four relatively unknown Masters – Jean [a.1131–d.~1153], BarthÈlÈmy [~1153], Itier [~1154], and Hughes de Saint-Pol [~1155–d.1157]. Hughes was eventually succeeded by Raymond du Puy [a.1157–d.1158/60], the incumbent Master of the Hospitallers of Saint John[3].

The mid-12th century saw the formal organization of both Orders with Statutes being drawn up for the Order of St. John by Raymond du Puy in ~1150[4] and for the Order of St. Lazarus possibly by BarthÈlÈmy in ~1154. From the fragmentary survivals of the latter statutes, it appears that these sought the advice of a rival religious Crusader Order – the Order of the Temple – established about 1118 and receiving recognition by the Council of Troyes in 1129. It has been suggested that BarthÈlÈmy may in fact have been a Templar knight who left the Order to reap the rewards of ministering to the sick[5]. Subsequent late 12th century Masters of the Order of St. Lazarus in Jerusalem included Rainier [~1164], Raymond [~1168], Gerard de Montclar from Auvergne [~1169], and Bernard [~1185-1186] [6]. Jerusalem was lost to Sultan Saladin after the battle of Hattim in October 1187 and the three Orders transferred their headquarters to Acre in 1191 after this was regained by the Third Crusade.

The first three decades of the 12th century saw the Order of St. Lazarus gradually increased its influence in the Holy Land. In 1142 King Fulk of Anjou donated land in Jerusalem to "*the church of St. Lazarus and the convent of the sick who are called miselli*" [7]. A description of the Holy City in 1151 places the leper hospital "*outside the walls of Jerusalem between Tancred's Tower and Saint Stephen's Gate*" [8]. In addition a female Convent of St. Lazarus was extant in Bethany. This convent was extant by 867 A.D. when it is mentioned by Bernard the Wise in his pilgrim travelogue[9]. This convent is further mentioned by the 12th century chronicler William of Tyre. The chronicler records that Princess Sibylla had been raised in this convent under the direction of the

abbess who was the maternal aunt of King Fulk[10]. The village of St Lazarus, which belonged to the canons of the Holy Sepulcher, seems to have been settled by *clientes*, who held been awarded *feuda* or fiefs. An act of 1129 mentions a holder of a fief, a *confrater* of St Lazarus, whose daughter was to marry a *nutritus famulus* of the canons[11].

No contemporary descriptions of the Jerusalem leprosarium are extant, but the edifice has been depicted in a 1717 Dutch map [engraving 20.0x32.9 cm] by Franciscus Halma [1653-1722] entitled *De Stadt JERUSALEM als zy Hedendaeghs bevonden wordt* [see figure and detail below]. This map, showing a traditional bird's-eye view of Jerusalem from the east, was based on an on-site drawing made in 1578. It presents an accurate picture of the city as it appeared after the walls were rebuilt by Suleiman the Magnificent [1520-1566], the same walls that surround the Old City today. Numbered legends at the bottom identify 45 holy sites and historical landmarks. Building No. 37 situated outside St. Stephen Gate, labeled "*Net Zeiken Huys*" [Dutch *ziekenhuis* = hospital, infirmary] is presumed to depict the Leper's Hospice[12].



16th century view of the Medieval City of Jerusalem and a detail of the Domus Leprosorum

[source: Franciscus Halma, 1717 based on c.1578 view]

The seal of the *Domus Leprosorum* shows a priest holding a crosier and the inscription "*St. Lazarus of Jerusalem*" on one side; on the other side is a leper holding a clapper with his face covered in spots and the inscription "*The seal of the leper*" [13]. The seal may be intended to illustrate the dual nature of the 12th century Order's organization based on monkish [*Church of St. Lazarus*] and sick [*convent of the sick*] members as defined in King Fulk's 1142 land donation. Unlike the inmates of the hospital run by the Order of Saint John who were generally merely needy visitors; the lepers cared for by the leprosarium run by the Lazarite Order were condemned to perpetual seclusion from the outside world. Such was the degree of seclusion imposed on lepers that the third Lateran Council of 1179 found it necessary to comment that "*Although the Apostles says that we should pay greater honour to our weaker members, certain ecclesiastics, seeking what is their own and not the things of Jesus Christ, do not allow lepers, who cannot dwell with the healthy or come to church with others, to have their own churches and cemeteries or to be helped by the ministry of their own priests. Since it is recognized that this is far from Christian piety, we decree, in accordance with apostolic charity, that wherever so many are gathered together under a common way of life that they are able to establish a church for themselves with a cemetery and rejoice in their own priest, they should be allowed to have them without contradiction. Let them take care, however, not to harm in any way the parochial rights of established churches. For we do not wish that what is granted them on the score of piety should result in harm to others. We also declare that they should not be compelled to pay tithes for their gardens or the pasture of animals*" [14].

The *Domus leprosorum* was run by a master, almost invariably a priest, who was assisted by nursing brothers and sisters. In some leper hospitals of the Middle Ages even the master had to be chosen from among the lepers. It is not proved, though it has been asserted, that this was the case at Jerusalem. It has been maintained that Article V of the ancient statutes of the Order lays down that "*The chief of the Order shall be taken from this side of the sea; he shall be a healthy knight*" [15]. However, this rule may in fact date to a later period when Pope Innocent IV in 1253 altered the rules of the Order at the request of the brothers to permit "*any healthy knight from amongst the brothers of the house*" to be appointed master-general since according to Robert de Nantes, Patriarch of Jerusalem "*all the leper knights of the house of St. Lazarus were killed*" in the Battle of Gaza against the Khwarizmians at La Forbie in October 1244[16]. This military disaster was further confirmed by the chronicler Matthew Paris[17].

The leper patients were also regarded as brothers or sisters of the house which sheltered them, and obeyed the common rule which united them with their religious guardians. As full members, the inmates thus had a say in the management of their affairs. The members of the convent lived in two sets of accommodation, one for healthy brothers and one for lepers, who ate and slept separately. The day was governed by a strict *horarium* based around services and meals, and punishments were imposed on transgressors of the rule. The hospital provided little or no attempt at curing its sickened inmates further than furnishing a good diet, comfortable sleeping quarters and relieving their suffering by bathing. The hospital probably could accommodate up to a thousand people under the supervision of the warden, providing them with clothing, shelter and care – though most of these were temporary residents possibly pilgrims or migrant lepers visiting Jerusalem[18]. The hospital code for the Jerusalem leprosarium has not survived, but it probably was similar to Ancient rules of the Leper Hospital of Saint Mary Magdalene in Dudstone just west of Gloucester, U.K. attributed to Bishop Ivo of Chartes [d.1115]. The Saint Mary Magdalene Leprosarium in Dudston was not managed by the Order of Saint Lazarus, but was dependant on the Llantony Priory whose followers adopted the Augustinian Rule. It was founded in 1127 and housed 13 lepers.

