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MALTA COLLEGE OF FAMILY DOCTORS

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PRESCRIBING INFORMATION

INDICATIONS

Upper Respiratory Tract Infections e.g. Sinusitis, tonsillitis, otitis media. **Lower Respiratory Tract Infections** e.g. Acute and chronic bronchitis, lobar and bronchopneumonia, empyema, lung abscess. **Skin And Soft Tissue Infections** e.g. Boils, abscesses, cellulitis, wound infections, intra-abdominal sepsis. **Genito-Urinary Tract Infections** e.g. Cystitis, urethritis. pyelonephritis, septic abortion, puerperal sepsis, pelvic infections, chancroid, gonorrhoea. **Other Infections** e.g. Osteomyelitis, septicaemia, peritonitis, post-operative infections. AUGMENTIN intravenous is also indicated for prophylaxis against infections which may be associated with major surgical procedures involving gastro-intestinal, pelvic, head and neck, cardiac, renal, biliary tract and joint replacement surgery.

DOSAGE

Adults and Children Over 12 Years. Oral:- Mild-moderate infections: One 375mg AUGMENTIN tablet three times a day. Severe infections: One 625mg AUGMENTIN tablet three times a day or two 375mg AUGMENTIN tablets three times a day. The 625mg AUGMENTIN tablet is not available in all countries. **IV Injection/Infusion:-** Usually 1.2g 8 hourly. In more serious infections increase frequency to 6 hourly intervals. **Children. Oral:-** Children 7-12 years: 10ml AUGMENTIN 156mg syrup three times a day* or 5ml AUGMENTIN 312 mg syrup three times a day*. Children 2-7 years: 5ml AUGMENTIN 156mg syrup three times a day*. Children 9 months-2 years: 2.5ml AUGMENTIN 156mg syrup three times a day*. Children 0-9 months: No suitable oral presentation is currently available for this age group. *In severe infections these dosages may be doubled. Treatment with AUGMENTIN should not be extended beyond 14 days without review.

CONTRA-INDICATION Penicillin hypersensitivity.

PRECAUTIONS Changes in liver function tests have been observed in some patients receiving AUGMENTIN. The clinical significance of these changes is uncertain but intravenous AUGMENTIN should be used with care in patients with evidence of severe hepatic dysfunction. In patients with moderate or severe renal impairment AUGMENTIN dosage should be adjusted as recommended in the Package Insert Leaflet.

USE IN PREGNANCY AND LACTATION Use of AUGMENTIN in pregnancy is not recommended unless considered as essential by the physician. During lactation, trace quantities of penicillins can be detected in breast milk.

SIDE EFFECTS Side effects, as with amoxycillin, are uncommon and mainly of a mild and transitory nature. Diarrhoea, pseudomembranous colitis, indigestion, nausea, vomiting, and candidiasis have been reported. Nausea, although uncommon, is more often associated with higher oral dosages.

If gastro-intestinal side effects occur with oral therapy they may be reduced by taking AUGMENTIN at the start of meals. Urticarial and erythematous rashes sometimes occur but their incidence has been particularly low in clinical trials. An urticarial rash suggests penicillin hypersensitivity and treatment should be discontinued. Erythematous rashes are frequently mild and transient but may be severe when associated with infectious mononucleosis, in which case treatment should be discontinued. Rare cases of erythema multiforme, Stevens-Johnson syndrome and an occasional case of exfoliative dermatitis have been reported. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions and angioneurotic oedema have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy, it has occurred in patients taking oral penicillins. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens. Hepatitis and cholestatic jaundice have been reported.

AVAILABILITY 375mg AUGMENTIN tablets: White oval film coated tablets engraved "AUGMENTIN" on one side. Each tablet contains 250mg amoxycillin and 125mg clavulanic acid. 625mg AUGMENTIN tablets: White oval film coated tablets engraved "AUGMENTIN" on one side. Each tablet contains 500mg amoxycillin and 125mg clavulanic acid. 156mg AUGMENTIN syrup: Powder for preparing fruit flavoured syrup. When dispensed each 5ml contains 125mg amoxycillin and 31.25mg clavulanic acid. 312mg AUGMENTIN syrup: Powder for preparing fruit flavoured syrup. When dispensed each 5ml contains 250mg amoxycillin and 62.5mg clavulanic acid. In oral presentations amoxycillin is present as the trihydrate and clavulanic acid as the potassium salt. Not all presentations are available in every country.

Further information is available on request to:
SmithKline Beecham International, SB House,
Great West Road, Brentford, Middlesex TW8 9BD, England.

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Editorial

Dear Readers,

This is a very important, and exciting, time for our College. A number of projects of importance which have involved the efforts of many committee members for a number of years will bear fruit over the next few weeks.

The European General Practice Research Workshop will be held in Malta from the 3rd to the 6th October at the Forum Hotel in St. Andrews. This workshop is an international meeting of academics who present and discuss data and research in the field of Family Practice. The workshop is to be held here as a result of contacts developed over the past three years by the College. Over the past years, College members have regularly attended EGPRW meetings, with active participation including presentation of research papers and participation in international research projects. The workshop is important in increasing the College's international status, developing international contacts, and advertising our country to our European colleagues, many of whom have never come to Malta. The conference is sponsored by Marsovin, San Michel Table Water, and the NTOM. NSTS Travel International are helping in the organisation of the workshop and the social programme. We have had a lot of help from local pharmaceutical companies in the form of sponsorship to allow us to travel abroad, and Interpharma Ltd. have sponsored the conference folders.

I have been fortunate to have been able to publish a Directory of Social Welfare Organisations for family doctors, with the sponsorship of Auto Sales Ltd., and the assistance of Ms. Sina Bugeja of the Health Promotion Department. This will be launched soon, and I hope it will be of use to many of us.

The College has been involved in the Joint Seminar in Paediatrics and Obstetrics and Gynaecology to be held in November. A number of college members will be chairing sessions and presenting papers at the seminar. We are sure that this increased co-operation between specialities can only promote the better practice of our profession.

In the weeks to come, the Synapse will be launched. This is an internet server with a special interest in the medical profession. Our International Secretary, Dr. Wilfred Galea, is together with Dr. Gauden Galea the driving force behind the Synapse. Many services will be offered, and the site promises to be full of information of interest to the profession, including the home pages of many pharmaceutical companies, searchable databases of interest to practitioners, and a BBS for doctors.

Many developments indeed ... the future of Family Practice in Malta has never looked brighter!

Jean Karl Soler

Cover Photo taken by J.K. Soler: *Auberge d'Italie.*

The first Government Dispensary was established on the 14th April 1832 at the *Auberge d'Italie* – hence the reference to it and its successors as *IL-BERGA* in popular parlance. It was set up through the endeavour of Dr. John Davy who served in Malta as Inspector General of British Army Hospitals (1824-35).

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THE ILL DIABETIC PATIENT

DR STEPHEN FAVA
SPECIALIST IN INTERNAL MEDICINE

Introduction

Diabetes mellitus is one of the commonest diseases that afflicts mankind; in Malta there is a particularly high prevalence. Diabetes mellitus is therefore one of the diseases which we encounter most frequently in our professional lives. A diabetic patient can become ill either because of a reason directly related to his diabetes, or due to other diseases that also afflict the non-diabetic population. We will consider each in turn.

ACUTE METABOLIC DISORDERS

Hypoglycaemia

Although hypoglycaemia can also occur spontaneously in liver failure, Addison's disease, hypopituitarism and insulinoma, it is largely a side effect of anti-diabetic treatment. Both insulin and sulphonamides can cause hypoglycaemia; metformin rarely, if ever, does so.

The usual causes of hypoglycaemia in a diabetic patient are an excessive dose of insulin or sulphonamides, missed or ill-timed meals or unusually strenuous exercise.

Prevention

A most important aspect of hypoglycaemia is its prevention.

This includes:

i Patient education regarding the importance of proper dietary regime. It cannot be overemphasised that insulin and sulphonamides should always be taken 30-45 minutes before meals. It is also important to stress the importance of the mid-morning and late evening snacks.

ii Long-acting sulphonamides such as chlorpropamide and glibenclamide, should be avoided in the elderly or in those with renal failure as these drugs would accumulate with an increased risk of hypoglycaemia. Shorter-acting sulphonamides such as tolbutamide, gliclazide and glipizide are preferable in these circumstances.

iii Avoid excessive dosage of sulphonamides and insulin.

iv Special care should be exercised in those with liver disease in view of their increased risk of developing hypoglycaemia.

v There is usually little point in aiming for very tight glycaemic control in the elderly, who are more at risk from the effects of hypoglycaemia than from long term complications of diabetes.

TREATMENT

Hypoglycaemia requires prompt treatment if permanent neurological deficits are to be avoided. Treatment modalities include oral glucose (in those who can swallow), glucagon and intravenous dextrose. Glucagon has the advantage that it can be given by the intramuscular or subcutaneous routes. It can therefore be given by the patient's relatives even if the patient is vomiting or is unconscious. It works by mobilising liver glycogen; it is therefore unlikely to be effective in long-standing or recurrent hypoglycaemia as liver glycogen would be depleted under these circumstances. Intravenous glucose is the fastest and most effective way of relieving hypoglycaemia; it can be used in the patient who is unconscious or is vomiting and does not depend on an adequate store of liver glycogen. It is, however not always available (eg. at the patient's home) and requires medical supervision.

It is important to realise that hypoglycaemia can recur if it is due a long-acting sulphonamide or insulin; hence such patients need admission for continuous intravenous infusion of glucose.

