Journal of the Malta College of Family Doctors

Issue No. 6 October 1994

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Editorial

Autumn and Winter promise to be a very busy time for the new council. A number of interesting proposals are being discussed and elaborated for presentation to college members for approval.

The most interesting is the proposed family doctor register which would be the first of its kind in Malta and will list all doctors practising family medicine full time. Furthermore, College members fully credited with CPD points and maintaining a good standard of practice will be credited as such in this register. This will further the Council's aim to ensure recognition of the family doctor as a specialist in his field.

The council is proposing to host the meeting of the European G.P. Research Workshop in Autumn 1996, and is sending two representatives to this year's meeting.

The Council aims to organise short courses on various topics on a regular basis in the near future and is working to raise the prestige of the College in local and international fora.

I refer you to the various notices of international conferences posted in this issue and invite you to contact the secretary or myself if you are interested in attending.

Jean Karl Soler

Continuing Professional Development 1994 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 has been 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 student 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**

Correspondence and contributions to this journal are to be sent to:
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"The Family With a Disability"

Dr J. Muscat addressing The Medical School
22nd April 1994

I would like to start by quoting the Head of Psychology at the University of California, an international authority on autism, Dr. Lovaas, who during the research that led to his excellent programmes admitted;

"The first serious mistake we made was to treat the children within an institutional (hospital or clinic) environment ... We had hospitalized the children in the first place because we still held the old view we had been taught, that children like those with whom we worked were *ill*. It seemed to follow then, that since they were *ill*, they needed *treatment*, ideally in a hospital.

Given our background, it was an easy mistake to make. We decided then to change the place of treatment from the institution to the children's natural environment; that is we began to treat him in his home and school.

We were successful and this brought us to question the necessity or desirability of using a hospital as a teaching and learning environment. Our goal was to help these children to live and function in the real world and not in an artificial setting, such as an institution."

(Teaching Developmentally Disabled Children)

The Eden Foundation was set up by a group of parents determined to achieve a better future for their children than the present situation of institutionalisation or hospitalization offers.

The Eden Foundation's programme is essentially an educational one and is based on the strong belief that people with disability are educable provided they follow a system which is intended to bring out the abilities hidden behind the disabilities.

This system, in turn, is based on Eden's view that people with disability rather than ill or diseased, are simply "different", and that what was needed was an environment in which the child could learn. So the place of intervention became the child's own home and we chose to teach the children, whenever possible, in the same way normal parents teach their normal children. We supplanted treatment by teaching and de-emphasised diagnostic testing.

Allow me briefly to explain how our systems function.

In the Early Intervention Programme for children up to the age of 5, we have about 100 clients. After assessment by the various professionals involved, a case conference is held which determines each child's individual programme. This is the starting gun that sees the child receiving a lesson at home together with speech, physio and occupational therapy sessions on a weekly basis.

Naturally there is constant meeting of these professionals on an informal basis, but teachers meet regularly every other Tuesday while Departmental Heads meet every forthnight. Review meetings are now being conducted at 3-monthly intervals while Enhancement Courses aimed at creating a Transdisciplinary model are on-going and take place twice monthly. Eden indeed teems with creative activity and I assure you that you would be most welcome to visit and see for yourselves.

That of course, is only one programme. We have gone into the homes and institutions to take out adults lying idle, living on the state disability pension of almost Lm1000 a year, and put them to work. Adults between the age of 18 and 30, who had never gone anywhere on their own in their life, were taught to travel by public transport to our Centre in Valletta. After 3 months of life and social skills aimed at making them function as people, where they learn to shop, count their change, make a telephone call, reach a destination, etc, they embark on another period of 3 months of on-the-job training where the abilities that had been identified are now translated into job-holding skills. Job coaches, specially recruited for the purpose, accompany the trainees during this period and help them to integrate with their work companions.

There are 10 of these people now working independently, doing normal work and earning a normal salary. 10 people whose very parents had long given up on them after the long years of failure. Who, when their disability was first diagnosed would have bet that one day they would be working?

There are 14 others doing on-site training while 90 await their turn. The first intake of trainees have now been working independently for over 3 months.

Eden achieved this with people whose schooling did not amount to much, and during a period when we were still finding

our feet. For the young children benefiting from our services and who by the time they have left school will have absorbed so much from our programmes, the future should be far brighter.

The systems we are using have been advocated before by far-seeing people in our society as far back as 1989 to my knowledge. At Eden we have simply had the courage to put them into practice. Very conscious of the fallout that would arise, we decided that the time had come to admit that the medical model was not adequate enough on its own. As doctors, our knowledge of disabilities and how to deal with them is scanty and it is indeed time for medical students to be taught how to identify disabilities and how to treat them.

I speak nothing but the truth when I tell you that there have been instances of parents being put off by some doctor from enrolling their child with Eden because professionally he could see no reason for it, only to have these same parents begging to be allowed to join the programme a few months later when the disability had become more evident.

Precious months had been lost to children who are not in a position to readily make up for lost time.

I have just mentioned parents. From the very beginning at Eden we had to face a familiar problem: where to draw the line separating the parent from the professional. Again I believe you will agree with me when I say that in Malta the professional brooks no interference. We feel that medical problems being so complex, only highly educated persons can be allowed to view the way we work.

In turn of course, this has burdened us with a tremendous responsibility. In English colonial times, in the East they used to speak of "the white man's burden", meaning that the Europeans, having persuaded the natives to view them as superior beings, could never afford to own to a mistake or weakness.

We too have fallen into this trap. This is a mistake. At Eden we reason differently. We parted from the obvious position that there simply are not enough professionals available to meet the educational, therapeutic and psychological needs.

Secondly, if parents didn't know exactly what their child's treatment programme consisted of, what we were doing, why we were doing it, and what the final goals were, then they wouldn't be able to help their child maintain the gains made in therapy, and the child would regress. The parents and teachers are the child's primary therapists while the specialists act as consultants.

If a child's behaviour is influenced by the environment in which he lives and learns, and since a child's environment is composed of several different settings (such as school, home and neighbourhood) then it follows that the child's *total* environment should be arranged to become therapeutic and educational if the child is to make maximal gains in treatment.

And this is where a great concern of mine comes in. In a system where, quite rightly, the parents' role is essential, we have to be careful not to overburden the parents. And they are tremendously overburdened. There are their endless hospital appointments in hospital with their often discouraging results. There is their membership of any organisation that offers a quick fix to their problem. Torn as they are between conflicting loyalties, they are in danger of collapsing, and if the parents collapse, their child and his future – despite everybody's good intentions – will collapse.

I appeal here to those of you present who have the power to provoke change, to join Eden round the table and find ways and means of collaboration to spare the family that reduplication of services, that hostile jealousy they at times encounter in quarters that should know better, that mad chase from one place to another; all so unnecessary and certainly in no way acting for the good of the child we all claim to be concerned with.

Believe me when I say that Eden does not want to intrude on anybody's turf. Our joys are simple ones. We celebrate when the child whose parents assured us he would never talk, is now talking and more, understanding concepts. The child who up to three years had not walked and, according to the medical diagnosis was not really expected to walk, is now slowly, painfully making a few steps, enough to fill his parents with that dose of hope that will enable them to carry on.

It is time for us to accept that, as doctors, we cannot work alone. In the modern world there are many other professionals in possession of skills that could do mankind – and especially disabled mankind – a lot of good. To some extent this is a principle we all accept and practice. People who suffer a stroke are sent for physiotherapy; people who suffer accidents are given occupational therapy. But we do not seem to apply this principle right across the spectrum. In the case of developmental disabilities this could be a case of tacitly accepting that the input required is so great that the medical profession on its own cannot possibly deliver it.

And it is right that it should be so. Most of the money spent on medical treatment and medical rehabilitation will be of little value if we forget that it is our duty to bring the disabled person back to a social life and to give him the

possibility of living such a life. What is the use of stretching rehabilitation services to meet ever increasing demands if in so doing the real needs are not met?

That is why Eden's slogan is "Towards an Independent Life". We believe in the integration of the individual, for all psychological and sociological investigations show the impossibility of improving the individual resources of a person if he lacks stimulating contacts with other human beings.

That is why the social and psychological situation of the disabled will be a better one if those who meet him do not fix their interest on his disabilities but on his abilities. There is a need for Rehabilitation and Disability Medicine in which very few medical people are interested. There is need of **Prevention Child Care Programmes. At Eden, we have noticed how often our children seem to fall sick with consequent loss in lessons and therapy not to mention the parents' distress.** Indeed, since the Eden Foundation is affiliated to the Institute For Child Development of the University of Malta, I am looking forward to the day when this joint venture between the two parties will initiate research that we at Eden – unhampered as we are by bureaucratic considerations – can immediately put to the test.

And while we are far from claiming that we have all the answers, or even half the answers or only a few, we do have the facility of being able to initiate action within the constraints in which we operate. That is the main reason behind the results already achieved in the space of 15 months since we commenced operations.