The Dudston constitutions were primarily intended to create good order and a purposeful life in a complex residential institution. They were not concerned with medical requirements.

The regulations thus fostered a monastic pattern in the leper community. Male and female patients followed regular schedules that included frequent prayer and periodic silence. Men and women were to avoid becoming romantically involved with one another, and members were forbidden to run about unaccompanied. Clothes were uniform; food was plentiful with meat being supplied three times a week, though occasional fasting was prescribed. A formal promise of stability was required and disciplinary measures were specified. Allowance for physical infirmity was however made and the bedridden were granted special privileges[19].

The *Domus leprosorum* received all leper patients whatever their social status. The *Livre au Roi*, the legal code of the Latin kings drawn up c.1198-1205, required any knight with leprosy to join the convent of St. Lazarus "*where it is established that people with such illness should be*" [20]. Similarly, the rules of the Order of the Temple required any knight infected with leprosy to leave the respective Order and join the brethren of Saint Lazarus. Templar Rule No. 443 in the *Regle du Temple* states that "*When it befalls any brother that, by the will of Our lord, he contracts leprosy and the thing is proven, the worthy men of the house should admonish him and ask him to request permission to leave the house and go to Saint Lazarus, and take the habit of a brother of Saint Lazarus*" [21]. Grandmaster Hugues de Revel [1258-1277] of the Order of Saint John established the statute that "*if in any country there be a Brother who is a leper, he may not wear the Habit from that time forward, and may not come among the Brethren, but he should be provided with food and clothing*" [22].

The increasing presence of leper knights in the Order and the changing politics in the Holy Land after 1123 required the setting up of a military fraction of the Order of St. Lazarus with the aim of contributing towards the defense of the Holy Land from the forces of Islam. Saint Bernard of Clairvaux may well have had the Lazarite knights in mind when in 1129 he admonished Crusader knights "*to hear matins and the whole of the divine service, in accordance with canonical institution and the custom of the regular masters of the holy city. For that reason it is especially owed by you, venerable brothers, since* ***despising the light of the present life, being contemptuous of the torment which is of your bodies****, you have promised in perpetuity to hold cheap wordly matters for the love of God: restored by the divine flesh, and consecrated, enlightened and confirmed in the Lord's precepts, after the consumption of the divine mystery no one should be afraid to fight, but be prepared for the crown*" [23].

The Battle of Hattim at Tiberias in 1187 was to be the turning point for the Crusader Kingdom of Jerusalem and Sultan Saladin pressed his advantage to re-conquer Jerusalem. With rare mercy, Saladin allowed the garrison of Jerusalem to march out in three parties from the postern near Saint Lazarus[24]. The Order of St. Lazarus, together with the other Crusader forces, transferred its headquarters to Arce, where it owned a hospital and convent outside the city walls. The buildings were incorporated into the northern suburb of Montmusard after Louis IX extended the fortifications of Acre in the 1250s. In Acre, the Lazarite knights continued succoring lepers and maintained their military duties in the defense of the Holy Land. In 1255 Pope Alexander IV spoke of "*a convent of nobles, of active knights and others both healthy and leprous, for the purpose of driving out the enemies of the Christian name*"; while in 1259, Matthew Paris included the Lazarites among the "*defenders of the church fighting in Acre*" [25]. The Lazarite knights actively participated in a number of local and general campaigns against the forces of Islam including the Battle of Gaza [1244], the Seventh Crusade in Egypt [1248-1250], the Syrian Campaign [1250-1254]. The Lazarite Order also became involved with inter-Orders political conflicts[26].

While maintaining its convent in Acre, the Order in 1254 transferred its Magisterial headquarters to France with the consent of Pope Alexander IV and King Saint Louis IX of France. This anticipated the eventual fall of the last Crusader outpost in the Holy Land[27]. The final death toll to the Crusader Kingdom of Jerusalem came in April 1291 when the Saracen army under the leadership of Sultan Khalid laid siege to Acre. In spite of a spite of the bravery of the defending forces, the last Latin stronghold fell to the Saracen onslaught on the 14th May. All the military brethren of the Order of Saint Lazarus present at Acre were killed during the defense.

The earlier transfer of the Magisterial headquarters of the Order to western Europe before the expulsion from Acre enabled it to survive throughout the centuries in spite of several attempts at incorporating its holdings with politically more powerful Orders. The Military and Hospitaller Order of Saint Lazarus of Jerusalem has during the last century expanded its philantrophic activities on a worldwide level, inclusive the Maltese Islands. The Order maintains its contribution in the fight against leprosy in countries still plagued by the infection.

St. Louis Hospital, Jerusalem

The Jerusalem *Domus Leprosorum* run by the Order of Saint Lazarus suffered from the ravages of time and Islam occupation throughout the centuries. The area now hosts the forty-four bed St. Louis Hospital that serves as a hospice for persons with advanced disease and is sponsored by the French Sisters of St. Joseph.

Hansen Hospital, Jerusalem

Jerusalem still hosts a Leprosy Centre called Hansen Hospital with thirty beds, even though leprosy today is rare and non-endemic in Israel. However, cases of leprosy are invariably imported by immigrants or foreign workers arriving from endemic areas. Similarly in Malta, leprosy has been more or less sufficiently controlled to enable the closure of the last leprosarum at Hal Ferha Estate in Gharghur. The Grand Priory of Malta of the Order of St. Lazarus had regularly maintained its traditional support to the leprosaurum in Malta and in countries where the disease is still particularly rife, such as Kenya and Tanzania. The increasing influx of immigrants from Northern African regions still at risk of leprosy requires the Maltese medical body to remain vigilant for the clinical signs of this chronic infective disorder particularly during the indeterminate stage. The earliest visible lesion of leprosy is usually a poorly defined slightly pink or hypopigmented macule 1-2 cm diameter. This is usually associated with varying anaesthesia in the extremities. This stage may heal spontaneously or progress to several distinct later forms.

References

1 C. Savona-Ventura: The first hospital of the Order of St. John of Jerusalem. *It-Tabib tal-Familja – Journal of the Malta College of Family Doctors*, 1999, 17:p.17-21

2 E.E. Hume: *Medical Work of the Knights Hospitallers of Saint John of Jerusalem*. John Hopkins Press, Baltimore, 1940, p.26; J.J. Algrant, J. Beaugourdon: *Armorial of the Military and Hospitaller Order of Saint Lazarus of Jerusalem*. van den Akker, Delft, 1983, p.464-465.

