As I promised in the launching issue, "It-Tabib tal-Familja" is determined to further seek and improve the academic understanding and position of family doctors in Malta. As is evident from this second issue, the format has already changed and resembles more closely that of a journal. This quarterly issue should serve as a stimulus and opportunity for all family doctors to actively participate through write-ups or research projects. Suggestions and comments are greatly welcomed. The success of this journal greatly depends on the contribution of doctor members. Membership has encouragingly been boosted to 106 doctors.

In the last three months, the College Council has established a system of accreditation and launched a programme for Continuing Professional Development (CPD) for the year 1991. This issue gives a clear insight into the workings of the College Council. The Journal of the Malta College of Family Doctors has a valuable role to play in Maltese family practice. Hopefully, the coming New Year will start a new era where family practice in Malta will take a rightful place among the medical specialities. A special word of thanks goes to the sponsors of this issue of the Newsletter: Pharmasud Ltd., Charles de Giorgio Ltd., and Alfred Gera & Sons Ltd. A Merry Christmas and a Happy New Year to all doctor colleagues and their families.

Godfrey Farrugia

SPECIAL THANKS TO THE SPONSORS OF THE SECOND ISSUE:
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CONTINUING PROFESSIONAL DEVELOPMENT — 1991 PROGRAMME

Accreditation is to take the form of credit units and the system of credit allocation will take into consideration both active and passive involvement in Continuing Professional Development (CPD) activities, the former attracting more credit units than the latter. Each member of the College must accumulate 27 units annually to retain the right to membership. A CPD logbook will be distributed to all members to allow recording of credit units as they are accumulated.

SOURCES OF CREDIT UNITS

Informal (Active) Learning:
1. Presentation of lecture at College or PGMC CPD activity ........................................ 5
2. Publication of paper in College or other medical journal ............................................. 5
3. Active participation in research, such research to be approved by Council for accreditation purposes .................................................. max 10
4. Acceptance of a medical student for a training attachment as organised by the Faculty of Medicine ........................................... 1 unit per week.
5. Any other activity which a member feels may attract credit units after submission to Council for approval for such purpose. .......................... Discretion of Council

Formal (Passive) Learning:
1. Attendance at CPD lectures organised by the College or PGMC. The units attracted by each lecture will be published by the College beforehand. ................................................................. 3,2,1
2. Attendance at any CPD activity other than those specified in 1 above; such activity to be approved by Council for accreditation purposes. max 2
3. Attendance at any local/overseas conference/course after approval by Council for accreditation purposes. .......................................................... Discretion of Council

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A number of working subcommittees are to be set up. Interested members are to contact Dr. Ray Busuttil.

Editorial Board: Chairperson and editor: Dr. Godfrey Farrugia
Members: Dr. Gauden Galea, Dr. Wilfred Galea

Correspondence and contributions to this newsletter are to be sent to "It-Tabib tal-Familja", Malta College of Family Doctors, P.O. Box 70, Paola, Malta.

Design and Typesetting: a-t-w-o-r-k-s
# Evaluation of the Autumn CPD Meeting

There was a very encouraging response to the College's first full CPD (Continuing Professional Development) meeting, both as regards the number of family doctors attending as well as the feedback received. On Day 1, which dealt with Record-Keeping, 37 of the 45 individuals who attended completed an evaluation form; of these, all but one agreed that the seminar was relevant, all but three felt their knowledge or awareness increased, and 93% of the doctors who responded stated that their patient care will be modified as a result of the seminar.

On Day 2, when the subject was Practice Premises, 35 of the 40 who attended responded. Everyone agreed that the subject was relevant, and all but one felt their knowledge/awareness increased. However only 57% said their patient care will be modified; this is more than understandable under present circumstances. On Day 3, which dealt with the reasons Why Patients Consult, 32 attended and 24 returned the evaluation form. All but one thought the seminar was relevant, all but three felt their knowledge/awareness had increased, and 79% envisage a modification in their patient care as a result. There were many helpful suggestions, some of which are already being implemented (e.g. written notes). The topics proposed for the next Meeting have been studied by the Council and some have indeed been selected. The evaluation form has proved to be a useful tool for communication between College Members and the Council.

Hugo Agius Muscat

<table>
<thead>
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<th>Title</th>
<th>Page</th>
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150mg roxithromycin tablet twice daily
A NEW MACROLIDE FROM ROUSSEL RESEARCH

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Family medicine is a very different speciality to secondary care or specialist care medicine. A whole new set of knowledge and skills need to be acquired by the doctor moving from hospital specialist medicine to family medicine in the community. Part of the reason for this is the completely different presentation of illness in a family medicine setting.

Traditionally, medicine has dealt with patients and diseases. The common pattern of medicine is that a patient is a person who has a disease. The disease has a cause. If the cause is dealt with, the disease disappears and the patient becomes a person again. Over the past fifteen years it has become clear that this picture is inadequate to explain many medical consultations. The classic work on this subject was done by Zola in Massachusetts, USA. He showed that what brought people to a doctor was not necessarily a disease at all. Zola’s work has been repeated and confirmed by McWhinney in Canada, Howie in Edinburgh, and other workers in Holland, Sweden, Italy and Finland. Why then do patients present to doctors? What do we mean by illness and what is a disease?

**HOW PATIENTS PRESENT**

Most patients present to their family doctor with either a symptom or a problem. In population surveys, it has been found that at any one time, more than 80% of the population have symptoms. Stewart McWhinney and Buck have shown that the severity of the symptom is not a reliable indication of whether it will be presented to the doctor. Several quite separate factors determine whether patients present to doctors — and these factors seem reliable predictors of consultation with the doctor across widely varying cultural divides. What then are these factors?

