the family physician

it-tabib tal-familja
WHEN THERE IS A RISK

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CHALLENGE THE RISK!
Dear Readers,

We are fortunate to be treated to three articles directly related to family practice in this issue.

Vinker et al analyse discharge summaries in Israel, and throw light on this important element of the interface between primary and secondary care. It is obvious that there is much room for improvement in the use of this instrument of communication between doctors, and I assume that we can apply some of the comments made to our local situation.

Svab invites us to take a new look at independence, and the complex relations between the general practitioner, the patient and society.

Yaman looks at residents' perceptions of working conditions in Turkey. Some of their perceived problems, such as dissatisfaction with management and poor appreciation of work done, may be found in other countries too.

I hope that you will find our colleagues' research and experiences illuminating, and stimulating. It would be very nice to see similar research performed locally.

Jean Karl Soler
Editor
1. COUNCIL MEETINGS:
Twelve meetings were held since the last AGM of 18/5/2000, the last of which was on 23/3/2001. Five of these meetings (6th July, 13th July, 20th July, 31st July, 10th August 2000) were devoted to preparations for the 6th Mediterranean Medical Congress. Council members’ attendance was as follows:

| J.K. Soler | 12 | D. Soler | 9 |
| F.P. Calleja | 11 | A. Mifsud | 9 |
| J.G. Pace | 10 | W. Galea | 8 |
| A.P. Azzopardi | 10 | P. Sciortino | 6 |
| M.A. Borg | 10 | J.P. Gauci | 1 |
| M.R. Sammut | 10 | |

2. 6th MEDITERRANEAN MEDICAL CONGRESS:
(Adapted from a report drawn up by Congress Chairman Dr Jean Karl Soler).

The Malta College of Family Doctors hosted the 6th Congress and the 2nd Summer School of the Mediterranean Medical Society from the 9th to the 10th September 2000 at the Westin Dragonara Resort in Malta.

The first three days were dedicated to the Summer School, where foreign and Maltese speakers tackled the popular topics of hypertension, hyperlipidaemia and diabetes. The event was quite popular, and more than 70 local and foreign doctors attended.

The opening ceremony of the 6th Mediterranean Medical Congress took place in Mdina Cathedral on Thursday 7th September. After opening addresses by University Rector Prof Roger Ellul Micallef, College President Denis Soler and MMS President Prof. Oreste Manoussos, the President of the Republic of Malta H.E. Prof. Guido de Marco delivered a memorable speech, that touched an emotional chord in many of us when he praised the work of the family doctor in the community.

The Congress ran for two and a half days from Friday 8th to Sunday 10th September. The central theme was "Challenges for the New Millennium". There was a special focus on meeting challenges in the fields of Medical Education, Development and Health Care, and Clinical Topics. High points of the Congress included the opening by the Hon. Louis Deguara, Minister of Health, and the excellent keynote speeches by Gauden Galea, regional health advisor for WHO, based in Manila; Michael Alkan, head of the Infectious Diseases Institute in Beersheba, Israel; Rosslynne Freeman, from Landar University in Guildford, UK; Giora Almagor from Israel; David Hall, Professor of Community Paediatrics in Sheffield, UK; and Michael Boland, President Elect of the World Organisation of Family Doctors (WONCA) and President of the Irish College of General Practitioners, from Ireland.

Sixty-six oral presentations were delivered by participants, and by local and foreign invited speakers. There were another 28 presentations in four round table meetings dealing with inflammatory bowel disease, liver disease, infections and diabetes. A number of enrichment sessions dealing with Maltese cultural topics were delivered, and 135 posters were presented in the hall of the conference centre. The Congress and Summer School were successful in the quality and variety of the scientific papers presented by foreign and local speakers alike, by the participation of more than 330 doctors and health care professionals, and by the new channels and contacts set up between local and Mediterranean doctors for future scientific collaboration.

3. CPD ACTIVITIES:
- The Malta Association of Public Health Medicine invited the College to participate in the organisation of a lecture by Prof. David Miller on 'Childhood vaccine dilemmas: how safe is safe?' on 3rd October 2000. Council agreed that such lecture be accredited in the College CPD Scheme.
- The Winter CPD Meeting was held on the 24-26 January 2001 at the Medical School. It was entitled Laboratory Tests in Family Practice and held in collaboration with the Malta College of Pathologists and under the sponsorship of Vivian HealthCare. The programme was as follows:

**Wednesday 24th:**
- Anaemias – Dr Alex Aquilina
- Hypothyroidism - Dr Gerald Buhagiar

**Thursday 25th:**
- Deranged liver function – Dr Gerald Buhagiar
- Cytology - Dr James DeGaetano
**Friday 26**th:

**Tumour Markers / Screening** – Dr Bridget Ellul

Asking for a culture - Dr Paul Caruana.

- **A series of lectures on Paediatrics** were organised with the Maltese Paediatric Association as follows:
  - 23/2/2001: Seizures in Childhood – Dr S Buttigieg, Dr M’D Soler; sponsor: GlaxoSmithKline
  - 23/3/2001: UTIs in Childhood – Dr M R Sammut, Dr J G Torpiano; sponsor: Eli Lilly.

- **The Spring CPD Meeting** will be held at the Medical School as a Paediatric Update in collaboration with the Maltese Paediatric association on the 25-27 April 2001.

- **A one-day seminar on “Special concerns of women”** will be organised by the College in collaboration with the Malta College of Obstetricians and Gynaecologists and Eli Lilly on 19th May 2001.

4. **LOCAL NEWS:**

- **Draft Health Care Professions Act, 2000:** a reply was sent in August 2000 (to the Director General (Health)’s request for feedback on the subject) regarding aspects affecting the family doctor and family medicine, and supporting MAM’s general recommendations on the draft act. Feedback regarding a second draft was sent in October 2000.

- In September 2000, the Department for the Welfare of the Elderly informed the College that it was in the process of setting up a new multidisciplinary team to provide a specialised geriatric service in the government homes for the elderly. The College suggested that the GP is invited to the team assessments, and requested that the College is kept informed of further developments.

- In October 2000, the College found no objection to a draft information-form that the Jehovah’s Witnesses were proposing to be filled in by their members and presented to their doctors.

- In October 2000, replying to a letter dated 30th September 2000 by Dr D Soler regarding a report in The Times entitled “Sickness certificates under scrutiny”, Deputy Prime Minister Dr L Gonzi explained the situation and was to instruct his staff to arrange for a meeting with the College (which however never materialised).

