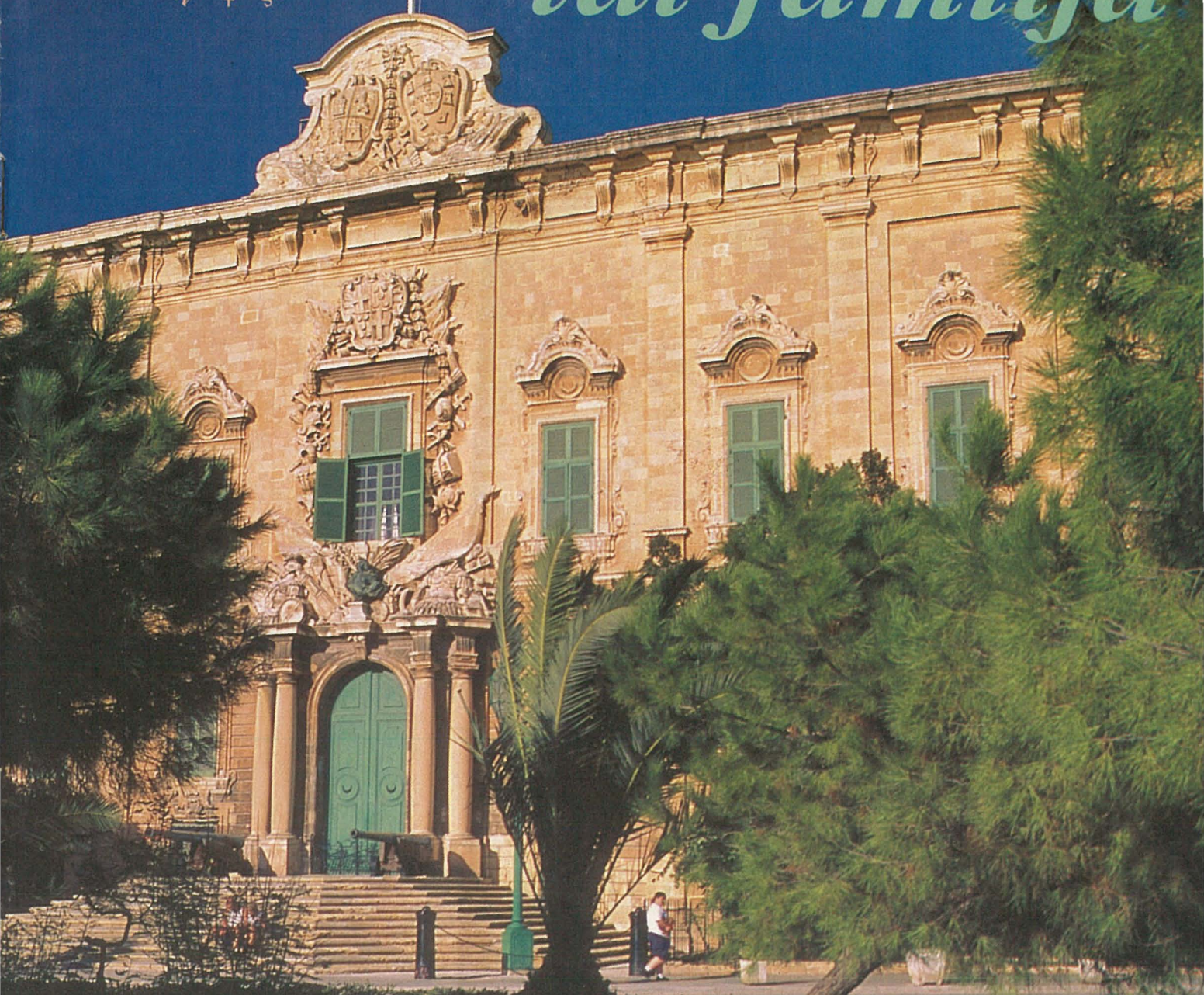




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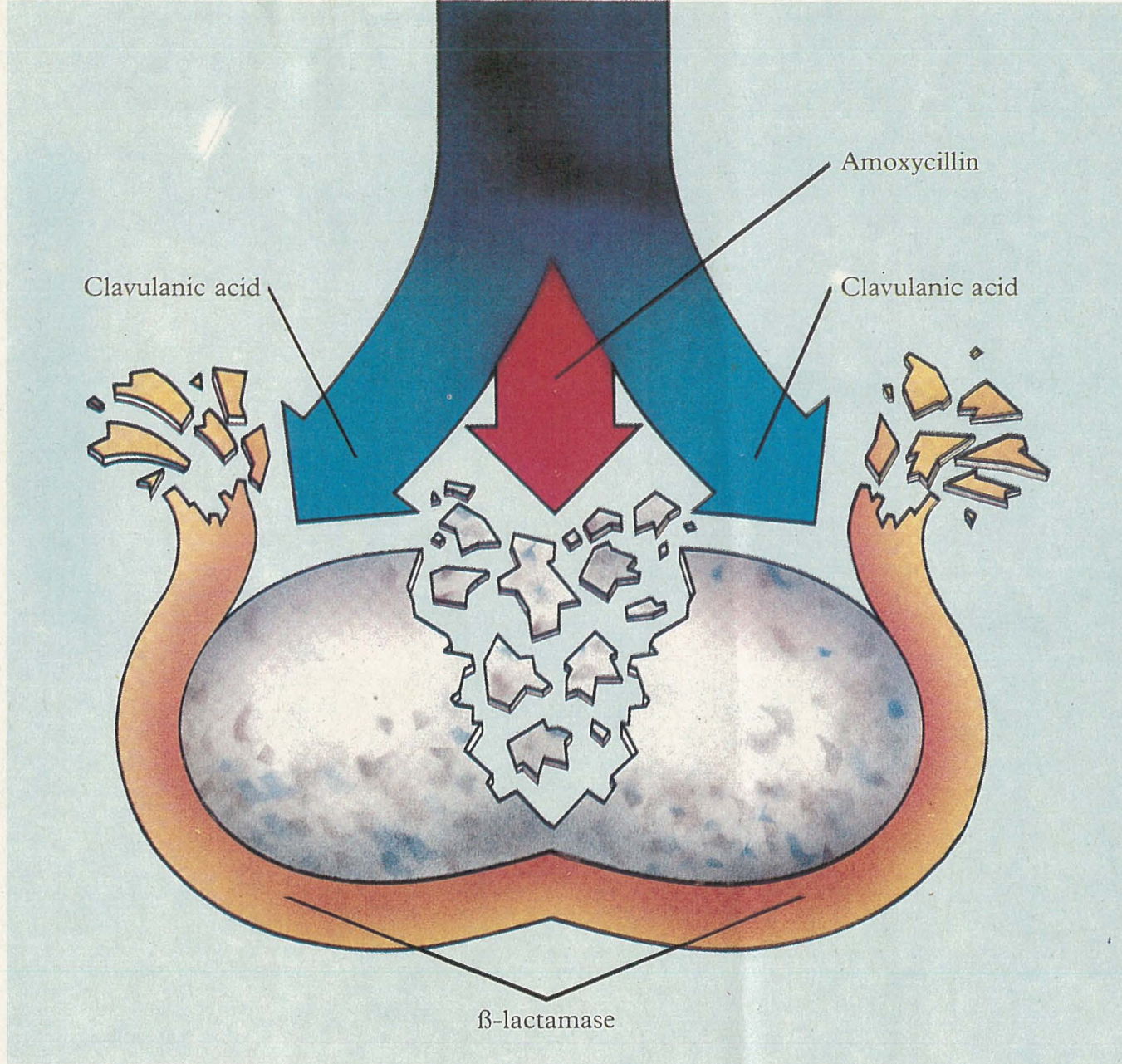


JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

ISSUE No. 9

DECEMBER 1995

- Acute Neurological Admission and Exposure to Carbon Monoxide
- Summary of Survey Results: Physicians' Attitudes Towards Notification of Infectious Diseases
- Factors Involved when a Child is Brought for a Medical Consultation
- Inaugural Conference of the WONCA Region Europe - European Society of General Practice/Family Medicine (ESGP)



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References: 1. Bluestone CD, Drugs 1986; 31(Suppl 3): 132. 2. Jaffe AC, et al. Postgrad Med 1984; Suppl Sept/Oct: 199.
3. Focht J, et al. Chemother 1988; 34(4): 332. 4. Lim BT, et al. J Drug Dev 1989; 2(Suppl 1): 15. 5. Finch R. Med Int 1988; 52: 2146.
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Editorial

Dear Readers,

This issue will be published late, mainly due to the delay in publishing the first issue of 1995, which was in turn due to the numerous changes to the layout. I hope you will bear with us, and you can expect the next issue to be published around June.

In this issue we are introducing a new feature. A paper written by a specialist will discuss the management of clinical entities encountered in our practice. The first article by Dr. Martin Balzan is about carbon monoxide poisoning, which though not so common, may be easily missed with tragic consequences. We are also reproducing Dr. Peter Fenech's "A lesson I've learnt", an interesting article by Dr. Muscat Baron looking at the consultation from an unusual angle and a study by name of author about our attitudes towards notification of diseases.

The college was represented at the Inaugural Conference of the European Society of General Practice/Family Medicine (ESGP). A full report is reproduced in this issue.

The college continues to be engaged on the formulation of a specialist training programme in family medicine. The recent visit by Prof. Douglas Johnson was very opportune, as we had an opportunity to discuss our plans with him in detail. The college also wishes to review its plans with various international contacts before going on to release the final document.

Preparations for the European General Practice Research Workshop in October are in a very advanced stage. The workshop will be held from Friday the 4th to Sunday the 6th October at the Atlas Hotel in St. Andrews, and local doctors are invited to attend. The workshop deals with research in General Practice, and will be attended by leading academics from European colleges and universities.