Once hypoglycaemia has been treated one should try to identify its cause and take corrective action; this might include patient education on dietary regime or decreasing the dose of insulin or sulphonamide.

HYPERGLYCAEMIC STATES

Diabetic ketoacidosis is a medical emergency occurring due to a severe deficiency of insulin. It can be the mode of presentation of type 1 diabetes, or occur in a previously diagnosed type 1 diabetic patient as a result of missed insulin therapy, gross dietary indiscretion, the presence of an acute stressful condition (eg. acute myocardial infarction, an acute abdomen or an infection) or a combination of these factors.

The hallmarks of the condition are hyperglycaemia, systemic metabolic acidosis with consequent hyperventilation, glycosuria and ketonuria.

Hyperosmolar non-ketotic syndrome is thought to occur due to a lesser degree of insulin deficiency so that there is hyperglycaemia (often severe) but no ketosis. There is an increased thrombotic tendency in this condition which carries a relatively poor prognosis.

Lactic acidosis is not specific to diabetes but can occur whenever there is tissue hypoxia, such as heart failure and shock. Lactic acid is a product of anaerobic combustion of glucose. Biguanides can precipitate lactic acidosis; phenformin is particularly dangerous in this regard and therefore should no longer be used. Metformin is safer and is the biguanide of choice. Biguanides should not be used in those with renal or hepatic impairment, heart failure, coronary artery disease, a history of alcohol abuse or previous an episode of lactic acidosis.

Diabetic ketoacidosis, lactic acidosis and hyperosmolar non-ketotic syndrome all require hospitalisation and intensive management including intravenous insulin, meticulous attention to fluid and electrolyte balance and frequent monitoring. Prophylactic heparin is often used in the hyperosmolar non-ketotic syndrome in view of its thrombotic tendency.

CONDITIONS NOT DIRECTLY RELATED TO DIABETES

Diabetic patients can suffer from any acute illness that a non-diabetic can. Indeed diabetes predisposes to a number of other diseases, including coronary artery disease and infections.

Any acute illness such as an infection or an acute coronary event can precipitate loss of glycaemic control as insulin demands are increased in these circumstances. Diabetes can, in turn, inhibit resolution of an infection.

Glycaemic control is therefore of paramount importance in an ill diabetic patient. It can be summarised thus:

- If possible maintain an adequate calorie intake and continue on the patient's usual treatment regime.
- If necessary top up anti-diabetic treatment by increasing the insulin dose.
- If necessary change over to insulin (often requires hospitalisation) until the acute episode has resolved.
- Stop biguanides in situations at risk of lactic acidosis (such as dehydration, shock, acute coronary events).
- If a patient or insulin treatment is not eating or is vomiting, he requires hospitalisation for intravenous glucose and insulin.
- **NEVER STOP INSULIN.**

DIABETES AND INFECTION

Diabetes mellitus and infection interact in a number of ways:

- Diabetic patients are more prone to infection (eg. urinary tract infection, pyothorax and abscesses). It has, for example, been shown that neutrophils from diabetic subjects exhibit impaired bactericidal activity.
- Signs of infection may be modified.
- Infection worsens diabetic control (there are increased insulin demands as a result as increased counter-regulatory hormones such as cathecolamines and glucocorticoids).
- Poor glycaemic control inhibits resolution infection.

It is therefore of paramount importance to:

- Treat bacterial infection promptly.
- Achieve good glycaemic control.

If infection does not respond adequately to treatment consider:

i Changing antibiotic regime. This can mean using a different antibiotic or a different route. Enteral absorption of an antibiotic can be impaired in any ill patient; diabetes can be associated with further impairment, possibly as a result of autonomic neuropathy. If an infection is not responding to treatment, this may signify the need to change over to intravenous antibiotics.

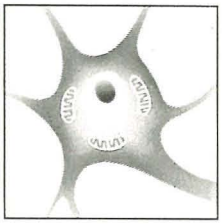
ii Presence of an abscess/ collection of pus that needs drainage.

iii Presence of necrotic tissue (eg. in the diabetic foot). Antibiotics do not penetrate necrotic tissue; this requires surgical debridement.

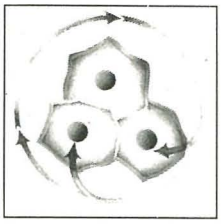
iv Alternative diagnosis. Fever can be due to a non-infective cause, such as antibiotic-induced fever.

SERVIER INTERNATIONAL RESEARCH INSTITUTE

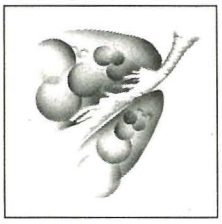
Servier International Research Institute has actively contributed for over 30 years to the progress of world medicine in the following therapeutic areas:



NEUROLOGICAL DISEASES
1. piribedil: dopaminergic treatment for cerebral impairment in the elderly and Parkinson's disease
2. duxil: metabolic treatment for cerebrovascular disease

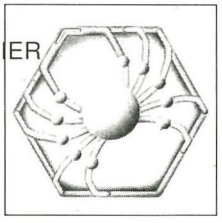


METABOLIC DISEASES
1. gliclazide: metabolic and vascular treatment for diabetes
2. fenfluramine: metabolic treatment for obesity
3. benfluorex: treatment of disorders of lipid and carbohydrate metabolism
4. dexfenfluramine: specific serotonergic agent with selective effects on eating behavior and body weight



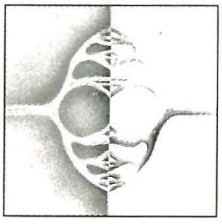
RESPIRATORY DISEASES
1. almitrine: a new therapy for hypoxemic COPD patients which improves both arterial blood gas parameters and clinical status
2. fenspiride: antiexudative, decongestant treatment for inflammation of the respiratory mucosa
3. fusafungine: locally-acting antibacterial and anti-inflammatory agent

SERVIER



CANCEROLOGY
1. fotemustine : a new amino-acid linked nitrosourea with high cellular penetration and significant antitumoral activity in disseminated malignant melanoma

PSYCHIATRIC DISORDERS
1. amineptine: dopaminergic antidepressant with rapid onset of action
2. tianeptine: serotonergic psychotropic drug for mood disorders and anxiodepressive states



CARDIOVASCULAR DISEASES
1. indapamide: antihypertensive chlorosulfonamide derivative which reduces peripheral arterial resistance and normalizes vascular hyperreactivity
2. perindopril: high-performance ACE inhibitor which reverses the structural and functional alterations in hypertensive arteries
3. tertatolol: antihypertensive beta blocker with a beneficial effect on renal perfusion and glomerular function
4. trimetazidine: anti-ischemic agent active at the cellular level, for angina pectoris, and cochleovestibular and chorioretinal disorders of ischemic origin
5. daflon: specific treatment for venous disease, restores the endo-endothelial fibrin lining
6. rilmenidine: the first of a new class of antihypertensives with a selective action on the medullary and renal imidazoline binding sites involved in the regulation of blood pressure

The Practice of a Surgeon in Gozo in 1813-1815

Dr Paul Cassar
Medical Doctor & Historian

The Manuscript

Among the manuscript holdings of the National Library at Valletta there is one that reflects several aspects of the health conditions of Gozo in 1813-1815.

The ms. (Lib. 1432) consists of a note-book of 46 pages written on both sides of the page. The paper is so thin and the ink is so dark that at times the writing on the back shows through to the front rendering the text of variable legibility. The size of the notebook measures 21cm by 15cm.

The leaves are bound to form a booklet but the binding is not the original one. The front and back covers are of hardboard. There is no title-page, no author's name and no indication as to how the ms. was acquired by the Library and when.

The last page ends with an incomplete entry. The last complete note is dated 17 June 1815. The ms. breaks up at this point. It is not known if the ms. was continued in another book which might have long since been lost.

Contents

The manuscript consists of a collection, in chronological sequence, of the notes of certificates issued and signed by surgeon *(chirurgo)* Calcedonio Speranza as they were submitted to the Health Authorities and to the Law Courts of Gozo. They are recorded according to the date of examination of the patient; but to get a clear view of the nature of Speranza's professional practice I propose to consider his notes according to the topic they deal with. For this purpose I have grouped them under the following headings:

- Death certificates and causes of mortality
- Medico-legal reports of injuries and post mortem examinations
- The plague of 1813-14
- The smallpox epidemic of 1813-14

Death Certificates

It appears that there was no standard official form of a death certificate issued by the health authorities at the beginning of the 19th century – at least none has so far been met with to my knowledge. Surgeon Speranza used a set form of wording beginning with the phrase *cessò di vivere* (ceased to live) or with the euphemistic expression that the patient passed "to eternal rest" or "from this life to a better one". Then followed the name, age, locality and cause of death. Here are two specimens (translated from Italian):

(a) "B.T. eighty years old, passed to eternal rest during the night in consequence of a lung disease and loss of blood. I have examined his body but found no signs of a contagious illness 23rd July 1814."

(b) "G.M. son of S.Z., four years old passed from this life to a better one. He suffered from smallpox and dysentery and died after an illness lasting a month. I have inspected his body but found no signs of a contagious illness except the scars of smallpox. In truth thereof I sign my name by my own hand today the 30th July 1814." The allusion to a "contagious illness" derives from the fact that at that time, besides smallpox, there was an epidemic of bubonic plague.

Causes of death/mortality

Convulsions in infants and children. Seven cases, one of which ascribed to dentition.

"Dysentery" in adults. Seven cases.

Erysipelas of right leg attributed to a prick from a scissors, made worse by neglect and bad treatment.