- In January 2001, the College made recommendations for the new MAM – Association of Insurers agreement regarding the maximum benefits payable to family doctors.

- In January 2001, **St Philip’s Hospital** terminated its provision of free services to the College. Following this, Dr D Soler had written to Capua Palace Hospital requesting hosting fac-

- In January 2001, Council identified a number of secretarial duties needed by the College, and asked Mrs Elizabeth Saliba to perform part-time secretarial duties for the College. Mrs Saliba accepted.

- **Vocational Training Scheme in Family Medicine:** Following a request by Dr R Busuttil, Director General (Health), in January 2001, Dr M R Sammut and Dr P Sciortino presented the lists of criteria they had prepared for the selection of 12 trainers and 1 coordinator for the above course. Such lists were approved by Council for forwarding to the DG(H).

- In March 2001, the Medical Association of Malta invited the College to nominate two representatives to sit on the MAM General Assembly. The Council agreed to write to MAM for more information regarding the function of the General Assembly and its consultative role, its terms of reference, and details of the benefits/obligations of joining.

- In March 2001, the College submitted suggestions for amendments to the present ‘ticket of referral’ in reply to a request from the Department of Institutional Health.

- In March 2001, Council decided that a permanent P.O. Box address be procured for the College, namely P.O. Box 69, Gzira GZR 01.

5. **INTERNATIONAL NEWS:**

- In May 2000, Dr A Mifsud and Dr J K Soler represented the College at the EGPRW Meeting in Maastricht, the Netherlands, with the theme of ‘Research in clinical skills in general practice’.

- In June 2000, Council agreed that the Journal participates in ExtraMED, a project originally founded by the WHO, where some 300 biomedical journals are placed on a monthly CD-ROM as full text, at no cost to the journals, and with a share in sales of subscriptions.

- In October 2000, Dr A P Azzopardi presented details of a Distance Learning Diploma in Therapeutics for General Practice organised by the Irish College of General Practitioners. Council agreed that details are circulated to College members, asking for those interested to submit their names.

- In November 2000, Dr A P Azzopardi represented the College at the 18th Workshop of EQuIP held in Athens, Greece.

- In November 2000, Dr M R Sammut represented the College at a meeting of the EUROPREV Council held in Barcelona, Spain.

- Dr J K Soler represented the College at the EuroMed-Data Workshop held in Brussels on 8-9/12/2000.

In June 2001, Dr D Soler, Dr J K Soler and Dr A Mifsud plan to represent the College at the 2001 Regional WONCA Europe Conference in Tampere, Finland.

6. MEMBERSHIP AND ACCREDITATION:
- Six College members failed to pay their 2000 subscription fee by the end of October 2000 despite repeated reminders. As such, these were deleted from the College register as per Council decision of 13/9/94.
- Membership at present stands at 132.
- Thirty College members were accredited for 2000, 13 of which have maintained their accreditation status for the ten consecutive years since 1991.

7. COLLEGE JOURNAL AND NEWSLETTER:
- In October 2000, Council agreed to Editor Dr J K Soler's following plans in line with its recommendations that the College Journal be upgraded academically:
  - three international peer reviewers to review papers at no fee (Prof. F Dobbs, Dr R Bridgewater and Dr I Svab);
  - an international scientific advisory board be appointed to recruit (and translate, if needed) papers from the Mediterranean region, so that the Journal develops into a journal for the area;
  - Prof. C Lionis be appointed to the Editorial Board, with the latter keeping a majority of Maltese members;
  - an addition be made to the official name of the journal to read: 'The Family Physician — It—Tabib tal—Familja: the Journal of the Malta College of Family Doctors
- One issue of the College Journal (June 2000) was published since the last AGM. This included two GP-related articles, one entitled 'Piloting GP Surveillance for Influenza-Like Illness, Malta 1999-2000 Season' and the other 'Transhis — the Maltese Experience with ICPC-2'.
- The Newsletter continues to be sent on a regular basis exclusively to College members, with local and international news of special interest to family doctors.

MCFD-AGM, 17th April 2001
A DEVELOPMENTAL CRANIAL ANOMALY FROM ANTIQUITY

C. SAVONA-VENTURA, A. MIFSUD

ABSTRACT

Two skull specimens datable to the Classical Age showing the presence of a rare developmental anomaly are recorded.

INTRODUCTION

The skull has a complex developmental history that is associated with its progressive modification in vertebral phylogeny and with the adaptive specialisation of many of its components. It consists of a protective case around the brain – the neurocranium; and of the jaw skeleton – the viscerocranium. The neurocranium develops from a series of cartilages ventral to the brain to form the calvarium and the facial skeleton. Ossification centres appear in these cartilaginous plates early during embryonal development and extend to form a number of bony plates separated from each other by a series of cranial sutures. At birth, ossification of the skull bones is incomplete with many consisting of several bony elements united by fibrous tissue or cartilage. Obliteration of the sutures of the vault of the skull takes place as age advances (Warwick and Williams, 1973). Alteration in the developmental process may give rise to non-pathological anomalies of cranial structure. A developmental anomaly of the cranial sutures has been previously described from a Neolithic skull excavated from the Hal Saflieni Sanctuary in Malta. This skull showed an absent sagittal suture between the parietal bones, so that the calva has only a coronal suture [Savona-Ventura and Mifsud, 1999]. A different anomaly with persistence in adult life of a cranial suture that normally fuses and disappears in childhood is herein described.

DECEMBER 2001

Material

The skull remains kept at the St. Agatha Museum collection [Rabat, Malta] were examined as part of an anthropomorphologic study [Savona-Ventura et al, in press]. This series of 23 skulls has been dated archaeologically to the Classical Period. Two skulls [SA004 and SA008] in this collection show a rare non-pathological anomaly of cranial structure.

Description

The two adult skulls [SA004 and SA008] in the series of 23 skulls datable to the Classical Age [prevalence 8.7%] are characterised by the persistence of the metopic suture. The persisting metopic suture in both specimens runs in a straight line along the whole length of the frontal bone. The smaller skull [SA004] probably belonged to a female individual, while the larger skull [SA008] belonged to a male. Both skulls are fragmented, with the larger skull [SA008] being only partially fractured only on the right side, while the smaller specimen [SA004] being more severely fractured. The anthropomorphologic measurements of these two skulls are given in Table 1.