3 J.J. Algrant, J. Beaugourdon, 1983: *op. cit.*, p.337.

4 E.J. King: *The Knights Hospitallers in the Holy Land*. Methuen, London, p.324-328

5 D. Marcombe: *Leper Knights. The Order of St Lazarus of Jerusalem in England, 1150-1544*. Boydell Press, Woodbrige [U.K.], 2003, p.8-9; M. Barber: The Order of St Lazarus and the Crusades. *The Catholic Historical Review*, July 1994, 80[3]:p.439-456.

6 J.J. Algrant, J. Beaugourdon, 1983: *op. cit.*, p.464-465

7 A. de Marsy [ed.]: Fragment d'un Cartulaire de l'Ordre de Saint-Lazare en Terre Sainte. *Archives de l'Orient Latin*, 2 Paris, 1884 [reprint: New York, 1978], p.123-124

8 J.J. Algrant, J. Beaugourdon, 1983 *op. cit.*, p.330

9 *The Voyage of Bernard the Wise A.D. 867*. In: T. Wright [ed.]: *Early travels in Palestine*. Dover Publ., New York, 2003 [originally published: H.G. Bohn, London, 1848], p.28

10 J.J. Algrant, J. Beaugourdon, 1983: *op. cit.*, p.330; William of Tyre: *Historia rerum in partibus transmarinis gestarum*, XXIII, 1, *Patrologia Latina* 201, p.890-92, translated by J. Brundage: *The Crusades: A Documentary History*, Marquette University Press, Milwaukee, WI, 1962, p.148-50. The Medieval St. Stephen's Gate is today's Damascus Gate. The Crusader remains of Tancred's Tower [or Goliath's Tower] are still found outside the walls of Jerusalem today.

11 N.P. Zacour, H.W. Hazard, editors: *A History of the Crusades. Vol. V: The impact of the Crusades on the Near East*. **University of Wisconsin Press, Madison, Wisconsin, 1985**, p.162

12 Franciscus Halma: *De Stadt JERUSALEM als zy Hedendaeghs bevonden wordt* [map engraving 20.0x32.9 cm]. Leeuwarden, Netherlands, 1717.

13 D. Marcombe, 2003: *op. cit.*, p.5; S. Shahar: Des lepreux pas comme les autres. L'ordre de Saint-Lazare dans le royaume latin de Jerusalem. *Revue Historique*, January-March 1982, 541:p.31-32; C. Clermont-Ganneau: 1. Seal of the crusading period, from the leper hospital of St. Lazarus at Jerusalem. *Palestine Exploration Fund Quarterly Statement for 1901*, p.109 - 113

14 N.P. Tanner [ed.]: *THIRD LATERAN COUNCIL [1179] - Introduction and translation taken from Decrees of the Ecumenical Councils*. Provided Courtesy of: Eternal Word Television Network *http://www.ewtn.com/* [accessed 9th May 2005]

15 J. Riley-Smith: *Hospitallers. The History of the Order of Saint John*. Hambledon Press, London, 1999, p.22-24

16 D. Marcombe, 2003: *op. cit.*, p.13-14

17 H. Nicholson: *Extracts from the chronicles of Matthew Paris relating to the Templars, Hospitallers, and Teutonic Knights translated from the Rolls Series editions by Helen Nicholson*. 1989 [Internet site: *www.cf.ac.uk* accessed 24th December 2004]: Matthew Paris: *Flores Historiarum* [taken from H. R. Luard, *Rolls Series 95*, London, 3 vols, 1890, vol. 2:p.272].

18 D. Marcombe, 2003: *op. cit.*, p.9

19 *Registrum Magnum* is P.R.O., Ms. C 115/K 2/6683 (formerly called C 115/A 1): as reported by E.J. Kealey: *Medieval Medicine. A Social History of Anglo-Norman Medicine*. J. Hopkins University Press, Baltimore, p.108-109, 200-201.

20 A.A. Beugnot [ed.]: *Le Livre au Roi. Assises de la Haute Cour, Recueil des Historiens des Croisades, Lois*. Paris, 1841, 1:p.636-637; D. Marcombe, 2003: *op. cit.*, p.11

21 H. de Curzon [ed.]:–*La Regle du Temple*. Societe de l'Histoire de France, Paris, 1886, p.239-240

22 E.E. Hume, 1940: *op. cit.*, p.62

23 Baron of Richecourt: A living document on Templar Quotes, Statements and Writings. *http://www.ordotempli.org/ancient_templar_quotes.htm* [accessed 8th May 2005].

24 The Old French Continuation of William of Tyre, para.57 as translated in P.W. Edbury: *The Conquest of Jerusalem and the Third Crusade. Sources in Translation*. Ashgate, Aldershot, 1998, p.63.

25 EJ King, *op. cit.*, p.33; D. Marcombe, 2003: *op. cit.*, p. 12,14

26 H. Nicholson, 1989: *op. cit.* - Matthew Paris: *Chronica Majora* [taken from H. R. Luard, ed., *Rolls Series 57*, London, 7 vols, 1872-84, vol.2:p.365; vol.5:p.196,745-746]; *Historia Anglorum* [taken from F. Madden, *Rolls Series 44* London, 3 vols, 1866-9, vol.2:p.90,95]; E. Wedgwood: *The Memoirs of the lord of Joinville. A New English Version*. *http://www.ordotempli.org/memoirs_of_the_lord_of_joinville.htm* [accessed 8th May 2005], p.277-279

27 EJ King, *op. cit.*, p.304.

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Teamwork in Primary Health Care Centres

Dr Josianne Cutajar

Teamwork is one of the latest buzzwords in the delivery of healthcare. Rightly so as when we consider team working from any perspective, be it administrative or clinical, it has been shown that

"The whole of the effort is greater than the sum of the individual contribution" R. B. Reich[1]

Situational Analysis

Both in the publicly and privately owned health clinics together with general practioners there are various secondary ambulatory and paramedical services available. However most of our general practioners seem to be working in isolation. Patients in Malta are neither registered to practitioners nor are they entitled to see a particular doctor of their own choice in the public sector. They tend to wander from one doctor to another and from department to department without effective guidance or follow-ups. As no one seem to be responsible for the patient, very few carers tend to put an entry note in the patient's records when this is available or at least send a reply note to the referring practitioner regarding the patient's treatment and outcomes.