Epilepsy. One case in a man of sixty years who died in the Male Division of the General Hospital *(Ospedale dei maschi)*. His certificate is the only one that bears the full signature of *Calcedonio Speranza. Incarrigato (sic)* (i.e. The practitioner in charge of the hospital. (9 June 1814).

Fever. Unspecified. Five cases.

Foetus born during a difficult labour. Two cases. One was delivered with the cord round the neck and died "after receiving baptism at home"; the other presented with prolapse of the right hand and died in spite of all "operations" (manual?) carried out. The mother survived.

Old age. Thirteen men and women whose ages varied from eighty to ninety eight years. In four of them, in addition to senility, there were also "hydropsy of the lungs", gangrene of the buttocks, "abscess of the neck" and "abscess in the right thigh".

Smallpox. Thirty-nine children. In a few instances small pox was complicated by "dysentery" or "obstruction of vital organs".

Spinal "tumour". A girl was born with a very large swelling filled with "lymph" situated over the lumbar vertebrae. As this tumour was a "penetrating" one (communicating internally?), in Speranza's view, the girl could in no way "escape death". He ascribed the origin of the tumour to a severe fall of the mother during pregnancy. (22 May 1814).

Syphilis *(lue)*. On 5 January 1815 he certified that some two years previously he had seen Maria... for *lue confirmata* as shown by ulcers in the throat and articular pains. He treated her with mercurial inunctions.

Three months previously he had seen another case of *lue confirmata* – in a girl of three-and-a-half years "contracted from her parents". She presented with ulcers in her mouth and her privy parts. (24.9.1814).

Spleen. Two cases of "obstruction" of this organ accompanied with long standing "dysentery".

Tetanus. On the 10 September 1814, he saw a girl with wounds in her right index and middle fingers sustained in a fall. There was gangrene of the middle finger. Tetanus appeared on the ninth day.

The Plague of 1813-14

Bubonic plague invaded Malta between the 16th April and the 5th May 1813. It extinguished itself by the 7th March 1814. In the meanwhile, on the 18th February 1814 it appeared in Gozo at Xaghra to which village it remained confined. It carried off one hundred and four persons before it came to an end by the 13th June 1814.

Surgeon Speranza's first allusion to the plague is an indirect one. It occurs in a death certificate addressed to the *Protomedico* (Chief Government Medical Officer) on the 2nd May 1814. It runs as follows in a free translation from Italian then the language of professional and cultured persons in the Maltese Islands: "Giuseppe ... of the late M... of about eighty years of age died this morning of diarrhoea in the Male Division of the (General) Hospital. I have examined his whole body and found no suspicious signs of plague. In witness of the truth thereof I sign (this certificate) with my own hand".

Other cadavers examined by Speranza revealed no signs of a "suspicious illness"; in fact he had no occasion to deal with plague cases during this epidemic but he continued to examine the corpses of his patients for plague until the 27th January 1815 long after the epidemic had ceased.

The Smallpox Epidemic

On the 1st September 1814, Speranza received the following instructions from the Acting *Protomedico* of Gozo, Dr Cutajar (freely translated from Italian): – "It is the precise wish of His Excellency (the Governor of Malta) that the *Protomedico* of Malta be kept informed of every illness occurring in the Island of Gozo. I, therefore, advise that you carry out this order with all exactitude i.e. to report to me in writing every person calling upon you to be treated so that I can keep informed the *Protomedico* of Malta of such occurrences".

There is no reason to believe that Speranza failed to abide by the instructions of Dr Cutajar; indeed he issued no less than thirty-nine reports of smallpox in children between the 8th July 1814 and the 16th June 1815.

Medico-legal reports

During the period of eighteen-and-a-half months covered by this manuscript, Speranza drew up a number of medico-legal reports and certificates at the behest of the judicial authorities of Gozo whom he addresses as *Signori Loro Illustrissimi* (Your Most Illustrious Sirs). The one written on the 16th December 1813 reads (translated from Italian):

"I have gone at your behest to the village of Ghajnsielem, in the vicinity of the Qala Cross, to examine G.B., son of the late Andrea. He suffers from a small wound involving the skin caused two days ago by a sharp-pointed instrument. It is situated in the left side of the back between the fourth and fifth ribs near the inferior angle of the scapula. It does not constitute any danger to life; on the contrary I consider it to be of a slight nature so much so that it is already healing with a scar. In truth thereof I append my signature by my own hand".

On the 14th February 1814 he issued another report in conjunction with Dr...Arpa and Dr...Pace: "We have been to the Public Prison to examine G.Z. We have carefully examined his genital organs and found that his right testicle was swollen due to venereal disease *(lue venerea)* contracted some time ago and left untreated. He complains of pain in his urethra and of difficulty of micturition.

Besides he has been suffering from joint pains all his life. On account of these impairments to his health he is unfit to undergo "strict imprisonment and to live in a humid environment as such

conditions may result in grave prejudice to his health."

The prisoner was seen some time later by the same medical examiners who recommended a "universal treatment", that is with mercurial preparations, as without such medication he would suffer such a deterioration in his health that "the medical profession would not be capable of offering any means for the total restoration of his health." It was recommended that the prisoner should be admitted to hospital where he would be in a position to benefit from the medical and surgical care available there. The prisoner was eventually transferred to hospital. By this time he was suffering from retention of urine. Speranza submitted to the Court that because of this condition, G.Z. needed to do some exercise, while in hospital, to ensure "the movements of his humours" as confinement to bed would result in great harm with aggravation of his illness" (9.4.1814).

On the 1st March 1814, Speranza was appointed by the Court to perform a post-mortem examination on the body of a murdered man admitted to hospital: "After carefully examining the body I found the following lesions – (a) three wounds, the first on the left side of the neck; and the other two on the trunk which are not penetrating ones and are of no importance. The neck wound is about five *pollici* (inches) deep and filled with clots of blood from severance of the subclavian artery; (b) no pathological changes in the internal organs beyond turgidity in the lobes of the lungs derived from the spread of blood from the neck wound. I consider that the severance of the (subclavian) artery, was the cause of death which under the above circumstances was inevitable."

On the 2nd February 1815, he was called to inspect the dead body of a woman that had been found drowned in a well at Gharb. An external examination of the body revealed no signs of injuries, wounds or beatings. In his opinion death was due to obstruction of respiration from drowning due to her falling into the cistern.

Occasionally livestock that happened to be ailing came within his previews. On the 18th March 1814, he was assigned the task of a veterinary practitioner by the Law Court when he was ordered to assess the fitness for human consumption of an injured cow at Mount Ghelmus. He found the cow to be quite alert but on examining her he found that she had sustained a dislocation of her hip joints caused by skidding while running in a swift career across a grazing field. There was no other sign indicative of disease. He, therefore, certified that the cow was fit to be killed at the slaughterhouse and its meat sold to consumers without prejudice to the public health.

Certificate of Injuries for Court Purposes

The certificates of injuries issued by Calcedonio Speranza involved the following parts of the body:

Skull	26
Face & Neck	11
Fingers	10
Arms and Forearm	7
Vertebral Column *(Lumbar Region)*	6
Ribs	2
Abdomen	2
Breast *(Woman)*	1
Eye	1
	Total 66

The injuries were either contusions or lacero-contused wounds. There were no fractures and penetrating wounds. The injuries were all caused by blunt objects except in two instances produced by a cutting instrument; and in a solitary case, caused by two balls shot from an arquebus.

Of the total of 66 injuries only two were declared by Speranza to present a danger to life i.e. one involving the lower abdomen and extending to the sacrum, and a lacero-contused wound on the skull over the sagittal suture with exposure of the bone.

In only one instance he did not feel so sure about the outcome of the injury. On the 28th November 1814 he examined a patient with a contusion of the left iliac crest caused by a blunt instrument. He saw the patient again five days later following the development of fever and the onset of spasmodic abdominal pains. The only certificate that he issued this time stated that he was reserving his opinion to a later date. Unfortunately, there are no further allusions to this case and we are left wondering as to the final outcome of the patient's condition.

Certificates of "Cure"

Two certificates of healing relieve the somber aura of morbidity and mortality. On the 1st August 1814, Speranza wrote thus (translated from Italian); "I certify that about five years ago the wife of M.Z. was under my care for the French Disease *(morbo gallico)* for which she received a *cura universale* (i.e. a course of mercurial inunctions). Since then she has been enjoying perfect health".

Another certificate of the 7th February 1815 concerned a "head wound" sustained by G.P. and treated by Speranza ten years previously. Speranza had considered the wound to be dangerous to life but after treatment the patient "was perfectly cured" and able to resume his occupation.

Who was Calcedonio Speranza?

We know very little about him. Up to the present the records discovered about him are very scanty and he remains a very elusive

figure. He was a product of the eighteenth century when there was a distinct separation in the medical hierarchy between the physician and the surgeon. The former received an academic education, and spoke and wrote Latin. He obtained his medical doctorate from a medical school abroad, such as Salerno and Montpellier, and on his return to Malta he had to spend a number of years practising at the Holy Infirmary before he received his warrant to enter into private practice.

On the other hand, the surgeon underwent no such studies. He started his career at a very young age at the Holy Infirmary of Valletta as an apprentice. He followed lectures in anatomy and surgery and attended dissections and post mortem examinations at the same Infirmary. After approval, at the end of his training, by the surgeons of the Infirmary, he would become a *barberotto* or barber-surgeon.