The college will be represented at the WONCA meeting in Stockholm, Sweden in July, and at the European General Practice Research Workshop in Vaxjo, Sweden being held in May.

The enormous crowd present for the funeral of Graziella, daughter of the College Hon. Secretary Dr. Mario Sammut was a very moving experience. We shall continue to remember her and her family in our prayers.

Jean Karl Soler

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Cover Photo taken by J.K. Soler: Castile Palace.

ACUTE NEUROLOGICAL ADMISSION AND EXPOSURE TO CARBON MONOXIDE

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Abstract

Carbon monoxide poisoning produces central nervous system hypoxia and frequently presents clinically in occult form. From December 1994 to March 1995 we screened 305 patients admitted for acute neurological problems to St. Luke's hospital for exposure to Carbon monoxide by determining blood carboxy-haemoglobin levels on admission. A questionnaire on indoor air pollution was also administered.

Three cases of acute intoxication are documented. The mean carboxy-haemoglobin of the other 302 patients was 3.24% (95% CL 0-7.4, n=43) for smokers and 0.73% (95% CL 0-1.90, n=259) for non-smokers. Five non-smokers and two smokers had levels higher than the upper limit. This level was probably only clinically significant in one case of a heavy smoker with transient ischaemic attack. There were no cases of exposure amongst strokes (n=141), epileptic fits (n=39), or episodes of loss of consciousness (n=87). However 3 out of 29 patients with impairment of consciousness without focal neurological signs had intoxication.

Although this intoxication does not appear to be very common, a high index of suspicion must be maintained, as 34% of the patients questioned had at least one potential source of carbon monoxide within their household. For this reason we suggest that, information on indoor heating should be part of routine history taking of acute neurological problems, particularly when impaired consciousness is persistent in the emergency room. Carboxy-Hb levels should be taken when there is even the slightest suspicion of exposure, as early treatment of this intoxication with high concentration oxygen therapy is very effective.

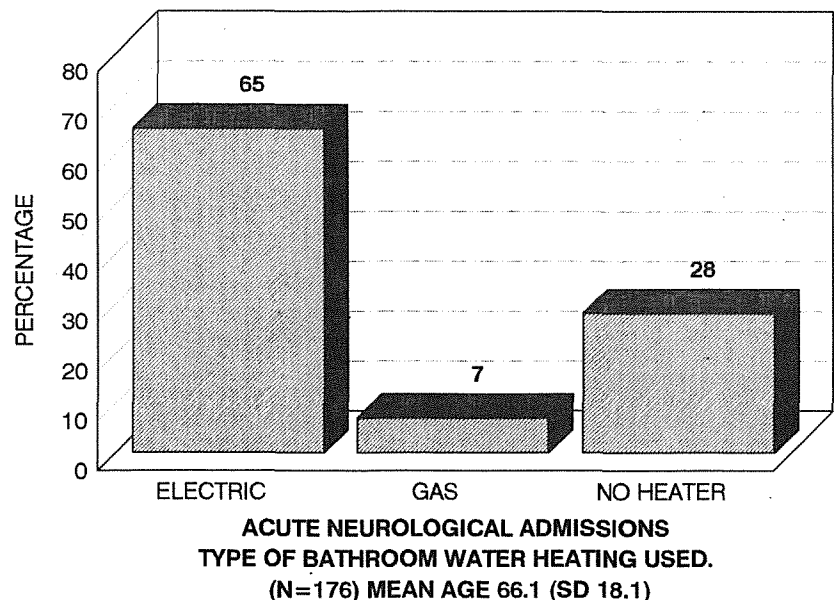
Introduction

Carbon monoxide is produced mainly by incomplete combustion of fossil fuel. Carbon monoxide (CO) binds to the haemoglobin molecule with much greater affinity than oxygen, and shifts the oxygen dissociation curve of the remaining haemoglobin to the left. The central nervous system and the myocardium, being the most susceptible tissues to hypoxia are most frequently affected¹.

The classical clinical picture of severe CO poisoning with carboxy-haemoglobin (CO-Hb) levels of above 50%, is that of unconsciousness with or without epileptic fits.^{1,2} Lower levels i.e. 20-50% tend to cause fainting episodes, headache³, vertigo, or

exacerbation of angina pectoris⁴. The clinical diagnosis of this condition, for which treatment with hyperbaric oxygen therapy⁵ is so effective, may not be easy.

First of all the gas is colourless and odourless and the patient, his family, ambulance and emergency room staff may not be aware of the exposure. None



of the presenting clinical features are unique and the patient might be admitted to hospital with a working diagnosis of 'stroke' or 'unexplained unconsciousness' or 'confusion'^{6,7,8}. Furthermore it has been shown that patients with underlying cerebrovascular or cardiovascular disease could present a different and atypical clinical picture with CO-Hb levels as low as 10-20%. These patients could be admitted to hospital with 'epileptic fit'^{9,10} or 'unstable angina'⁴ without this toxic exposure being recognized.

The aim of this study was to screen a population of acute neurological admissions to a general hospital during the winter months so as to (i) identify and describe cases of CO poisoning, particularly trying to identify 'occult' presentations, (ii) to determine the indoor fossil fuel utilization of this group, so as to establish what percentage of this patient population has a potential source of intoxication within the household.

Patients and methods

St Luke's hospital is the only acute medical facility serving the whole of the island of Malta (population around 330,000). From the 5th December 1994 to the 31st March 1995 all acute neurological admissions were to be included in the study. Diagnostic categories were (i) presumed stroke i.e. patients presenting with recent onset of dysphasia, dysarthria, or unilateral weakness or numbness. (ii) Generalized or focal motor seizures; (iii) Episodes of loss of consciousness, with full recovery. If the cause was evident e.g. hypoglycaemia, heart block, drug overdosage the patient was still included; (iv) Any patient with unconsciousness, obtunded sensorium or confusion but with no focal neurological signs on admission and (v) history of recent headaches. Patients with anaemia were excluded. (<12g/dl females, <14g/dl males).

Blood CO-Hb was determined on admission with an IL 482 CO oximeter (Instrumentation laboratories, Lexington, Massachusetts). Two CO-Hb calibration standards were used regularly to check the calibration of the instrument. An effort was made to make the result available to the attending clinician within one hour of admission so as to be able to provide treatment where necessary.

average quantity of cigarettes smoked per day in the week prior to admission was noted. Patients were questioned on the use of gas and kerosene space heaters and bathroom water heaters in the household and exposure to fires or car exhaust. In the absence of questionnaire data, smoking data was obtained from the patient's case notes.

	SMOKERS	NON-SMOKERS	TOTAL
Mean age (years)	52.8 (S.D. 21.4)	69.0 (S.D. 18.3)	66.7 (S.D. 19.6)
Mean CO-Hb (%)	3.24 (S.D. 2.12)	0.73 (S.D. 0.59)	1.09 (S.D. 1.09)
Male (n)	29	99	128
Female (n)	14	160	174
Total	43	259	302

Table 1. Acute neurological admissions; control group
CO-Hb=Carboxy haemoglobin

When calculating peak CO-Hb levels, a standard reference chart was used¹. The possible shortening of the half life of CO-Hb by oxygen given by ambulance or emergency room personnel was not included in the calculation. This could have led to an underestimation of peak CO-Hb levels. It was assumed that there was no further decay in CO-Hb levels after blood sampling¹.

The morning following admission a standardized questionnaire was administered to the patient or one of his household if he was unable to communicate. Only two of the authors of the paper collected this information. Besides basic demographic information, the

Results

336 patients were eligible for inclusion into the study. CO-Hb was determined in 307 (91%) patients. 2 patients were excluded because of anaemia. Three patients had clear evidence of CO poisoning. (Cases 1,2 and 3). The other 302 patients were used to determine a control value for mean CO-Hb in both smokers and non smokers. 141 (46.7%) patients had presumed stroke or transient ischaemic attack, 87 (29.8%) an episode of loss of consciousness, 39 (12.9%) epileptic fits, 26 (8.6%) impaired consciousness and 9 (3.0%) headaches. Table 1, shows the characteristics of the whole group. There was no significant difference between the mean CO-

SOURCE OF CO	NUMBER	%
Kerosene Heater	31	(14.4%)
Kerosene Stove	27	(12.5%)
Gas space heater	17	(7.9%)
Gas water heater	12	(5.6%)

Table 2. Source of CO in acute neurological admissions.
(n=215, mean age 65.4 s.d. 18.9, female 116, 54%)
CO=Carbon monoxide:

*some patients have more than one source

Box 1**Clinical features of CO poisoning and CO-Hb levels***

<10%	Asymptomatic
10-20%	Unstable angina in coronary artery disease
20-30%	Headache, Vertigo
30-50%	Severe headache, Vomiting, Disturbance of Consciousness
>50%	Coma, Convulsions, respiratory depression death

**Broad individual variation*

Hb of all 5 diagnostic categories in smokers and non-smokers respectively.

5 non-smokers had a CO-Hb level outside the 95% confidence limits. As the CO-Hb levels recorded were all between 2-3% none was considered clinically significant. Two smokers had a CO-Hb level outside the 95% confidence interval. One had cerebral haemorrhage and a CO-Hb level of 8%, and it was assumed that this was of no clinical relevance to the neurological diagnosis. A second patient with a CO-Hb of 8.9% will be described as case 4.

Complete information on indoor heating and indoor pollution was only obtained in 215 patients (71.2%) as seen on Table 2. However, the age and gender distribution mirrored the whole 302 patient group very faithfully. 73 (34%) had at least one potential source of intoxication in their house hold.