1. **Limit of Tolerance.** Above a certain threshold, symptoms are reliably presented to doctors, thus few people with acute pancreatitis or an acute ischaemic limb do not present.

2. **Limit of Anxiety.** A relatively mild symptom that is interpreted as indicative of a serious disease may be taken to the doctor. For example, a chest pain is presented to a doctor at a lower level of intensity than a limb pain. A person worried about a melanoma may rapidly present a tiny, innocuous freckle.

3. **Unrelated Personal Crisis.** If a person is upset or anxious, he or she will present a symptom to the doctor earlier than when they are happy or contented. Recent work in the UK has shown that when people are made redundant, they consult their family doctors much more frequently for symptoms that they would previously have coped with by themselves.

4. **Interference with Lifestyle.** Symptoms that interfere with a person’s job or social life will be presented early. For example, a strained leg muscle would be presented earlier by a ballerina or a labourer than by a typist.

5. **Social Sanctioning.** Most people discuss their problem with family and friends. Sometimes these friends will send people along to their doctor who would otherwise not have attended because the friends are concerned about the cause of a symptom.

6. **Failure of Self-Medication.** All over the world it has been found that family doctors are not the first recourse for people who feel unwell. Many people take household remedies first and only present to doctors when their own medication has not produced relief.

7. **Contact with Illness.** The relatives of sick people consult doctors significantly more than average and about milder symptoms. This may be because of a disturbance of their narcissism or because they perceive the cause of their relative’s illness influencing them too.

**PRESENTATION OF THE PROBLEM**

When the patient comes to the doctor the problem is usually presented in terms he has previously learned are acceptable to the doctor. The problem may be presented as a diagnosis: “Doctor, I’ve got tonsillitis.” It may be presented as a request for treatment or a certificate, or the patient may have learned to present his troubles merely as a symptom or problem, leaving the doctor the satisfaction of giving it a name.

Occasionally the problem is presented non-verbally by the patient breaking down crying, or in a hidden way as an afterthought to another minor symptom. The way that the patient presents varies according to what he wants done, how the doctor has taught him is acceptable to present problems, and how the patient understands the concept of disease.

**DIAGNOSIS AND MANAGEMENT PLAN**

Traditionally, when a hospital doctor sees a patient he perceives himself as taking a full history and
doing a thorough examination. He will do relevant tests. A diagnosis will be made, the patient will be treated and then discharged.

Doctors moving into family medicine are surprised to find a different system of reaching a diagnosis.

In family medicine, a hypothesis about the nature of the problem is made early in the consultation with relatively little information collected. Much of the consultation is then concerned with testing this hypothesis and discarding, revising or confirming it by a search for information. An important part of the information used in this process of diagnosis is gleaned from the family doctor’s knowledge of the patient’s family and from his notes. Much of the decision-making, both in formulating a hypothesis and in testing it involves a binary mode of thought: is the patient’s problem urgent or not urgent? The patient has an acute abdomen or does not have an acute abdomen; he needs attention tonight or he does not need attention tonight. This is different from collecting facts and then making decisions by logical inductive thought, which the hospital doctor perceives himself practising. One interesting sideline is that evidence being collected at Dundee University about hospital consultations seems to indicate that hospital consultants actually do not make decisions as they perceive themselves doing. It seems that on the whole, they use the same binary mode of thought as family doctor but they didn’t realise that they were doing so.

**Patterns of GP Medicine**

Much of family medicine then involves a cue hypothesis search confirm or revise system of diagnosis. This is one aspect of the widely different perception of working methods of family doctors and hospital doctors. The family doctor accepts a responsibility for making an initial decision on every problem his patients present to him.

The hospital doctor’s role is usually limited by his speciality or by the area of the hospital he works in, e.g. the accident department.

Family doctors usually have to make a decision in a consultation lasting between 5 and 15 minutes. Illness presents at an earlier stage in family medicine and physical signs are often absent. The history is of greater importance than signs and decisions have to be made at a lower level of probability. Even the history may not comply with what the textbooks say. Most medical textbooks are written by hospital doctors. However, by the time patients reach hospital, they have thought about their problem, talked to their family doctor and he has helped the patients to organise their thoughts into a form understandable to the hospital doctor. This is not the stage the problems present to us and great skill is needed in dealing with these early stages of presentation.

The decisions taken after diagnosing a problem also differ in family medicine. A family doctor may decide that he will wait and see what happens without treating a person with, say, rheumatoid arthritis — many of them remit. If the patient reaches hospital, this usually means that they have not got better either with the passage of time or with the treatment given by the general practitioner, so a more active role is usually taken by the rheumatologist.

The general practitioner also has to deal with multiple problems, and individual problems that affect patients physically, socially and psychologically. The action taken for any one problem may be influenced by its likely effect on other problems, or by the effect on a different part of a patient’s life. In some consultations, the general practitioner never defines what the problem is: the patient may use the doctor as a resource person, or as a sounding-board with which to solve his own problem without revealing its nature.

**Models of Disease**

If the doctor is to define a problem sufficiently to help with its resolution, he must make that problem fit into a category that renders it understandable to him. This means that he must fit it into a model of disease that has (a) an understandable reason, (b) an understandable present state, and (c) an understandable course.

In order to make the problem fit into a model, the doctor must know:

- the nature of the disease
- the nature of the patient
- the nature of the environment within which the patient experiences his disease. For example, a viral sore throat presents differently in a man bored and about to retire from his job, than in a young man about to go on holiday.

The doctor may have no difficulty in fitting a problem into a disease category. However, most patients will also have categorised the problem before they consult the doctor. If the models differ, there may be difficulties.