At the publicly owned health centres there is no co-ordination among the different sectors and no communication between the carers. This is leading to the delivery of a fragmented healthcare service characterised with a lot of work being duplicated and inefficient use of resources. In addition administration also has to deal with staff shortages as well as cost containment. In the meantime demand is on the increase due to demographic changes, a rise in patient expectations and the ever-increasing developments in medical technology.

Teamwork: A Possible Solution.

Teamwork has been shown to improve the quality of health care and patient satisfaction by putting an emphasis on an integrated patient-centred approach of health care delivery[2].This can only be achieved through successful partnerships of multidisciplinary carers involved in primary healthcare. So we are now moving away from health care provided by individual practioners to healthcare delivered by a 'Team of Professionals'.

The team approach to patient care is viewed as a means of building and maintaining staff morale, improving status of a given profession and creating over all improvements of organisational efficiency[3].

Main Challenges

We must not delude ourselves in thinking that teambuilding is easy. The ability to create teams may not always come naturally. We can easily organise people to work in groups but this does not necessarily mean successful teamwork. Developing team spirit is crucial for coherent teamwork. We have the duty to provide the culture and structure in which good teams can flourish perhaps using protocols for their management and development in much the same way we would apply protocols for the management of patient care.

Multi-professional teams have to face new challenges. Only by being aware of these challenges and preparing to deal with them can these teams function efficiently and effectively. The local scenario presents three main challenges.

A. Diversity in Multi-professional Teams

Davis[4] states that the problem of scientific professionals is essentially one of adjusting their own highly specialised interest and rather solitary way of life to the integrative way of life in an organisation that brings together many other different or specialised interests. The members in a multidisciplinary team will bring with them different philosophies of practice as well as diversity in their personal beliefs and culture. This reflects the situation at the health clinics. Davis describes professionals as 'cosmopolitan' oriented, that is, loyal primarily to their own profession's standard and goals rather than organisational/team oriented.

B. Scarce Resources

The increasing financial pressures, the limited resources and new technological development demand decisions regarding coverage and access to healthcare services. Teams responsible for the delivery of healthcare have a difficult task to ensure a fair balance between maintaining equity, cost-effectiveness, and improving the quality of care.

C. Holistic Care

Primary health care is only successful if patients are cared for in their real life situations. In general practice we are not only treating the individual but we are also concerned with the patient's family and their community. Our teams must maintain this holistic perspective when dealing with patients. Care has to be co-ordinated intersectorially and intrasectorially. It is the patient's right to be appropriately cared and have access to the necessary services according to his needs.

Key to Success: An Ethical Framework

A shared ethical code for all health care professionals is a guarantee for the successful performance of multidisciplinary teams at the primary healthcare centres. Bioethical values are based on Tolerance, Compromise and Education. This ethical framework is capable of co-ordinating the different sectors and guides them towards a common vision of patient-centred care. Through bioethics our professionals can settle their differences, overcome the new challenges and deliver integrated care.

The common code of ethics being proposed here consists of Basic principles and Teamwork principles.

1. Basic Principles

Separate ethical codes for different health care professionals do not encourage a cohesive approach to patient care. A shared ethical code unifies health care professionals. The British Medical Journal in 1997 recognised this shared ethical code as vitally important to bring all stakeholders together with a more consistent moral framework. Following this publication the Tavistock group[5] of multidisciplinary professionals was set up in 1999. The group formulated a set of five basic and generic principles. These principles must be embraced by all health carers whatever the set up maybe. I am sure that many of us already have put to practice these general ethical values which include:

- Healthcare delivery should be patient-centred.
- Healthcare is a human right. WHO emphasises that everybody is entitled to live a healthy life.
- The responsibility of healthcare delivery systems should include the preventing of illnesses and alleviating of disability.
- Co-operation with each other and with patients is imperative for those working within the healthcare system. No man is an island.
- All individuals and groups have the continuous responsibility to improve quality of care.

2. Teamwork Principles

In addition to the basic ethical principles there are a few more concepts pertaining to the multidisciplinary team context. These are;

Common Goals: A well-functioning team is one where individual goals are congruent with team goals. In other words there must be a shared common vision. The setting up of teams will help to increase professional empathy and awareness of other professional skills, raising confidence and taking patient care in a holistic perspective. The integrated approach to healthcare is only possible if decisions are made by consensus.

Respect: Each member of the team is equally important and his/her point of view must be taken into consideration. Every professional must know what his /her responsibility is and also be aware of the responsibilities of other members. The team must have a leader, not a dictator but mainly as a co-ordinator or catalyst helping team members to reach consensus.

Communication: Team members need to establish good communication among them. There should be regular meetings to evaluate the objectives and processes. Communication within teams will than reflect at their working level. Harmful health care often happens as a result of lack of communication or a breakdown in communication channels between several providers. It may also result from inefficient communication between providers and patients. So the teams must create efficient channels of communication not only internally but in all directions.

Learning: Health carers at the clinics should be given the opportunity to learn together especially at a postgraduate stage[8]. Postgraduate, because by this time the carers know the responsibility pertaining their specialised field and can extend their knowledge and skills in other disciplines. Through interdisciplinary learning, members of a team can proactively plan and co-ordinate care across disciplines. This performance model will lead to an increased level of trust among professions and a deeper level of understanding of what each profession can contribute. This will also bridge or minimise differences in the philosophies of practice among the different carers.

Guidelines for Team Working

So how can we go about developing a healthy team practice? What guidelines are available that may help to build a healthy team spirit? Sir Charles George[3], a leader in the philosophy of teamworking expanded on the Tavistock group values and provided us with some concrete guidelines.

Multidisciplinary teams must;

1. Have a purpose and values, that is a common vision
2. Be open and honest about professional performance.
3. Persuade other team members to change their mind when decisions taken could harm a patient, and take actions themselves to protect the patient's safety
4. Use recommended clinical guidelines and standards set by professional bodies.
5. Take a consistent and systematic approach. They must have an organised way of doing things but not a rigid set of rules or red tape that may itself compromise the efficiency by which the teams can function
6. Effectiveness and efficiency must be reflected in the care delivered.