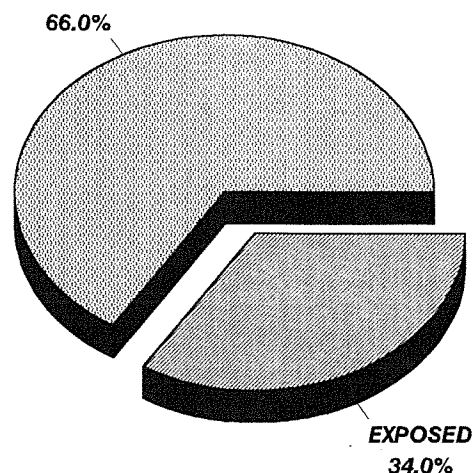
Case 1. A 28 year old man attempted to commit suicide. He switched on his car and stayed inside the car which was lying in a communal three car garage. Inadvertently he had left the garage door ajar. After about 1 hour an owner of a second car inside this garage found him

unconscious. The car was switched off and he was carried out of the garage into the open air. Within twenty minutes of exposure he was in the emergency room. He was deeply comatose with a CO-Hb level of 60.2%. Peak CO-Hb levels probably reached 70%. Electrocardiogram was normal apart from sinus tachycardia. He was started on 100% oxygen and transferred to a hyperbaric chamber in 20 minutes. He was given 100% oxygen at 2.8 atmospheres for 90 minutes by the end of which he was fully conscious. He was also treated with dexamethasone 2mg 8 hourly and cimetidine 200mg twice daily intravenously. Two other courses of hyperbaric

therapy were administered every 8 hours. By the third day he was up and about with some headache. Dexamethasone was tailed off over 10 days.

Case 2. A 75 year old man was found unconscious by his wife in a one car garage. According to his wife he had been attempting to repair his car. He had switched on his car about 10 minutes before. The door was closed. He arrived in the emergency room, about 20 minutes later. His CO-Hb was 25.2%, and probably peak level had been around 30%. He was semi-conscious and responded to name. His reflexes were brisk but there were no focal signs. The electrocardiogram only showed a partial right bundle branch block. He was started on 100% oxygen and about 30 minutes later received 100% oxygen at 2.8 atmosphere for about one hour in the hyperbaric chamber.

At the end of this treatment he was fully conscious. He received dexamethasone 2mg 8 hourly and cimetidine 200mg twice daily intravenously. However over the next three days he complained of severe headache and a cerebellar gait was noted. He improved rapidly and could walk unaided after 10 days. Dexamethasone was tailed off.



ACUTE NEUROLOGICAL ADMISSIONS. (N=215)
PROPORTION OF PATIENTS HAVING A SOURCE OF CARBON MONOXIDE INDOORS

Box 2

Difficulties in the Diagnosis of CO poisoning

- *Gas is colourless, odourless and non-irritant.
- *Patient may be unaware of the exposure.
- *Ambulance staff, co-habitants unaware of exposure.
- *Patient with impaired consciousness unable to give history.
- *No pathognomonic feature of the intoxication. (Textbook cherry red colour, a rare finding).
- *Mimics common conditions such as unstable angina, drug overdosage, status epilepticus.
- *Patients with underlying cardiovascular and cerebrovascular disease can have an atypical presentation.

Case 3. A 78 year old lady, who suffered from diabetic nephropathy and retinopathy and was previously already in a frail condition was referred to hospital with severely obtunded sensorium. She was a non-smoker and at 9.00 am her CO-Hb was 4.5%, and blood glucose 11.2 mmol/l. She has been well until the previous day. Her daughter had then used a kerosene heater in the patient's bedroom from 10.00 am to 9.00 pm. She had noticed her mother to be very sleepy and decided to switch off the heater. By 7.00 am next day she found her mother to be unarousable.

In casualty she was noted to respond to pain but not to name. Reflexes were absent but plantars were upgoing. There were no localising signs. CT scan of the brain was not performed. She was rehydrated and given intravenous cefuroxime, but she died of bronchopneumonia 6 days later. A metabolic screen did not reveal any alternative explanation for her deterioration. It was calculated that the peak CO-Hb levels 12 hours before admission would have been around 15%.

Case 4. A 43 year old man was seen in the emergency room for right hemiparesis with dysarthria. CO-Hb on admission was 8.9%. He had no source of indoor pollution in his household but had been smoking up to 40 cigarettes per day. Two hours before admission he had had the same neurological deficit but his resolved completely within 15 minutes. He had not smoked a cigarette since that moment so that his peak levels were probably around 12-14%. However, the same symptoms occurred again one hour later.

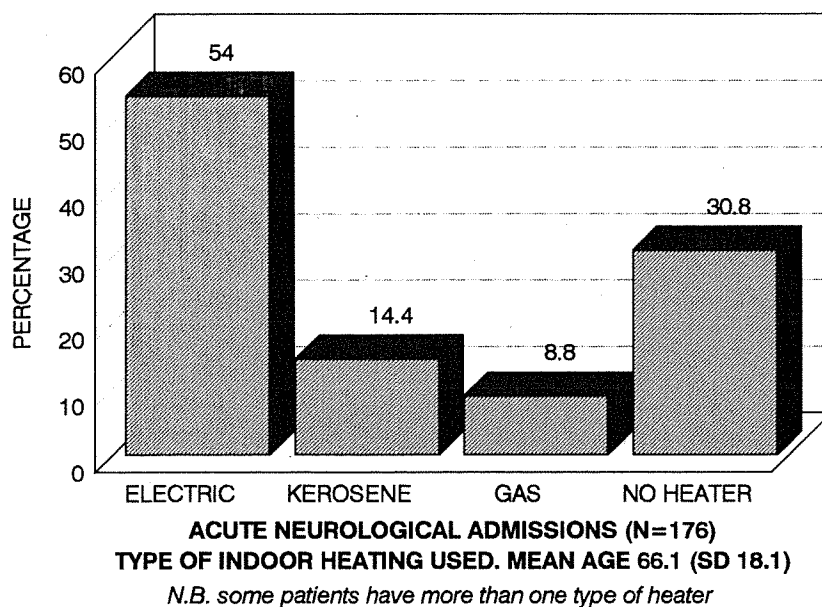
CT scan of the brain was normal and within 24 hours of onset there was no neurological deficit. There was no source of emboli in his heart and carotids. However, this was considered a case of cerebrovascular thrombosis or embolism with ischaemia exacerbated by high CO-Hb levels from cigarette smoking.

Discussion

Out of 305 patients screened, only three patients had evidence of intoxication. In two patients the diagnosis was made by ambulance staff who immediately recognised the intoxication. Only one case, was 'occult' or discovered as a result of the study.

None of the patients with stroke had evidence of intoxication, while none of the patients with intoxication had focal neurological signs. All three patients had impaired or obtunded sensorium. If one had to look just at patients with obtunded sensorium with no focal neurological signs, then 3 out of 29 had intoxication, that is around 10%.

Out of 39 patients admitted with epileptic fits, none had evidence of intoxication and the mean CO-Hb level was not



Box 3

Tips for the clinical diagnosis of CO poisoning

Why is it important to diagnose?

- *To identify those patients likely to need 100% or hyperbaric oxygen treatment so as to prevent long term neuro-psychiatric sequelae.
- *To recognise a source of CO intoxication before fatal or life threatening exposures can result.

When to suspect it?

- *Impaired consciousness or coma in casualty with no focal or lateralizing neurological signs.
- *Epileptic fits.
- *Headaches, or flue-like illness in the emergency room.
- *Unstable angina.

What to ask about?

- *Accident sites likely to result in exposure. Garage, warehouse, bathroom, car, fire.
- *Multiple simultaneous complaints in co-habitants.
- *Type of indoor heating used.
- *Take CO-Hb levels blindly when the patient is unconscious and no history is available.

Pitfalls

- *Chronic metabolic conditions e.g. diabetes, uraemia, opiate addiction, do not exclude CO intoxication.
- *Patients being discharged from the emergency room for minor complaints, rather than being admitted to hospital, could also have CO intoxication.

different from other groups. It is possible in theory that levels of around 20% could cause a fit in susceptible epileptic patients⁹. Heckerling et al. in a similar study described two cases of sub-acute CO poisoning out of 43 cases with epilepsy. However this could have been co-incidental.

The four cases presented here show an interesting spectrum of the neurological presentation of CO poisoning. Case one is a typical, classical presentation^{11,12} of an individual with coma, very high CO levels, and quick response to treatment. Case two is very similar in presentation although this time is dealing with a 75 year old man. The exposure was much shorter i.e. 10 minutes instead of sixty, the peak CO-Hb levels much lower, and the recovery much slower, clearly illustrating the elderly man's greater vulnerability to central nervous system hypoxia. This vulnerability is further illustrated in the chronically ill 78 year old woman who lost consciousness probably with peak CO-Hb levels as low as 15%. Probably these chronically ill patients are the patients most likely to have 'occult' presentations.

Case four is a man who sustained two transient ischaemic attacks. Indeed the probable cause was cerebral artery embolism or thrombosis. CO-Hb levels of 10% are usually of no consequence in smokers¹³, however undoubtedly during those crucial moments of cerebral ischaemia caused by acute cerebral artery occlusion, a raised CO-Hb level may exacerbate the ischaemia precipitating infarction. To date there appear to be no studies documenting the effects of 100% oxygen therapy in heavy smokers with transient ischaemic attacks.

This study was carried out in an island population with only one acute medical facility. However, it is possible that a number of patients were either not referred to hospital and treated at home, or else they could have been discharged from the emergency department. For this reason a number of cases could have been missed.