<table>
<thead>
<tr>
<th>CRANIAL MEASUREMENTS</th>
<th>SA004 Female</th>
<th>SA008 Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glabella-occipital</td>
<td>169</td>
<td>177</td>
</tr>
<tr>
<td>Basobregmatic</td>
<td>-</td>
<td>122</td>
</tr>
<tr>
<td>Auricular length</td>
<td>105</td>
<td>113</td>
</tr>
<tr>
<td>Baso-proston</td>
<td>-</td>
<td>95</td>
</tr>
<tr>
<td>baso-nasion</td>
<td>-</td>
<td>96</td>
</tr>
<tr>
<td>cranial breadth</td>
<td>131</td>
<td>158</td>
</tr>
<tr>
<td>frontal breadth</td>
<td>117</td>
<td>128</td>
</tr>
<tr>
<td>Bizygomatic breadth</td>
<td>124</td>
<td>144</td>
</tr>
<tr>
<td>nasal breadth</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>nasal height</td>
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<td>50</td>
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<tr>
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<td>35</td>
<td>37</td>
</tr>
<tr>
<td>orbital height</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>nasio-proston</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>nasio-gnathion</td>
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<tr>
<td>Nasal Index</td>
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<tr>
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<tr>
<td>Palatal Index</td>
<td>83</td>
<td>84.6</td>
</tr>
<tr>
<td>Gnathic Index</td>
<td>-</td>
<td>99</td>
</tr>
</tbody>
</table>

Table 1
Discussion

The frontal bone in the adult skull is shaped like a shallow, irregular cap and forms the region of the forehead. It is ossified in fibrous tissue from two primary centres that appear in the eighth week of intrauterine life. From each of these centres ossification extends upwards to form the corresponding half of the bone. At birth the bone consists of two halves separated by the frontal or metopic suture, but union begins in the second year, and the suture is usually completely obliterated by the eighth year (Warwick and Williams, 1973). In a small percentage, the two halves of the frontal bone remain separate, and the metopic suture persists in adulthood. Persistence of the metopic suture in adulthood has been associated with a degree of racial variation (Montagu, 1951; Tongerson, 1951; Berry, 1975).

The prevalence of persistence of the metopic suture has been variously estimated and shown to vary between various races from 0 – 10%. A study of 206 adult Nigerian skulls showed complete or incomplete persistence of the metopic suture in 3.4% of skulls [Ajmani et al, 1983]. A prevalence of 2.66% was reported in a series of 1,276 adult Indian skulls [Agarwal et al, 1979]. The prevalence of persistence of the metopic suture in the mongoloid race was estimated at 10% [Woo, 1949]. No information is presently available as to the prevalence of metopism in the modern Maltese population.

No mention of a persistent metopic suture is made in the detailed description of a series of six Classical Maltese skulls [Thurnam, 1870]. An anthropomorphic study carried out in Malta on a series of Classical (Phoenician) skulls kept by the Museum in 1912 similarly made no mention of the presence of any anomalies in the skulls. However, one ellipsoid skull pictured in this study showed clear evidence of the presence of a partial metopic suture [Bradley, 1912]. A further anthropomorphic study of 11 Prehistoric, 23 Maltese Classical (Romano-Maltese), 463 Early Modern and 42 Recent skulls similarly failed to note the presence of a metopic suture [Dudley Buxton, 1922]. It is possible that author failed to record the variation even if it was encountered, since he also failed to record the absence of a sagittal suture in one of the Prehistoric skulls in his series [Savona-Ventura and Mifsud, 1999].

The period prevalence of persisting metopic suture during the Maltese Classical Age based on the present series approximates 8.7%. The relatively high prevalence rate in the present series suggests a racial or genetic relationship between the two specimens. One must however interpret population studies based on burial remains with caution since these are often cross-sectional and need not necessarily reflect a true population sample [Waldron, 1994].

Any population sample used in palaeoepidemiology has inherent factors that bias the randomness of the sample. The specimens recovered are only a proportion of the total dead population since a number of specimens may be lost due to poor preservation and disturbance in antiquity. At the St. Agatha catacomb complex, the minimum total number of adult inhumations recorded was 305, suggesting that the skull recovery rate was only 7.5% [Camilleri, 1984]. A further possible epidemiological source of error is the fact that a burial assemblage is a social or cultural sample, and not necessarily a biological one. Thus the burial sample may not in any way be typical of the population to which it appertained. To compound matters further for the palaeoepidemiologist, a burial population may represent individuals who had died many hundred of years apart [Waldron, 1994]. For these reasons, prevalence rates based on burial populations must be viewed and interpreted cautiously since a high prevalence rate in a particular population sample may very likely be simply due to chance.
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J. Thurnam: On the human remains, and especially the skulls, from the rock-tombs at Ghain Tiffiha and Tal Horr, and from other places in Malta. *Soc. Antiquaries Lond.,* 1870, 40:p.488-499


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G. ZIBULEVSKI2 - O. GORODESKI2
A. SCHATTNER3, Associate Professor - E. KITAI1, Associate Professor

1 Department of Family Medicine, Rabin Medical Center, and Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel
2 The General Sick Fund, Central District, Israel
3 Department of Medicine, Kaplan Medical Center, Rehovot, and the Hebrew University - Hadassah Medical School, Jerusalem, Israel

ABSTRACT

Background: In the continuum of patient care, admission to the department of medicine constitutes a brief yet critical period. Subsequent patient care depends on the discharge summary (DS) and its implementation.

Aim: To evaluate the department of medicine - family physician interface by a discharge summaries audit.

Method: A retrospective study analyzing all admissions and discharges between a department of medicine and a primary care clinic over a period of ten months.

Results: 129 DS were evaluated and compared to 97 available primary care medical charts. Most admissions were due to a medical emergency (95%), the patients were often elderly and 23% lived alone. Hospital stay averaged 4.0±2.4 days, readmission rate was 15.8%. In 73% of the DS at least one new drug was prescribed. The family physician was the one expected to continue treatment in most of the cases, but in over a third of the patients, a referral to further consultation was deemed necessary. The DS was found in 82% of the primary care charts. Median time interval between discharge and consultation with the family physician was three days (range 1-30). Home visits by physicians were documented in eight cases only.

Conclusion: Most discharged patients require further evaluation and newly prescribed medications, making a timely and coordinated continuous care in the community mandatory. A high quality, rapidly available DS is therefore important for the family physician. Whether improved communication will reduce readmissions and improve patient prognosis and quality of care should be clarified by further study.