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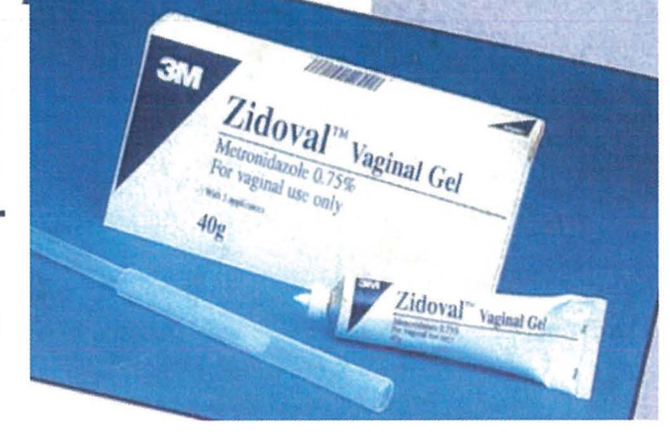

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9. Overall acceptability of evidence-based performance as this will achieve trust and confidence of patient, employer and professional colleagues.
10. Willingness to learn
11. Adopt an active and supportive approach to professional development of team members.
12. Suitable procedure for looking into complaints and avoiding unnecessary risks. This will perhaps direct health care delivery towards a more customer oriented approach.

A Word of Caution

Teams must be aware of what may go wrong and try to avoid such situations[6].

1. **Team Metaphor.** The word team may instil competitive feelings and behaviour. Medical and clinical teams are not in competition with one another. Performance measures and interpretations based on statistical values only, are detrimental. They may lead to a situation where team members indulge in cover-up behaviour for faults that endanger the patients' health.
2. **Locus of Authority for Decision-making.** In a team sometimes it maybe difficult to define responsibility of action. Therefore each member must be considered as the professional expert in his discipline and should be the one responsible for decisions concerning that particular speciality.

Ideal Team: The Patient a Team Member

Patient participation is perhaps the ultimate expression of teamwork. Teamwork can potentially transform the present quality of care in the clinics to a more patient-centred approach. Multidisciplinary teams can provide a framework which enhance patient empowerment and establish patient involvement in the delivery of healthcare. Multidisciplinary teams will deliver integrated, co-ordinated and patient-centred care. After all, is this not the shared vision we all have for primary healthcare in our country?

References

1 Reich R. B.(1987) 'Entrepreneurship Reconsideration The Team As Hero'. Howard Business Review ; 65 pp 77-83.

2 Firth-Cozens J. (1998). 'Celebrating Teamworking, In Quality Healthcare'.BMJ: 7 [suppl.]: S3-S7.

3 George C. (2000). 'Team Working In Medicine'. London General Council; UK

4 Davis, K. (1972). "Human Behaviour at Work", in Managing Scientific and Professional Employees, fourth edition, chapter 18, p.343-358, U.K; McGraw-Hill Publishing.

5 Nolan M (1995). 'Towards An Ethos of Inter-Disciplinary Practice'. BMJ:305-307: Jul.29

6 Agius E (2001). ' Celebrating Teamwork In Healthcare' -Inter Professional Ethics in Healthcare Conference, Malta.

7 Berwick D, Hiatt H, Janeway P, Smith R (1997). 'An Ethical Code for Everybody in Healthcare', BMJ 1997, 315:1633-1634.

8 Buttigieg S. (2001). 'Teamworking And Training Of Healthcare Professions'. Inter-Professional Ethics In Healthcare Conference, Malta.

9 'Working Together'. Government White Paper - H.M.S.O. London 1999

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Answers to Self-Assessment quiz on page 65

Q1 E	Q6 A B C D
Q2 E	Q7 B C D
Q3 C	Q8 E
Q4 E	Q9 B C
Q5 D	Q10 D

Thyroid Disease: Diagnosis and Management of Hyperthyroidism

Dr Noel Caruana

This short review article aims to provide updated information on the diagnosis and management of hyperthyroidism. A second article will focus on the management of hypothyroidism.

The most appropriate management of hyperthyroidism depends to a large extent on the proper diagnosis based on recognition of symptoms and signs of the disease followed by determination of the underlying pathology. Graves disease is the most common underlying pathology followed by thyroiditis, multinodular goitre, toxic adenomas and iatrogenic causes. Graves disease, toxic adenoma and toxic multinodular goitre may be treated by surgery, antithyroid drugs or radioactive iodine. Treatment for hyperthyroidism caused by thyroiditis is usually symptomatic as the condition is usually transient. Treatment is not always straightforward however, as in such cases of associated ophthalmopathy in Graves disease and in patients who are pregnant or breastfeeding. It is very important to plan appropriate treatment with the patient.

Thyrotoxicosis or clinical hyperthyroidism is due to the effects of surplus thyroid hormone and can be caused by different disorders. Prevalence of hyperthyroid disease based on community studies has been estimated at 2% in females and 0.2% in males. Thus a family practice of 2500 patients is expected to have a prevalence of ten thyroid cases with one new case annually. The clinical diagnosis of an over active thyroid can be difficult as the initial clinical deviations from normal can be minimal.

Symptoms are caused by the thyroid hormone's stimulation of the enzymatic catabolic activity and increased sensitivity to cathecholamines. Symptoms are usually more florid in younger patients, elderly patients may present with only cardiovascular signs such as atrial fibrillation and tachycardia, or with unexplained weight loss. Common symptoms and signs are listed in Table 1 with an emphasis on the differences in presentation between old and young patients.

Signs and Symptoms	Older Patients >70 years %	Younger patients <50 years %
Tachycardia	71	96
Fatigue	56	84
Weight loss	50	51
Goitre	50	94
Tremor	44	84
Apathy	41	25
Atrial fibrillation	35	2
Anorexia	32	4
Nervousness	31	84
Hyperactive reflexes	28	96
Depression	24	22
Increased sweating	24	95
Polydipsia	21	67
Heat intolerance	15	92
Increased appetite	0	57

Table1: Incidence of Signs and Symptoms of hyperthyroidism

Tests for thyroid disorders

Thyroid function tests

With the highly sensitive TSH assays it is now possible to distinguish suppressed TSH levels in hyperthyroid states from low but normal-low TSH levels in the euthyroid state. It should however be noted that tests on their own are not foolproof and should be interpreted with the clinical situation in mind. Serum tri-iodothyronine (T3) and free thyroxine (T4) measurements can be useful in suspected T4 toxicosis where serum T4 levels may be normal. T3 and T4 levels are also useful for monitoring patients on treatment for thyroid dysfunction.

Thyroid autoantibodies

Raised **antimicrosomal** and **antithyroid peroxidase** antibodies are indicative of **Hashimoto's** autoimmune thyroiditis. **Antithyroglobulin** and **antimicrosomal** antibodies are characteristically elevated in **Graves' disease**. Thyroid stimulating antibody (Thyroid-stimulating hormone receptor antibodies) levels are also used to monitor the effects of treatment of Graves' disease with antithyroid drugs.