Indeed the frequency of carbon monoxide poisoning will depend on the use of fossil fuel made by the community providing the catchment area of the hospital. In

this study 34% of patients screened had a potential source of CO within the household. This does not in any way necessarily represent the patterns in the community. However, knowing that fossil fuel use in this hospital population is very widespread shows that one should always keep a high index of suspicion for CO poisoning^{14,15}, particularly when consciousness is impaired on admission. The type of indoor heating used should be included in routine history taking.

CO-Hb levels should be determined where there is the slightest suspicion of intoxication, particularly in those cases with impaired consciousness when no information is available, as treatment with high concentration oxygen therapy in good time can greatly limit the extent of long term neurological sequelae.

Acknowledgements

We would like to thank, Prof. F. Fenech F.R.C.P., and Prof. M. Cauchi F.R.C.Path for making this study possible and: emergency room doctors and nurses who helped in obtaining blood samples, Dr S. Shah, and Mr C.

Grima in particular. We also thank the staff of the Emergency Laboratory at St Luke's hospital, particularly Mr Ralph Camilleri B.Sc., A.I.B.M.S.

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NEW MEMBERSHIP OPPORTUNITIES FOR PHYSICIANS WORLDWIDE IN FAMILY PHYSICIANS' GROUP

Kansas City, MO – The American Academy of Family Physicians (AAFP), the organization representing more than 82,000 family physicians, family practice residents in training and medical students in the United States, has opened its doors to encourage family physicians around the world to join the association.

The AAFP's governing body, the Congress of Delegates, voted to establish an international membership category for physicians practising family medicine outside the U.S.

Dan Ostergaard, M.D., vice president of education and scientific affairs for the AAFP, says this provides an excellent opportunity for family physicians from many countries to join their colleagues to enhance the practice of family medicine around the world.

"Family physicians are rapidly realizing a global responsibility to assist in the creation of competent generalist physicians for improved health care throughout the world," Dr. Ostergaard says. "The participation of our colleagues from abroad in our annual scientific assembly and other medical education programs will enrich our American experience and appreciation of family practice worldwide. And hopefully we will be able to share some of what we have learned with both the industrialized world of the family practice and the developing world."

Physicians who join the AAFP must practice family medicine, the speciality which encompasses care for the whole patient and family. Family physicians who join the AAFP in the new international membership category will enjoy its many benefits, including the following publications:

FP Report—this monthly newspaper provides the latest AAFP news and information on the speciality of family practice.

American Family Physician—the official clinical journal of the AAFP, published 16 times a year, offers a wealth of the latest clinical information and continuing medical education for family physicians.

Family Practice Management—this journal is published 10 times a year, featuring articles on socioeconomic and practice management issues impacting family physicians.

The AAFP also offers international members numerous continuing medical education offerings, products and services. International members can attend the world's largest continuing medical education event for family physicians at the regular membership registration fee. This annual event offers hundreds of clinical seminars, procedures workshops and lectures on the latest medical and practice management issues.

For more information on international membership, write to: Membership Development Department, American Academy of Family Physicians, 8880 Ward Parkway, Kansas City, Missouri, U.S.A., 64114.

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SUMMARY OF SURVEY RESULTS: PHYSICIANS' ATTITUDES TOWARD NOTIFICATION OF INFECTIOUS DISEASES

WENDY COOK

MEDICAL STUDENT – DEPT. OF PUBLIC HEALTH

The following is the final report of the study of physician's attitude towards notification, held late last year.

Demographics:

Most respondents (50%) have been in practice between six and fifteen years, while 30.4% have been practising more than fifteen years, and 19.6% less than five years. Respondents were evenly divided between health centre affiliated practice and practices which are entirely private. Most doctors 80.4% (n=37) were either working in health centres with additional part time private practices 43.5% (n=20) or in full time private practices 37.0% (n=17) only. The remaining 19.6% (n=9) worked only in health centres or were in part time private practice.

There was a significant relationship between years of experience and type of practice for doctors with private practices and those working both in health centres as well as privately ($p=0.000018$ and $p=0.0039$ respectively). Seventy-one percent of doctors in full time private practice had been in practice for at least fifteen years. Conversely, 95% of doctors in the health centres had been practising for less than fifteen years.

Notification Practices:

Previous studies have revealed that doctors may not be aware of their legal responsibility to notify, or the logistics of obtaining and sending in notification certificates. However, given the survey responses, it would appear that in Malta, knowledge of responsibilities and practices

does not seem to be a major barrier to notification.

Legal responsibilities:

Nearly seventy per cent were aware of their legal obligation to notify, when they disagreed that 'physicians were only morally obliged' to do so. However, given that 17.4% were not sure, and that 13.0% believed they were not legally bound, clarification of notification responsibilities by the Public Health Department (PHD) may be of use in some cases. Apparently, doctors' major sources of information on notification (PHD circulars for 37%, medical school for 28.3%, and notification certificates for 21.7%) have not been completely effective in disseminating this basic information.

Certificate availability:

Availability of notification certificates is also not likely to be at the root of under-notification. They seem to be generally obtainable and kept in places where they are accessible for use. Only 10.9% of doctors thought that certificates were not easily available. Most doctors (60.9%) reported getting new certificates at the health centres while 30.4% contact the Health Department. One respondent did comment however, that it took several phone calls before new certificates arrived from the PHD. In addition, 63.0% of doctors carry the certificates at home. However, only 54.3% report that they are on hand for use, should the need arise.

Notification patterns:

With respect to use of the certificates, 34.8% of doctors reported that they usually fill out the certificates in front of their patients, while 21.7% do this after the patient's visit, 28.3% at the end of the day and 13.0% at the end of the week. A further 4.3% fill out the certificate only when prompted by the Department. Many commented that if they did not do the paperwork immediately, they would be likely to forget if it was left for later.

This difficulty in getting around to 'form-filling' may also underlie the variance in the timing of notifications by doctors. Although required by law to notify as soon as they are aware a patient has a notifiable disease, only 41.3% reported that they notify immediately. Another 32.6% notify within the week and 26% believe no time limit exists for notifications.

Criteria for notification:

When asked whether they would notify a list of 22 conditions based on a suspected or confirmed diagnosis, doctors showed a tendency to await confirmation of diagnosis. Indeed, few (28.3%) favoured a switch to notification of all conditions based on suspicion. However, of all the conditions, food poisoning was the most likely to be notified on suspicion (47.8% would notify on suspicion). Indeed, food poisoning is the one of the few conditions which physicians are

required by law to notify on suspicion only. The others are scarlet fever and varicella, although only 28.3% and 39.1% respectively said they would notify these conditions when suspected.

Reliance on others to notify:

Another area of concern is the apparent reliance by 84.8% of respondents on hospital doctors to take the responsibility for notification when cases are referred to hospital. Based on comments by doctors as they filled out the survey, there appears to be a high level of confidence that notification from hospital doctors does consistently occur. This is reinforced by the finding that 87% of doctors agreed that 'physicians do not notify because their patient is referred to hospital where a hospital colleague will be expected to notify'. More doctors concurred on this than any other suggested explanation for non-notification. Given this attitude, two options present: either primary care and hospital physicians would use different reportable disease lists (thus eliminating the redundancy of double notifications, and delaying the report until the diagnosis is confirmed) or the responsibility to notify, even when the case is referred, as is currently the case, must be reinforced for primary care physicians (who are in a position to report earlier, although at the cost of a potentially uncertain or non-specific diagnosis).

Fewer doctors (32.6%) reported such strong reliance on the laboratory to report. It seems that some were unaware that the laboratory is also required by law to report the same list of infectious diseases. Indeed, there was only a slightly positive response (47.8% agreed and 17.4% were not sure) to the suggestion that this is a cause of under-notification.

The notifiable disease list:

The survey used a list of 22 infectious diseases, all but three of which are notifiable. Exceptions were HIV serology, gonorrhea, and syphilis. Ninety-three percent of doctors reported that they would always notify AIDS and 89% would do the same for HIV. Conversely, 76.1% said they would never notify varicella, and 52.2% would rarely report gastroenteritis. Responses were weighted so as to determine a rank order of the conditions. Lists below show diseases which doctors would notify with the greatest frequency apposed to those conditions considered most important to notify. Conditions least likely to be notified are listed in descending order (i.e. rubella being notified more frequently than influenza) as are those ascribed the least importance.

Diseases most frequently notified	Most important diseases to notify
1. AIDS	1. AIDS
2. HIV serology	2. HIV serology
3. Typhoid fever	3. Food poisoning

4. Acute encephalitis	4. Typhus fever
5. Typhus fever	5. Acute encephalitis
6. Food poisoning	6. Dysentery
7. Congenital rubella	7. Typhus fever
8. Scarlet fever	8. Pertussis

Diseases least frequently notified Least important diseases to notify

1. Influenza	1. Influenza
2. Gastroenteritis	2. Erysipelas
3. Granular conjunctivitis	3. Gastroenteritis
4. Erysipelas	4. Varicella
5. Pneumonia	5. Pneumonia
6. Puerperal fever	6. Mumps
7. Gonorrhea	7. Puerperal fever
8. Rubella	8. Rubella

Reasons for under-notification:

The following is a rank list of the 'most popular reasons chosen by doctors as reasons for under-notification. The line through the list demarcates the division between those which doctors agreed with and those with which they disagreed.

It is of note that in spite of a number of doctors commenting quite strongly about issues of confidentiality and information disclosure given that Malta is a small tightly-knit country, the group as a whole did not consider this to be a very important reason. This is also reflected below in preferences for interventions. Due to the nature of the doctor-patient relationship, private G.P.s may be more likely to see confidentiality as a barrier rather than those in health centres.