Key Words: Discharge communication, continuity of care, hospitalization, family physician.

INTRODUCTION

Admission to the department of medicine constitutes a brief, yet critical point in the continuum of patient care. In today’s era of cost effectiveness and increasingly competent family physicians, ambulatory investigation, treatment and follow-up have largely replaced prolonged and costly hospitalizations1,2. The hospital admission usually marks a “crisis” in the patient’s medical condition. Most admissions focus on the evaluation and treatment of acute states or deal with exacerbations and complications of chronic illnesses. In both, revision of the patient’s management is commonly needed during hospitalization; this includes introducing new medications, withdrawing others, making use of non-pharmacological interventions and recommending further studies as indicated. Such management and treatment decisions are also related to more extensive testing and to multi-disciplinary in-hospital consultations. However, hospital stay is becoming progressively shorter and treatment is continued in the community chiefly by the family physician.

New information gathered during hospitalization should be effectively delivered to the family physician and the modality used is the discharge summary (DS). The DS quality often leaves much to be desired. Frain et. al. noted dissatisfaction among family physicians with the quality of DS. They interviewed a medical senior house officer from each of a hundred hospitals in England and found that only six of them received teaching about DS writing when they were at medical school, and most learnt “by osmosis”3. Over two thirds of the doctors had never received any formal feedback on the quality of their summaries. Thus, the assumption that every hospital physician can write a good DS should be revised. These difficulties...
are further highlighted by McWilliam who found that difficulties in communication between members of the health care team in the hospital and in the community created significant problems in the continuity of care².

The interface between discharge from the department of medicine and continuation of care by the family physician is critical. To evaluate it we analyzed hospital admissions and DS as well as the primary care files of patients referred from a primary care clinic to a department of medicine.

**Methods**

In Israel the family physician is not involved in treatment of hospitalized patients; decisions of admission or discharge is sovereign to in-hospital physicians. There are no regular inward visits by the family physician and direct communication with the physicians of the department of medicine depends exclusively on the family physician initiative.

In a retrospective study, all hospital admissions to the department of medicine of a large, regional teaching hospital over a period of ten months (January to November of 1995) were identified through the hospital computerized admission system. Included in the study were hospitalizations where the patient was discharged to the community. Cases where the patients had been transferred to other departments of the hospital, long term institutions or died in the index hospitalization were excluded.

We have focused on the patients registered in one teaching primary care clinic in the district, with orientation to academic and research activity and a special focus on documentation and accuracy of the medical records. This clinic serves a population of about 4,000 adult patients by three qualified family physicians.

The patient’s hospital charts as well as their medical files in the primary care clinic were then retrieved and reviewed by two family physicians according to pre-planned criteria, with special emphasis on the discharge summary (DS). When disagreement occurred between the two physicians the file was further analyzed by a third physician and a consensus by all three was reached. The information extracted included the following:

a) Demographic data of patients.
b) Main diagnosis of the hospital admission, coded according to the ICPC coding system.
c) DS recommendations regarding medication prescriptions - number of medications, chronic vs. short term, newly prescribed vs. continued use.
d) DS general recommendations - recommendations regarding further evaluation and follow up.
e) Inclusion of the DS in the primary care medical chart and the time interval between discharge and the first examination by the primary care physician.
f) In the primary care medical file: problem list and chronic medications list (before and after admission) and actions of the primary care physician as a result of the DS (home visits, further tests, consultations etc.).
g) Readmissions - defined as a new admission less than a month from the previous discharge.

Descriptive statistical analysis was performed using a commercial spreadsheet.

**Table 1: Main discharge diagnoses of 129 admissions to the department of medicine from one regional primary care clinic over a period of ten months**

| Cardiac causes - 56 (43%) | Chest pain - 9  
| Acute myocardial ischemia - 9  
| Acute myocardial infarction - 3  
| Pulmonary edema or congestion - 9  
| Atrial fibrillation - 5  
| Syncope - 5  
| Cardiac catheterization - 1  |
| Infectious diseases - 37 (29%) | Pneumonia - 11  
| Exacerbation of chronic obstructive lung disease - 10  
| Urinary tract infection - 8  
| Gastroenteritis - 3  
| Cellulitis - 1  
| Acute febrile diseases - 4  |
| Other diagnoses - 36 (28%) | Cancer - 7  
| Anemia - 6  
| Diabetes, metabolic complications - 5  
| Cerebrovascular accident or transient ischemic attack - 4  
| Varied other conditions* - 14  |

* - Dyspnea, leg edema, epigastric pain, general deterioration, acute bronchial asthma exacerbation, chronic renal failure, jaundice, cirrhosis, dysphagia, drug abuse, suicide attempt.
Results

Over the period of the study 136 patients from our primary care clinic had a total of 190 admissions to the department of medicine. Their age was 63.9±15.4 (mean±S.D.); 41% of the patients were >70 years old; 54% females and 23% living alone (widowers - 19%, divorced - 3%, unmarried - 1%). Hospital stay averaged 4.0±2.4 days (range 1-15 days). The vast majority of admissions followed an acute referral from the community to the emergency room (95%). Other patients have been transferred to the department of medicine from the coronary care unit or from other departments in the hospital. Readmission within a month from previous discharge rated 15.8%.

The discharge summaries (DS) of 172 admissions were retrieved. Eight patients died during hospitalization and another 26 were transferred to other departments or geriatric institutions. For the remaining 138 admissions, 129 DS were written (nine pairs of closely related admissions were covered by a single DS), and were issued for further analysis. Primary care medical charts concerning 75% (97/129) of the DS were found. Most of the remaining patients moved to another location or to another primary care clinic, or subsequently died, and their files were therefore unobtainable.

Main discharge diagnoses as reflected by DS analysis are listed in table 1. A new medical condition was the main diagnosis in 35% of the DS. In the others an exacerbation or deterioration of a known problem was the main DS diagnosis.

The DS recommendations included 3.1±1.4 general recommendations (range 0-8) and 4.0±2.5 medication prescriptions (range 0-12). In 73% of them at least one new medication was prescribed. Table 2 lists the recommended follow up modalities as reflected in the DS. The family physician was the one expected to continue the treatment and follow the discharged patient in most of the cases (64%). Ambulatory evaluations recommended included: echocardiography, exercise stress tests, thallium cardiac scans, X-ray and CT scan imaging or blood analyses.