If a man presents with epigastric pain that awakes him at 3 a.m., is relieved by antacids and a previous barium meal showed a scarred duodenum, the doctor has no difficulty in fitting this discomfort into the category of a recurrent duodenal ulcer. He may prescribe cimetidine [Tagamet]. However, if this same patient’s father-in-law, after a period of epigastric pain, was found to have cancer of the stomach and is now terminally ill, the patient’s model of disease may be different from the doctor’s. It is by no means certain that the patient will tell the doctor his worry.

However, if the doctor does not find out what the patient feels is wrong with him, and just prescribes cimetidine, it is unlikely that the patient will comply with the treatment. The treatment will be unsuccessful, and the patient will
attend frequently for his epigastric pain. The patient will become anxious; he will be less able to cope with other symptoms and will present these more frequently to the doctor as well. Eventually, both the patient and the doctor may get frustrated and irritated.

**Patients’ Agendas**

When patients attend doctors, they do not come with a problem and a blank mind. They usually come with an agenda, i.e. something that they want done. Patients usually do not tell their doctors what they want done, and if they do, the doctor is often annoyed. Most doctors do not like to be faced with a demand for penicillin; they prefer to make the diagnosis of tonsillitis — which the patient already knew because he had looked down his throat before he came — before prescribing penicillin. Our patient with epigastric pain wanted tests to exclude cancer, not treatment for an ulcer. Patients may come to a consultation wanting any or all of the following:

- a certificate
- tests
- a diagnosis
- a medical reason for what they have already decided to do
- to be confirmed in the sick role
- to be reassured that somebody cares.

Usually, if the doctor does not fulfil the patient’s agenda, the patient will present again with problems that are more likely to fulfil his aim.

**Organising Disorganised Problems**

If the doctor is to treat the whole person presenting to him, and to fulfil the covert as well as the overt aims of the patient in each consultation, he must:

- find out why the patient has come
- find out why the patient feels this makes him unwell
- find out what the patient perceives as the cause
- find out what the patient’s expectations are of the doctor
- find out what the patient’s expectations are of treatment
- negotiate a problem description
- negotiate management ideas
- interpret these in physical and emotional terms, and in terms of the patient’s lifestyle
- if the patient is to be referred to another agency, the doctor and patient need to agree on an organisation of the problem that will be understandable to that agency.

In many consultations this process will be relatively easy and will progress smoothly. This will be more likely to happen if the doctor and patient know each other and each has an accepted role. Circumstances where difficulties are more likely to arise are as follows:

1. Where the Patient is Inarticulate. It may be difficult for the doctor to determine why the patient came and what he wants. In some cases the patient himself may find it difficult to define his problem. Such a consultation may progress through several appointments with the doctor before a satisfactory problem definition is reached. Irritation shown by the doctor may prevent such a definition ever being reached, and may lead to multiple unsatisfactory consultations.

2. Different Models of Disease. Patients whose models of disease differ from the doctor’s may present problems in consultation. Where the patient sees his illness as caused by God, Allah, or by somebody who has cast a spell, a prescription of a medicine is unlikely to lead to a resolution of the problem. The doctor has the difficult task of negotiating a problem definition with somebody whose cultural beliefs differ widely from his.

3. Signal Behaviour. Some patients present their problems in a hidden manner. This may either be because they are uncertain whether the doctor will accept the problem, or because the patient is too frightened to confront the problem. A typical demonstration of this behaviour is the patient who produces his main problem just as he is leaving the consulting room, or the lady with a lump in her breast whose presenting problem is a cough.

4. Games. Some people play games in the consultation. Often, these are extensions of games that these patients play in their everyday lives. A typical game is “Yes, but…”. The patient produces a problem and the doctor presents a solution. But for each solution, the patient has a reason why it will not work. This continues until the doctor is defeated and it is proved that the patient’s problem is no fault of his, and he bears no responsibility for it.

5. Hidden Agendas. Sometimes it is impossible to define the problem that the patient is presenting because he has an ulterior motive. The motive of the consultation may be to seek the continuation of the sick role to relieve the patient of intolerable responsibilities. Alternatively, the patient may just be seeking the continuation of a relationship with the doctor, the only person with whom he feels safe. Unless this motive is uncovered, the problem will never be resolved.

6. Misunderstanding the Triggers to Consultation. If the problem is accepted at face value, rather than questioning
why this problem was presented at this time, in this way, then the trigger leading to consultation may not be defined. The patient may be presenting a problem, as we said at the beginning, not because of its severity, but because his tolerance of anxiety and/or discomfort is reduced as a result of other circumstances in his life. If this trigger factor is not defined as the main problem and dealt with, numerous other problems normally tolerated as discomforts will be presented for medical help. (The average person has a new symptom every six days).

7. The use of "Target" Patients. In sick families, the problems of the family group may be rationalised by defining one member as sick. Howie described how, when women were weaned off tranquillisers, they presented their children to doctors more frequently for minor illness. The mothers' anxiety was expressed by defining the children as ill. Accepting the problem as presented, and dealing with each of the child's discomforts, would lead to a perpetuation of this behaviour pattern.

CONCLUSION

It might seem impossible to practise good medicine in family practice. Not only are we expected not to miss a wide range of major diseases among the patients passing through our doors every six minutes, but we must also practise prevention, we must counsel, we must prescribe frugally and generically, and we must audit what we are doing. It all sounds impossible when one considers that the problem presented by the patient himself may not always be accepted at face value. However, family practice has one resource that makes possible the practice of good medicine: the relationship between the doctor and the patient and his family is usually a continuing one. This means that the patient can be trained by the doctor to present his problems in a way that can be understood. The doctor can be trained by the patient to consider him in his unique life situation. The notes, if well-kept, give a continuing record of this relationship. A consultation can go over several meetings in the surgery, in the patient's home and even in the supermarket.