Strongly agree

1. expect hospital colleagues will notify
2. lack of feedback from the PHD
3. certain diseases not considered hazardous
4. disease list is too outdated
5. not all doctors are familiar with the entire disease list
6. no penalties are enforced against non-notifiers
7. expect that the lab will notify the case
8. disease list is too extensive
9. no remuneration for notification
10. no time to notify
11. case is already being treated.
12. involving authorities exposes patients to harassment / embarrassment
13. little is done by the PHD in response to physician notifications
14. pressure by patients not to notify
15. hesitation to notify so as not to cause a false alarm
16. violation of patient confidentiality

17. patient refuses permission to disclose information
18. doctors are morally, not legally bound to notify
19. no disease treatment is available

strongly disagree

Perceptions of the system:

Many have pointed out that the success of any surveillance system depends on a strong relationship between the Health Department and those providing the information. According to doctors in the survey, this is the area in which many of the problems lie. Indeed, 84.8% of doctors say they are not satisfied with the feedback they receive from the PHD.

When asked what they think the PHD does with physician notifications, many doctors' initial response was one of puzzlement: they had never been told. There was, however, a generally favourable response. Nearly half of physicians said the PHD always acts to prevent disease spread and 44.4% thought this happened occasionally. While 22.2% thought notifications were used solely for case counting, only 4.4% believed that notifications were filed away without action. The general perception seems to be that doctors believe the PHD is trying to 'do something' but that its efforts are not enough. That many respondents approached this issue with a degree of cynicism or uncertainty, speaks to the fact that much needs to be done to build up a more positive image of the PHD.

Preferences for change:

The most highly favoured interventions also seem to be a reflection of a desire for a more active role of the PHD in the notification system. In addition, they point to a need for re-evaluation of the notifiable disease list. Interventions are listed from most to least popular as follows:

1. regular PHD publication of outcomes of notification, current disease trends
2. telephone confirmation of outcome of investigation to those who notify
3. feedback of national notification rates for personal comparison
4. have only the lab notify certain diseases
5. use a set of standard diagnostic criteria as criteria for notification
6. emphasize notification responsibilities in medical school
7. shorten the disease list
8. use telephone / answering machine reporting
9. use more discretion in PHD investigations
10. use knowledge of legal obligations as criteria for passing qualifying exams
11. award accreditation units to those who conscientiously notify
12. send reminders to non-notifiers
13. link remuneration with notification
14. use anonymous reporting for socially stigmatised diseases
15. notify only on suspicion
16. enforce criminal penalties for non-notification



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ROYAL COLLEGE OF GENERAL PRACTITIONERS

Rural general practice is a neglected area in medicine. Despite the fact that 20% or more of the population in the UK live in rural areas, the problems of inner city dwellers are much better known and understood. The development of a rural practice policy is hampered by uncertainty about the definition of rurality, lack of information about health needs and costs, misconceptions about country life, and lack of choice for patients.

The founding fathers of the College – notably Will Pickles of Wensleydale – were well known for their research from country practice, but since then the College's interest in rural practice has tended to wane rather than wax. It is, however, committed to all its members and having recently published *Inner Cities, Occasional Paper 66*, it is now pleased to maintain the balance and publish this new *Occasional Paper*, from a Working Party of the College chaired by Dr Jim

RURAL GENERAL PRACTICE IN THE UNITED KINGDOM OCCASIONAL PAPER 71

Cox, which it is hoped will help to raise the profile of rural practice in the UK.

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ROYAL COLLEGE OF GENERAL PRACTITIONERS

Having a baby is one of the most fundamental events of any woman's life and an essential function in the preservation of the race. It is therefore inevitable that childbirth attracts immense personal and public interest.

Relationships between the three main professional groups involved in maternity care – generalists, specialists and midwives – are sometimes strained because of their different views on status, control and territory. However, the growing influence of the feminist movement, an increasing emphasis on choice in all health services, and a growing challenge to the assumption that all labours are best taken in hospital have all led to the need for review.

This new *Occasional Paper*, the Report of the RCGP Maternity Care Group, chaired by Dr John Noakes, has been approved by the Council of the College as a discussion document. It sets out the facts, clarifies a number of legal issues, and describes what many professionals believe is the content of

THE ROLE OF GENERAL PRACTICE IN MATERNITY CARE OCCASIONAL PAPER 72

maternity care. In particular, it stresses the need for closer collaboration between members of the primary maternity care team and underlines the important contribution general practitioners can make. Its purpose is to stimulate debate and it is hoped that all who have an interest in this subject will take part.

The Role of General Practice in Maternity Care, Occasional Paper 72 is available from RCGP Sales, price £10.00 (£11.00 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 0171 225 3048.

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Dr John Noakes OBE FRCGP Simpson House Medical Centre 255 Eastcote Lane Harrow Middlesex Tel: 0181 864 3466	RCGP Sales Office 14 Princes Gate Hyde Park London SW7 1PU Tel: 0171 823 9698

FACTORS INVOLVED WHEN A CHILD IS BROUGHT FOR A MEDICAL CONSULTATION

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Introduction

A child is not well. Someone has to notice that something is wrong. What makes the child carer eventually decide to go to the doctor? The reason leading to this decision is often thought by professionals to be obvious i.e. because the child is ill. One rarely stops to think about other underlying factors why the consultation was made. This help-seeking behaviour depends on a variety of inter-related factors.

Health and Illness:

Health and illness are quite elastic concepts. They can be viewed as a spectrum of 'well-being'. There's a thin line that medically separates minor disorders from those that are 'ignored, tolerated or self-medicated'.¹ Moreover, psychological and cultural features could be added to the traditionally medically-oriented definitions of health and illness.² Illness behaviour covers the ways in which people 'perceive, evaluate and respond to physical and psychological discomfort'.³ Therefore behaviour towards illness may be expected to be different in every human being.

Several studies have been carried out to investigate this behaviour. Briscoe ME mentions a gender difference whereby women, especially in the childbearing age, were found to consult their GP more frequently than males.³ This may indicate that females seek help even for mild illnesses and discomfort.

Women as providers of health care:

Women are believed to be among the main providers of health care in the community, especially in the case of children.^{4,5} They try their best to

provide a healthy environment for their children and family. Mothers make daily decisions regarding their children's well-being or illness and care for their children when sick.

Women, being the main care givers of children, are in the front line when it comes to noticing whether their child is well or on the verge of an illness. By spending time with their children, they automatically learn the skill of knowing what their child's 'normal' well-being is like, and so 'any deviation from the norm' is picked up easily. Experience increases with having more children and subsequently consultation rates decrease. In fact it has been noted that mothers tend to consult more with their first-born child.⁶ However, every child is different and therefore the reaction to the illness will be different. The mother actually develops this skill for every child (one sick child may retain the appetite while another may go off food completely). Another explanation for diminishing consulting rates with increasing number of children may be that the mother has less time to spend with each child and therefore develops a higher threshold for consulting.⁵

This 'normality' or rather 'acceptance of well-being' is also

dependent on other factors such as cultural beliefs, knowledge drawn from past experience and media pressure. Professionals, peers, friends, and relatives may influence what the mother considers 'normal'.⁴ It has been postulated that the individual, in this case the mother, goes through the following phases before the decision to consult is made: 1. whether her child is well or ill; 2. what to do about it; 3. when to put aside home-made remedies and seek professional medical aid.¹

'Appropriate mothering': There's a common belief that the well-being of a child is an indicator of 'appropriate mothering'. This may compel mothers consciously or subconsciously to take care of their children more. This may indirectly produce a rather low threshold for seeking professional help. Mothers believe that if they are not seen to worry or fuss over their child they might be judged by others as being incompetent mothers. Some may even become anxious that their child might be taken away from them, especially where a socially-deprived family situation already exists.

Some situations such as having a baby who cries a lot or a child who is not eating or sleeping well, may be seen to reflect inadequacy of mothering.

Mothers sense this feeling and this acts on their self-esteem. This in turn, is bound to, and affects their child's behaviour and development. All this influences the final decision to seek medical aid. Professionals can help alleviate some of this psychological burden.⁴

Psychological State of the mother:

The mother's own frequency of consultation and her psychological state have been found to be among the main factors influencing their decision making.⁵ An emotionally disturbed mother may delay seeking professional help for her ill child either because of bad judgement or denial.¹ Doctors should try to find out if there are any other reasons, besides physical ones for bringing the child over for the consultation. The mother might well be the patient herself. It may also result that the child's illness is contributing to the mother's state of mind.

Past Experience:

Experience of caring for other children before, helps decrease the frequency of consultations.⁵ On the other hand, any past bad experience may have an augmenting effect on the rate of consultation. A baby may previously have had an episode e.g. of crying which was not taken seriously by the mother, but which later resulted in a life-threatening situation (e.g. intussusception requiring surgical treatment). At that time the mother might have been blamed by professionals for seeking help rather late. Following such an episode, this same mother and any close acquaintances who hear the story, would become overcautious and seek professional help quickly, even for trivia.

Bothering the Doctor:

It has been mentioned above that due to past bad experience, some mothers might overreact and consult early. One might mistakenly come to the conclusion that mothers are shrugging off responsibility and rushing to the doctor for any simple complaint. However, in the study by S. Cunningham-Burley and U. Maclean it was found that mothers did not take the decision to consult their GP lightly.⁴ They would first go to a health visitor or a pharmacist for their opinion without any embarrassment, but they felt rather stupid going to the GP for just anything.

It has been quoted that 40% of childhood problems are dealt within the family using advice from friends, relatives or the local chemist.^{6,7} These were utilised as a stepping stone before the decision is taken to seek professional medical aid. They even asked their advice whether the problem necessitated professional attention.⁶ Mothers were also strongly concerned with not wanting to waste the doctor's time. The GP was portrayed as a 'busy' person and not to be bothered with trivial complaints.^{4,6} These beliefs differ to some degree in different cultural societies.