In fact Speranza started his career as a barber-surgeon in the Order's navy. He was then appointed barber-surgeon at the hospital at Gozo. He claimed that a paternal grandfather, an uncle and two brothers were surgeons. We then lose sight of him until 1786 when he addressed a petition to the Grand Master that he had a son, Giuliano, who desired to follow in the foot steps of his father as a barber-surgeon and aspired to be appointed in this capacity at the Gozo Hospital as successor to his father Calcedonio. The request was granted. The records stop there.

From other sources we know that there were other "Speranzas" engaged in the practice of the healing arts during the eighteenth and nineteenth centuries. Indeed they formed quite a dynasty but Calcedonio's relationship to them has not been yet ascertained.

Comment

The exceptional importance of Speranza's manuscript and its contents derives from the fact that (a) it depicts the epidemiological scene in Gozo in the first two decades of the nineteenth century; (b) it is the only notebook about a surgeon's practice that we know of; (c) it provides a first-hand record of the medico-legal aspects of trauma and death as presented to the Law Courts in Gozo between 1813 and 1815; (d) it is a reminder that the concept of specialisation in medicine and surgery had not yet dawned with the result that every practitioner was expected to be knowledgeable and competent in all branches of medical science.

3rd European Congress on Family Medicine/General Practice, WONCA

Dr Mario R. Sammut
Honorary Secretary,
Malta College of Family Doctors

Introduction

Through the generous sponsorship of the registration fee by the Swedish Association of General Practice, a delegation from the Malta College of Family Doctors was able to be one of sixty from countries around the world participating in the 3rd European Congress on Family Medicine/General Practice, WONCA (World Organisation of Family Doctors), held at the City Conference Centre in Stockholm, Sweden, on June 30 - July 4 1996. The Malta delegation consisted of Dr. Denis Soler M.D. F.R.C.G.P., College President, Dr. Wilfred Galea M.D., International Secretary, and Dr. Mario R. Sammut M.D., Honorary Secretary.

Congress Scope & Theme

As described by Carl Edvard Rudebeck and Jonas Sjogreen, Congress President and Vice President, "recent dynamic political developments in the whole of Europe are a challenge for us all. Our society is changing rapidly and so are the tasks facing our health care systems. The **scope** of this congress was to contribute towards meeting the growing need for setting up networks and strengthening bonds between family doctors.

Every general practitioner has an obvious need for **continuing medical education.** CME is the key to the development of personal competence and to quality assurance and improvement. In the last few years there has been great activity in this particular field in Europe. Research, experimentation and investigation have led to new knowledge, new educational techniques and new strategies. The main goal of the congress was to utilize all this and to stimulate the development of CME through intercollegiate discussions and the exchange of ideas."

Inauguration Ceremony and Symposium, 30th June

Family doctors playing Swedish Folk Music started off the **Inauguration Ceremony** of this congress on a tuneful note. With Dr. Jonas Sjogreen acting as compere for the evening in his historical uniform of an olden-day Swedish district medical officer (complete with cocked hat, tails, sword and all!), speeches of welcome were made by Dr. Carl Edvard Rudebeck, President of the Organising Committee and Chairperson of the Scientific Committee, Dr. Frede Olesen, President of the European Society of General Practice/Family Medicine (ESGP) and Dr. Goran Sjonell, President of WONCA. These were followed with the customary presentation of the Hippocrates Award by Drs. Ingvar Krakau and Frede Olesen to Professor Gosta Tibblin of Sweden in recognition of his services to family medicine.

The **Inauguration Symposium** entitled **"Life-long Learning – Personal Reflections given by Experienced General Practitioners from their Varying National and Cultural Backgrounds"**, was chaired by Bengt Mattsson (Sweden), with presentations being made by Bernardine Wanrooij (Netherlands), Michael Weingarten (Israel) and Aili Pick (Estonia).

Main Programme, 1st-4th July

The titles of the daily opening keynote lectures were the following:

- **Wants and Needs in CME** – Michael Boland (Ireland);
- ***The Individual in Clinical Practice*** – S. Kay Toombs (USA);
- **General Practice/Family Medicine in the New Europe – Changes and Challenges** – Joan Gene I Badia (Spain);
- **General Practice and Society – An interactive tale** – Per Fugelli (Norway).

College representatives also attended for the following presentations, symposia and workshops:

1. **CME – Incentives and Formats,** chaired by Jacky Hayden (UK).
2. **CME – Groups, Mentors, Plans,** chaired by Bernardine Wanrooij (Netherlands)
3. **CME – Patient Needs,** chaired by Igor Svab (Slovenia).
4. **CME – long distance, information technology,** chaired by Aldo Lupo (Italy).
5. **CME – academic work, research,** chaired by George Bellos (Greece).
6. **WONCA Working Party on Informatics,** a workshop chaired by Michael Kidd (Australia),

where the College, having already appointed its representatives on this working party, made a strong presence through active participation.

7. **The Internet for General Practice,** a workshop chaired by Ian Purves (UK).
8. **Prevention,** chaired by Robert Hall (Australia).
9. **Methods for Assessment of Competence in General Practice,** chaired by John Hasler (UK).
10. **EGPRW: Research in General Practice/Family Medicine in Europe,** chaired by Paul Wallace (UK).

International Contacts

Various contacts were made during the congress, as follows:

Copies of the College's **Specialist Training Document** were presented to the following international experts for their opinion, constructive criticism and recognition. These were **Dr Philip Evans (UK),** President of the International Committee of the Royal College of General Practitioners, **Prof Jan Heyrmann (Belgium),** President of the European Academy of Teachers in General Practice (EURACT), **Dr Jonas Sjogreen,** President of the Swedish Association of General Practice, **Prof. Michael Weingarten** of the University of Tel-Aviv, Israel, **Prof. Paul Wallace (UK) and Dr. Igor Svab (Slovenia),** President & Secretary of the European General Practice Research Workshop (EGPRW), **Dr Vaclav Benes (Czech Republic),** Vice-President of ESGP, **Dr Robert Higgins (USA),** President-Elect of WONCA, **Dr Michael Boland (Ireland),** representative of the European Working Party on Quality in Family Practice (EQuiP) on the ESGP executive, and **Dr Christos Lionis (Greece).**

Dr Goran Sjonell, President of WONCA, was asked about the possibility of WONCA organizing a database of the resources available from different Colleges. He was optimistic about this and asked that the College formalize the request in a letter.

A meeting was held with representatives from Greece and Israel about the possibility of forming a **WONCA Eastern Mediterranean Sub-Group** of colleges, initially comprising Malta, Greece, Israel, Cyprus and Turkey, to enable collaboration in family medicine between these countries. It was decided that each of the colleges prepare a presentation for circulation, and that another meeting be held during a regional conference in November where presidents of the regional colleges are to be invited.

Finally, a copy of the book *"Malta 360 degrees"* was presented on behalf of the College to Dr. Jonas Sjogreen and Dr. Anna Kallkvist of the **Swedish Association of General Practice** as a token of thanks for sponsoring the registration fees of the College representatives in Stockholm.

Closing Ceremony

The congress was brought to a close with various speeches and a couple of presentations inviting participants to the 1st Conference of the European Society of General Practice in Prague, June 30 - July 4, 1997, and to WONCA '98 – the World Conference of Family Medicine in Dublin, June 14 - 18, 1998.

Dr Jonas Sjogreen (second from left), President of the Swedish Association of General Practice, being presented with a copy of the book "Malta 360 degrees" *by Dr. Denis Soler (second from right), President of the Malta College of Family Doctors, in the presence of (from left) Dr. Mario R. Sammut, Dr. Anna Kallkvist and Dr. Wilfred Galea.*

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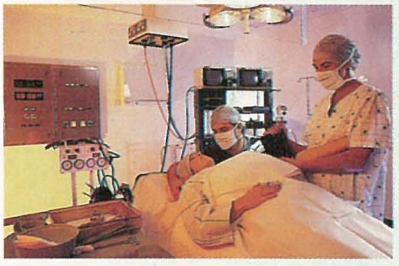




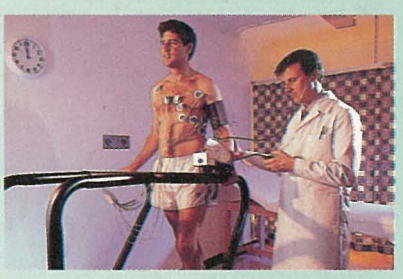

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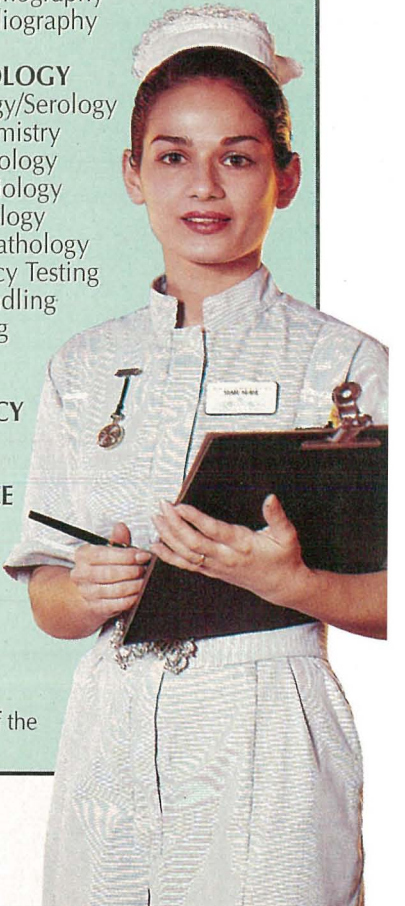

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Early Social Relationships in Childhood Contribute to Later Psychological Development

A. Muscat Baron
Paediatrician SLH
Y. Muscat Baron
Gynaecologist SLH

Introduction

Humans are social beings. Social relationships are an integral part of human life. Gathering different experiences through social interactions influences future psychological development. A break in a social relationship may be considered a major life event and the persons involved may be adversely affected psychologically in the short and possibly even in the long-term. The psychological state of the person has a significant impact on his behaviour and his emotions. It is therefore important to realise and understand the effect that social relationships have on our lives.