It is this investment in shared knowledge and trust that should allow the continuing care of patients as whole people in family practice, despite the disorganised mass of problems and discomforts presented to the doctor.
shifted to a younger mean age due to the development of three housing estate projects since 1973.

The 500 consultations in this study were done by 308 different patients. Of these 181 consulted once during the period of the study, 84 consulted twice, 29 consulted three times, 9 consulted four times, 2 consulted five times and 3 consulted six times.

Table 1 broadly categorises the consultations. Table 2 shows the frequency of the six most commonly occurring reasons for consulting.

**DISCUSSION**

Besides dealing with acute episodes of disease the family doctor also plays a very important role in the management of chronic disorders, notably hypertension, diabetes, depression and asthma. Our role as primary health care providers is seen in well-person and developmental checks, immunisation and monitoring of pregnancy.

It seems that painful conditions and pain are very important triggers for patients to consult their doctor. If one had to group ENT problems, most of them painful, with all other painful conditions, one would find that pain accounts for 25% of reasons for consultation.

In spite of the differences in population characteristics in the sample studied there are important areas of agreement regarding the content of family practice not only on Malta but also internationally.

The reasons for consultation in family medicine clearly demonstrate the different roles played by the family doctor in the management of patient problems, support and caring for patients and the family doctor’s role in prevention and health education as well as a gate keeper to access to various areas of secondary care. All this starts with the consultation and this is why the consultation and its dynamics must be very well understood.

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**TABLE 1**

<table>
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<th>Type of Consultation</th>
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<tr>
<td>New Problem</td>
<td>215</td>
<td>43</td>
</tr>
<tr>
<td>Chronic/Follow-up</td>
<td>195</td>
<td>39</td>
</tr>
<tr>
<td>Preventive</td>
<td>90</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
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<td><strong>100</strong></td>
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**TABLE 2**

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<tbody>
<tr>
<td>ENT Infections</td>
<td>54</td>
<td>10.8</td>
</tr>
<tr>
<td>Pain (Orthopaedic)</td>
<td>53</td>
<td>10.6</td>
</tr>
<tr>
<td>Well-Person Check</td>
<td>50</td>
<td>10.0</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>49</td>
<td>9.8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>34</td>
<td>6.8</td>
</tr>
<tr>
<td>Depression</td>
<td>30</td>
<td>6.0</td>
</tr>
<tr>
<td>All other reasons</td>
<td>230</td>
<td>46.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
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**THE PRACTICE RECORDS**

Fred Demanuele

In the present society we have come to appreciate the value of information and in fact a major part of the economies of industrialised societies are based and depend on processing of information. Most well-run businesses need to have a good information-base to stay alive in this competitive world. In the service organisations such as in clinical medicine information is the very soul of the practice. It is generally agreed that documentation of clinical patient records do not have more form or content than a personal memo to jog their memories and assist them in their billings.

**PURPOSE OF RECORD-KEEPING**

In Primary Ambulatory Care, the physician usually takes on a patient for the long haul and ‘contracts’ to look after the future health care needs of the patient. The
The patient record is the repository of all the information gathered over a period of time from various sources in one location. The doctor will then, having at his fingertips all the clinical information on the patient, be in a position to co-ordinate the management of any problems that arise. He will be able to provide a complete clinical picture, with the patient's consent, to other health care providers. In the case of absence, his/her replacement will be able to form an opinion, after consulting the record, of where the patient stands.

Continuity of care involves the bringing to bear of past experience with the patient on the current problem. The manifestation of symptoms and signs in a particular disease is oftentimes specific to the individual patient and tends to have similar pattern over different episodes. Many times we see patients, at about the same period of the year come with vague symptomatology which on consultation with the record show the onset and evolution of a recurring illness.

Information on sensitivity and response to treatments and medications, obtained from past experience, is valuable in the future care of the patient.

Baseline data on ECG, X-Rays, haematology, biochemistry, etc. produce a patient's own reference values for future comparisons.

Recording of risk factors, time of immunisations and revaccinations, screenings and special re-examinations will serve as reminder in monitoring the patient's health.

Patients are reassured and their confidence in their doctor increased when they know that their health record is in the safe keeping of their medical practitioner.

The totality of patients' records in one doctor's practice is a rich source of clinical information for epidemiological studies and research interests.

Completion of forms on patients for purpose of disability reporting, pensions, insurance, transfer of patients, admission to nursing homes, social service applications, etc. is an on-going activity of today's general practitioner and requires the backup of well-kept records.

As more third parties become involved in the health care system, physicians are finding that they are accountable to more than their patients and are required to keep satisfactory records.

Auditing of practice records by self or by peers is a 'healthy' educational activity in the assurance of maintaining standards.

**Content and Form of Records**

There are several systems of record keeping, almost as many as there are solo-practising physicians. One extreme consists of notes scribbled on 4” by 6” cards, placed in an envelope together with folded reports of consultants and investigations. The other extreme is the computerised complete medical record. And somehow we are finding ourselves drifting (willingly or cajoled) to the right side of this continuum.

Reluctance by doctors to be meticulous in this side of their practice has to do with the pressure of time on their hands, lack of education in their training, both in record-keeping and applications, preposterous illegibility of their handwriting and disorganised office management. There is a belief that good record-keeping is not essential for practising good medicine; but good general practitioners are very orderly in their thinking processes as usually reflected in the records they keep. Good practice records do not have to be voluminous and detailed to the extreme — in fact, too much information is most distracting especially if presented in a disorganised state. The information is quite satisfactory if presented in item form, in a 'headline' type of style and in an acceptable abbreviation e.g.

36 yr. old female c/o — headaches, 2/12 duration — SOB, etc.