Having consulted a GP, the mothers felt that they were invariably being judged for maternal competence, and therefore had to have a valid reason for consulting. General practitioners should be careful not to pass undesirable comments, making mothers feel embarrassed. The GP should make the mothers feel that they have dealt with the situation within their competence and therefore help to raise their self-esteem. Explanation on how things could have been done better without making one feel inadequate, may be helpful.

Social Class:

Social Class also affects help-seeking behaviour. Parents with less formal education e.g. Social Class V or the unemployed, are known to consult doctors more than higher social class families. They are thought to be abusive of the service provided and are constantly consulting for trivia. However, certain conditions, especially respiratory illnesses were found to be commoner among Social Class V and the unemployed. Thus their chance of consultation is expected to be higher.⁸ Other factors found to be related to increased consultations were family living in rented accommodation and no family car.⁵

Ethnicity:

One physical symptom may be abnormal to one cultural group but rather normal to another. Different consultation rates were found among several ethnic groups in a study by A. Clarke and J. Hewison² in 3 general practices located in Leeds (a multiethnicity area). Asian families were more likely to have consulted than non-Asian families (e.g. for respiratory illnesses). In fact, as part of the study their opinion was requested as to whether they thought that a cold got worse or better if it was left alone. Sixty-six percent of Asian families (mainly Muslim and Sikh) believed that colds got worse if left alone, as opposed to Afro-Caribbean and Whites who were represented in this category by 50% and 16% respectively.

Symptomatology:

Certain symptoms worry mothers more and make them consult a doctor earlier than others. An association has also been found between the number of symptoms and the degree of anxiety of the mother, leading to an increase in the rate of consultation. Children under the

age of one year was found to be a strong positive predictor for consulting a doctor.⁵ Furthermore, the reported severity of symptoms e.g. cough in this same study, was more pronounced in the materially disadvantaged families than in the higher social class. Therefore this may explain why low social class parents were consulting more. It may also be argued that materially disadvantaged parents subconsciously reported symptoms as being even more severe than they actually were, maybe for fear of missing out on anything. Being in lower social classes possibly compounded by low self-esteem, they knew that they were naturally more open to criticisms and might easily be blamed as neglectful. So a 'better safe than sorry' attitude is taken. However, after controlling for severity of cough symptoms, there was no longer a link between social class and the rate of consultation.⁸ In a study by Osman and Dunt, it was found that mothers were more likely to consult their GP if symptoms were present for more than 2 weeks.⁶

Social Interactions:

Consultation behaviour is influenced by friends who observe the child from an objective point of view. They may bring to light physical symptoms or behavioural problems which the mother may not have noticed or subconsciously did not want to accept.⁹

Simple Home Remedies:

Home-made remedies, cough mixtures, paracetamol and herbal remedies are used by parents very commonly whatever race. Paracetamol is commonly used by white families and herbal remedies mostly by Afro-Caribbeans. These are used for different reasons such as to alleviate symptoms or to help children sleep at night. Some parents confess that they use

these remedies simply to be seen by their children as doing something. A very small percentage believe that these remedies were curative for the illness. If these remedies produced no good effect, the parents would then decide to consult the doctor.²

Expectations:

Above all, what are the parents expecting to get from the doctor after consulting? In the study by L.M. Osman and D. Dunt, mothers were concerned whether the GP would be sympathetic to them and their complaints.⁶ Educating the parents by giving explanations has a positive effect on future consultations by decreasing them and making them more worthwhile. S. Cunningham-Burley and U. Maclean concluded that the mothers wanted reassurance and explanation of the cause of the illness rather than prescriptions.^{4,10}

The study by A. Clarke and J. Hewison shows that 50% of families wanted reassurance rather than antibiotics or other medicines. The other 50% were among the ones who consulted the doctor most. Interestingly enough, reassurance was mostly 'needed' by white families rather than Asian families. It might be that language may have played a part, since to have any positive effect, reassurance would require a well-spoken parent. Thus in the case of Asians, a prescription may have been more tangible than reassurance. Asians perhaps would expect reassurance more if there were no language barriers.²

Doctor-Child Relationship:

Consultation rates are affected by the professionals themselves. The parents' satisfaction with the way the doctor and maybe even the practice nurse interacted with the child and the family as a whole is important. Parents

expect a sympathetic and understanding doctor who manages to put the child and parents at ease in an otherwise uneasy situation.² The satisfaction can come from both the family doctor or even a 'proper' doctor suggested by a friend. It has been shown that the rates of consultation to a doctor advised by a friend, compared well to rates of going to the family GP. This emphasises the importance of a friendly, sympathetic doctor, even if met for the first time. The quality rather than length of the relationship is obviously more important. The family doctor would have some advantage over others since he would know the parents' views of health and sickness to some extent and therefore might have a better idea of what the reasons for consultation were. This would affect the way the doctor manages the consultation.

Accessibility:

Finally, geographical accessibility to the practice and surgery hours influence consultation behaviour. Other factors such as lack of money or time, no one to take care of other children may also delay consultation temporarily or even definitely. The time of the appointment and the waiting at the practice may also affect their decision making.^{2,3}

Conclusion

This process of working through the various factors takes place each time a decision is made to consult a doctor. These factors are all interrelated in some way and several of them may affect the final decision. Child carers, be it mothers, fathers or other persons responsible for the child, subconsciously take more or less every factor into account. By finding a balance through this multifactorial association, they decide whether the problem should be dealt with by the doctor

or not. Frequent consultation with a child may mean that there's psychological distress on the part of the carer. Being aware of this combined problem should lead to proper management of both the child and the family. One should not take lightly or disregard a carer's genuine concern for a child because this would have been more often than not a painstaking decision on the part of the carer, and maybe even a cry for help!

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CONJOINT SCIENTIFIC ASSEMBLY – MARITIME CHAPTERS OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

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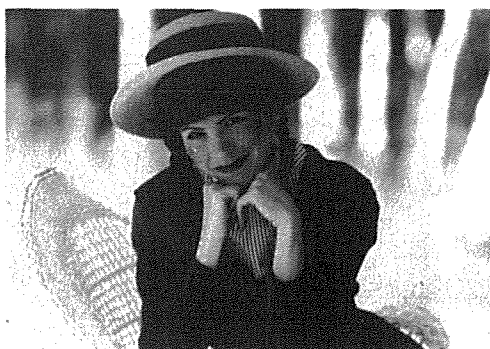
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EVALUATION OF THE AUTUMN CPD MEETING

11-13 OCTOBER 1995

Day 1: Wednesday 11th October 1995

External Diseases of the Eye – Mr Richard Soler

Complications and Treatment of Diabetic Retinopathy – Mr Thomas Fenech

Forms returned: 34

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

Disagree: 0
Undecided: 2
Agree: 32

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

Disagree: 0
Undecided: 2
Agree: 24

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

Disagree: 0
Undecided: 4
Agree: 23

The best feature of today's seminar was:

Slides (x5)
Both (x3)
Diabetic retinopathy (x3)
External diseases of the eye (x3)
Simplicity
Practical advice and take home points

Today's seminar would have been better if:

Demonstration on use of ophthalmoscope
2nd talk more oriented towards
general practice
Slides in 1st talk (x3)
Started earlier + refreshments

Please suggest your name to speak on a specified
topic in future CPD meetings:

Nil

Day 2: Thursday 12th October 1995

Visual failure – Cataract and Glaucoma – Dr Mario Tabone

Forms returned: 36

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

Disagree: 1
Undecided: 5
Agree: 30

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

Disagree: 0
Undecided: 5
Agree: 30

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

Disagree: 4
Undecided: 5
Agree: 20

The best feature of today's seminar was:

Ability to deal with a complicated topic
in a simple and fluent way
Practical points (x4)
Interesting general knowledge
Slides

Today's seminar would have been better if:

Shorter
Better visual aids

Please volunteer your name to speak on a specified
topic in future CPD meetings:

Dr C. Zarb
Modern approach in management
of Craniofacial sinostosis

(Compiled by Dr. Anthony Mifsud M.D.,
Secretary for Research)

Day 1: Wednesday 24th January 1996

Skin Tumours / Cutaneous Leishmaniasis – Dr Joe Pace

Doctors present: 44
Forms returned: 34

Today's seminar was relevant to family medicine/general practice:
Disagree: 0
Undecided: 0
Agree: 34

Today's seminar increased my knowledge and/or awareness of issues:
Disagree: 0
Undecided: 0
Agree: 34

My patient care will be modified as a result of this seminar:
Disagree: 0
Undecided: 1
Agree: 33

The best feature of today's seminar was:
Slides (x30)
Power of Internet (x6)
Latest management of melanoma via internet (x2)

Today's seminar would have been better if:
More slides of melanoma

Please suggest your name to speak on a specified topic in future CPD meetings:
Nil

Day 2: Thursday 25th January 1996

Psoriasis – Dr. Dino Vella Briffa

Doctors attending: 45
Forms returned: 30

Today's seminar was relevant to family medicine/general practice:
Disagree: 0
Undecided: 0
Agree: 30

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

Disagree: 0
Undecided: 0
Agree: 30

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

Disagree: 0
Undecided: 2
Agree: 28

The best feature of today's seminar was:

Very thoroughly treated in a non-boring way
Latest management of Psoriasis
Good slides (x10)
PUVA Rx

Today's seminar would have been better if:
Video was not repetitive

Please volunteer your name to speak on a specified topic in future CPD meetings:
Nil

Day 3: Friday 26th January 1996

Knowledge testing: Slide Presentations – Dr. Joe Pace

Doctors attending: 33
Forms returned: 12

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

Disagree: 0
Undecided: 0
Agree: 12

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

Disagree: 0
Undecided: 0
Agree: 12

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

Disagree: 1
Undecided: 0
Agree: 11

The best feature of today's seminar was:
Self-assessment
Slides
Learning from one's deficiencies

Today's seminar would have been better if:
More time taken to discuss
slide presentations

Please suggest your name to speak on a specified topic in future CPD meetings:

Nil

*(Compiled by Dr. Anthony Mifsud M.D.,
Secretary for Research)*



ROYAL COLLEGE OF GENERAL PRACTITIONERS

The sudden and unexpected death of an apparently well baby is one of the most harrowing tragedies that family doctors are called upon to witness. It is a devastating blow for family and friends. The sense of loss is heightened when no-one is able to explain why the baby died.