Research

The dramatic effects on children being separated from parents by admission to hospital or to a residential nursery, concerned child psychology researchers for quite some time. This generated increased attention to the psychological needs of children. One important result was the improvement in children's wards. Besides this, greater knowledge has developed regarding children's social relationships and their impact on psychological development. It is generally thought that the evolution of social interactions is dependent and influenced by earlier experiences and family make-up.[1]

Social Relationships in Childhood

The family has a major role in children's social development by creating the ideal environment.[2] The important role of social interactions in life can be particularly appreciated when these interactions are lacking or improper as in the case of autistic children.

It is now believed that infants are social beings from a very early stage in their development.[1,3] The need to have and enjoy social interactions is inborn. It is part of instinct and is not learnt from scratch. At birth however, these particular social capabilities are immature. Socialization develops and matures throughout life. These social relationships indeed form a major part of our everyday lives at any age.[3]

Social Reciprocity

Development in children is a continuous process and the transitions from one stage to another take place over a period of time. As soon as babies are born, they start exploring their environment, looking around especially at bright objects, trying to make sense out of these new surroundings. They have no preferred face or object as yet, but are attracted by faces in general and bright objects including light itself. Newborns in fact, were found to be attracted to a face-like stimulus, a simple picture of 3 sharp blobs (in the place of the eyes and the mouth). As babies grow older, they become more interested if there is more detail on the face, and if the face moves (e.g. speaks, smiles, makes funny gestures).[4]

This has been extensively investigated by researchers especially in the past two decades. Employing "looking" and "sucking" responses, they monitored the varied reactions to different stimuli.[3,4] This important research has enlightened us about many different cognitive capacities (previously unnoticed) of the newborn and very young infants.

Smiling and vocalizing then sets in, especially when spoken to in a responsive and conversational manner. At about 2-3 months, babies respond preferentially to their parents whom they now recognise. Social interactions at this stage become

more integrated and organised. During the next 3 months, babies contribute more to the relationships by initiating responses themselves. This initiative gives the baby greater control over the relationship, becoming equal social partners to the parents.[1,3]

Selective Attachments

At around 6-8 months of age, babies start to develop specific attachments to particular persons, usually the parents. They protest and become upset if this person/s leaves the vicinity, especially when frightened or in a strange place. They become wary of strangers but this is more of a cautious rather than a fear reaction. They are actually afraid of the unknown at about 1 year of age. This happens particularly if they are suddenly faced with an unfamiliar situation or with a new person who intrudes rather ungracefully.

The Clingy "I Want Mummy" Phase

The fear of strangers coincides with the development of anticipatory responses based on past experiences towards the end of the first year of life. Between 1 and 3 years of age they become very clingy to mummy and can become quite upset and distressed when separated. The mother or any attachment figure provides a "secure" base from where to start. Separation anxiety is seen very clearly on admission to hospital, if the parents are not allowed to stay or they leave on their own accord. Children at this age have more than one selective attachment, usually 3 or 4. The father, the grandparents, older siblings or any other close relative or friend may well serve this purpose but the hierarchy is still maintained with the mother giving the best comfort. The father may be the better companion at play time but not necessarily have the anxiety reducing function of the mother.

Cognitive Capacity

During the next two years until school age, children gain more confidence and the close physical contact with their attachment figure becomes only necessary at times of illness, when tired or following separation experiences.[1] They can now be easily comforted by strangers. Children start to comprehend why parents have to leave them for short periods such as to go to work, but become distressed if this separation is unexplained or capricious. As children become older, they are able to maintain relationships even when separated from the attachment figures. This happens because children at this age start to gain cognitive capacity, enabling them to understand that the person still exists although not seen, and hence the interaction continues. They are able to appreciate that relationships can persist over time and space.[3]

Attachment Behaviour

Attachment is a vitally important part of a child's social relationship. Attachment tendency is inborn in social beings universally, including animals, and does not require rewards for it to develop. It is a means of providing "security". This summarises the purpose of attachment as presented by Bowlby (1969); a statement which has revolutionized all other subsequent attempts at defining "attachment".[3]

Attachment can have different meanings. However it is usually taken to refer to a dyadic relationship and not attachment to any individual characteristic. The quality of one child's relationship to a parent may be different from that of the same child with the other parent.[1] Attachment provides a secure base to which children can refer to, e.g. when playing. They may be playing at a distance from their attachment figure, but feel secure because they can still see this person, usually the mother. It allows exploration and diminishes anxiety. Attachment in social relationships is different from the type of attachment present in playful interactions.

Selective Attachment

It has become increasingly suggestive that for a "proper" social relationship to develop in adulthood, children should have had relationships with attachment properties earlier on in life. Lack of such selective attachments predisposes to difficulties in close relationships (including sexual) in adulthood.[3] Selective attachment to a particular person in infancy is important. Usually this figure is the mother but it makes no real difference who it is, as long as there is a selected person to attach to.[3]

In the case of abused children, they will cling and seek refuge even from the perpetrator, if no one else is available. If the perpetrator is not at hand, then the child will cling to inanimate objects, which will serve the purpose at the time. However this is not as healthy an attachment as one with parents or peers as this does not lead to normal social relationships later on in life.[1] Autism is another circumstance

where selective attachment is not exhibited in a normal way.

Institutionalized children still have a favourite person as a specific attachment figure and tend to cling more than other family-reared children. However it has been shown that children having this kind of selectivity are less secure and incapable of exercising normal social behaviour later on in life, as accepted by society in general. This is thought to be due to the constant turnover of non-personalized caregivers at the institution.[3]

Hinde in 1982 described an "attachment behaviour system".[1] This postulates that as children grow older the relationships they have are influenced by past experiences. This has led to the hypothesis (Bowlby 1973, 1980) that secure, dyadic relationships are important in shaping personality.[1]

Security in Attachment

Secure attachment at approximately one year of age produces a self-confident and independent person later on in life Such children grow up to possess better social competence and peer relationships.[1,3]

Insecure attachments on the other hand, may be initiated by parents who are stressed themselves. These parents, who may also have an unstable marriage, easily get irritated by children. A poor parent-child relationship leads to this type of insecurity. Such insecure attachments in early childhood lead to abnormal reactions towards stressful events that occur in adult life.[1] Emotional and behavioural problems in adult life have been blamed on insecure attachments in early childhood, but more evidence is required in this area.[3]

Greater insecurity seems to be felt during adolescence, especially if the surroundings are not ideal and supportive. In a follow-up study of ex-residential nursery children by Hodges and Tizard,[3] children restored to their biological parents, who are often disadvantaged, did not fare very well. Most of these children developed conduct problems requiring psychiatric treatment or ended up as criminals. The ex-residential children who were adopted by better off families fared much better, although compared to the general population, they still showed a higher incidence of anxiety and emotional problems.

However, both adopted and restored children showed a similar pattern with regards adolescent peer relationships. Ex-residential children had been used to child-adult relationships in their past. Subsequently it was difficult for them to form peer relationships. More often than not, they did not have a special friend to confide in or turn to for emotional support, a need which is deeply felt at this age. Adolescents who have gone through these experiences are more prone to psychological problems, especially in choosing and getting on with their peers.

Selective attachment during the first 3 to 4 years of life are an important ingredient for close relationships, including sexual, love relationships and later parenting. This has been supported by animal studies performed by Harlow et al.[3] Moreover, a 36 year prospective study by Franz et al. has shown that children who have been brought up by stable and loving relationships with their parents during their early years of life, are expected to have long and happy marriages themselves.[3]

Breaches in Early Attachments

Hospital admissions act as acute breaks in an ongoing relationship. When these admissions occur at preschool age, they may have an impact on the psychological development of the child, especially if these are recurrent and where "rooming in" of the parents is not normal practice. On returning home after discharge, the child frequently exhibits adverse behaviour. The negative impact on the psychological development of the child is further exacerbated if the parents misinterpret the child's adverse behaviour as naughtiness. On the contrary they should be helping to restore the secure attachment that existed previously. Moreover, family discord does not help this situation.[3]

Grief reactions, such as bereavement (i.e. loss of a social relationship) affect children differently and less adversely than adults. Children are quicker at establishing new relationships than adults. Thus the loss of a sibling or a friend or even a parent does not affect them in the same way as it affects an older person. They do grieve, but this is short-lived. Children do not ruminate about the past and the future, unlike adults. The loss of a parent can be made more difficult, because the bereaved child has to cope with the grief of the other parent. This, and the fact that the quality of the subsequent parenting may be less suitable, affects the child's psychological development.[3]

Parental divorce can be viewed as worse than parental death. This is because it is not just grief that is experienced by these children. The psychological disturbance in these children precedes the divorce because of parental discord and disagreement that goes on before. This disturbance is greater than that suffered after the death of a parent and is similar to and as common as that which exists in children living in "discordant undivorced families".[3] A conduct disorder type of psychological disturbance is more likely to follow than a depression in such situations. Aggression, impulsive behaviour and poor peer relationships may occur as a result. This effect on the psychological development of the child is more likely if the parents continue to dispute and if the parental care after divorce is inadequate. It has been observed that these disorders particularly affected temperamentally difficult boys more often than girls.[3]

Due to children's well-known ability to adjust and form new relationships, these acute disturbances are usually over by about two years following the divorce.[3] This is made possible and easier with the presence of social support and proper, stable parental care, following the break-up of the marriage. However, the impact on these children's psychology remains imprinted and will nonetheless affect their behaviour, thoughts and decision-making in their future life. Flashbacks of their past will invariably occur. Children's ability to adjust to new situations and relationships is seen clearly in *remarriage* circumstances. Young children usually benefit most from remarriage. Older girls may have more problems than boys in adjusting psychologically to the new parent. Adolescents experience more difficulty in establishing new relationships.