Thyroid ultrasound

A thyroid ultrasound is usually more sensitive at detecting thyroid nodules. With ultrasound it is easier to diagnose a multinodular goitre which was clinically thought to be a solitary nodule (other nodules not being palpable clinically). This finding has clinical and prognostic significance as a multinodular goitre is said to be less likely to be malignant than a single nodule. It can also differentiate a solid mass from a cystic one. Also, high resolution Ultrasound is better than CT in assessing glandular texture.

CT scan

This examination is particularly useful to determine if there is any compression of the trachea and if there is any retro sternal and retrotracheal extension as sometimes happens in Hashimoto thyroiditis. It will also show the presence of a calcified adenoma or cyst.

Fine needle Biopsy

This is the most cost-effective test in the diagnosis of thyroid nodules, when the nature of the goitre is still in doubt. It is also the best way to assess a nodule for malignancy. Multiple biopsies may be taken under local anaesthetic, but it is to be remembered that with small biopsy specimens, false negative result is a possibility.

Aetiology *(see Table 2)*

Graves Disease

This is the most common cause of hyperthyroidism, and accounts for up to 75% of all cases.

It is classified as an autoimmune disease caused by an anti TSH receptor antibody which stimulates the gland to synthesize and secrete more thyroxine. There is an increased prevalence of HLA-DR3 which thus appears to occur in a genetically predisposed population, and may be associated with other autoimmune diseases. An infiltrative ophthalmopathy accompanies Graves' disease in 50% of cases.[4]

Toxic Multinodular Goitre

This usually has a more insidious onset, and typically occurs in patients over the age of 50 years who have a longstanding history of goitre. The nodules are usually tender.

Toxic Adenoma

These are usually found in younger individuals especially in iodine deficient areas. There is a single autonomously functioning nodule which is not tender to palpation.

Thyroiditis

Typically is abrupt in onset and usually follows a viral infection. The symptoms may be quite severe and are due to

Cause	Pathophysiology	Gland size	Nodularity
Graves disease thyroid stimulating ab	Increased stimulation of gland	Increased	None
Toxic multinodular goitre	Autonomous hormone production	Increased	Multiple nodules *
Subacute thyroiditis	Leakage of hormone from gland	Increased	None*
Toxic adenoma	Autonomous hormone production	Decreased	Single nodule
Lymphocytic thyroiditis	Leakage of hormone from gland	Increased	None
Iodine-induced (iodide, amiodarone contrast media)	Substance causing stimulation of gland	Increased	Multiple or None
Functioning pituitary adenoma (TSH; trophoblastic tumour hCG	Increased glandular stimulation	Increased	None
Factitial hyperthyroidism	Exogenous hormone intake	Decreased	None
Metastatic thyroid cancer	Extraglandular hormone production	Decreased	None

**Tender gland*

Table 2: Aetiology

hormone leaking from an inflamed gland. Symptoms usually resolve within a few months.

Postpartum thyroiditis can occur in up to 10% of women in the first six months after delivery. The hyperthyroid state may lead to a transient hypothyroid state before resolution.[5]

Tumours

It is indeed quite rare to have a tumour as a cause of hyperthyroidism. Such tumours include: metastatic thyroid cancer, ovarian tumours that produce thyroid hormones and trophoblastic tumours that produce human chorionic gonadotrophin which activate TSH receptors. Pituitary tumours also produce TSH.

Investigation

The initial most significant test to be done in a patient with signs and symptoms of hyperthyroidism is TSH estimation. A very low TSH level is diagnostic of hyperthyroidism. An algorithm for investigating suspected hyperthyroidism is illustrated in figure 1. An elevated TSH warrants the estimation of freeT_4 levels, which if high, indicate secondary hyperthyroidism and necessitate pituitary gland imaging.

Antibody studies

Raised **antimicrosomal** and **antithyroid peroxidase** antibodies are indicative of **Hashimoto's** autoimmune thyroiditis. **Antithyroglobulin** and **antimicrosomal** antibodies are characteristically elevated in **Graves disease**. Thyroid stimulating antibody levels are also used to monitor the effects of treatment of Graves disease with antithyroid drugs.

Management of hyperthyroidism

Main principles of management:

1. Establish precisely the cause for the hyperthyroidism before starting treatment (Figure 1)
2. Educate your patient and emphasise the need for lifelong monitoring due to possibility of relapse
3. Monitor for cardiovascular complications and osteoporosis

The aim of treatment is to correct the hypermetabolic - state with the least possible side effects including hypothyroidism. The main treatment options are; antithyroid drugs, radioiodine and surgery. The choice depends on the patient's age, size of goitre, co morbidity and patient's desires.

Anti-thyroid drugs

This class of drugs works by interfering with the organification of iodine thus suppressing thyroxine levels. Carbimazole is used locally with a dose of 10-45 mg daily (Methimazole and propylthiouracil are two agents used in the United States) Relapse can occur in up to 50% of patients hence the importance of regular follow-up. A recent RCT[6] showed that patients with a large goitre, who smoked and had high thyroid-stimulating antibody levels at end of treatment had higher relapse rates.