Table 2: Recommended follow-up modalities in 129 discharge summaries

<table>
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<tr>
<th>Family physician</th>
<th>83 (64%)</th>
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<tr>
<td>Hospital internal medicine clinic</td>
<td>7 (5.5%)</td>
</tr>
<tr>
<td>Other hospital clinics</td>
<td>22 (17%)</td>
</tr>
<tr>
<td>Consultants in the community</td>
<td>18 (14%)</td>
</tr>
<tr>
<td>No follow-up recommended</td>
<td>20 (15.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>150*</td>
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</table>

The DS was found in 82% of the 97 charts. The mean time interval between discharge and presentation to the family physician was 3.5 days (median 3.0 days, range 1-30 days). The main actions taken by the family physician included revision of the patient's problem list, asking for a consultation or a test and ordering laboratory checks. Home visits were documented in eight cases only.

Discussion

Most of the patients included in our study were admitted via the emergency room and their diagnoses indicate that hospitalizations resulted from urgent acute problems. Our patients' demographics and their medical complexity further highlight the importance of continued medical care. Significant changes in treatment and ambulatory work-up were indicated in most patients. A high quality DS which is made available to the family physician and implemented as soon as possible is essential for a proper continuous treatment.

The DS often reach the primary care physician at a late date and sometimes, not at all. Furst found that only 46% full case summaries of his discharged patients were eventually obtained, and moreover, the time lapse between the patient's discharge and arrival of the DS was unacceptably long5. Bragner et al. compared traditional and electronic data interchange for admission/discharge reports between the hospital and family physicians. Whereas reports arrived after a median of 2-4 days interval via paper mail, electronic communication made all reports available to the family physician within one hour of their generation6. Thus, the traditional DS constitute a vital but often imperfect link in the patient care.

In recent years, prohibitive costs of hospitalizations in conjunction with large number of admissions per bed in the medical wards in our medical center have resulted in increasingly shorter hospital stays. This most likely increased the burden on family physicians in the community. It is also may be related to a relatively high number of readmissions. Other, previously identified factors which influence
readmission rate are the quality of the relationship with the family physician, the status of the closest family caregiver and the need for social and nursing services prior to admission. All these seem of rather secondary importance when the very short hospital stay of medically complex elderly patients is considered. Thus, it is even more crucial that the family physician should be well informed in detail about the patient’s hospital course. Furthermore, the DS should be available to the family physician as soon as possible. We found a high proportion of the DS in the primary care medical files (82%), as compared to 14-63% reported by others. The three days (median) interval between discharge and consultation with the family physician in our series was similar to that reported by Bragner et al. and shorter by half than the seven days documented by Williams. However, it may be too long in many cases. Using electronic means of communication will shorten this interval to few hours. However, this would obviously not replace the need for a carefully generated DS compiled by trained hospital physicians.

Burns et al. found that one in four elderly patients did not have his new prescription issued eight days (median) after discharge. This is a further demonstration of the vulnerability of the period between discharge and actual implementation of the discharge recommendations. It also supports the need to make this period shorter and better supervised. One important way to achieve it, are home visits which can be carried out either by the family physician, a nurse or a social worker. Yet even a study which noted a relatively high rate of home visits (about 50%) revealed that most were initiated by patients and their families and not by the family physician. When a nurse had made a home visit on the day after discharge and the family physician within two weeks, after one year of follow-up, significantly less patients who were monitored have been admitted to nursing homes, in comparison with patients who were not. When a nurse had made a home visit on the day after discharge and the family physician within two weeks, after one year of follow-up, significantly less patients who were monitored have been admitted to nursing homes, in comparison with patients who were not. A recent study however, demonstrated that contrary to all expectations, an intensive follow up at home by experienced medical personnel did not result in any significant benefit to the patients, casting doubt on the advisability of a too rigorous home monitoring program. In our data, few home visits by physicians were recorded. This is partly explained by visits made by nurses which we were not able to trace. At any rate, our results may reflect the decline of house calls by physicians.

In conclusion, our study shows that admissions to the department of medicine are mainly due to acute disease states and the average hospital stay is very short. Most patients require further evaluation and newly prescribed medications, making timely, well-informed and properly coordinated continuous care in the community an absolute necessity. A high quality, rapidly available discharge summary is therefore an important tool for the family physician. Whether these measures will reduce readmissions and improve patient prognosis and quality of care should be clarified by further study.

REFERENCES


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December 2001
PROFESSIONAL INDEPENDENCE IN GENERAL PRACTICE
I. SVAB FAMILY PHYSICIAN, SLOVENIA
(KEYNOTE LECTURE AT THE 18TH ICGP NATIONAL SCIENTIFIC MEETING)

INTRODUCTION

The first association one gets when thinking about independence is that independence is good. We all want to be independent and free. For me, coming from Slovenia, this feeling is perhaps even deeper. Slovenia regained its independence after a thousand years of being ruled by Germans, Austrians, Italians, Hungarians and Serbs. Nevertheless, we have always cherished the fact that we are different and have tried hard to maintain our independence as much as possible. What is interesting is that even though it took us a thousand years to reach independence, we are now trying very hard to join the European union. We are trading our independence for a value of belonging to EU. And the feelings of pride that we are achieving its standards are comparable to the feelings of pride when we became independent from Yugoslavia. This is a strange contradiction.

When I lecture about independence to medical students, I do that in a context of family as a unit of care. I try to describe family as a system and how it develops over time and the problems it faces during various stages. I can not do that without addressing the systems theory, which is very useful in describing complex systems.

Systems Theory - A Short Overview

The general systems theory is a response to the limitations of the nineteenth century science and its reductionistic approach. The theory approaches problems from another point of view: not by reducing problems, but by including all the relations and describing them. Nature is, according to this theory, ordered in a hierarchy of systems, both living and non-living. Each level in the hierarchy is both a whole in itself and also a part of a greater whole. Each system has features that are unique to that level and can only be explained by criteria that are appropriate at that level.

The reason why the elements of the systems form a system is because by joining they also get an added value, as they can perform certain functions that they could not as separate entities. Because of this higher systems, like families, can not be explained using the methods for the explanation of the subsystems. The person can not be explained in terms of biology and biochemistry, for instance.

The reason why two individuals join together is because they gain love, as I explain poetically in my lecture to medical students. The reason why professionals join together and form scientific societies is because they are much better represented in politics and can influence political decisions.

But the creation of a system comes with a price. There are two main prices to pay. The first is that the system in itself needs some energy to maintain its function. The more complex the system, the more power it takes to maintain itself. Additional energy is needed for its coordination. If doctors want to join together in a society, they need additional resources, for instance.