Peer relationships in childhood may somewhat predict future psychological behaviour. Emotionally disturbed children (e.g. following death or divorce) react adversely towards friends, and consequently their relationships are threatened. On the other hand, peer relationships influence the personal behaviour of the individual. Isolated boys were found to be less likely to get involved in criminal acts, since such antisocial activities are group behaviours and these boys were less likely to be part of such groups.[3] Institutional care has already been shown above to have a negative effect on peer relationships. *Peer rejection* or even isolation increases the risk of psychosocial and psychiatric disorders later on in life. Peer rejection places the child in a difficult and stressful situation. Such children are more easily ridiculed, bullied, lack self-esteem, are lonely and therefore are not learning through social experiences. There are two possible results of peer rejection. There are those children who are withdrawn and shy as a result and this may lead to anxiety and depressive disorders in adult life. The other type are the ones who react to rejection with aggression. This may predict psychopathological disorders as these children grow older. These two pathways may overlap. Antisocial personality disorders may lead to depression following life events such as broken love relationships and loss of jobs.[3]

Conclusion

Socialization is an important aspect of psychological development. It is primarily inborn but develops and matures as the child grows. Social relationships are an important ingredient making up our life at all ages. Gathering different experiences through these interactions produces an impact on the psychological development of human beings. Social interactions with the appropriate secure attachments, have been shown to affect a child's life positively. However unhealthy, disruptive social relationships can lead to severe psychological disturbances at a later age. It is thus important to understand the consequences that early social relationships have on our psychological development. More research is however necessary to continue uncovering previously unsuspected mechanisms in this prominent field in child psychology.

References

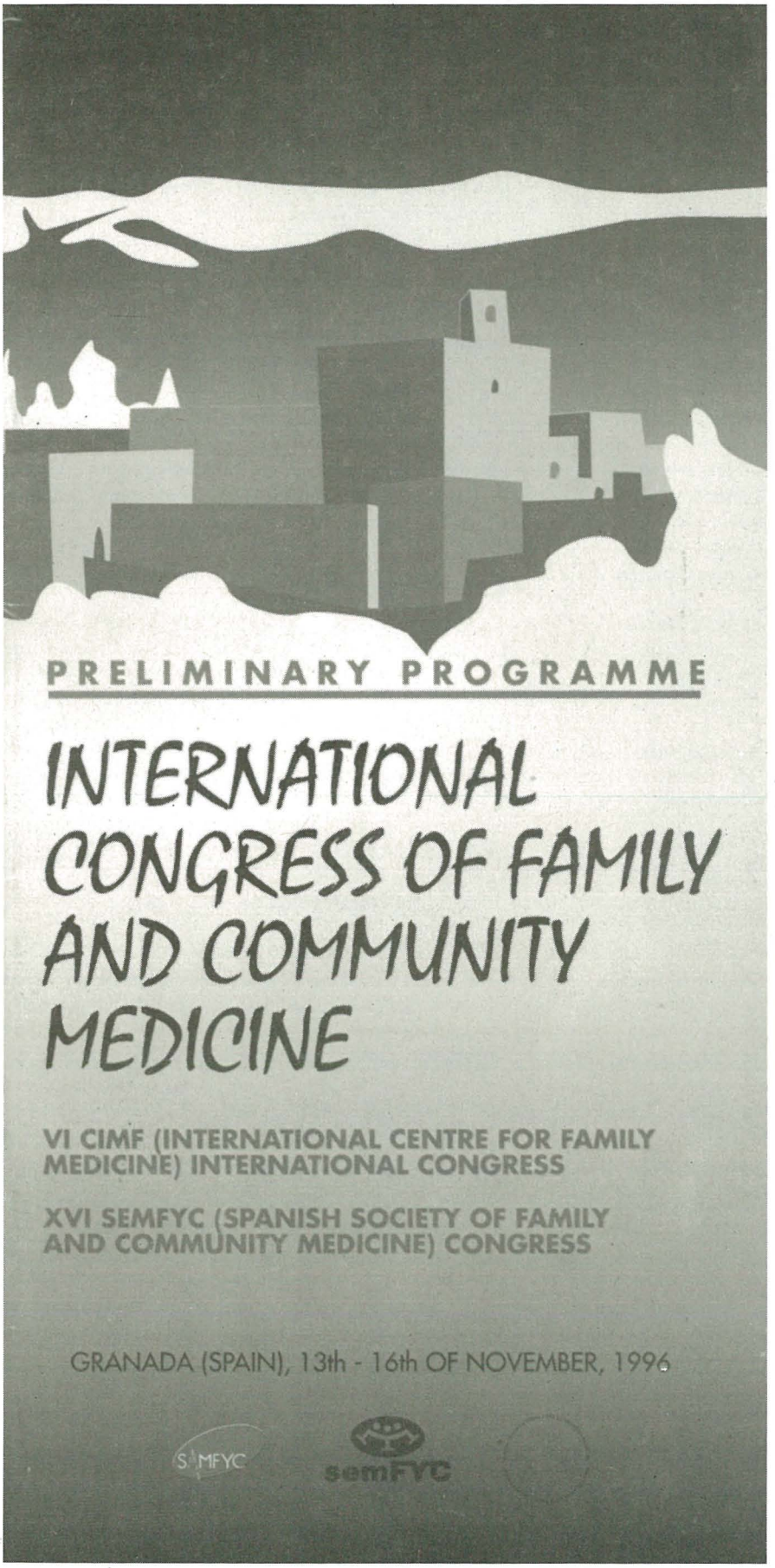
1 Wilkind S. and Rutter M. Separation, Loss and Family Relationships. In: Rutter M. and Hersov L. Child and Adolescent Psychiatry. 2nd edition. London: Blackwell Scientific, 1987: 34-40.

2 Barker P. Developmental Considerations. In: Basic Child Psychiatry. 6th edition. London: Blackwell Scientific, 1995: 1-11.

3 Rutter M. and Rutter M. The Growth of Social Relationships. In: Developing Minds: Challenge and Continuity across the Life Span. Harmondsworth: Penguin Books 1993: 110-155.

4 Karmiloff-Smith A. Annotation: The Extraordinary Cognitive Journey From Foetus through Infancy. J. Child Psychol Psychiat 1995; 36(8): 1293-1309.

MESSAGE FROM THE ORGANIZING COMMITTEE



Granada, April, 1996

Dear Colleague,

We are introducing you with the Preliminary Programme of the International Congress of Family and Community Medicine which will be celebrated in Granada, Spain, from 13th to 16th of this coming November.

You are sure to have realized that, as usual in our congresses, the scientific programme offers a wide range of lectures, tables and workshops, with a variety of clinical, organizational, community or public health subjects. For the first time, we have also included two pre-Congress courses of interest to the family doctor.

The SemFYC national congresses have already proved their high scientific level; the number of participants has increasingly risen every year to become one of the most important congresses, not only in our country, but also abroad. This year, its importance is even greater since it coincides with the VI CIMF (International Centre for Family Medicine) International Congress, so we will have colleagues from different countries as lecturers and participants. Besides, some awards will be granted to the best communications by the semFYC and the Congress Organizing and Scientific Committees.

This programme may be particularly suitable so that the desired unification of the primary attention doctors starts being a reality. As a matter of fact, the first lecture will be given by members of the semFYC and the SEMERGEN together and introduced by the presidents of both societies.

And Granada is the best place for this important Congress to be celebrated!

We are sure that you will not want to miss it. We are waiting for you.

Organizing Committee

Report on Activities of the Malta College of Family Doctors During 1994-96

Mario R. Sammut
Honorary Secretary

1. COUNCIL MEETINGS:
15 (5 in 1994, 8 in 1995, 2 in 1996)

Attendance:

Dr D. Soler	15	Dr J.G. Pace	12
Dr M.R. Sammut	15	Dr J.K. Soler	12
Dr A.P. Azzopardi	15	Dr M.A. Borg	9
Dr A. Mifsud	14	Dr J. Gauci	8
Dr J. Padovani	13	Dr R. Busuttil	6
Dr W. Galea	12		

2. SUB-COMMITTEES:

- **A Family-Doctor Directory Sub-Committee** was set up in May 1994, formed of Dr W. Galea (Chairman), Dr F.P. Calleja, Dr J.K. Soler and Dr M.R. Sammut. An initial report was presented in October 1994, followed by the directory itself which has been made use of by the College.
- **An Organising Committee for the EGPRW Malta Meeting** in October 1996 was set up on 13 September 1994, consisting of Dr A. Mifsud and Dr J.K. Soler. This is preparing for this international meeting to be held locally (see below).
- **A Specialist Training Sub-Committee** was set up in March 1995, formed of Dr W. Galea (Chairman), Dr F.P. Calleja, Dr J.K. Soler and Dr M.R. Sammut. Dr Sammut subsequently resigned due to pressure of work, and Dr P. Sciortino joined later on. This subcommittee has worked hard, having produced 4 separate reports that are being amalgamated into one document to be presented to international expertes in the field.
- **A Computerized Medical Records Sub-Committee** was set up in April 1995, with Dr A.P. Azzopardi as chairman and Dr H. Agius-Muscat and Dr W. Galea as members, to advise on the minimal requirements for a database for medical records so that basic criteria can be standardised. To date no recommendations have been presented to Council.