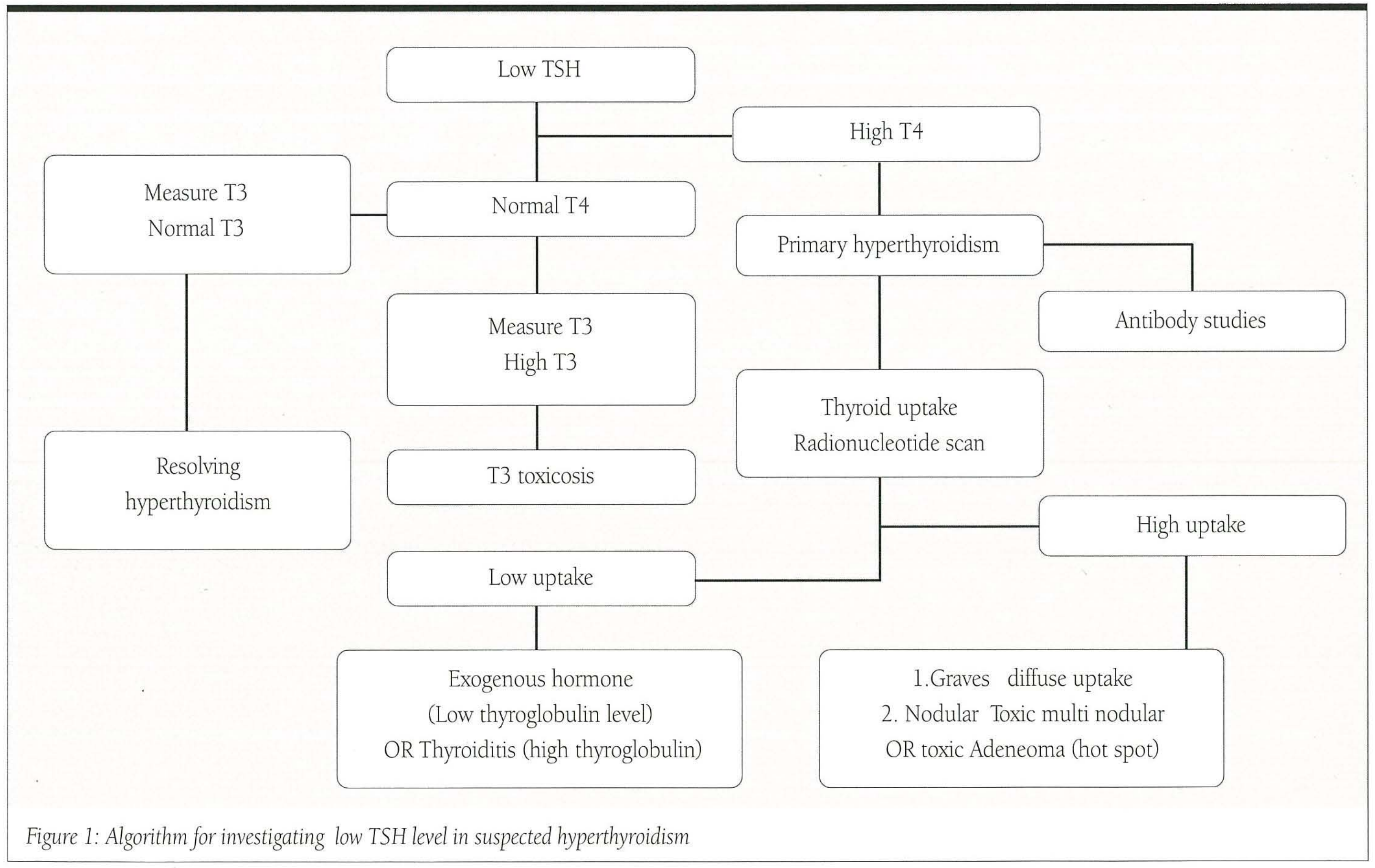

Figure 1: Algorithm for investigating low TSH level in suspected hyperthyroidism

Carbimazole is usually the drug of choice(Propylthiouracil 100-200mg daily is used in pregnancy), with a starting dose of 10mg daily and can be given in combination with Propranolol 10-40 mg 6-8 hourly.[7] The beta blocker is tapered down over a period of one to two months, and the carbimazole is titrated according to clinical response and monthly free T_4 towards a normal T_3 and T_4 level. It is important to note that the TSH levels may remain very low despite the patient having returned to the normal state with treatment, and should not be used to gauge treatment. After one year of treatment, if the anti-TSH-receptor antibodies are not detectable one can stop the anti-thyroid treatment [4]. The patient should be monitored every three months during the first year as relapse on stopping treatment is common. Once a relapse occurs it is usually recommended that radioactive iodine (^{131}I) therapy or subtotal/ total thyroidectomy be considered. The risk of agranulocytosis is the most serious complication of antithyroid treatment and patients should be warned to stop treatment if they develop sudden fever or sore throat. Arthralgia and polyarticular arthritis may also occur, although to a minor extent.

Surgery

A subtotal thyroidectomy is the most common performed procedure; it preserves some thyroid tissue and hence reduces the risk of hypothyroidism. Total thyroidectomy is reserved for very large goitres and those with very severe symptoms, in whom recurrences are likely. This procedure however carries a high risk of hyper parathyroidism and laryngeal nerve damage[8].

Radioactive therapy

Radioactive iodine is gradually replacing surgery, and in the United States it is the preferred mode of treatment for Graves' disease and toxic nodular goitre. There is still much debate about the treatment regime of radioiodine. Gland-specific dosage , based on the estimated weight of the thyroid gland, allows a lower dosage to be given and is associated with lower incidence of hypothyroidism, but may have a higher recurrence rate. There is still reluctance to use radiotherapy in women of child bearing age because of the possibility of cancer of thyroid, genetic damage to offspring and leukaemia, however long term study of these patients has failed to support these fears[9]. Patients with toxic adenomas and toxic nodular goitre are more radio resistant and need higher dose regimen to achieve remission. It is important to note that up to 15 % of patients treated with radioiodine, may develop Graves' ophthalmopathy. Opthalmopathy may be controlled or its incidence reduced with the use of 40 to 80mg of Prednisolone daily[10].

Precautions on radioactivity hazards. Most radioactive sodium iodide is excreted via saliva, urine and feaces within 48 hours of receiving the dose. Close contact with persons should be avoided for up to three days, especially children and pregnant women. It is also recommended to double flush toilet and repeat hand washing for 12 weeks [9].

Outcome and follow-up

Patients receiving appropriate management have a good prognosis. Some extra-thyroid manifestations of the disease, notably ophthalmopathy, and cardiac complications are resistant to all forms treatment. In view of increased morbidity, patients who have been treated for hyperthyroidism should be screened annually, with special emphasis to atherosclerosis, osteoporosis, diabetes and insidious hypothyroidism[11].

References

1. Turnbridge W M, Evered DC, Clark F et al. The spectrum of thyroid disease in a community: the Whickham survey. Clin Endocrinol (Oxf) 1977; 7: 481-93.
2. Trivalle C, Doucet J Chassagne P et al. Differences in the signs and symptoms of hyperthyroidism in older and younger patients. J Am Geriatr Soc 1996; 44:51.
3. Weetman AP. Graves Disease. New England J Med 2000; 343:1236-48.
4. Woeber KA. Update on the management of hyperthyroidism and hypothyroidism. Arch Intern Med 2000;160:1067-71.
5. Slatosky J, Shipton B, Wahba H. Thyroiditis: differential diagnosis and management. Am Fam Physician 2000; 61:1047-52.
6. Nedrebo BG, Holm PA, Uhlving S et al. Predictors of outcome and comparison of different drug regimes for the prevention of relapse in patients with Graves' disease. Eur J Endocrinol 2002; 147:583-9.
7. Cooper DS. Antithyroid drugs. N Engl J Med 2005; 352:905-17.
8. Alsanea O, Clark OH. Treatment of Graves' disease: the advantages of surgery. Endocrinol Metab Clin North Am 2000; 29:321-37.
9. Meier DA, Brill DR, Becker DV et al. Society of Nuclear Medicine Procedure guideline for therapy of thyroid disease with sodium iodide. http://interactive.snm.org/docs/pg_ch26_0403.pdf.
10. Bartalena L, Malocci C, Bogazzi F et al. Relation between therapy for hyperthyroidism and the course of Graves' ophthalmopathy. N Engl J Med 1998; 338:73-8.
11. Tene C, Zarate A Basurto L et al. Correction of insulin resistance in methimazole-treated patients with Graves' disease. Rev Invest Clin 2001;53:531-5.