The second is that by joining in a system the individual elements of the system lose some of its autonomy. As I explain to my students, the price of love is relinquishing a bit of one’s own independence. If physicians join together, they must decide to obey some common rules, which are imposed on their individual freedom. Some of them may have problems with that and would prefer not to belong to an organisation at all.

The balance between independence and gained values of love or acceptance is difficult to maintain, but it is necessary. Survival is impossible on either of the extremes: to be entirely independent means to be entirely alone and forgotten, to be totally accepted means that one loses one’s values and ceases to exist as a person.

To make things even worse, the balance is also changing all the time. We all belong to societies,
families, cultures that change constantly and in a changing system we need to adapt to the changes.

It is also important to say that the balance is highly individualised. Europe, for instance, has a tradition of culture, where people work together in a society and share a responsibility for weaker vulnerable groups of the population. The balance in America which cherishes independence and individual responsibility at the expense of social security is a different one. The socialist system that has prevailed in the countries of central and eastern Europe has tried and failed to maintain a different balance with much less individual freedom. Because of this individual balance it is very difficult to pass judgements from one situation to another, from one health care system to another.

Application to the Health Care System

If we look at the health care system from the systems theory point of view, we can see that the health care system is a complex one and that it has in itself the following main elements:

- the profession,
- the users of health care
- the payer.

Each of them consists of different elements. Therefore in addressing the issue of autonomy, I can consider the autonomy of the medical profession within the health care system and the autonomy of the individual doctor within the medical profession.

The Autonomy of Medical Profession and General Practice

Because of the issue of the conference I will spend most of my time talking about the relation between the medical profession and the payer (= government) and the power struggle between the two.

The medical profession has a special role in a society which is a result of its importance. If general practice would not be important, government would not spend time and efforts to deal with it. We would be totally independent and allowed much more freedom that we are experiencing now.

The privileged role of the medical profession and general practice within it is changing constantly. Although health has always been one of the key values in human life, the relative autonomy of medicine within the society has decreased. The development of modern technical medicine has created a very complex health care system, where general practice was regarded as anachronism in terms which would soon become extinct. There were some serious critics of modern medicine. The two most famous critiques have been delivered by Ivan Illich and Ian Kennedy who claimed that medicine is counter productive and that medical interventions produce more harm than good. The critics that were attacking the technically developed medicine have pointed to the difficulties modern medicine has encountered because medicine was forced to change from a paternalistic approach towards patients to a partnership orientated role where the doctor and the patient are considered as partners deciding about care.

There has also been an important change in the relative importance of general practice over the past decades. Because of the problems of modern medicine, the public needed someone to talk to, someone who would guide them through the maze of medical experts. This was the period of the renaissance of general practice throughout the world, which has started in the early seventies with the creation of the old Leeuwenhorst group and the EGPRW (European General Practice Research Workshop). Some countries had to create a new name for general practice and they called it family medicine. This has occurred in many European countries and in the USA.

The politicians have also recognized the importance of the newly developing discipline. General practice is now clearly seen as probably the only profession that can help in maintaining the health care system in a manageable state. Without the contribution and cooperation from general practice no health ministry can hope to manage the health care system. The managers of the health care system were trying to seek partnership with general practice and the way to influence the profession. This recognition of the importance of general practice has also meant a threat to its autonomy.

The most effective mechanism through which the government ties to influence general practice is through a payment system.
In general practice in principle the following ways of payment exist:

- salary
- a contract with the payer individually

A lot of research in public health has been done looking at the effects of the payment system on physician performance. If I would be allowed to make a simplification, it is fair to say that the main problem of the salaried system is the motivation of physicians. This is especially a problem when the salaries are low. In countries of central and Eastern Europe, all the physicians were salaried public employees. Not only that: their wages were quite often very low and sometimes lower than the wages of taxi drivers, for instance. The result of that was corruption and quality of care which was very low. The independence of general practice was low and professional independence within the practice was the only freedom they have got. On the other hand, some other countries also have salaried physicians (Spain, Portugal) with quite good results.

But generally, the contractual agreement where the payer pays the provider directly is a better solution. The problem are the terms of the contract, which is usually a combination of a fee for service and capitation. If a fee for service is the main item for billing, the problems of high number of unnecessary tests, examinations and procedures quickly emerge. The system based almost entirely on capitation is an equally problematic one, having similar problems like the salaried system. Increasingly, more innovative approaches are tried throughout the world, a lot of them without any scientific evidence and without testing the schemes in advance. This results in constant health care experiments which is perhaps interesting reading but also an illustration how difficult it is to organise health care in a modern changing society from the point of view of the payer.

The functions that can be delegated to the profession usually include the following:

1. The ability to reach a dialogue with policymakers through a body that is representing the profession.
2. The ability to guarantee quality of professionals that start working in practice
3. The ability to guarantee quality of everyday care
4. The ability to perform research and to implement research findings in practice
5. The ability to educate its own members and to contribute with its educational potential to education of other professionals.

Bearing that in mind it is possible to make a list of questions that address professional autonomy in a country. This is very useful when one tries to assess the position of the profession in a country (see Table 1).

<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>INDICATOR</th>
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<tbody>
<tr>
<td>The ability to reach a dialogue with policymakers through a body that is representing the profession.</td>
<td>Is there a college of general practice? What are its functions?</td>
</tr>
<tr>
<td>The ability to guarantee quality of professionals that start working in practice</td>
<td>Is vocational training obligatory for independent practice?</td>
</tr>
<tr>
<td>The ability to guarantee quality of everyday care</td>
<td>How is peer review organised? Who recertifies the practitioners?</td>
</tr>
<tr>
<td>The ability to perform research and to implement research findings in practice</td>
<td>Is there a scientific journal of general practice?</td>
</tr>
<tr>
<td>The ability to educate its own members and to contribute with its educational potential to education of other professionals.</td>
<td>Is there a department of family medicine at the university? Is it independent?</td>
</tr>
</tbody>
</table>

The Price of Professional Independence

The partnership between the policymakers should be based on trust if it is to be effective. One of the important reasons why we feel so strongly when we believe that professional autonomy has been challenged is due to the fact that we believe that the trust has gone. Ideally, the policymakers trust that the profession is able to perform some of the important tasks and this is why they delegate some of their authorities to the profession. General practice then tries to demonstrate that it is capable of responding to these needs. In countries where general practice is well developed, a lot of the functions are performed by organisations of general practice. In countries where the autonomy of general practice as a profession is low (which also means a low standard of general practice), these functions are performed by other agencies. This is the second reason why we feel so strongly when the autonomy of the profession is challenged: because we believe that lower professional independence is an indicator of a low level of the profession we belong to.