You cannot give holistic education using specialists, however gifted, however dedicated and committed, if they come from several departments all of which tend to operate within castle walls higher than the Valletta bastions and who consider the protection of their turf to come before any other consideration.

You have heard me give you the details of how we operate. In all honesty, and I say this quite humbly, despite our shortcomings, despite all we have yet to learn, what government department is in a position to deliver the same? Can any other department ever be able to function in this unique, highly focused way?

At Eden my staff know only when the day will start, never when it finishes. Ring up and find out for yourself. At Eden we have members of staff who forfeit, of their own free will, expenses due to them for services rendered. At Eden, when the need arises we go in even during the weekends. At Eden, despite the enormous pressure of work, we have staff who refuse lucrative offers from other educational organisations because they know that nowhere else will they find the same atmosphere, the same commitment, the same family set-up based on the slogan **"working together as a family for the good of the family."**

The Eden Foundation is not the Garden of Eden and we do have our disagreements but it is nothing like what prevails in the normal places of work. This is the primary resource that every other state department lacks and can never hope to possess. And all this activity is carried out after a day's work elsewhere, for most of our staff work part-time.

And it is with my heart full of this goodwill that animates our work that I most earnestly request you not to let this conference end up as yet another bit of printed paper, a showcase of good intentions that nobody buys. Let us, all together, be partners in a noble quest for the good of disabled persons and before we leave this hall fix a date when, gathered around a table, we can pool resources, apportion limited expertise and set up a functioning model aimed at providing persons with disability with the opportunity they need in order to show that their contribution to their country and their society can be as valid, in human terms, as that of the best among us.

Thank you
Josie Muscat
President – The Eden Foundation

WINTER C.P.D. MEETING

Wednesday, 5th October 1994
Pitfalls of the Chest X-Rays – *Dr. M. Crockford*
How I Manage ... – *Dr. J.K. Soler*

Thursday, 6th October 1994
Well Woman Clinics – *Dr. A.P. Scerri*
A Lesson I've Learned – *Dr. P. Sciortino*

Friday, 7th October 1994
Promoting Health in the Family
A Forum Presented with the Help of the Promotion Department
Miss S. Bugeja – Health Promotion Manager
Miss S. Scicluna Calleja – Psichology Lecturer
Mr. A. Zammit – Physiotherapist
Dr. G. Farrugia – Family Doctor & Local Council Mayor
Reception

Meeting Kindly Sponsored by Vivian Commercial Corporation Limited

Antibiotic Prophylaxis in Obstetric and Gynaecological Surgery

Dr. M.A. Borg
Senior Registrar (Microbiology) – Dept of Pathology – S.L.H.

Infectious complications have a great influence on the outcome of surgery. They not only increase the work load for health care workers, the need for additional surgery medication and costs but just as important are an additional source of morbidity and sometimes mortality for our patients. Infectious complications prolong hospital stays and certainly decrease success rates in surgery considerably.

There is therefore no doubt that the prevention of postoperative infections is of the paramount importance. The surgeon's skill and knowledge are the most important factors in preventing post operative wound infections and antimicrobials are no substitute for surgical expertise. Antibiotic prophylaxis cannot correct fundamental surgical errors.

However when expertly carried out, antibiotic prophylaxis in surgery has saved more lives than any other improvement in surgery over the last two decades. A proper regimen of antibiotics decreases the total amount of antimicrobials needed and smoothens the burden on the hospital antibiotic budget. The choice of antibiotics should be based on fact rather than fiction and made according to available data on pharmacology, microbiology, clinical experience and economy.

The goal of prophylaxis is to achieve sufficient antimicrobial tissue concentrations before possible contamination and ensure that adequate levels persist throughout the operation to prevent subsequent bacterial colonisation and growth. For this reason the timing of the initial administration is crucial. It has been clearly shown that optimum results are achieved when prophylaxis is started approximately 30 minutes before the surgical intervention. A notable exception is Caesarean section where fears of drug toxicity to the foetus preclude this practice. Trials have however shown that equal efficacy is obtained when antibiotic administration is initiated immediately after clamping of the cord. The practice of starting antibiotic cover after the operation has ended is frankly ineffective because by the time tissue levels have been reached the bacteria would have had enough time to colonise and multiply at the wound site. Antibiotic concentration could subsequently be insufficient to stop bacteria division in the log phase whereas the same antibiotic concentration would have been enough, if given earlier, to abort an infection in the lag phase of bacterial growth.

Ideally antibiotics should be used for as short a time span as possible. This not only decreases the risk of resistance developing in the hospital bacterial population but also lessens the frequency of side-effects. The older 5-day regimens have given way to a 3-dose protocol covering the perioperative period and the first 24 hours post-operatively. Single shot surgical prophylaxis is a fairly recent development and has been shown to be highly cost effective resulting in considerable savings in time and money. If such therapy is adopted the choice of antibiotics is crucial as besides a suitable spectrum of activity, the antimicrobial chosen should have a sufficiently long half-life to cover the at risk period. The actual length of this "at risk" interval is a matter of debate. The work by Khan and colleagues would indicate a time period of approximately 12 hours[1].

Not all gynaecological operations require antibiotic prophylaxis; it is only in a few that convincing evidence favouring prophylaxis is available. Prophylaxis is certainly indicated in operations involving the vagina when microbial contamination by the vaginal commensal flora is often unavoidable and increasing evidence indicates a use also in abdominal hysterectomy. The use of antibiotics in Caesarean Section has been extensively reviewed by Enkin[2]. It is evident that over-enthusiastic use of antibiotics for all women undergoing this operation could be counterproductive – its possible benefit outweighed by drug toxicity to mother and infant and the emergence of resistance. It is therefore reasonable to select patients at higher risk namely those undergoing non-elective section particularly after prolonged labour or rupture of membranes, women who have experienced many vaginal examinations or attempts at delivery, the presence of meconium, maternal anaemia and possibly low socio-economic status. It is interesting to note that whilst antibiotic prophylaxis in Caesarean sections has resulted in a significant reduction in post-partum endometritis and septicaemia, it has not been shown to be equally effective in reducing post-operative wound and urinary infection rates[3].

The choice of the antimicrobial to be used is obviously a

crucial one, whether single or multiple dose prophylaxis is to be adopted. They should be chosen in the light of local antibiotic sensitivity patterns to the more likely pathogens. It is essential that the antibiotic chosen should provide good cover against Staphylococcus aureus – by far the most common cause of post-operative wound infections. Furthermore the vagina constitutes a rich microbial environment with Streptococci, Gram Negative aerobes and Gram positive and Gram negative anaerobes abundant. The importance of adequate cover for both aerobes as well as anaerobes has been highlighted by the work of Brown and colleagues. It is unnecessary to cover the whole of the potential range of infecting organisms but aim to cover the more important pathogens namely Staphylococci, Streptococci, Enterobacteriacae and Bacteroides.

Monotherapy, as in any other antibiotic application, is always preferable but this is not always possible with all antibiotics in all occasions. Any drug chosen should have a track record of excellent tolerance and a wide safety margin.

In conclusion:

1 Antibiotic prophylaxis should be regarded as an adjunct to surgical skill and infection control principles.

2 Prophylaxis is mainly indicated in operations with known high rates of post-operative infections.

3 Effective tissue levels are mandatory from start to end of surgery.

4 The "at risk" period usually extends to 12-24 hours post-operatively after which continued antibiotic administration is cost-ineffective.

5 The antibiotic or antibiotic combination used should have an antimicrobial spectrum that covers both aerobes and anaerobes.

References:

1 Khan MS, Begg HB, Frampton J, Hughes TB (1980) A comparative study of the prophylactic effect of one dose and two dose intravenous metronidazole therapy in gynaecological surgery. Scan. J. Inf. Dis. suppl. 26:115-117.

2 Enkin M, Enkin E, Chalmers I, Hemminski E (1989) Prophylactic antibiotics in association with Caesarean section. In: Chalmers I, Enkin M, Keirse MJN (eds) Effective care in pregnancy and childhood, vol 2, part VIII, chap 73 Oxford University Press, Oxford.

3. Swartz MN, Grolle K (1981) The use of prophylactic antibiotics in Caesarean section. A review of the literature. J. of Rep. Med. 26:595-609.

ROYAL COLLEGE OF GENERAL PRACTITIONERS

PORTFOLIO-BASED LEARNING IN GENERAL PRACTICE

OCCASIONAL PAPER 63

Portfolio-based learning is one of the newest and most important developments in adult education and one which is expected to make a considerable impact on professional development.

This latest *Occasional Paper* comes from a College Working Group, chaired by Dr Roger Pietroni, which was set up by the Education Division of the College to explore how higher professional education might be provided, and recognized, in general practice. The paper not only describes the essential features of portfolio-based learning, such as modularization and the use of a mentor, but offers concrete examples of their application both in vocational training and continuing medical education.