Many years ago, a group of health researchers met together in a conference with the view of defining an ideal health record. After many days of frustration they had to satisfy themselves with coming up with a consensus on what they called a "Minimum Basic Data Set" of components in order to achieve some degree of uniformity and comparability of ambulatory data. The content of the Minimum Basic Data Set is made up of 15 elements of data, divided into two categories: registration data and encounter data.

**Registration Data:**
- Person Identification
- Residence
- Date of Birth
- Sex
- Marital Status
- Race

**Encounter Data:**
- Place of Encounter
- Provider Identification
- Person Identification
- Billing Data
- Date
- Reason for the visit
- Assessment of the problem or diagnosis
- Management procedures, diagnostic or therapeutic
- Disposition of Patient

In our offices, on the first visit of the patient, registration data is collected by the receptionist on a card; together with the above data we ask for the health care number, home telephone number, business phone and we also find useful to have on hand the patient's pharmacy telephone number.

Very early in our acquaintance with the patient we
make arrangement for a general examination in order to start to form a baseline for assessing the health risk factors, personality characteristics and life-style on which we can formulate a plan for counselling on preventive measures and patient education. This information is collected on a separate general assessment form which is placed in a prominent place in the patient’s file.

As the first page in the file, as an index to the rest of the chart, we have a one-page form, which is called the Cumulative Patient Profile (CPP). This form is divided into several sections:
1. identification, address, etc.
2. psycho-social section for data relating to occupation, living situation, hobbies, etc.
3. past medical history, risk factors (including family traits)
4. allergies and immunisations
5. date of first visit, dates of general physical examinations
6. list of on-going long-term problems and diagnoses,
7. list of continuing medications
8. names of other health care providers and lastly
9. the name of the most responsible health care provider.

The CPP is started after the first few visits and is updated whenever a change of status occurs.

Information collected on regular office visits are recorded on a progress notes form in a SOAP format (as of Problem-Oriented Medical Record), SOAP standing for

Subjective — symptoms, reason(s) for the visit,
Objective — signs and results of the examination,
Assessment of the problem, diagnosis (es) and
Plan of management and disposition.

The rationale and adequacy for writing these notes involves a chain of justification going from step to step — (going backwards), the patient was given a certain therapy for an assessed condition which was arrived at through an examination and history.

The progress notes form is a sheet of paper with the patient’s name and age on top, vertically ruled in four columns — leftmost for the dates, next for subjective and objective data, then a column for the assessment/diagnosis and lastly for the management plan. This arrangement is found useful in reviewing past visits, as glancing down the columns one can tell easily the dates of the various problems and medications.

There are other useful forms used by other family physicians. One of them is the flow sheet for following up patients with chronic conditions such as diabetes, hypertension etc. These forms usually have a wide column on the left side of the page for writing down a list of clinical parameters that one is interested in monitoring, e.g. weight, BP, BS (Blood Sugar), urinalysis, recurring symptoms, such as headaches, dysuria, blurring of vision etc., biochemical values, screening tests etc.

The rest of the page is ruled vertically to enter various codes or check marks, headed by the dates of the visits. Glancing along horizontally across the sheet one can easily see the progress of the patient over time. There is no reason why one cannot make a general sheet for all kinds of patients who are seen on a regular basis. Other forms for special types of patients are widely used: prenatal forms, well-baby visit forms etc.

As one ages with one’s patients, the charts tend to become thick, overflowing with information, and difficult to sort through. It is recommended that periodically, or at times of special events, such as on hospitalisation, referral to a consultant, etc. a synopsis or summary of the record be made. This practice will be found very useful when one wants to review a patient or has to fill some third party forms. This is the equivalent of a discharge summary from hospital.

Designing a practical encounter form for capturing relevant information at each visit is very important nowadays for billing purposes and as we are on the verge of a computerised office, will also serve as a data entry form. As the legibility problems will in this fashion be overcome, we hope that the attention given to the quality of the information recorded will improve and will be self-rewarding in the feedback we will be getting from practice records.

Some Definitions

Datum (plural data) is the symbolic representation of a factual characteristic about a patient: 50 Kg is the weight of the a patient, 30 years is the age, female is the sex etc. Data are gathered by a process of measurement.

Information is made up of the assertion or negation of a combination of data: has blue eyes, does not have a gall-stone, has systolic murmur, etc. and is usually of a derivative, comparative or referential nature: splenomegaly (mass in LUQ), severe pain, grade II/IV etc. Information requires some process of interpretation of the results of an examination done on the patient (expertise obtained during medical education).

Making an assessment of a patient’s condition and arriving at a diagnosis is a complex act of medical intelligence which requires training and insight.

Patient record is the documentation and collection of information in a standardised mode for the purpose of the management of the patient.

Patient chart (file) is the paper collection of various forms, reports on one patient placed in one file.
It is today an undisputed fact that the care of a patient will be improved by the proper use of medical records. The state of medical record keeping in general practice in Malta has been the subject of many conjectures and no evidence exists to provide an indication of the real state of affairs.

The aim of this small study was to try and obtain some facts about the subject.

The study was carried out in August 1990. A short postal questionnaire was sent to 87 doctors, all founder members of the Malta College of Family Doctors. The questionnaire was designed to be short and to give some background information on the population sample of doctors. In addition, apart from seeking factual information on the type and extent of record keeping, it also explored doctors’ attitudes in this regard.

Out of the 87 doctors sent the questionnaire, 47 (54%) responded. Although the number of responders was small, representing about 12-15% of doctors working in part-time or full-time general practice, the age distribution closely reflected that of the total general practitioner population in Malta. The sample also represented a fair spread in the type and number of consulting premises used (one to four or more premises which range from a pharmacy to own home and to purpose-built premises) as well as in list size (Table 1).