Bearing that in mind it is possible to make a list of questions that address professional autonomy in a country. This is very useful when one tries to assess the position of the profession in a country (see Table 1).
Individual Independence

Individual doctors also need and want their independence within the profession. The professional independence of an individual is stronger in general practice than anywhere in medicine. General practitioners are used to work often alone, sometimes in their relative isolation and with little contacts between themselves. The changing society has meant a drastic change for this somehow idealised description of the GP’s work. Because of the pressure from society to prove that we are able to perform according to the standards of quality, the mechanisms of control are increasing. Professional independence in clinical care without any control is rapidly leaving general practice. The issue now is not whether we are going to assess our performance but who is going to do the assessment and how, who decides on standards of good practice and how.

The development in some countries of central and Eastern Europe is perhaps an interesting illustration of this trend. Before the collapse of the socialist empire, general practice was not important. Organisations of general practice were, at best, voluntary organisations within the medical society which was a voluntary organisation without any real power. General practitioners were independently working in their offices with absolute clinical freedom within the boundaries of the health care system. They were often providing bad health care for low wages. Their self-esteem was low and the only expression of their freedom was their professional independence in practice. The result of this was low quality of health care and a low esteem of the profession by the public.

After the breakup, the profession has tried very hard to maintain and to regain its professional independence. Professional organisations were created or were given a greater authority (e.g. to give licenses to physicians, to control quality of care). Vocational training became obligatory, so that the average GP now is less independent in his practice than before. But the position of the profession is clearly better. Nevertheless, some general practitioners want to protect their independence against the community and against their own medical societies. In that way, professional independence is a barrier to higher quality of health care. I have seen clear examples of that in Croatia, where independent GPs do not want to get involved in any kind of quality assurance programmes.

CONCLUSION

My research in the field of professional independence of general practitioners has led me to the following conclusions:

1. There is no total professional independence.
   We always work in an environment to which we are responsible. This is one of the core elements of general practice, which can never exist in a vacuum. The responsibility of general practice is not just to our conscience, but also to the society. Because of its importance, general practice will never be totally independent.

2. The way the balance is maintained is individual (country specific)
   There are many different examples of the countries how this is organised and it is very difficult to make general conclusions. Each country must decide according to its system of values and its own tradition.

3. Professional autonomy is given by society and is based on trust
   As long as society, represented by policymakers, believes we can provide some of the very important professional functions, we will maintain our autonomy. We will, nevertheless, be constantly challenged also because the policymakers are being challenged by the changing society.

   The way to minimise the problems is to base our relations on trust and communication.
PERCEPTIONS OF RESIDENTS' WORKING CONDITIONS IN FAMILY MEDICINE: A CROSS-SECTIONAL SURVEY IN TURKISH ACADEMIC TRAINING HOSPITALS

H. YAMAN
FAMILY PHYSICIAN, ISPARTA-TURKEY

Introduction

Family medicine (FM) has been recognized as a medical specialty in Turkey since 1984. In 1985 the first residents in FM were accepted to teaching state hospitals and were educated for FM specialization. In the nineties education for FM experienced an increase in residency places. In 1995 alone approximately 300 residents were accepted for postgraduate training in FM. Besides university departments, 9 teaching hospitals in 4 larger cities (Istanbul, Ankara, Izmir and Adana) offer postgraduate education (1,2).

According to the current curriculum in FM, residency lasts 3 years. It consists of 5 main fields (Internal Medicine, Pediatrics, Gynecology and Obstetrics, Psychiatry and General Surgery). On completion of the 3-year course and after passing the examination, the graduates are awarded a Specialist of FM title from the Ministry of Health.

Most residents are trained in teaching hospitals of the Health Ministry. Despite a high educational demand in these institutions, no FM department has been established yet and no official position for FM training coordinator exists. The aim of this study is to record perceptions of trainees in FM about their working places and to determine needs for education.

Material and Methods

This cross-sectional, descriptive study was conducted in 5 different academic teaching hospitals in Ankara, Turkey. 87 of 135 residents of family medicine working in these hospitals responded (Response rate 64%). 39 (45%) were female and 48 (55%) male.

The self-report survey was conducted between February and April 1998. Residents working in the Ankara Teaching Hospital (ATH), Ankara Numune Teaching Hospital (ANTH), Dr. Sami Ulus Children Teaching Hospital (SUTH), and Zekai Tahir Burak Womens Teaching Hospital (ZTH) were involved in this study. A questionnaire with 17 questions was developed. This questionnaire contained questions on sociodemographics, workload, support staff, management, recognition, resource support, and professional development.

Descriptive statistics, frequency distribution tables and Kruskal-Wallis (KW) Analysis were used. A significance level of p<0.05 was considered as statistically significant.

Results

The mean age of the participants to this survey was 31 ± 2.8 years. 29 (34%) were single (1 divorced) and 59 (66%) were married. 25 (29%) were freshmen (1st.year), 22 (25%) junior (2nd.year), and 40 (46%) senior (3rd.year) residents.

Questions on workload revealed that being on call was “too much” at the pediatrics course in SUTH. In all other hospitals the amount of time on call was found to be fair [KW(3)=19.58; p<0.05]. The number of support staff in three hospitals (ATH, ANTH, and SUTH), which have the highest workload in Ankara was stated to be insufficient [KW(3)=9.74; p<0.05]. The skills of support staff in only one hospital was claimed to be inadequate [KW(3)=7.17; p<0.05] (table 1).

The question on support by the management showed that in three hospitals (ATH, SUTH, and ZTH) more than half of the residents were dissatisfied with the hospital management’s support [KW(3)=4.84; p<0.05]. In almost all clinical departments the clinical management was perceived as inadequate [KW(3)=7.85; p<0.05]. In almost all clinical departments the recognition of work of residents was found to be satisfactory [KW(3)=6.77; p<0.05] (table 1).

Medical supplies were significantly less available in two hospitals (ATH and SUTH) [KW(3)=3.45; p<0.05]. In the same hospitals availability and condition of examination room equipment was inadequate [KW(3)=8.34; p<0.05]. Amount of examination room space was stated as significantly higher in ANTH [KW(3)=7.17; p<0.05]. No hospital had enough restroom space for residents (table 1).