Portfolio-based Learning in General Practice should be of special benefit to all regional and associate advisers and general practitioner tutors as they seek to develop opportunities for postgraduate education in their own localities.

Occasional paper 63 is available from RCGP Sales, 14 Princes Gate, Hyde Park, London SW7 1PU, Tel: 071 823 9698. Price £9.00 (£9.90 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 071 225 3048.

Any enquiries about the content of this *Occasional Paper* should be made to:

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Fax: 081 566 4034

Physicians and Domestic Violence

Dr. Jonathan Joslin
M.O. – Casualty Dept – S.L.H.

Domestic violence, spouse abuse, and battering all refer to the victimization of a person with whom the abuser has or has had an intimate relationship. Domestic violence may take the form of physical, sexual and psychological abuse, is generally repeated, and often escalates within relationships.

Most evidence indicates that domestic violence is predominantly perpetrated by men against women. Some evidence suggests that women are just as likely to use violence against male partners as men are against female partners. It is clear that the impact on the health of female victims of domestic violence is generally much more severe than the impact on the health of male victims.

Medical ethics require doctors to intervene in cases of domestic violence. Some may argue that the doctor's ethical obligations to patients who are battered are limited to treating the bodily injuries and other manifestations, and in doing more, physicians will step out of their medical role. Treating only the injuries and symptoms of abuse will not address the ongoing family violence that is at the root of its victims' health problems. When doctors do not diagnose abuse, it is most likely to continue and will often escalate. When a diagnosis of abuse is missed, treatment is likely to be inappropriate and potentially harmful. The most common drugs prescribed are analgesics and tranquillizers and this increases the risk of suicide in desperate cases. Further, such drugs may hamper the victim's alertness, making her more vulnerable to assault.

Failing to diagnose abuse may also further the victim's sense of entrapment and thereby contribute to victimization. Often when battered women seek help from others including the police, health care providers, friends and family, they are met with denials of the seriousness of the abuse. Inability to find help often causes victims to feel that there is no escape from the violence. These feelings of helplessness are associated with the psychosocial problems caused by abuse.

Physicians are particularly well situated to intervene in cases of domestic violence because persons who are in violent relationships often visit doctors for injuries and other symptoms caused by ongoing abuse. Battered women also often visit primary care physicians for a variety of medical complaints, such as abdominal pain, headaches and sleep disorders. Pregnancy appears to be a high risk factor for abuse.

Although the solutions to domestic violence extend into social and legal domains, in which doctors have limited influence, we can still provide a number of important interventions. Protocols for the detection and management of domestic violence should be developed; why not by the College itself, as they are the primary care physicians in association with other related bodies.

Probably the most important contribution doctors can make to ending abuse and protecting the health of its victims is to *IDENTIFY* and *ACKNOWLEDGE* the abuse. Identifying domestic violence can initiate the process by which people may get the necessary assistance to find safety. Other primary responsibilities include providing sensitive support, clearly documenting the abuse, providing information about options and resources and with the patient's consent making necessary referrals. Doctors must also assess the level of danger faced at home and if present must participate in efforts to secure a safe place, including offering hospitalisation, if necessary, for patients when there are no available shelters. Doctors in other clinical situations would not discharge a patient from the emergency department with a potentially life threatening condition. I remember two cases where women preferred being admitted to Mt Carmel Hospital rather than going back home to the violence.

A number of studies have shown that doctors often fail to diagnose abuse when signs and symptoms are present. One barrier to detecting and treating family violence is a lack of knowledge and training. This is a glaring omission in our curriculum at medical school. As a result physicians share a number of pervasive societal misconceptions about domestic violence that undermine the medical response to battering. The most harmful of these misconceptions include the following:

1. *domestic violence is rare;*
2. *violence does not occur in relationships that appear 'normal';*
3. *domestic violence is a private matter that should be resolved without outside intervention;*
4. *battered women are responsible for their abuse.*

1 The belief that domestic violence is rare stems from the traditional view of the family as a safe haven from the troubles of the outside world. From our experiences in casualty we have discovered the hard way that families and other intimate relationships are often anything but safe. Doctors' lack of awareness of the prevalence of domestic violence contributes to their reluctance to consider abuse in the differential diagnosis and to disbelieve that abuse has occurred even when the signs are evident.

In 1992 out of an annual 100,000 cases seen in the casualty department only 40 cases were of alleged wife beating. We are only seeing the tip of the iceberg.

2 The attitude that domestic violence does not occur in seemingly 'normal' relationships causes physicians to miss diagnoses of abuse. In particular, it is often assumed that abusers can be easily identified as pathological and excessively violent. Doctors may be especially likely to disbelieve that abuse has occurred when they know the suspected abuser as a friend. They appear especially concerned or attentive when they accompany their partner to receive medical attention either because they feel remorseful or they do not want to be suspected of abuse or more probable they do not want the patient to be seen alone.

At any rate, one thing we have noticed is that domestic violence cuts across racial and class categories.

3 Another common misconception is that domestic violence is a private matter and should be resolved within the relationship with the advice to try to work out their difficulties together. Unfortunately, without assistance, continuing to live in an abusive relationship can be the most dangerous course for the victims, since abuse is usually repeated and the injuries increase in severity.

4 Another societal misconception is that women are responsible for their victimization. They may be blamed for provoking the abuse by not leaving the relationship and not pressing charges. Many barriers prevent victims from leaving their spouse including the presence of children at home, fear of retaliation, not having a safe place to go to, financial dependency and/or lack of job skills, emotional ties; some hope that the situation may improve.

One of the primary aims when treating such victims is to bring them into contact with resources such as social services, legal assistance support groups and shelters. Unfortunately these shelters are almost always filled to capacity and the time has come to expand to other homes.

Physicians have an ethical obligation to maintain patient confidentiality so that patients feel free to make full disclosure of relevant information about their health. The need for the patient's trust in the physician is especially important since patients may feel embarrassed, ashamed or afraid that they have been battered. Spouses, partners or other third parties including the police should not be notified about an abuse diagnosis without the expressed consent of the patient.

Dynamics of Violence Against Wives

Types of partner abuse against women seen in casualty range from being slapped, punched, kicked or thrown bodily to being scalded. Shocked, smothered or bitten. Typical assaultive episodes often involve a combination of physical attacks, verbal abuse and threats. The repetition of aggression in families is facilitated by the fact that victims are readily available, the amount of time at risk is high, assaults can be carried out in private, and wife assault is relatively a low-risk behaviour for the aggressor.

... a sort of "if there is nothing on the telly why not beat up the wife" attitude.

Impacts on Psychological and Social Well-Being

During assaults the woman's primary reaction is one of self protection and survival. Reactions of shock, denial, withdrawal, confusion, psychological numbing, and fear are common. After the assault especially if this is repetitive, a victim may offer little or no resistance, in an attempt to minimize the threat of injury or renewed aggression. These effects of trauma are exacerbated by the fact that the aggressor is someone they may love, trust and depend on. There is a high prevalence of depression and suicide. Violence at home typically leaves no place in which defences can be let down by the victim.

Marital Rape

Marital rape is an integral part of marital violence however it is the least likely to be reported by victims. They suffer many of the same reactions of other rape victims.

Recommendations for Policy

1 The Hospital Authorities, College of Family Doctors working with other relevant bodies undertake a campaign to alert the health care community to the widespread

prevalence of violence against women, and to sensitize them to the needs of victims of violence.

2 That doctors routinely incorporate screening leading to identification of female patients who are victims of violence. This could be done at the entry points of contact between women and medical care: primary care, emergency services, obstetric and gynaecological services, psychiatric and paediatric care.

3 That doctors give due validation to the experience of victimization and of observed symptomatology as possible sequelae in their differential diagnosis

4 That doctors record a patient's victimization record, observed trauma potentially linked to the victimization. These are useful to assess progress or to indicate the need for more intensive interventions at a later contact with the patient.

5 That doctors, after diagnosing a violence related problem, refer patients to appropriate medical and community based resources as soon as possible.

6 That training on interviewing techniques, risk assessment, safety planning and protocols for help, be incorporated into undergraduate and continuing medical education programs.