Out of the 47 responders, only 18 doctors kept records for all their patients while a further 21 doctors kept records for patients with specific problems. Seven out of the 18 doctors who kept records for all patients also kept special record cards for their patients with specific medical problems.

Of the 18 doctors who kept records for all patients, 16 recorded all surgery consultations, 7 also recorded consultations taking place in the patient’s home, while none of the doctors recorded any details of telephone consultations. Only 8 doctors kept a record of investigation results and referral letters. All but one doctor kept the record card themselves and 3 have a compiled age/sex register of their practice. Two thirds of the 18 doctors had kept records since their entry into general practice or within one year of doing so; the remainder had started record keeping at some later stage, one doctor starting as long as seventeen years after entry.

Out of the 28 doctors who kept records for patients with specific problems, 18 kept a special record card for pregnancy, 13 for hypertension and 12 for diabetes. Other conditions for which a special record card was kept included cardiovascular disease, gynaecological disorders, neonates, forensic cases, and uncommon and chronic disorders.

In spite of the fact that only 18 doctors kept records for all patients, all the 47 doctors regarded record keeping as either essential or useful. ‘Not enough time’ was the main reason given by the majority of doctors who do not keep records. Other reasons included:

- No secretarial help
- No storage space
- More than one consulting premise
- Doctor shopping
- Fees too low
- Not enough patients
- Awaiting Family Doctor Scheme
- Impossible

All doctors who kept no records at all expressed a willingness to consider keeping records in the future.

The above results show that only 38% of the doctors who returned the questionnaire keep records for all their patients and this in a population of doctors who may be considered to be biased towards ‘good general practice’. Indeed if a wider sample of doctors were to be

<table>
<thead>
<tr>
<th>Table 1 List Size</th>
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<tbody>
<tr>
<td><strong>List Size</strong></td>
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<tr>
<td>100 –</td>
</tr>
<tr>
<td>500 –</td>
</tr>
<tr>
<td>900 –</td>
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<tr>
<td>1300 –</td>
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<tr>
<td>1700 – 2100</td>
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<tr>
<td>Over 2100</td>
</tr>
</tbody>
</table>

**SAMPLE RECORD FORMS**

Interested Family Doctors may apply to the College Council for sample record forms which include the Cumulative Patient Profile Form and a Continuation Sheet arranged in the SOAP Format. (See article by Dr F Demanuele)
questioned, the net figure may turn out to be lower. Factors that may have an influence on medical record keeping include list size (volume of work), number and type of premises used by the doctor (logistic problems) and years in practice (different attitude to record keeping). When the group of doctors who keep records for every patient was compared to those who do not (Table 2), there was no statistically significant difference between these variables. In view of the absence of any differences between the two groups of doctors in terms of practice characteristics and attitudes to record keeping, one may safely conclude that the main determining factor is sheer motivation on the part of the doctor. If the level of record keeping is poor, the quality of such record keeping does not appear to be in any better state. The evidence from the questionnaire suggests that in the majority of cases, the record keeping is incomplete.

This study, although small, provides substantial information to suggest that both the amount and quality of record keeping in general practice in Malta is poor. A larger more detailed study needs to be undertaken to be able to assess the true state of affairs. It appears that the profession has the right attitude toward record keeping, what it might lack is the motivation and knowledge on how to keep medical records. These are problems that the Malta College of Family Doctors should address if it is to “enhance, foster and maintain high standards of family practice” in Malta.

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>COMPARISON BETWEEN DOCTORS WHO KEEP RECORDS AND THOSE WHO DO NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record-Keepers</td>
</tr>
<tr>
<td>Mean Years in Practice</td>
<td>11.06 (SD 7.8)</td>
</tr>
<tr>
<td>Mean List Size</td>
<td>1254.0 (SD 636.0)</td>
</tr>
<tr>
<td>Mean Number of Premises</td>
<td>1.53 (SD 0.7)</td>
</tr>
<tr>
<td>Type of Premises</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>58.8%</td>
</tr>
<tr>
<td>Home</td>
<td>29.4%</td>
</tr>
<tr>
<td>Purpose built</td>
<td>29.4%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The premises where doctors and patients meet for that consultation and where medical records are made vary enormously with the habits and cultures of the individual communities. However, even with the subject of practice premises, there are certain principles. In this paper, I shall discuss these from the UK perspective and leave it to you to agree or disagree and relate any principles to the situation in Malta.

**WHAT ARE THEY AND WHAT GOES ON IN THEM?**

First of all then, what do we mean by Practice Premises? I take as my definition the premises at which a patient meets with a doctor or a member of his primary care team for a consultation relating to family practice. So I shall exclude any hospital premises or any satellite outpatient specialist units and concentrate solely on premises used for family medicine.

If one is going to consider designing a building or modifying one for a new use, it is important to think of what is going to go on in the building. Within the practice premises then:

1. Patients will arrange to meet with the doctor.
2. If appointments are made, there must be space for staff and appointment books.
3. When they arrive, patients will wait until their turn comes to see the doctor or their appointment is due.
4. The patient will go in to the doctor and have a consultation with him.
5. The doctor may need to contact the hospital to admit the patient or speak to a specialist colleague.
6. If any procedure such as minor surgery or an ECG is carried out, this may require a separate room.
7. Quite often, patients who attend may have diarrhoea or be nauseated. For these, as well as for other reasons, they will need access to toilets.
8. Patients may at times become acutely ill and require space in which to recover.
9. The patient may need to make arrangements after the consultation to come back at a different time for follow-up.
10. Notes will need to be filed and recovered.
11. The doctor or staff will need to be able to take messages about home visits.
12. Doctors and staff will spend a long time in the building, so they will need to have the facility to make tea or coffee.