3. CPD MEETINGS:

- **Joint CPD Meeting with Gozo Medical Association in Gozo** on Saturday 28th May 1994 – this was poorly attended by College members from Malta (only three).
- **Family Doctor Seminar on Community Psychiatry** (16-20 May 1994) had been an academic success, being attended by 21 family doctors, 20 of them College members.
- **Autumn 1994 CPD Meeting** (5-7 October), included Pitfalls of the Chest X-ray, How I Manage, Well-Woman Clinics, A lesson I've learnt, and Promoting Health in the Family – a forum presented in conjunction with the Health Promotion Unit.
- Evening seminar on ***L-Alkoholizmu, it-Tabib u l-Familja*** was organised together with MIRA on 18th NOVEMBER 1994.
- **Winter 1995 CPD Meeting** (18-20 January), included Sensible Prescribing in Family Practice, A lesson I've learnt, *More* Pitfalls of the Chest X-ray, How I Manage ..., and The Role of the Community Nurse in Family Practice.
- **CPD Lecture** on the Community Care Needs of Substance Misusers 14/3/95, organised with *Sedqa*.
- **CPD Lecture** on The Management of Asthma in Family Practice on 30th March 1995.
- **Spring 1995 CPD Meeting** (26-28 April) included Immunisation – Latest Developments, A lesson I've learnt, Epidemiology in Family Practice, How I Manage ..., and Psychology and Counselling in Family Practice.
- **Workshop on Counselling in Family Practice** on Saturday 29th April 1995, led by Dr Graham Curtis Jenkins MA FRCGP, Director, Counselling in Primary Care Trust, Staines, UK and Ms Jennifer Pace B.Ed. (Hons), B.A., M.A. (Counselling), Counselling Psychologist – 26 College members participated.
- **GP Seminar on Substance Misuse** was organised by *Agenzija Sedqa* on Saturday 20/5/95 afternoon for College members.
- **Autumn 1995 CPD Meeting** – 11-13 October – *The ABC of Ophthalmology*, including External Diseases of the Eye, Complications & Treatment of Diabetic Retinopathy, Visual Failure – Cataract & Glaucoma and an optional assessment for participants.
- **CPD Lecture** on Substance Abus – Designer Labels, organised with *Sedqa* on 27 October 1995.
- **'Take Care' Programme for Depression** was organised with SmithKline Beecham Pharmaceuticals and the University and Hospital Departments of Psychiatry as 11 presentations between October 1995 and February 1996.
- **CPD Lecture** on the Management of Angina was held on 7 December 1996.
- **Winter 1996 CPD Meeting** – 24th-26th January – The ABC of Dermatology, ending with an optional self-assessment for participants.
- Healthy Living Seminar for Family Doctors on 11th February 1996 during the Healthy Living Fair, Naxxar, in collaboration with the Health Promotion Department – this was poorly attended, probably as it was held on a Sunday morning.
- **Organ Donation Seminar for Family Doctors** was held on 29 February 1996.
- Clinical evening meeting on **TB in Malta** was organised with the Department of Public Health and the Medical School Department of Medicine on 28th March 1996 on the occasion of World TB Day.
- **Spring 1996 CPD Meeting** – The ABC of Diabetes – was set for the 24-26 April 1996, with the second and third evenings subsequently postponed to 9th and 10th May. The topics included The Ill Diabetic Patient,

The Diabetic Foot, Diabetes – a General Overview, The Use of Computers in Diabetes, and an optional self-assessment for participants.

4. *LOCAL NEWS:*

- Dr M.R. Sammut represented the College in the **Organisational Development Seminar for Mental Health Reform** (30-31 May 1994).
- The Lombard Bank (Malta) Limited **Family Doctor VIP Banking Service**, a financial package specially designed by Lombard for College Members, was launched in October 1994.
- Dr A.P. Azzopardi was appointed the College representative on the **Medical Faculty Board** in October 1994.
- Dr F.P. Calleja was nominated as College representative on the **National Steering Committee on Diabetes Prevention & Care** in January 1995.
- Dr D. Soler was appointed College representative on a **Steering Committee for the setting-up of the Academy of Medicine** formed by the PGMC on the 16th February 1995.
- Dr M.R. Sammut and Dr J.K. Soler represented the College in a workshop on 20/5/95 about **Substance Abuse Education for Professionals in the Health and Social Science Fields** organised by the Institute of Health Care.
- The College launched a **Home Page on the Internet** (http//fred.net/malta/doc2.html) in February 1996.
- Dr A.P. Azzopardi, Secretary for Ethical Affairs, was nominated in March 1996 to participate in study sessions on health promotion as part of the subject **"The Allocation of Resources in the Health Care Sector"** organised by the Department of Moral Theology of the Faculty of Theology of the University of Malta.

5. *INTERNATIONAL NEWS:*

- College **membership of WONCA** was maintained.
- College accepted invitation to become a **National College Member of EGPRW** (May 1994).
- College granted **official accreditation to EGPRW meetings** (May 1994).
- **The RCGP/Malta Fellowship** not renewed due to financial constraints (June 1996).
- Dr A.P. Azzopardi represented the College at the **First International Summer School on Quality Assurance in General Practice** between August 28 and September 2 1994 in Maastrict, the Netherlands.
- As a result, the **College was affiliated with EQuiP** and Dr A.P. Azzopardi was appointed as local representative.
- Dr A. Mifsud and Dr J.K. Soler represented the College at the **EGPRW Slovenia Meeting** in October 1994.
- Dr A. Mifsud represented the College at the **EGPRW Porto Meeting** in Spring 1995.
- Dr W. Galea represented the College at the **WONCA World Council Meeting and the 14th WONCA World Conference** (Hong Kong 7-14 July 1995).
- The College became a **founder-member of WONCA Region Europe – The European Society of General Practice/Family Medicine** as a result of Dr D. Soler and Dr M.R. Sammut representing the College at the Inaugural Meeting in Strasbourg on 5th - 7th October 1995.
- Dr J.K. Soler and Dr A. Mifsud represented the College at the **EGPRW Dublin Meeting** in October 1995.
- Dr D. Soler was invited to represent the College at the **First International Conference on Prevention and Health Promotion in Europe** in Santiago de Compostela, Spain on 23-25 November 1995.
- Dr J.K. Soler and Dr W. Galea were appointed as **College representatives on the WONCA Working Party on Informatics** in February 1996.
- Dr A. Mifsud and Dr J.K. Soler represented the College at the **EGPRW Vaxjo (Sweden) Meeting** on 9-12 May 1996.
- Dr D. Soler, Dr M.R. Sammut and Dr W. Galea will represent the College at the **WONCA 3rd European Congress on Family Medicine** in Stockholm, Sweden on 30 June – 4 July 1996.

6. *MEMBERSHIP & ACCREDITATION:*

- **1991-93 accreditation:** while 66 members were accredited for 1993, 47 were fully accredited for 1991-93. A certificate of accreditation for 1991-93 was awarded to those eligible at the College's **5th Anniversary Dinner** on 3rd December 1994.
- **4 members resigned** in 1994.
- **18 members were deleted** in November 1994 for failing to pay their subscription fee by the end of October 1994, with membership thus totalling 120.
- **15 members were deleted** in November 1995 for failing to pay their subscription fee by the end of October 1995, with membership thus totalling 120.
- **1 member resigned** in 1996.
- **Present membership** totals 125.
- **1994-95 accreditation:** 69 members were accredited for 1995. Certificates of accreditation were awarded to those eligible at the College **Biannual General Meeting** on 8th May 1996.

7. *THE JOURNAL:*

- The **sixth edition (October 1994)** was distributed in November 1994.
- The **seventh edition (December 1994)** was distributed in March 1995.
- The **eighth edition (June 1995)** – now with some pages in colour – was distributed late, in the beginning of 1996, due to circumstances beyond our control.

8. *FUTURE ACTIVITIES:*

- The **EGPRW Malta Meeting** on 3-6 October 1996 at the Atlas Hotel, St. Andrew's. The theme of the meeting is 'Coping with Social Problems in Family Practice'.
- One day **Seminar on Palliative Care** on Saturday 12th October at the Institute of Health Care, organised with the Hospice Movement and the Institute of Health Care;
- The **Autumn CPD Meeting** on 23-25 October 1996 at the University of Malta Medical School;
- A **Joint Seminar on Paediatrics and Obstetrics & Gynaecology** on 15-16 November 1996 at the University of Malta Medical School, organised with the Malta College of Obstetricians and Gynaecologists and the Paediatric Association.