STATUTORY WELFARE UNITS

		CONTACT PERSON	TELEPHONE NUMBERS
A	MINISTRY FOR HOME AFFAIRS AND SOCIAL DEVELOPMENT		
A1	Social Welfare Planning Unit Fort St. Elmo Valletta	Dr Tony Macelli Mr Frank Mifsud Nora Macelli	249995
A2	Directorate for Family and Social Affairs Ċentru Ħidma Soċjali Santa Venera		
	Director General	Mr Alfred Zammit Montebello	441311
A3	Department for Family and Child Welfare		
	Director	post not yet filled	
	Principal Social Workers	Mr Charles Pace/Mr Tony Mifsud	441311
	Intake Unit (Malta) Intake Unit (Gozo)	Mr Lino Camilleri/Mr Gino Galea Ms Grace Galea Ms Pauline Camilleri (CSWAS)	449614 557661
	Special Family Services Unit	Ms Carmen Zammit	441311
	Adoption and Fostering Unit	Ms Laura Agius (Adoptions) Ms Jane Azzopardi (Fostering)	441311 441311
	Probation Unit	Mr Godwin Steer	441311
	Services for Persons with Disabilities	Mr Joe Calleja/Mr Frans Spiteri	441311
	NGO Projects Unit	Mr Vince Tonna	441311
	Psychiatric Social Work Unit (Mount Carmel Hospital)	Mr Nelio Mulvaney/Ms Doris Gauchi/ Manwel Mangani/Ms Maria Cachia	434567/411993

		CONTACT PERSON	TELEPHONE NUMBERS
	Adult Training Centres		
	Mtarfa	Mr Joseph Pace	450579/459116
	Santa Venera	Mr Emanuel Debono	2501951/6
	Hal Far	Mr Paul Ellul	688788/681162
	Blind Section	Mr Publius Cauchi	446007
	Gozo	Mr John Camilleri	553886
A4	Drug Dependence Services		
	National Co-ordinator	Mr Joe Gerada	234497
	Santa Marija Hospital (for men)	Dr Maria Sciberras	244528/248884
	Dar Gubbio (for women)	Dr J. Maistre	487637
	Detoxification Unit (St Luke's Hospital)	Dr Maria Siberras	225096
	Detoxification Unit (Gozo General Hospital	Dr David Cassar	561600
A5	Alcohol Dependence Service		
	Rehabilitation Unit (Mount Carmel Hospital)	Dr Paul Sciberras/Mr Emanuel Mangani/ Ms Doris Gauci	415183
A6	Interdepartmental Commission Against Drug Abuse and Illicit Trafficking (ICADIAT)	Mr Paul Mifsud – Executive Secretary	442398
A7	Department of Correctional Services	To be set up	
A8	Department for Health		
	Physiotherapy Unit (St Luke's Hospital)	Ms Margaret Muscat	241251
	Occupational Therapy Unit (St Vincent de Paule Hosp.)	Mr Renè Mifsud	232108 Ext 220
	Child Guidance Unit (St Luke's Hospital)	Dr Joseph Saliba	223829
	Young Persons Unit (Mount Carmel Hospital)	Ms Pat Camilleri/Ms Mary Camenzuli	415183
A9	Dept for the Care of the Elderly and Special Needs		
	Director	Mr John Buhagiar	483603
	Handyman Services	Ms Carmen Pullicino	242725/242726
	Telecare Services	Ms Maryanne Gauci-Operations Manager	483603
	Home-Help Service (Malta)	Mr Victor Scerri	483603
	Home-Help Service (Gozo)	Ms Maria Micallef	557661
	Community Hostels:		
	Msida	Mr Tonio Naudi	340132/340238
	Gzira	Mr Alex Vella	31400/341781
	Floriana	Mr Fenech	237659/237619
	Mosta	Mr Ray Mamo	432720/415636
	St. Vincent de Paule Residence (SVPR)	Ms Marisa Scerri	238270
	Research and Statistics	Ms Marisa Scerri	483603
	Kunsill Nazzjonali ta' l-Anzjani	Dr Joseph Troisi – Hon Secretary	243860

		CONTACT PERSON	TELEPHONE NUMBERS
A10	National Commission Persons with Disabilities		
	Executive Secretary	Mr Alfred Bezzina	487789
A11	Secretariat for the Equal Status of Women	Ms Angela Callus – Head	446524/447220
	Action Group on Violence Against Women	Dr Lorraine Schembri Orland	446524/447220
A12	Inter-Agency Board for Housing Needs of Social Work Agencies	Mr Charles Pace	441311
A13	Department for Home Affairs		
	Victim Support Unit, Vice Squad Police General Headquarters, Floriana	Ms Sharon Zammit	224001
B	MINISTRY OF EDUCATION		
	Welfare Unit (Sarria School Annex) The Mall Floriana	Mr Tony Catania Principal Welfare Officer	243523
	Guidance and Counselling Services St Publius Square Floriana	Mr Joe Sammut – Education Officer	237906/248046
C	MINISTRY FOR SOCIAL SECURITY		
	Department of Social Accommodation	Mr J. Esposito – Director	
	REFERRALS Child Abuse & Wife Battering		
•	Ċentru Ħidma Soċjali, Santa Venera tel: 441311 or 446007 (24hrs/7 days a week) or directly to Intake Unit on tel: 449614 (up to 5.15 pm Monday to Friday)		
•	Victim Support Section Vice Squad, Police Headquarters tel: 224001		
•	Police Station (local)		
	ELDERLY ABUSE		
•	Social Workers at Dept. Care of the Elderly and Special Needs tel: 484112 (ask for Social Worker till 5.15 pm) or Ċentru Ħidma Soċjali Admission Ward – St. Vincent de Paule		

Compiled by:
Nora Macelli
Social Welfare Planning Unit
Ministry for Home Affairs & Social Development
Casa Leoni, St. Joseph High Road, Santa Venera
Revised January 1994

❀ Pakistan Society of Family Physicians ❀

FIRST SAARC CONGRESS
Lahore – Pakistan, 14-16 December 1994

❀ *Call for Papers* ❀

CONGRESS THEME

"The Family Physician in the Year 2000"

The countries of SAARC share many elements of a common heritage. Our populations remain the poorest in the world. Newer threats emerging from the *population explosion, rampant environmental degradation*, and the *AIDS epidemic* have brought to crisis proportions an already *precarious state of infant and maternal health* – characterised by *high mortality and infectious disease*. As home for a significant number of the world's population, SAARC members have a vast store of innovation which can be shared for our mutual benefit.

Recent years have witnessed a renewal of the role of the Family Doctor, and we see innovations in the practice of Family Medicine. While the profession is faced with new challenges, there are also newer opportunities which have emerged for family physicians and allied professionals during the last few years. Even though technology continues to race forward, the essence of Family Practice remains very much the same, embodied in the personality and competence of the family doctor.

As the world strives towards new goals for achieving "Health for All by the Year 2000", and as this year, designated as the Year of the Family comes to an end, it is fitting that the Family Practitioners of SAARC and other nations come together and lay the foundation of regular and meaningful interaction for our families and their health. Perspectives from our own SAARC nations, viewed against those from the more advanced countries promise to make this assembly most worthwhile. The First SAARC Congress on Family Medicine, in the enchanting city of Lahore will strive to attain this objective.

PROVISIONAL SCHEDULE

<table>
<tr><th>Date/
Time</th><th>Wednesday
14 December 1994</th><th>Thursday
15 December 1994</th><th>Friday
16 December 1994</th></tr>
<tr><td>08:00-09:00</td><td rowspan="5">Registration</td><td colspan="2">Breakfast Question / Answer Meetings</td></tr>
<tr><td>09:00-10:30</td><td>State-of-the-Art Lecture</td><td>State-of-the-Art Lecture</td></tr>
<tr><td>10:30-11:00</td><td colspan="2">Poster Session and Tea / Coffee Break</td></tr>
<tr><td>11:00-12:30</td><td>Symposium I</td><td>Symposium III</td></tr>
<tr><td>12:30-14:00</td><td colspan="2">Lunch Break</td></tr>
<tr><td>14:00-15:30</td><td>Inaugural Session</td><td>Symposium II</td><td>Symposium IV</td></tr>
<tr><td>15:30-16:00</td><td>II. Javaid Memorial Lecture</td><td colspan="2">Clinical Updates and Tea / Coffee Break</td></tr>
<tr><td>16:00-17:30</td><td>Poster Session</td><td colspan="2">Workshops / Free Papers</td></tr>
<tr><td>Evening</td><td>PSFP Meeting</td><td>Home Hospitality /
Free Evening</td><td>Cultural Programme/
Farewell Banquet</td></tr>
</table>

ISDE Workshop

Role of the General Practitioner in Environmental Protection

Cortona, 4-5 December 1993

A congress of international experts was held in Cortona (Arezzo), Italy on the 4 and 5 December 1993, on the theme "Role of the General Practitioner in Environmental Protection".

The Workshop was organized by the International Society of Doctors for the Environment (ISDE) who, although welcoming Specialists of many branches, sees its most numerous memberships represented by General Practitioners. ISDE gave the occasion for an exchange of opinions of the representatives of WONCA, the International Organization of General Practitioners, and those of the Italian representatives of the Paediatric world, of the Family medicine and of Politic.

From the reports and the debates, substantial identify of views emerged on several points: on the importance of the repercussions that pollution has on health; on the central and priority role that all over the world, the GP has on the protection of the citizen's health; and on the opportunity that this professional figure has, evermore, to concern himself with environmènt, to care better for his patients' health.