**WHERE SHOULD THEY BE?**

Having thought about what goes on in a doctor’s surgery, one
next needs to consider where the premises should be situated. The family doctor by definition looks after families. He also looks after extended families and communities. If the doctor is going to care for a community, his premises should be situated in the centre of that community and be easily accessible to the people he serves. If the people in a community shop in a certain area, then it is convenient for the premises to close to the shopping centre. If people come by bus, then the building, if possible, should be on the bus route. Where many young families are looked after, mothers find it convenient if the premises are near the school. Obviously in each community, the pressures for siting the premises in a certain place will vary. However in the UK it has been found that patients consider the convenience of the practice premises as one of the factors in choosing a particular doctor, and also that where surgeries are easier to get to, the patients make fewer house calls.

**DESIGN OF THE PREMISES**

The design of the premises will take into account the needs and wishes of the various people that use the building. These people are:
- The Doctor
- The Patient, and
- The Staff
- The health department, particularly if it subsidises part of the building may also have a say in the design.

**THE DOCTOR**

The doctor will probably spend most time in the building, so we will consider his priorities first. He will want the building to have certain characteristics:
1. His room should be of an adequate size so that he will not feel cramped.
2. He will need a desk, adequate lighting, a comfortable chair for himself and adequate seating for the patients.
3. His room should be warm in winter and cool in summer. So he will need to have an adequate system for heating and a cool design and fans for when it is hot.
4. Most doctors feel that the decor of their room communicates something to the patient about them and may put the patient at ease. Different doctors decorate their rooms in different ways, but to the individual doctor this can be very important.
5. He will have notes for each patient so he will need a convenient filing system, either which he can use himself or which can be used by the clerical staff to retrieve the notes for each patient.
6. If the doctor is going to use a computer, then there must be room for this equipment and it must be arranged on his desk in such a way that he does not need to turn or stoop to use it. It must also not come between him and the patient.
7. Confidentiality will only be maintained if the room is not overlooked and if the door between the consulting room and the waiting room is soundproofed.
8. If the doctor is going to do minor operations, ECG’s and other procedures, he will need another room, a couch, containers for his various instruments and some method of sterilisation.
9. The doctor will need an adequate telephone system to communicate with hospital and outside agencies.
10. At the end of a busy surgery, most doctors will want some sort of refreshment, so some sort of small kitchen is useful.
11. Medical equipment is valuable and some people may want to break in and steal this and perhaps also drugs. Thus when the doctor leaves his premises he will want them to be secure. This may involve deadlocks on the doors, bars on the windows and possibly an intruder alarm system.

So these are some of the priorities of the doctor. However the whole system is set up to serve people, So what are the priorities of the patient?

**THE PATIENT**

1. When the patient decides to consult the doctor, he or she first needs to find the surgery. The building should be clearly marked with the fact that this is a doctor’s office, with the name of the doctor and the opening times. Very small things can make a lot of difference in finding the surgery. I can remember going to see a colleague of mine who had premises in a building where he was only one of several tenants. I found the building quite easily, but because of poor signposting, I found it very difficult to find my way to the front door of the practice.
2. Once the patient reaches the surgery, he or she may feel quite nervous. It is important that they are quickly made to feel at ease. This perhaps is best done by having a member of staff to greet the patient. This in itself will involve the staff office being in a situation where there is a clear view of the entrance hall of the building.
3. The patient will probably have to wait some time to see the doctor. The patient will be happier and less anxious if the waiting area is comfortable. This can be made possible by ensuring:
   a. The chairs are comfortable, not clapped out old chairs.
   b. The waiting room is well decorated.
   c. There are toys for the children and playpens for the younger children. There is nothing worse than waiting to see the doctor when one is unwell and has a headache and having to control a fractious child at the same time. Children can also annoy other patients waiting in the same room. Toys often distract and amuse children while their parents wait.
   d. If parents are going to be comfortable and children are going to be able to play, it is important that the waiting room is not too small. Cramped conditions lead to irritation and anxiety.
   e. Many patients appreciate having magazines and news-
papers to look at while they are waiting. Doctors often make the mistake of putting in their waiting rooms the papers that they read, e.g., in the UK, the Times newspaper or the Economist magazine. However most patients do not have IQ's of 140 and can't understand these sort of publications. So it is wise to plan which publications to provide according to one's clientele.

f. I know some doctors here have music playing in their waiting rooms. I understand that this can have a very soothing effect.

g. As the patient is going to be sitting in the waiting room for some time, this is an ideal time to communicate with them using posters and displays in the waiting rooms. These posters are changed regularly. Between the poster displays, announcements about changes in the practice can go up on the noticeboards in the waiting rooms.

h. When it is the patient's turn to see the doctor, it is important that the call system is clear and not confusing. Some doctors go and fetch the next patient themselves. If they do not, then a clear call system using a tannoy or using their staff is required.

THE STAFF

Staff too will spend many hours in the building. It is important for them too:

1. That they have a comfortable office which is kept at a reasonable temperature.
2. That they have easy access to patients so they can see and advise them when they are unwell or confused.
3. If they are responsible for the filing of the records, they should be able to do this without excessive bending or stooping.
4. They should have an efficient way of communicating with the doctor and of telephoning out of the practice.

HEALTH AUTHORITIES

Where health authorities are providing subsidy for staff or buildings as they do now in many parts of Europe including Italy, the authority may have priorities such as:

(a) Having a separate room dedicated to an antenatal clinic or child development clinics, and
(b) Having community nurses or social workers based in an office in the doctor's premises.