The incidence of sudden infant death in Britain is falling; nevertheless cot death remains the single largest category of deaths in babies over the age of one month. The cause or causes of cot death remain unknown.

General practitioners may encounter cot death only once or twice in their professional lifetime; however, if faced with the tragedy of cot death, they must know how best to support the family in their grief.

This booklet summarises current knowledge on the subject, dealing with definitions and statistics; the epidemiological evidence of risk factors and theories on possible causes; the role of the general practitioner in prevention; and how to cope in the event of cot death.

For enquiries about the content of the book, please contact: Dr Duncan Keeley, The Health Centre, East Street, Thame, Oxon OX9 3JZ.

Copies available at £6.00 (£6.60 non-members) including postage, Access and Visa are welcome, 24 hour answerphone on number 0171 225 3048 or:

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CLINICAL SERIES – COT DEATH THE TASKS FOR PRIMARY HEALTH CARE IN PREVENTION AND MANAGEMENT DUNCAN KEELEY MRCP, MRCP



ROYAL COLLEGE OF GENERAL PRACTITIONERS

Nutrition, the process by which food is eaten and utilized by the body, is fundamental to the maintenance of good health and to the prevention of many common diseases. Yet, surprisingly, nutrition does not figure prominently in the undergraduate medical curriculum, the training of many related professionals, or indeed the vocational training for general practice.

This publication is the second in a series which provides doctors and others working in primary health care with a sound, up-to-date appraisal of current thinking on nutrition in relation to a broad range of topics. It attempts not only to provide the facts but to apply them in a practical way within the context of general practice.

Over the years a myriad of benefits have been attributed to different aspects of diet. But professionals have to be clear

about what nutrition can and cannot deliver—it is not necessarily the magic bullet it is sometimes portrayed to be.

Doctors and members of the primary health care team are perceived by the public as the most trusted source of information on nutrition – but in reality, just how good is the advice they give? This publication, which is packed with useful and practical information, provides those concerned with nutrition with the necessary facts upon which to base their advice.

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CLINICAL SERIES – NUTRITION IN GENERAL PRACTICE PART 2: PROMOTING HEALTH AND PREVENTING DISEASE JUDITH BUTTRISS PHD, SRD

A 53 year old man of sound constitution, and with a past history of peptic ulcer disease and mild diabetes mellitus, suddenly developed severe epigastric pain with occasional vomiting over the weekend.

I was called to examine him, but found no significant abnormal clinical signs except epigastric tenderness. He had opened his bowels, and appendicitis and intestinal obstruction were excluded. There was no icteric tinge, and his urinalysis was normal. He was an obese individual, known to be a mild diabetic well controlled with dietary measures alone. He was not on any regular medication, drank alcohol socially and smoked 5 or 6 cigarettes daily.

After 48 hours of conservative treatment, the pain, which was the predominant presenting complaint had not settled down. I called in a consultant surgeon for a home visit, and he advised urgent admission for investigation at St. Luke's Hospital, due to a possible epigastric mass.

See ticket of referral figure 1.

TICKET OF REFERRAL OF A PATIENT TO HOSPITAL

DEPARTMENT OF HEALTH

Part A

To be filled by Medical Practitioner referring a patient to hospital.

Referral to Hospital

Hospital No. (if any)

I.D. Card No. (if patient has an Identity Card)

Referred for Investigation To SOP Dept. Medicine

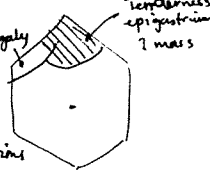
Relevant Clinical History

2 day episode of epigastric pain not associated with nausea or vomiting. PH: peptic ulcer.

2/6 obese, tenderness epigastric region with ? mass. ? Hepatomegaly.

Treatment/Operations

Advice: SOP for investigation



Date

Signature

Name and Address (Printed or Block Letters)

Dr. Peter A. Fenech
SLH

Investigation results were as follows:

ESR	34 mmol/l ↑
Random Blood Glucose	14 mmol/l ↑
Serum Amylase	33 units/l
Hb: 17.9 g/dl	WBC: 9,300
MCV: 89.6	MCH: 29.6
Platelets: 309,000	
Bilirubin: 16 μmol/l	
Alk. Phosphatase: 242 U/l (NV 98-279)	
Gamma GT: 225 U/l ↑ (NV 11-50)	
ALT: 24 U/l (NV 0-40)	
Urea: 5.4 mmol/l	[Na]: 132 mmol/l
[K]: 4.8 mmol/l	[Cl]: 95 mmol/l
Prothrombin time: 18 seconds (control 16 sec.)	
HBsAg: negative	
Mid-stream urine culture:	no significant bacteruria
Chest X-Ray:	normal
CAT Scan abdomen:	showed an enlarged left lobe of the liver and a 2 by 3 centimetre tumor of the left adrenal gland
Ultrasound abdomen:	noted gall bladder stones, a 12 by 7 cm mass in the epigastrium which appears to be in the liver.
Alpha fetoprotein, 17 ketosteroids, urine VMA's and serum cortisol were ordered.	

Over the next 48 hours, a gastroscopy and trucut liver biopsy were performed. The gastroscopy was normal, but the liver biopsy performed on the 12th April 1989 confirmed metastatic liver disease.

At this stage, the preliminary diagnosis was left adrenal tumor with metastatic disease of the left lobe of the liver, and non-insulin dependent diabetes mellitus.

On the surgeon's recommendation, the patient was referred to the liver unit at King's College Hospital within a week. Under Dr. Roger Williams, all investigations were repeated and his case was continually reviewed. Finally, in conjunction with a team at Adden Brooke's Hospital in Cambridge, Dr. Williams decided that this was a suitable case for liver transplant. The transplant was performed on the 13th June 1989 at Cambridge, exactly two months after I had seen him. After a three week stay, he was transferred to King's College Hospital, where he was housed in a specialised halfway house for liver transplant patients. He returned to Malta on the 21st August 1989 on the following treatment:

Azathioprine 100mg dly
 Cyclosporin A 400mg dly
 Prednisolone 10mg dly
 Zantac 150mg bd
 TXA 2 tabs bd -experimental thromboxane antagonist
 Warfarin 3mg dly -after the transplant the patient developed pulmonary emboli
 Insulin (Mixtard) 24U am - 10U pm

There were no signs of rejection, and blood samples were sent regularly to King's College Hospital for assessment.

See letter from Camberwell Health Authority - figure 2.



LIVER UNIT
 DEPARTMENT OF MEDICINE

JGO'G/JLA/D075688

11th December 1989

Dr Peter D Fenech
 St. Luke's Hospital
 G'Mangia
 Malta

Dear Dr Fenech

The following are the results of bloods forwarded to us recently:

Haemoglobin	15.8
WCC	12.4
Platelets	259
Sodium	139
Potassium	4.7
Calcium	2.53
Urea	9.8
Creatinine	78
Bilirubin	12
AST	27
Alk Phos	136
Gamma GT	76
Total Protein	74
Albumin	45
Cyclosporin level	305mg/l

COMMENT

Liver graft function is excellent. The Cyclosporin level is above the therapeutic range and if he is absolutely sure that this is a 24 hour trough level then the dose can be reduced to 250mg daily. Otherwise we suggest no change to his treatment. Hope he remains well.

Yours sincerely

Dr John O'Grady
 SENIOR LECTURER

He was reviewed at the liver transplant clinic at King's College on the 4th January 1990.

See letter from Camberwell Health Authority - figure 3.

He was soon able to return to his work as an Advertising Manager. However, by mid-March he was suffering from severe back pain with radiation to both lower limbs. Bedrest and analgesics did not control the symptoms, and he was unable to move his lower limbs.

He was again admitted to St. Luke's Hospital, and CAT Scan of the lumbar spine and pelvis showed a large infiltration of the right lateral mass of the sacrum, destroying bone and extending into the spinal canal and adjacent soft tissues. His diabetes was difficult to control, and pethidine was started for the pain. Palliative radiotherapy was also administered to relieve bone pain.

The patient eventually passed away on the 4th of June 1990, one year after his successful liver transplant. Cause of death was primary hepatoma with lumbo-sacral metastases, and diabetes mellitus.

This case struck me because of the sudden onset, and the fact there were no specific etiological factors



LIVER UNIT
 DEPARTMENT OF MEDICINE

JGO'G/JLA/D075688

2nd February 1990

Dr Peter D Fenech
 St. Luke's Hospital
 G'Mangia
 Malta

Dear Dr Fenech

Your patient was reviewed at the liver transplant clinic on the 4th January 1990. He is well apart from pain in the left side of his chest which is worse at night. Physical examination reveals he is obese, weighing 93.6 kg. Blood pressure is 150/70. No other abnormalities were detected.