The Workshop closed with a Round Table from which emerged common "recommendations", shared by both WONCA and ISDE, which they pledge to divulge among their members.

Both sides also underlined the necessity that a closer collaboration should take place in future between the two Associations. This is in consideration of the noticeable concordance of views, the similarity of objectives and methodology of WONCA's and ISDE's GPs, that has appeared from the reports of Dr. Newman, WONCA Vice-President, European Region; Dr. Chan, WONCA Vice-President, Asiatic Region; Dr. Nussbaumer, ISDE President and Dr. Romizi, ISDE Co-president and Responsible for its International Scientific Centre.

ISDE – Head office:
Vicolo Gesova 7
Gaza Gravesano (TI)
Switzerland
Tel: 091 59 33 44

International Workshop

During the final round-table there were the following interventions on the topic of the Workshop:

Dr. Roberto Romizi *(Co-president ISDE);*
Prof. Lorenzo Tomatis *(Director, IARC, Lyon);*
Dr. Lotte Newmann *(Vice-president WONCA, UK);*
Dr. Werner Nussbaumer *(President ISDE, Switz.);*
Dr. Eddie T. Chan *(Vice-president WONCA, Hong Kong);*
Dr. Duane M. Koons *(Phisicians for the Environment, USA)*
Dr. Dario Grisillo *(ISDE, Italy);*
Dr. Mario Costa *(ISDE, Italy);*
Dr. Mauro Biagioni *(Italian Federation of Pediatricians);*
Dr. Luigi Triggiano *(Aretine Association for Epidemiological Research, Italy);*
Dr. Franco Nocera *(Aretine Association for Epidemiological Research, Italy);*
Dr. Marcello Bordiga *(ISDE, Italy);*
Chairman:
Dr. Eva Buiatti *(Scientific Committee of ISDE).*

It was agreed by the participants at the Round Table to formulate an outline of the discussion results, in the shape of proposed RECOMMENDATIONS to be sent to all Doctors for the Environment.

Aims of the Recommendations are the following:

- contribute to the understanding of the role of physicians in the protection of the environment;
- suggest practical opportunities to develop this role at an individual and at a social level;
- clarify reasons for self-identification as a member of Doctors for the Environment organisation;
- promote sharing of methods and experiences of intervention in Environmental protection;
- identify the contribution of the organisation of Doctors for the Environment to the individual colleagues to help them in their commitment for environmental protection.

Recommendations (Draft)

1 The Doctor for the Environment (DE) is aware of his/her role as family doctor in orientating the social behaviour and personal life-style of the patients and of the community at large from the point of view of personal and community health; He/she is also aware of the need of scientific self-education and instruction on communication techniques on the specific topics. He/she currently dedicates some personal time to this up-dating and also to disseminate useful and accurate information on environmental and behavioural matters within the community.

2 For the same reason, the DE personally behaves consistently with the contents of the environmental orientation he/she gives to the community. In fact, the first rule is to use example as the main method

of personal communication. His/her method of education of the population is carefully oriented to avoid the development of inappropriate guilt feelings at an individual level.

3 The DE acts in the local situation promoting the participation of physicians to the social decisions on environmental matters. This participation represents at the same time a duty and a right of the physicians, as their competence is needed to point out the relevance of environmental protection acts in preserving human health.

4 The DE currently utilizes his/her competence on environmental risk factors for evaluating symptoms of the individual patients and for orientating the diagnosis. For this purpose, he/she evaluates the appropriateness of currently using an Environmentally Oriented Medical Record.

5 The DE develops a competence for epidemiological evaluation of environmentally-related diseases at a community level and is actively committed in the production of data and information on this matter for the community.

6 The Doctors for the Environment Association (ISDE) promotes activities of permanent education of physicians in the field of environmental health, communication techniques, epidemiological methods. This activity is developed through an appropriate SCHOOL in Cortona (Arezzo, Italy).

The SCHOOL of CORTONA organizes courses, workshops, seminars on the specific matters; produces didactic material both on paper and on video in Italian and English; implements a data bank collecting international literature and individual documents produced or provided by ISDE members.

7 The ISDE institutes a WORKING GROUP for the study of an Environmentally Oriented Medical record, to be translated in several languages and sent to DEs who are willing to use it in their practice.

8 The ISDE promotes meetings and workshops dedicated to the exchange of information on practical experiences conducted by individual physicians on environmental protection or on environmental-related health problems in their area, which involved ISDE members.

9 The ISDE promotes awareness and knowledge among its associates on the methods of 'ACTIVE MEDICINE', suggesting fields of application through the exchange of experience at an international level.

10 The ISDE promotes the participation at a local, National and International level of physicians in the development of politics for environmental protection.

COMMUNITY PARTICIPATION IN PRIMARY CARE

OCCASIONAL PAPER 64

ROYAL COLLEGE OF GENERAL PRACTITIONERS

"Patients are becoming increasingly aware of what constitutes good general practice. Government welcomes this trend, and believes that patients should be able to extend their influence in developing services to meet their need."

Department of Health, 1990

Primary care is at least beginning to be accorded its rightful place in the NHS. Since one of its key features is that it operates in the community, the right of patients to be involved in identifying local needs with a view of improving local services is being increasingly recognized.

The concept of community participation in primary care is not new. In the UK it has developed from the introduction of patient participation groups, which the College was quick to encourage in the early 1980s. This latest *Occasional Paper* brings together a number of authors from different disciplines who not only explore the issues raised by the concept but provide interesting examples of how community participation actually works in practice.

Community Participation in Primary Care, Occasional Paper 64 is available from RCGP Sales, 14 Princes Gate, Hyde Park, London SW7 1PU. Tel: 071 823 9698. Price £9.00 (£9.90 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 071 225 3048.

Any enquiries about the content of this *Occasional Paper* should be made to:

Ms Zoë Heritage
6 Green Lane South
Norwich NR 7
Tel: 0603 39027

EVALUATION OF THE WINTER CPD MEETING

19-21 JANUARY 1994

Day 1: Wednesday 19th January

Gastro-oesophageal disease – Dr E Pullicino
"How I manage ..." – Dr J. Padovani

Forms returned: 44

Status:

College member:	32
Other registered doctor:	5
Houseman:	5
No reply:	2

Today's seminar was relevant to family medicine/general practice:

Agree:	42
Undecided:	1
Disagree:	1

Today's seminar increased my knowledge and/or awareness of issues:

Agree:	35
Undecided:	7
Disagree:	2

My patient care will be modified as a result of this seminar:

Agree:	24
Undecided:	8
Disagree:	8
No reply:	4

The best feature of today's seminar was:

Gastro-oesophageal disease (x11)
Dr Pullicino's lecture/discussion was very interesting
Very enjoyable lecture by Dr Pullicino – taught me a lot about the surgical management
Treatment with omeprazole/newer drugs available
Quality of slides and presentation/in general clear slides
"How I Manage ..." (x6)
Dr Padovani's talk was very practical/ thorough
Both talks *(x2)*
The lectures were not too long – so did not get boring
Fluent talk, moving smoothly from one issue to another
Both talks were clear, interesting and most informative
Both topics were very common issues in GP practice
Interesting/very common topics
Presentation
Question time

Today's seminar would have been better if:

Introduction was shorter
The two topics discussed were related
Dr Pullicino's talk had been more clinically oriented
Some (of Dr Pullicino's) slides could be renewed
Clinical scenarios, which are very interesting, perhaps could be done more often
Dr Padovani had used visual aids (e.g. overhead transparencies) to improve the communication of her very well-prepared talk
Dr Padovani had looked and talked to the audience, not reading and ruining her very good preparation. More self confidence please next time
More GP-oriented
Started on time
Drinks were available

Day 2: Thursday 20th January 1994

A naval medicine chest of the 17th century from Malta – Dr P. Cassar

"What I've learnt ..." – Dr D. Cassar

Forms returned: 28

Status:

College member:	21
Other registered doctor:	3
No reply:	4

Today's seminar was relevant to family medicine/general practice:

Agree:	14
Undecided:	7
Disagree:	7

Today's seminar increased my knowledge and/or awareness of issues:

Agree:	14
Undecided:	5
Disagree:	8
No reply:	1

My patient care will be modified as a result of this seminar:

Agree:	10
Undecided:	1
Disagree:	15
No reply:	2

The best feature of today's seminar was:

A naval medicine chest of the 17th century from Malta (x2)
The fascinating detail of the medicine chest 800 years ago
Information on old medicine
Interesting pictures
"What I've learnt ..." (x5)
Dr D. Cassar's sensitivity and awareness of the patient's needs. Well done
Dr D. Cassar's talk which helped us to see that the patient is always right
Item of how to manage one's practice
A discussion of doctoring skills
Both talks *(x2)*
Both were informative and interesting
Dr Cassar's talk *(which one?)* was rather interesting

Today's seminar would have been better if:

The historical aspect was shorter
Subject were relevant to modern medicine – nice history though
(Dr P. Cassar's presentation) was directed to history lovers only
Words on (Dr P. Cassar's) transparencies were not small and inconspicuous, and could only be seen by binoculars
Couldn't be better
Start on time

Day 3: Friday 21st January 1994

On the occasion of the International Year of the Family:
A video forum-discussion:
The role of the doctor in family violence
Opening speech – The Hon. Dr Louis Galea
Speakers – Dr J. Joslin, Dr A. Buttigieg, Ms N. Macelli, Insp. Ms S. Zammit, Dr N. Grosselfinger
Chairman – Dr D. Soler

Forms returned: 23
(Some participants did not return their evaluation forms as they used them to keep notes!)