1997 Seoul WONCA
Asia Pacific Regional Conference

1997 서울 세계가정의학회 아시아 태평양 지역회의

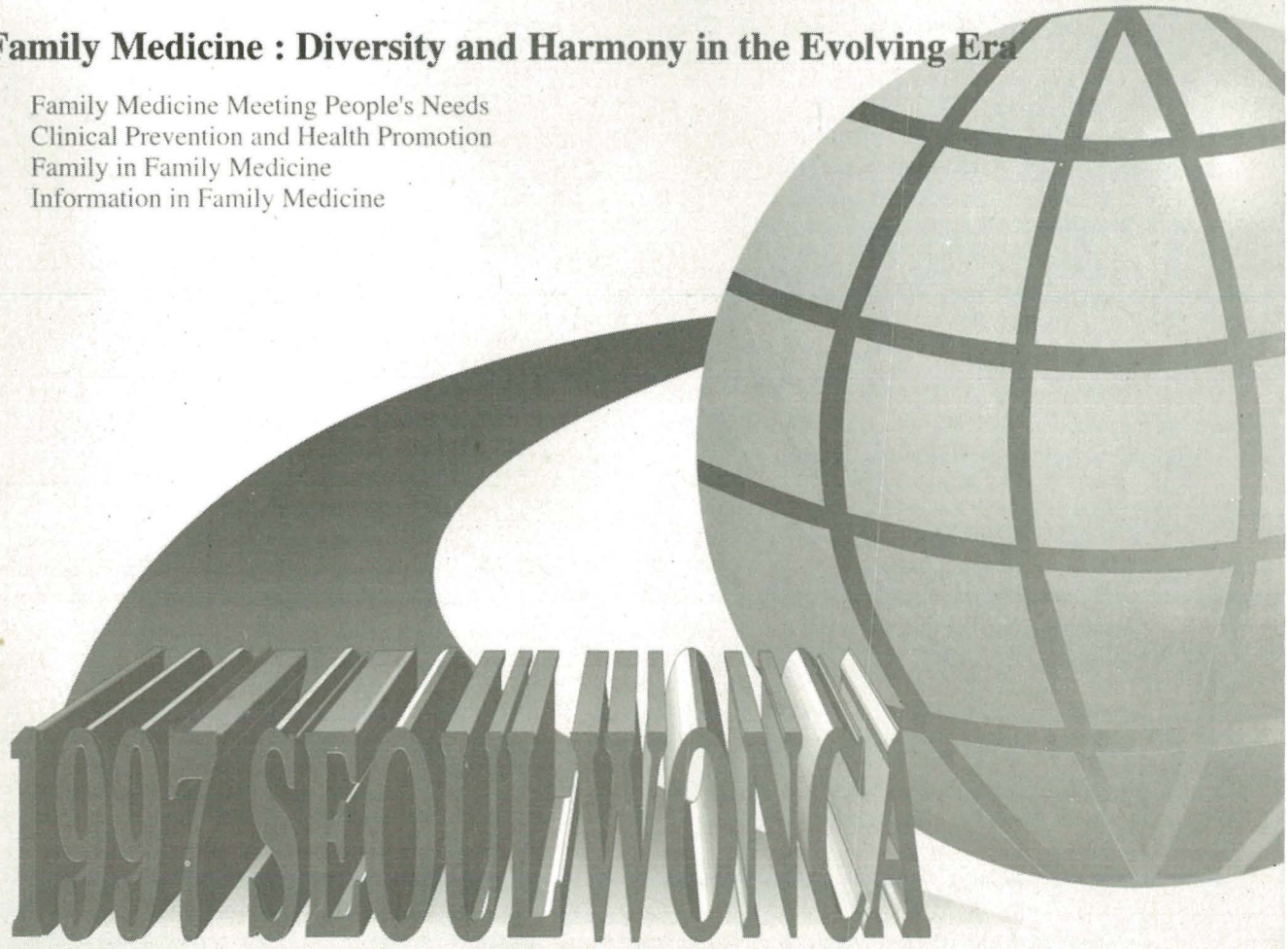
가정의학 새로운 시대의 다양성과 조화

The World Organization of Family Doctors
August 30-September 3, 1997
Sheraton Walker Hill Hotel & Towers
Seoul, Korea

Call for Abstract ; By Feb 28,1997
Pre-Registration ; By Jun 30,1997

Family Medicine : Diversity and Harmony in the Evolving Era

Family Medicine Meeting People's Needs
Clinical Prevention and Health Promotion
Family in Family Medicine
Information in Family Medicine



'97 8/27-29	WONCA	Council Meeting
'97 8/30	WONCA	AP Regional Council Meeting
'97 8/30	WONCA	AP Working Party
'97 8/30	WONCA	AP Journal Editor's Guild
'97 8/30	WONCA	Research Network Meeting
'97 8/30	WONCA	Working Party on Informatics Meeting
'97 8/31-9/3	WONCA	AP Regional Conference
'97 9/4-6	WONCA	FM Education Workshop

Hosted by
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Conference Secretariat
SL Kangnam PO Box 305, Seoul 135-603, Korea
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MALTA COLLEGE OF FAMILY DOCTORS
1996-99 COUNCIL

The 1996-99 Council of the Malta College of Family Doctors consists of:

Dr. Denis Soler, *President*
Dr. Joseph G. Pace, *Vice-President*
Dr. Mario R. Sammut, *Honorary Secretary*
Dr. Anthony Mifsud, *Honorary Treasurer*
Dr. Michael A. Borg, *Registrar*
Dr. Wilfred Galea, *International Secretary*
Dr. Anthony P. Azzopardi, *Secretary for Ethical Affairs*
Dr. Jean Karl Soler, *Secretary for Information*
Dr. Philip Sciortino, *Secretry for Research*
Dr. John P. Gauci, *Member*
Dr. Raymond Busuttil, *Member*

The 1996-99 Council of the Malta College of Family Doctors: *from left, sitting:* Dr. Anthony P. Azzopardi, Dr. Anthony Mifsud, Dr. Denis Soler, Dr. Mario R. Sammut, Dr. Joseph G. Pace, *standing:* Dr. John P. Gauci, Dr. Philip Sciortino, Dr. Jean Karl Soler, Dr. Wilfred Galea, and Dr. Michael A. Borg *(Dr. Raymond Busuttil is absent).*

Continuing Professional Development 1996 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:
"It-Tabib tal-Familja", Malta College of Family Doctors, Alamein Road, Medisle Village, St. Andrews STJ 14, Malta.
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Malta College of Family Doctors, Alamein Road, Medisle Village, St. Andrews STJ 14, Malta.

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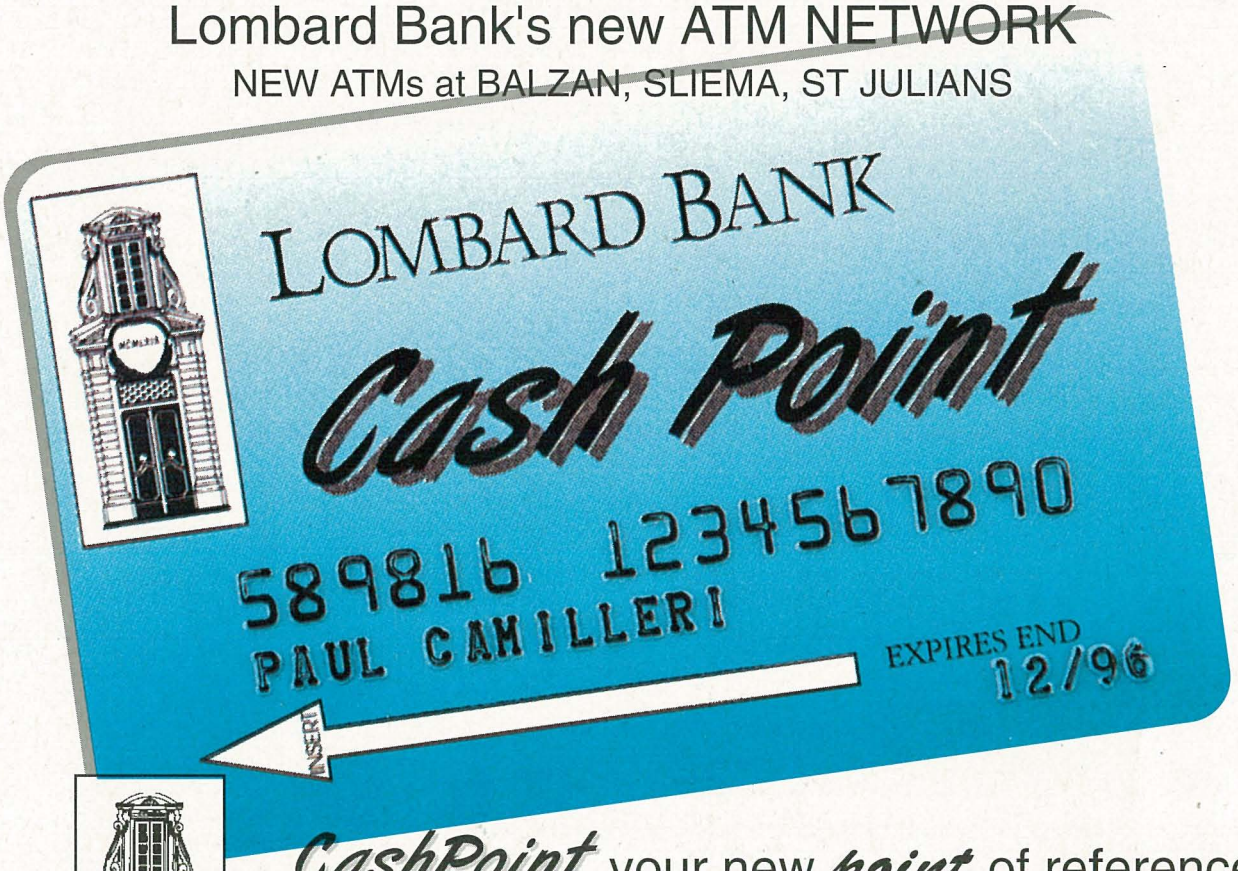

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