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Maltese Family Doctors Graduate with ICGP Diploma in Women's Health

Dr Mario R Sammut

Introduction

Seventeen Maltese Family Doctors who completed their studies by distance learning for the Irish College of General Practitioners (ICGP) Diploma in Women's Health during 2004-5 were presented with their diplomas on Saturday 5th November 2005 at the Royal Hospital Kilmainham in Dublin, Ireland (Figure 1).

The Ceremony

After registering in the Johnston Room, the Graduands and their guests took their seats in the magnificent Great Hall where at 3 p.m. the College Officers and Guests entered and took their places on the podium (Figure 2).

Following an address by the ICGP President Dr Michael Flynn, the MICGP Graduands for 2005 were presented with their certificates by the ICGP President. Afterwards, Distance Learning Graduands for the Diplomas in Prevention, Therapeutics and Women's Health, for the Certificates in Palliative Care and Diabetes Care and for the Postgraduate Certificate in Medical Education were invited to come forward to receive their Diplomas/ Certificates from Dr Flynn. The ceremony was brought to a close by the Chairman's Address from Dr Eamonn Shanahan, following which College Officers, Graduands and their guests were invited to a reception in the Baroque Chapel next door to the Great Hall.

Figure 2: Dr Eamonn Shanahan, ICGP Chairman, giving his address in the presence of College Officers and Guests on the podium of the Great Hall of the Royal Hospital Kilmainham in Dublin, Ireland.

Figure 1: From left, Drs Adrian & Jacqueline Padovani and Dr Carmen Sammut in the gardens of the Royal Hospital Kilmainham in Dublin, Ireland.

The Maltese Graduands

Among the Graduands for the Diploma in Women's Health, were seventeen Maltese Family Doctors, six of whom were present to receive their diplomas in person, watched by family members who had accompanied them to Dublin. These were Dr Marthese Bartolo, Dr Doreen Cassar, Dr Patricia De Gabriele, Dr Corinne Markham, Dr Jacqueline Padovani and Dr Carmen Sammut (Figures 3 & 4). Their eleven colleagues who graduated in absentia were Dr Sonia Abela, Dr Marcon Ali, Dr Michael A Borg, Dr Mariella Caruana, Dr Marie Ciantar, Dr Christianne Ellul, Dr Ethel Farrugia, Dr Anthony Formosa, Dr Sandra Gauci, Dr Mario Grixti and Dr Anna Maria Vella.

This was the third consecutive ICGP distance learning course which a group of Maltese family doctors completed through the Malta College of Family Doctors (MCFD). Following participation in the Diploma in Therapeutics during 2002-3 under

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Indications: Secretion disorders in acute and chronic bronchopulmonary affections
Dosage: Adults – 5 – 10mls syrup 3 times daily; 1-2 capules daily
Children – 5mls syrup 3 times daily
Side-Effects: Headache, nausea, gastrointestinal effects seldom reported.
Contra-Indications: Known hypersensitivity to the drug;
Serious hepatic and / or renal alterations
Precautions : Muciclar should be administered with
caution to patients affected by gastric ulcer.
M.A. Holder: Vecchi & C. Piam Via Padre G. Semeria,
5 – 16131 Genova Italy
MUCICLAR
15 mg/5 ml sciroppo
Ambroxol
Flacone da 200 ml
MUCICLAR 15mg/5ml sciroppo
Ambroxol
Flacone da 200 ml
Composizione
100 ml di sciroppo contengono:
Principio attivo: ambroxol cloridrato 0,3 g
Eccipienti: sorbitolo soluzione, glicerina, metile p-idrossibenzoato, propile p-idrossibenzoato, idrossietilcellulosa, alcool, saccarina, lampone essenza, acqua depurata.
Tenere il medicinale fuori dalla portata dei bambini.
Attenzione: per l'uso leggere attentamente l'istruzione acclusa.
Titolare A.I.C.: VECCHI & C. "PIAM"
Via Padre G. Semeria, 5 - 16131 GENOVA
A.I.C. 025009022
04/2008
scade
MUCICLAR RETARD
AMBROXOL
20 capsule
PIAM
For More Information Please Contact:
Pro-Health Limited Tel. 21461851; 21460194
Email: info@pro-health.com.mt

the coordination of Dr Anthony P Azzopardi, the latter was succeeded by Dr Mario Grixti who organised local GPs' participation in the Diploma in Prevention in 2003-4 and in the Diploma in Women's Health during 2004-5.

Graduation Dinner

After the Presentation Ceremony, the Maltese Graduates and their partners were invited to a Graduation Dinner held at Jacob's Ladder Restaurant in Nassau Street, Dublin, just a short walk away from the ICGP's premises in Lincoln Place. Towards the end of the delicious meal, Dr Mario R Sammut, MCFD Secretary for Education, presented MCFD silver pins as mementos to Mr Nicholas P Fenlon, Director of the ICGP Distance Learning Unit, Dr Ailís ní Riain, National Director of the Women's Health Programme (in absentia), and Dr Anne Mulrooney, Course Coordinator for the Diploma in Women's Health (in absentia).

Dr Mario R SAMMUT MD MScH DipHSc

Family Doctor
Secretary for Education, Malta College of Family Doctors
Assistant Lecturer in Family Medicine, University of Malta

Email: mrsammut@rocketmail.com

Figure 3: The Maltese Graduands in the audience: from second-right to left, Dr Marthese Bartolo, Dr Doreen Cassar, Dr Patricia De Gabriele, Dr Carmen Sammut, Dr Jacqueline Padovani and Dr Corinne Markham.

Figure 4: The Maltese Graduands in an official commemorative photograph with ICGP officials: from left to right, Dr Patricia De Gabriele, Dr Doreen Cassar, Dr Carmen Sammut, Dr Michael Flynn (ICGP President), Dr Jacqueline Padovani, Mr Nicholas P Fenlon (Director, Distance Learning Unit), Dr Marthese Bartolo and Dr Corinne Markham.

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