INVESTIGATIONS

Haemoglobin	15.4	Bilirubin	20
WCC	12.5	AST	41
Platelets	323	Alk Phos	148
Sodium	138	Gamma GT	131
Potassium	4.7	Total Protein	71
Urea	10.9	Albumin	43
Creatinine	85		
Random Glucose	17.5	Cyclosporin level	33ug/l

COMMENT

The liver function tests are satisfactory although there has been a slight increase in each of the parameters. This probably reflects the sub-therapeutic Cyclosporin levels and we have increased the dose to 400mg daily. The remainder of the immunosuppression remains unchanged. The random glucose is not suggestive of good diabetic control and we have advised him to increase his insulin. The anticoagulation is now being discontinued. Next planned review is in six months time but will be happy to see him at any stage in the interim should problems arise.

Yours sincerely

Dr John O'Grady
 SENIOR LECTURER

for primary hepatoma. It was disappointing that after a successful transplant the patient survived for only one year rather than the average five years, obviously due to metastases. A positive aspect is the success of the half-way house, which is an annex of the main hospital where patients can be monitored as they return to a normal way of life. Hospital doctors are on call 24 hours a day, and see to the patient immediately if the need arises. These half-way houses are now being used in the management of other types of organ transplant cases.

INAUGURAL CONFERENCE OF THE WONCA REGION EUROPE – EUROPEAN SOCIETY OF GENERAL PRACTICE/FAMILY MEDICINE (ESGP)

DR MARIO R. SAMMUT M.D.

Introduction

The Malta College of Family Doctors, a founder-member of the **WONCA Region Europe – European Society of General Practice/Family Medicine**, was represented by College President Dr Denis Soler MD FRCGP and Honorary Secretary Dr Mario R Sammut MD at the Society's **Inaugural Conference** in the Hemicycle, the Meeting Room of the European Parliament, Strasbourg, France on the 6th and 7th October 1995.

The idea of an umbrella academic society to coordinate all European organisations of family medicine originated in Lenzburg, Switzerland, during a meeting in January 1993 initiated by SIMG, Societas Internationalis de Medicinae Generalis. In Collaboration with WONCA, the World Organisation of Family Doctors, a 'Group of Eight' was formed which, together with the European bodies responsible for teaching (the European Academy of Teachers in General Practice – EURACT), for research (the European General Practice Research Workshop – EGPRW) and for quality assurance (the European Working Party on Quality in Family Practice – EQuiP) in family medicine, worked hard to create the structure of the European Society of General Practice/Family Medicine (ESGP) which was inaugurated in Strasbourg. Through its academic role, the Society will complement UEMO, the political body of family medicine in Europe.

Inauguration Assembly

The conference began with the **Inauguration Assembly of the ESGP** on Friday 6th October. Following introductions by the President of SIMG, Dr Fons Sips and the Regional Vice-President of WONCA, Dr Lotte Newman, the delegates of the Corporate Members of SIMG and the European Members of WONCA (among them Dr Denis Soler, President, and Dr Mario R. Sammut, Honorary Secretary of the Malta College of Family Doctors) introduced themselves. The following 29 countries were represented: Austria, Belgium, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Israel, Italy, Latvia, Lithuania, MALTA, the Netherlands, Norway, Poland, Portugal, Rumania, Russia, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom.

After discussion and approval of the bylaws for the ESGP, the election of officers took place with the following results:

President:

Dr Frede Olesen, Denmark

Vice-President:

Dr Vaclav Benes, Czech Rep.

Secretary:

Dr Philip Evans, UK

Treasurer:

Dr Anna Kallkvist, Sweden

The Executive Board is completed by the

representatives of the three network organisations, namely:

Prof. Jan Heyrman, EURACT,

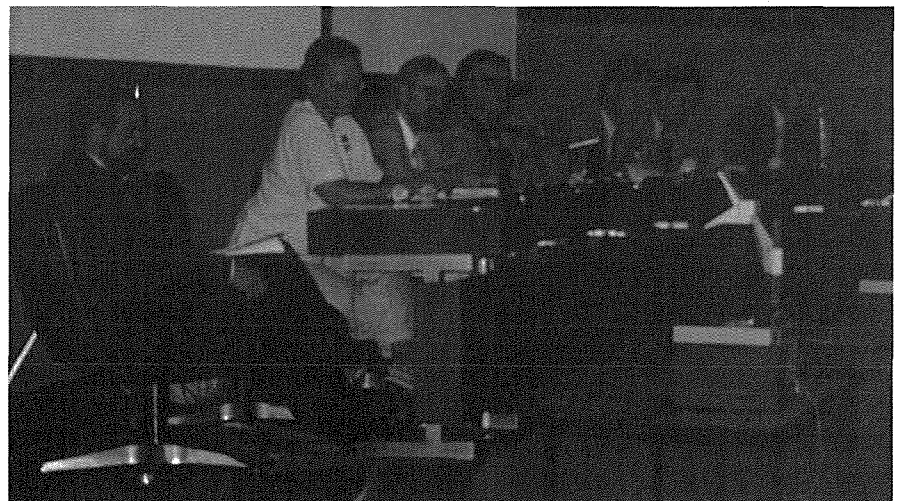
Prof. Paul Wallace, EGPRW, and

Dr Michael Boland, EQuiP.

The election was followed by the first **Council Meeting of the ESGP**, with new President Dr Frede Olesen outlining the aims and objectives and future activities of the ESGP. The Council Meeting accepted the **European Journal of General Practice** as the official medium of the ESGP.

Inauguration Conference

The Opening Ceremony of the **Inaugural Conference of the ESGP** then was introduced by



The Executive Board of the ESGP: from left, Prof. Paul Wallace, Dr Anna Kallkvist, Dr Vaclav Benes, Dr Michael Boland, Dr Frede Olesen, Dr Philip Evans, and Prof. Jan Heyrman.

Prof. Albert Hercek, President of the National College of Teachers of General Practice, which collaborated in the organisation of the conference. After speeches by the Regional Vice-President of WONCA and the President of SIMG, the new President of the ESGP, Dr Frede Olesen, was installed by the President of WONCA, Dr Goran Sjonell, after the latter was presented with the insignia of SIMG from Dr Robert Braun, the founder and first president of SIMG.

Following greetings by various European Official Representatives, the following **key-note presentations** were made:

1. "The patient Europe – calling for the general practitioner" – Prof. Per Fuggeli, Norway;
2. "Current state and future prospects for medical practice and health care systems" – Dr Michael Boland, Ireland;
3. "Teaching and learning in general practice" – Prof. Jan Heyrman, Belgium.

These were followed by a guest presentation on "Transplantation and organ donation, the role of the general practitioner" – SOFRES First European Poll – introduced by P. Weil, President of SOFRES.

The day was brought to an end with the **Inaugural Dinner** of the new Society, where two SIMG awards, the *Hippocrates Medal* and the *'Le Generaliste' Award*, were presented respectively to Prof. Jan Mulder of the Netherlands and Prof. Jean de Butler from France.

Scientific Programme

The **Scientific Programme** entitled **General Practice in Europe: State of the Art, Shape of the Future** was opened on Saturday 7th October with two keynote speeches as follows:

- A) **Structural Conditions of General Practice** – keynote speaker: Dr Philip Evans, UK: "Different paths but one unified discipline";
- B) **Organisational Improvements** – keynote speaker: Dr Joan Gene Badia, Spain: "Towards teamwork and outcome oriented care".

The Malta College was represented at a workshop dealing with topic A entitled "What are the basic conditions for defining general practice?" presented by Dr Bernard Gay, France.

The programme continued with two further keynote lectures dealing with the following topics:

- C) **Professional Developments** – presented by a substitute for indisposed keynote speaker Prof. Michael Kochen, Germany: "From medical school to retirement, national problems of professional developments";
- D) **Developing Primary Health Care in Central and Eastern Europe** – keynote speaker Dr

Eva Jurgova, Slovakia; "The WHO Charter" – Dr Josep Goicoechea, Andorra.

The Malta College was represented in a workshop on topic C regarding "Higher Professional Education in General Practice" presented by Prof. Jan Heyrman (representing EURACT on the ESGP Council), of Belgium, Dr Jacky Hagden, of the UK, and Prof. Harry Crebolder, of the Netherlands. Through its participation in this workshop, the Malta College of Family Doctors has become a member of a working group to discuss the possibility of organising Higher Professional Education on a European basis. *This is in line with the Malta College's present efforts to organise a Specialist Training Course in Family Medicine in Malta.*

The scientific programme came to a close in plenary session where the recommendations of all the workshops were presented. Dr Frede Olesen, President of the ESGP, brought the conference to an end with the customary speech and an invitation to the 3rd European Congress on Family Medicine on 30 June - 4 July 1996 in Stockholm, Sweden.



From left, Dr Mario R. Sammut, Mrs Marie Soler and Dr Denis Soler during the Inaugural Dinner of the ESGP.

CONTINUING PROFESSIONAL DEVELOPMENT 1995 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 PGMCPD 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 PGMCPD. 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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Hon. Secretary: Dr Mario R. Sammut • *Hon. Treasurer:* Dr. Jacqueline Padovani
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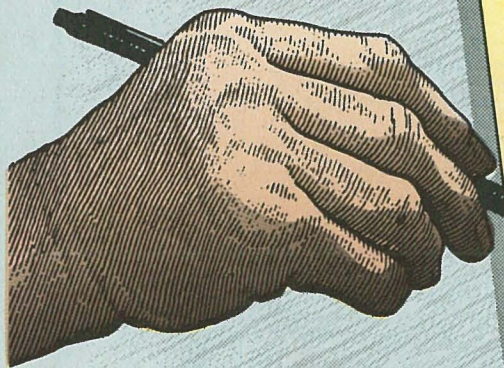
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 Correspondence and contributions to this journal are to be sent to:
 "It-Tabib tal-Familja", Malta College of Family Doctors, Alamein Road, Medisle Village, St. Andrews STJ 14, Malta.
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☐

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☐
☐

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☒
☐

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