ACCESSIBILITY

One thing that we have not dealt with so far is the matter of accessibility and mobility:

1. We spoke earlier about where the premises should be sited so that patients can get to them.
2. Once patients are at the surgery, they need to be able to get to the waiting room and doctor's office. Steps are very difficult when one is hemiplegic or walking with sticks.
3. If one is old and dodderly, long corridors are easier to manage if there are hand rails.
4. Doors and toilets need to be designed to take wheelchairs if one is going to be dealing with older people.
5. If mothers bring their children, there needs to be somewhere for them to leave their prams.

FUNDING

I think most family doctors in most parts of the world would agree with most of what we have just discussed. However, having agreed with these principles, how is one going to pay for it all? Doctors all over the world face this dilemma: "Do I spend more money on the premises for my patients and leave my family less well-off, or do I practice from poorer premises?" The choice may be even starker: "Can I afford good premises at all?" Under some circumstances, the local civic or health authorities provide the premises themselves and rent it out to the doctors for a reasonable sum of money. This solves many problems. However, if a government authority provides the premises, that authority usually has the last word on the design of the premises, or at least on the overall sum that can be spent on them. In other countries, such as in the UK, the health authority provides cheap loans for the purchase or rent of practice premises. Under these circumstances, the doctor makes the final decision about the design and the only limit on the cost is the amount of the loan that the health authority is prepared to subsidise. Many practices, including my own, go over this sum and have a part subsidised and part full cost loan. If one follows this path, one lands up with a pleasant capital sum when one retires and sells the premises to supplement one's pension.

This matter of funding is crucial when considering practice premises. Up until 1964, British family doctors had no subsidy for staff or premises from the UK government. Most family doctors practised as single-handed doctors from the front rooms of their homes with their wives taking messages for them and arranging their records. In 1964, the government introduced subsidies for staff and buildings. Since that time family doctors have developed much improved premises, employed staff and started to work together in groups. One consequence of this is that a wider range of problems are now dealt with more competently within the cheaper and more friendly environment of family medicine in the community. The morale of British family doctors has improved, their training has improved enormously and now the cream of medical school students are going into family practice recognising it as the speciality of medicine where most can be done for the patient and which provides the most challenging and rewarding speciality of our profession.
MCFD WINTER CPD MEETING

The panel of speakers consists of local and foreign contributors. Specially for the occasion, the Malta College has again invited, Dr Edwin Martin, the Malta Fellow from the Royal College of General Practitioners and Dr Fred Demanuele from the University of Toronto, Canada.

Wednesday, January 16th, 1991
The Primary Health Care Team
1. Role and Function of the Primary Care Team
   E. Martin
2. The Family Doctor-Consultant Relationship
   J. Gauci, J.M. Cacciottolo

Thursday, January 17th, 1991
Screening in General Practice
1. Paediatric Screening
   S. Portelli
2. Adult Screening
   F. Demanuele

Friday, January 18th, 1991
The Family Doctor
1. His Health — E. Martin
2. His Welfare — F. Demanuele
3. Local Scene — A. Azzopardi

Each presentation is to be followed by an open discussion on the topic of the day. Attendance for the full programme of the Winter CPD meeting will be accredited 9 units. Registered medical practitioners who are non-members, may attend at a fee of Lm6. Medical students and pre-registration medical doctors are invited to attend (admission free).

POSTGRADUATE MEETINGS

Lectures/Symposia for January through May 1991:
1. Urinary Tract Infections in Childhood
2. Headache
3. Bone Changes in the Elderly
4. Interventional Radiology?
   Dawn of the Golden Age
5. Leishmaniasis
6. Infertility
7. Fungal Infection in General Practice
8. Diseases caused by Medicines
9. Lead Poisoning — is it a problem in Malta?
10. Psychiatric Problems in Childhood and Adolescence
11. Modern Successes in Cancer Treatment

Titles in italics carry two credit units (the discussion will be led by a family doctor). Other sessions carry one unit.

NOTES

Response to Questionnaires: As the academic interest in our specialty increases, so will the number of family doctors who carry out research projects. A number of these projects will require you to take some time to answer a questionnaire. Please give this activity its due importance. An effective research programme requires your collaboration in giving your experience when called upon to do so through questionnaires. Respond carefully and actively — we all stand to gain.

"Dizziness": "Dizziness" means a lot of different things to different people. The words stordut and sturdament are very common in the presenting complaints of our patients. What do Maltese patients mean by these terms? How can we distinguish between the different meanings? How can we understand (and manage) these patients better? What is the frequency of actual labyrinthine causes, of that due to (or associated with) high blood pressure (or iatrogenic)? I am sure that these questions pass through our minds when we meet these patients. If you are interested in the design and conduct of a research project on this subject, please contact Dr. Wilfred Galea on Tel 456257 or 456402 or at the Malta College of Family Doctors, P.O. Box 70, Paola. Help in the design and conduct of the study will be given by the College. (Let’s all join in for some academic fun!)

First Seizures, a reminder: Our College is participating in a Multicentre Study on First Seizures. Members who would like to take part are requested to contact Dr. John Gauci for a questionnaire. You will be asked to fill in one of these whenever you encounter a patient with his/her first seizure (whatever the cause).

Call for Speakers: If you have ideas for lectures/seminars that you would like to lead, please contact the College Council. We are constantly on the search for new speakers and new themes for discussion. Tell us what you would like to do. Remember, under the accreditation scheme, leading a discussion at a CPD activity attracts 5 credit units.

Thanks for Supporting the Autumn CPD Meeting:
The College would like to thank the following for their support through financial donations:

• Allied Drugs Co Ltd who donated Lm40 through their representative Mr. Alan Miller (ICI).
• V. J. Salomone who donated Lm30 through their representative Dr. Frank Pace (Upjohn).
TO:

NEWSPAPER POST