Status:

College member:	20
Medical student:	1
Other:	2 (1 university student)

(Most, non-medical, participants simply ignored the evaluation form given to them!)

Today's seminar was relevant to family medicine/general practice:

Agree:	23

Today's seminar increased my knowledge and/or awareness of issues:

Agree:	21
Undecided:	1
Disagree:	1

My patient care will be modified as a result of this seminar:

Agree:	15
Undecided:	4
Disagree:	2
No reply:	2

The best feature of today's seminar was:

Although most battered women approach health-centre doctors simply for a police certificate, they cannot be followed-up (even if they requested help) due to the absence of medical record-keeping. At least I now can offer them help-line phone numbers, thanks to Mrs Macelli!
The conclusion of an attempt to set up a point of contact and action (official) for the abused
Challenging doctors from social work field
Information as to set-up of system
The multidisciplinary approach
Open discussion
Very well organised but too many speakers so got boring through repetition
Positive presentations
Beginning to end
Dr Joslin's talk *(x2)*
Dr A. Buttigieg's talk

Today's seminar would have been better if:

The video-presentation had been of better quality *(x2)*
The attack on doctors could have been done away with
Ms Macelli's presentation had not been very poor
A family doctor had been involved
Papers had not been repetitive
No politicians present
The Hon. Minister had not left after his opening speech, thus missing the practical recommendations made by the panel and the audience during the discussion!

EVALUATION OF THE SPRING CPD MEETING

20-22 APRIL 1994

Day 1: Wednesday 20th April 1994

Recent advances in the management of common colonic disorders – Mr A. Zammit

'How I Manage ...' Dr J.P. Cauchi

Forms returned: 35

Status:

College member:	28
Other registered doctor:	4
Houseman:	2
Medical Student:	1

Today's seminar was relevant to family medicine/general practice:

Agree:	33
Undecided:	1
Disagree:	1

Today's seminar increased my knowledge and/or awareness of issues:

Agree:	28
Undecided:	4
Disagree:	3

My patient care will be modified as a result of this seminar:

Agree:	22
Undecided:	3
Disagree:	7
No reply:	3

The best feature of today's seminar was:

Mr Zammit's *"Recent advances in the management of common colonic disorders" (x11)*
Dr Cauchi's *"How I Manage ..." (x3)*
Both were exciting/interesting *(x2)*
Very GP-oriented talk about management of colonic disorders
The mode of presentation given by Mr A. Zammit's talk
Detail of the lecture given by Mr Zammit
Insight into surgical procedures
High technical content
The thought that the second lecture could be over in a much shorter time than the first one

Today's seminar would have been better if:

Mr Zammit's presentation was more GP-oriented and less surgically technical *(x3)*
Mr Zammit's overheads had been better/ clear *(x3)*
Mr Zammit had addressed the floor/faced the audience *(x4)*
The first lecture were much shorter/more to the point/telegraphic *(x6)*
The surgeon specialist was given as much time as is given in conferences abroad
Mr Zammit's time limit had been adhered to by a chairman, otherwise these meetings would be reduced to schoolday times
It were not too long and boring!
Chairman's role is important in these meetings
More discussion
Started on time

Day 2: Thursday 21st April 1994

The Changing Face of Medicine in Malta Prof. V.G. Griffiths

'A lesson I've learnt ...' Dr C.T. Paris

Forms returned: 23

Status:

College member:	21
No reply:	2

Today's seminar was relevant to family medicine/general practice:

Agree:	14
Undecided:	8
Disagree:	1

Today's seminar increased my knowledge and/or awareness of issues:

Agree:	12
Undecided:	8
Disagree:	3

My patient care will be modified as a result of this seminar:

Agree:	8
Undecided:	5
Disagree:	8
No reply:	2

The best feature of today's seminar was:

Prof. V.G. Griffiths' *"The Changing Face of Medicine in Malta" (x3)*
It has been interesting listening to the change in medical care
Dr C.T. Paris' *"A lesson I've learnt ..." (x2)*
Dr Paris' honesty *(x2)*
Interesting/entertaining but no new information *(x2)*
Relaxing feature

Today's seminar would have been better if:

First lecture were shorter *(x5)*

Day 3: Friday 22nd April 1994

On the occasion of the International Year of the Family:
A forum on:
The family with a handicapped person
Chairman & Opening Speaker – Mr J. Camilleri;
Other Speakers – Mr & Mrs Azzopardi (Parents);
Dr P. Vassallo-Agius (CDAU);
Dr J. Muscat (Eden Foundation)

Forms returned: 29

Status:

College member:	21
Other registered doctor:	2
Other:	3 (1 student counsellor)
No reply:	3

Today's seminar was relevant to family medicine/general practice:

Agree:	28
Disagree:	1

Today's seminar increased my knowledge and/or awareness of issues:

Agree:	25
Undecided:	2
Disagree:	2

My patient care will be modified as a result of this seminar:

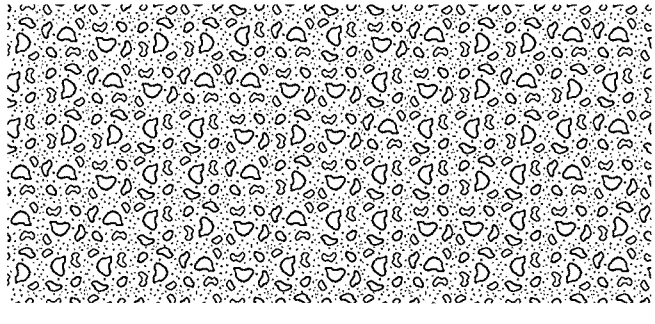
Agree:	20
Undecided:	4
Disagree:	2
No reply:	3

The best feature of today's seminar was:

The opportunity to confirm that a disparity between state and privately funded projects exists and that a lack of funds dictates policy
(The exposition of the) discrepancy of attitudes between consultant paediatrician and work being done by a voluntary association
The bringing together of CDAU and Eden, hoping that this sees the start of a new era of cooperation between them for the good of, who else but, the person with a disability!
Very optimistic views on such a heartbreaking, pessimistic subject
Well done!
Clarification of available services for disabled persons
Presence of key figures concerned with the subject
The ideas presented by Eden Foundation
Optimism despite different views
Mr Camilleri's introduction
Dr J. Muscat's talk *(x2)*
Parents' experience

Today's seminar would have been better if:

Where to refer, CDAU or Eden? Still not clear
How to actually educate the public at large apart from medical and ancillary personnel as such; funds too are more important as commitment to disabled people's management grows. So perhaps directors of/or social service staff should have attended. No funds = no progress
Disabled persons and/or their parents who had been to Eden and the CDAU could have spoken and shared their experiences with us
A government and/or health department representative was present
"The Handicapped Child" can be the subject of a 3 day symposium, and not everything crammed in one session
Appetizers served before the lecture. It was a long lecture and I was hypoglycaemic at the end!!
There was less "bla bla bla"
Not so long



TRAINING SEMINAR ON COMMUNITY PSYCHIATRY

REPORT OF DISCUSSIONS & RECOMMENDATIONS MADE BY THE PARTICIPANTS – DR. MARIO R. SAMMUT

16-20 MAY 1994

Introduction

In collaboration with the *Malta College of Family Doctors*, a **Family Doctor Training Seminar on Community Psychiatry** was organised on the 16-20 May 1994 at the University of Malta by the *Department of Policy and Planning, Health Division.* The Seminar was held under the auspices of the *Med-Campus Scheme of the European Union "Mental Health Action Project Malta"* who, besides Director Dr Joseph Saliba's multidisciplinary team of local speakers from the Department of Psychiatry, provided the following **foreign lecturers**:

Professor Franz Boro,
Professor John Henderson,
Dr Michel Malfroid.
Professor Alfred Sand,
Professor Morton Wagenfeld,

As part of its reform strategy, the Mental Health Reform contemplates the introduction of psychiatric services at community level. For this purpose the **Scientific Board for Mental Health Reform** has identified Qormi as its pilot area – covering Qormi, Zebbug and Siggiewi districts – with the Qormi Health Centre being earmarked as the focal point from where these services will be extended.

Most of psychiatry is (as it should be) managed in the community by family doctors, with referral for specialist care only when needed. Therefore the aim of this seminar was as a refresher/ introductory course for family doctors in the prevention and management of specific common psychiatric problems.

The training seminar was targeted primarily at doctors working in the pilot area but was also made open to members of the Malta College of Family Doctors. The **participating family doctors** were:

Dr Louis Bonello
Dr Francis Borg
Dr Alexandra C. Buttigieg
Dr Moses Camilleri
Dr Wilfred Galea
Dr John Gauci
Dr Jacqueline Kunovska
Dr Mark Mangion
Dr John Mifsud Navarro
Dr Tania Mizzi
Dr Valerio Vella Catalano
Dr Christopher Muscat
Dr Jacqueline Padovani
Dr Joseph Portelli Demajo
Dr Mark Rosso
Dr Alexander Sammut
Dr Carmen Sammut
Dr Mario R. Sammut
Dr Eric Scerri
Dr Marcel Schembri
Dr Philip Sciortino

Monday 16 May: Morning Session

Theme: **MENTAL HEALTH CARE IN A PRIMARY SETTING**

Panel: Prof. F. Baro, Prof. A Sand, Dr J. Saliba (Psychiatrists), Mr J. Busuttil (Occupational Therapist), Mr N. Mulvaney (Psychiatric Social Worker), Mr J. Borg (Psychiatric Nurse), Mr P. Sciberras (Clinical Psychologist)

Recommendations made by participants during the discussion:

- That **continuity of care** be improved through (a) **registration** of patients with a doctor or group of doctors and (b) the keeping of **medical records**;
- That family doctors be given more **time to develop a personal relationship** with their patients, through (a) the provision of **secretarial help** to cut down on

the time wasted on paperwork, and (b) the introduction of an **appointment system** for patients to be followed-up;

- That a **system of referral** to the other members of the **multidisciplinary team** be introduced, together with an effective **system of communication** between the family doctor and the other members of the team;

- That family doctors are provided with **training** (a) **in counselling** skills and (b) **in management** skills (including time management);

- That **inadequate staff-levels** of health-centre doctors and other members of the multidisciplinary team (clinical psychologists, occupational therapists, psychiatric nurses, and psychiatric social workers) **be corrected.**

Monday 16 May: Afternoon Session

Theme: **PSYCHOSOCIAL ASPECTS OF MENTAL HEALTH CARE**

Chair: Prof A. Sand (Psychiatrist), Dr M.R. Sammut (Family Doctor)

- Psychosocial Factors in Mental Health Care – Sense of Coherence: *Prof M. Wagenfeld*
- The Roles of the Social Worker, Psychologist & Occupational Therapist: *Ms D. Gauci, Mr M. Micallef, Ms D. Bonello*

Questions, comments & suggestions made during the discussion:

Dr W Galea asked whether the **sense of coherence** described by Prof Wagenfeld **can be influenced by the medical profession**, and on a 'longitudinal basis', i.e. as a generation growing up. Prof Wagenfeld replied in the affirmative, stating that the sense of coherence is part of the person's personality which is **built up during the person's formative years.** The answer to Dr J. Portelli-Demajo's question whether the sense of coherence is **transferable to other life situations**, was also in the affirmative.

Mr P. Sciberras, a psychologist, remarked however that the **resources of strength**, especially of health carers themselves, **are not limitless**. Therefore, to relieve carers of stress, patients may need temporary admission to some form of institution (**respite care**). Prof Wagenfeld agreed and stated that persons with a strong sense of coherence would be more liable to seek **help from health-care professionals.**

Dr A Buttigigieg asked for more information for family doctors concerning the full utilisation of the **services of the psychiatric social worker (PSW), the clinical psychologist (CP) and the occupational therapist (OT)**, as she was under the impression that these services were still inaccessible to family doctors. Dr J. Saliba here remarked that in fact family doctors at present can only **liase with PSWs in emergency situations.** Referrals to **CPs and OTs should be made through the psychiatric O.P.** department – however doctors should indicate specifically the reason for referral.

Dr J. Portelli-Demajo complained about the **lack of communication** between the family doctor and the other members of the multidisciplinary team. Ms D. Gauci, a PSW, admitted that this was a problem as in an increasing number of cases **patients do not have their own family doctor.** Mr N. Mulvaney, a PSW, pointed out that if the family doctor is to become the mainstay of the community mental health service, one cannot imagine this succeeding if the present primary health care system persists with its **lack of continuity of care** and hence **no lasting doctor-patient relationship.** This was agreed to by the doctors attending the conference.

Wednesday 18 May: Morning Session

Theme: **FAMILY ASPECTS OF MENTAL HEALTH CARE**

Panel: Prof A. Sand, Dr J. Saliba, Dr J. Vella Badacchino (Psychiatrists)

Questions, comments & suggestions made during the discussion:

Prof A. Sand and Dr J. Saliba emphasized the importance of the parents as **authority figures** for the child/adolescent – but **in a responsible way**, discussing and guiding rather than imposing, added Dr J. Vella Baldacchino.

Prof Sand noted that parents have an important role in helping their children digesting and **understanding the information they get from the media** to avoid their unknowing copying of criminal behaviour, in a reply to a question by Dr P. Sciortino.

Dr J. Saliba stated that parents have to **avoid being excessively protective** of their children so that the latter can learn from experience (**"burning one's fingers"**). They must try to be always in tune with their children while striking a fair balance, agreeing with Dr W. Galea. Dr Vella Baldacchino added that **single incidents must be taken in a wider context,**

looking deeply for the reason behind any actions of delinquency.

Dr M. Camilleri raised the problem of **adolescents abusing of drugs** from their parents' supplies. Dr Vella Baldacchino emphasized the important role of the family doctor (FD) here in **digging deep for the underlying reason** for any substance abuse and **providing the necessary counselling.** Prof Sand added that it is important, as a first step, for the parents to **just be there** for the child in such cases (e.g. simply going fishing together) to fill the void felt by the child which caused him/her to turn to drugs in the first place.

In reply to a comment by Dr M. Rosso, Prof Sand disagreed with the tradition that mothers are always given custody of the children in cases of separation, and stated that ideally **custody should be shared equally** by both parents. The panel agreed with Dr Saliba's comment that the troublesome behaviour of a child in a divided family may be a **subconscious attempt** to try to get the parents back together.

Families which have been **officially reconstituted** *(after divorce)* may offer a **more stable environment** to children than the locally-prevalent situation of unofficial cohabitation **(after separation)**, by **allowing them time to accept a "new" parent,** commented the panel in reply to questions by Drs A. Sammut and W. Galea.

Dr Vella Baldacchino agreed with Dr E. Scerri's comment that some parents, due to ignorance, tend to **overemphasize negative aspects** in their children's behaviour. Dr Saliba added that FDs have a role here in educating parents that a certain amount of friction and **misbehaviour is the norm** in most families.

Youngsters should be helped in **coping with stressful situations through cognitive therapy** rather than being given benzodiazepines: they have to learn to face certain problems, rather than conveniently bypassing them, stated Dr Vella Baldacchino in reply to a question by Dr L. Bonello. Dr Saliba said that they might have to be tided over the crisis for a few days, but in the long run the **underlying problem of parental pressure has to be tackled.** Dr A. Buttigieg emphasized that the present pressure of the Maltese education system which puts **too much accent on examinations** needs to be corrected, stressing the importance of guidance by **genuine well-trained counsellors** here. Doctors have to bet the balance right between **enhancing health while soothing distress,** added Dr Saliba.

In conclusion, Dr Saliba revealed that, according to research, the **cause of adolescent suicides would be considered a mundane reason** by others, although for the adolescent it was big enough to push him/her over the edge. Prof Sand described the difficulties, after an adolescent suicide, of **helping parents with their guilt-feelings.**

Wednesday 18 May: Afternoon Session

Theme: **THE FAMILY WITH A DISABLED MEMBER**

Panel: Mr J. Camilleri (Commission for the Disabled), Prof A. Sand (Psychiatrist), Dr E. Tanti Burlo (Psychologist), Mr G. Scerri (Eden Foundation), Parent

Recommendations made by the participants during the discussion:

- That parents be educated so that when the disabled person is ill, he/she should not be taken straight to the specialist, but that they **seek the advice of their family doctor (FD) first;**
- That **services available** for the disabled and their families not only **be made know to the FD,** but that the **FD actually be involved** in the care by these services;
- That there be a **sense of courtesy in communication between professionals** (so that, for example, a referral to a specialist does not result in a lost client);
- That persons with disabilities are, as far as possible, **not segregated from but integrated with** society (e.g. a child in a mainstream not a special school);
- That the care of persons with disabilities be done in a **holistic manner** by an **independent multidisciplinary team** (free of any bureaucratic interference);
- That some FDs be **humble enough to admit their limitations** and refer for further management when needed; and that some specialists **give the exact diagnosis of a disabled child** to parents so that they can seek further help from the right place;
- That the public be **educated on how to behave with and treat** persons with disabilities;
- That FDs and specialists be circulated with **information on developmental disabilities to help them to make an early diagnosis** and enable super-specialist intervention to be as early as possible;

- That the government **assist the development of support groups** to help families with persons with disabilities;

- That the Eden Foundation's **IEP (Individual Education Programme)** – used to tailor education according to the need of the disabled individual through a facilitator – **be more widely adopted** by other educational establishments;

- That, just as the ETC is **subcontracting the training** of disabled adults to the Eden Foundation, other government organisations do the same (where possible) with other forms of care to the relevant competent NGOs.

Thursday 19 May: Morning Session

Themes: **COMMUNITY ASPECTS OF MENTAL HEALTH CARE & THE ROLE OF THE COMMUNITY PSYCHIATRIC NURSE**

Panel: Prof A. Galea, Dr M. Malfroid, Dr D. Cassar (Psychiatrists), Mr M. Haydn (Community Psychiatric Nurse)

Recommendations made by the participants during the discussion:

- That **patients are registered with family doctors.** At the moment, psychiatric patients are registered with the psychiatric outpatient department so that any relapsers are sent for and, as happens in Gozo, a community psychiatric nurse is sent out to investigate if a patient does not respond.

- That the family doctor (FD) have under- and post-graduate **experience in mental health care**, together with **rapid access to specialist** advice and management.

- That the **lack of communication** between the FD and the specialist services in the present system **be corrected.**

- That there is the development of a **multidisciplinary team with coordination** of the different community services to avoid the present system of each community worker working on his/her own in a disparate way. This coordination of course has to be preceded by **awareness and goodwill.** The members of the team have to know clearly their **specific area of responsibility:** although they are all on the same hierarchical level, with the **FD at the hub**, one member however must have **overall responsibility.**

- That more people are trained directly for the role of **community psychiatric nurse (CPN) to fill the gap** that is sorely felt for them in community psychiatric care.

- That this **role of the CPN cannot be filled by the psychiatric social worker** (PSW) – rather, they have to **work together.** The CPN can be sent by the FD to be first on the scene in a community psychiatric case, and then report back. Also, the CPN (together with the PSW) can make sure that rehabilitated patients who are discharged back to society have a suitable family and home awaiting them and then follow them up.

Thursday 19 May: Afternoon Session

Theme: **VIOLENT BEHAVIOUR IN THE FAMILY**

Panel: Dr M.R. Sammut (Family Doctor), Prof A. Sand, Dr D. Cassar (Psychiatrists), Ms M. Cachia (psychiatric social worker), Ms C. Zammit (senior social worker), Supt D. Gatt (Supt i/c Vice Squad)

Questions, comments & suggestions made during the discussion:

The panel agreed with the point made by Dr W. Galea that **not only abused need help**, but also the abuser and the other members of the family.

Dr P. Sciortino suggested that the victims are educated to **seek help early on** when the problem is more amenable to a remedial measures.

Dr A. Buttigieg clarified that the **situation re-consultation in cases of family violence differs** in health centres, where victims are referred by policy just for a certificate to be presented as evidence in court, from private family medicine, where the problem is that the family doctor (FD) is involved with only one side (e.g. the victim) while another FD ends up acting for the other side (the aggressor)!

Dr J. Portelli Demajo noted that in cases of family violence the aggressor usually has a **family history** of the problem (fighting between his parents). Dr Portelli Demajo revealed also that he tries to **quiz prospective wives for any signs of incipient violence** by the prospective groom so that, in such cases, he can open their eyes to a possible future of wife-battering with a view to prevention.

Dr J. Mifsud Navarro indicated the **different point-of-view in cases of family violence of the police** (regarding protection of the abused and proceeding against the abuser) **and the family doctor** (who tries to care for the family unit as a whole).

Supt Gatt, in answer to a question by Dr L. Bonello, stated that there are **specific types of injury which by law have to be reported** to the police. At this point, Dr C. Sammut noted that it is **not simple to classify injuries only as slight or grievous** (as specified by the law), as many injuries can be described as moderate and others involve psychological harm. Supt Gatt replied that **in cases of psychological victims, the court asks psychiatric experts** to draw up reports.

Dr W. Galea asked what the legal position is of a wife voluntarily leaving her home due to battering by her husband. After describing the **facilities available for battered wives** (Dar Merhba Bik and Cini Home) and the **financial help available** to them from the DSS, Ms Zammit stated that if a wife has a good reason for willingly leaving home, she will **not lose the legal right to her property**.

Dr M. Schembri brought up an example of **child abuse** which was plausibly explained away by the parent, making the point that any **suspect cases should be referred** at once to the social workers. Ms Cachia echoed this advice, stating that the **earlier they can intervene, the better** it is for the victim.

Dr M.R. Sammut concluded by urging the participants to make **good use of the available statutory welfare units** through the list of contact names and telephones numbers distributed courtesy of the Malta College of Family Doctors.

Friday 20 May: Morning Session

Theme: **ADDICTIVE BEHAVIOUR AND SUBSTANCE MISUSE**

Panel: Prof. A Sand, Dr J. Mifsud, Dr J Vella Baldacchino (psychiatrists), Mr J. Gerada, Dr M. Sciberras, Dr M. Camilleri (Santa Marija Hospital & Detoxification Unit)

Questions, comments & suggestions made during the discussion:

- That a service is set up providing a **first contact with trained personnel** to provide information and guidance for parents, relatives, teachers, etc. with a problem of a suspected drug abuser. Prof A. Sand and Dr J. Vella Baldacchino revealed the provision of **telephone helplines** in Belgium and Italy.

- That the introduction of a **patient registration system in community care** would go some way towards solving the problem of uncontrolled repeat prescriptions for benzodiazepenes in health centres.

- That a strategy be developed for **prevention of the drug-abuse problem at places of work.** Dr J. Portelli Demajo emphasised the **importance of the sign of pilfering** at home or work as a symptom of drug abuse.

- That **urine testing for drugs be used more** to investigate suspected drug-abusers – this test can be ordered even at health centres, according to Dr J. Mifsud, who emphasised the **importance of the supervision of the patient** in that he is actually passing the urine for the sample him/herself. Dr J. Portelli Demajo reminded participants that the **patient's consent** has to be obtained for such tests.

- It was revealed by Dr M. Sciberras in reply to a question by Dr M. Schembri that there is an **agreement with the police** force that prisoners at the CID Lock-Up who are **addicts are taken to the Detoxification Unit** at St Luke's Hospital in case of a problem of **suspected withdrawal.**

- Dr M. Sciberras and Dr M. Camilleri appealed that **family doctors refer addicts to the Detox Unit** for help (who offer them the 'carrot' of methadone to get hem to attend in the first place).

- That the problem of lack of **communication between the Detox Unit and the psychiatric services** be ironed out because, as revealed by Dr J. Mifsud, this is causing difficulties with, e.g. the different policies re the provision of methadone.

- In answer to Dr C. Sammut, Dr M. Sciberras stated that, although it is not being done enough, **families are tried to be involved** in the care of the addict. In court cases, a **sentence is left hanging over the addict to serve as a deterrent.**

- Dr M.R. Sammut expressed the wish that the **service of free syringes** for addicts at health centres, which is serving to prevent the spread of infection among them, would be **utilised as a contact** perhaps for counselling and reaching-out. Thus it was recommended that there be a **service of reaching out to and motivation of addicts.** Moreover, **families have to be educated** in not enabling the addicts to continue, but rather to stop!

- Dr P. Sciortino made the point that prevention is better than cure. As the FD is in the first line, how can he be helped and backed up in this? Dr M. Sciberras offered **help in testing any suspicious substances** at Detox, and gave details of a clinic she is running at Paola where **parents with children with a (suspected) drug problem can come for initial advice and guidance.** Its details are:

Address: 17, G. Damato Street, Paola
Opens on: Tuesday at 6-8 p.m.
Telephone: 66 60 54

- In **case of overdose**, Dr M. Sciberras stated that this can happen with even a normal dose if the addict is in withdrawal. The signs with different drugs are:

	Heroin	Cocaine	Barbiturates
PUPILS	pinpoint	dilated	normal
HEART/RESP RATE	decreased	tachycardia +++	decreased
Crises intervention involves:	support respiration refer to hospital give antidote		

- Dr J. Mifsud finally described his experience of **group therapy for addicts in prison**, where attempts were actually made to use him as a source of drugs, thus forcing him to stop this specific service, although psychiatric counselling continues on an individual basis.

Participants at the Training Seminar on Community Psychiatry