Concerning professional development only ANTH and SUTH have been found adequate for enhancing professional skills [KW(3)=6.21; p<0.05]. In most hospitals the opportunity was given to discuss cases with colleagues [KW(3)=10.7; p<0.05].
Discussion

This study presents the perceptions of FM residents about their working life and found significant gaps in organisational and educational matters of academic teaching hospitals in Ankara.

The workload in pediatrics is high in Turkey, because the population is mostly young. Most residents who work in children's hospitals claim that they are "too much" on-call. The workload of Dr. Sami Ulu's Children's Hospital is particularly high because it is a referral hospital for central and east Turkey and it is the only facility for people who have no social security. But clinical training in this hospital has been found to be good. Most of the residents who worked there stated that they had opportunities to enhance professional skills and to discuss cases with colleagues. These ratings were higher than in other hospitals.

The number of support staff has been found to be low in nearly all hospitals, where residents have been required to work harder. Residents who choose to attend the gynecological and obstetrical course in the women's hospital do not closely participate in clinical work, so this question might have been perceived differently, in this case.

The skills of support staff were mostly satisfactory in teaching hospitals. No special demands of care were mentioned for nurses at hospitals. Most routine work is done by the relatives of the patients or the physicians in charge of the patient.

Support by clinical management has been perceived in nearly all hospitals to be low. There is no "real" coordinator of family practice in these hospitals, who cares for the problems of FM residents. Seminars and educational programmes are organized by the residents themselves. Dissertations are completed in different departments, and relate to problems of these specific fields. In one survey 74% (68) of the FM residents stated that the administrators did not know anything about FM and 99% (91) suggested that teachers in these academic training hospitals should be trained in FM (3). Most of the FM residents are also dissatisfied with the management of the clinical departments. In each of the five courses which they have to complete, they begin as freshmen and are exposed to a high workload. Because they are FM residents, they do not belong to these clinics and because FM does not conceptually make any sense to the clinic staff, they are humiliated by them and seen sometimes as rivals of their practice (especially in Gynecology and Obstetrics).

Recognition of work by the clinical department has been perceived as slightly low. This is a general problem in postgraduate training. Residents have to do the hard work (4).

All of these hospitals are state hospitals which have to care for all underserved and non-insured members of the population and are managed by officers of the Health Ministry. Because of fiscal restraints, availability of medical supplies and medicines is sometimes interrupted. This happens in nearly all hospitals, as was apparent from the responses in this study.

FM education is performed in large training hospitals, where rural and primary care involvement is minimal. The posts for residents in training hospitals are enough in number and sometimes more than are required. Only in four big cities in Turkey is postgraduate training offered in governmental training hospitals. To respond to increasing demands for medical specialists the number of residency places are held high. However the amount of examination room space and restroom space was perceived as low.

As can be seen, the major problems in the training of FM specialists in Turkey are organizational and educational. First there are concerns on the current curriculum of FM training. This curriculum does not provide specific training in primary care. Departments of 5 specialties are not sufficiently equipped with knowledge and skills to train family physicians for Turkish primary health care demands. Further, no FM training coordinator exists, who is directly involved in the training process and who is competent in FM.

There are now efforts by the Turkish Association of Family Physicians and the university departments of FM to reorganize this subject and to arm family physicians with appropriate knowledge and skills. Courses with international participation are being organized to improve family physicians' skills in adult teaching. New suggestions have been made to the Coordination Council of Medical Societies to change the curriculum. Contemporary curricula are used in university departments of FM and well equipped family practice facilities are provided to improve FM training in Turkey.

Further work has to be done to make specialists in family medicine significant contributors to the primary health care system. Abilities of family physicians have to be disseminated to the whole population, to achieve a well recognized medical discipline in Turkey. Monetary and status problems of primary care physicians should be addressed with the highest priority.

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As with any other medication, there is a possibility of adverse drug reactions occurring in patients taking Nexium®. Common adverse drug reactions include headache, abdominal pain, nausea, diarrhea, constipation, flatulence, anxiety, fatigue, dizziness, drowsiness, dry mouth, dyspepsia, increased sweating, rash, rash pruritic, pruritus, dyspnoea, dysgeusia and dysphagia.  

Additional information on adverse drug reactions can be found in the full prescribing information.  

PREVENTIONS: Nexium® tablets containing esomeprazole magnesium corresponding to 20 mg or 40 mg esomeprazole. Date of preparation: July 2000.  

Since indications, dosage forms and strengths may vary from country to country, please consult your local prescribing information. For further information please contact AstraZeneca, 5-431 83 Mölndal, Sweden, or the local AstraZeneca subsidiary.  

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ACKNOWLEDGEMENT

I wish to thank Drs. Mehmet Özen and Altug Kut for their contributions in this study.

This study has been presented in part at the IV National Congress of Family Medicine;1999 Oct 14-17; Istanbul, Turkey.

Table 1: Perceptions of family medicine residents about their workload, support staff, management, recognition, resource support, and professional development in different teaching hospitals

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LASER TREATMENT OF PORT-WINE STAINS
M. J. BOFFA
DERMATOLOGIST

Introduction

A state-of-the-art pulsed dye laser machine to treat port-wine stains and other vascular lesions has been available in the Malta Health Service since 1999. This article reviews the pathophysiology and clinical features of port-wine stains and describes the principles of laser treatment for this condition.

Pathophysiology

A port-wine stain (syn. naevus flammeus) is a vascular capillary malformation characterised by ectasia of superficial dermal capillaries. Increased blood flow through these dilated vessels produces the persistent erythema which is seen clinically. The malformation represents a developmental anomaly and is not inherited; lesions occur familial no more frequently than by chance. In two large series the incidence of port-wine stains in the newborn was 0.5% and 0.3%, with an equal sex distribution. Disturbances of neural supply and reduced vasoreactive responses have been demonstrated in port-wine skin. Compared to normal skin there is a reduction in the density of perivascular nerves around the superficial dermal vascular plexus and it is likely that reduced influence on vascular tone contributes to the development of port-wine stains.

Clinical features

Port-wine stains are usually congenital i.e. present at birth, although their presence may initially be masked by the normal pink colour of neonatal skin. Rarely they may be acquired, appearing in childhood or adult life. Clinically they present as well-demarcated areas varying in colour from light pink to deep red or purple (hence the term ‘port-wines stain’) and in size from a few millimetres to several centimetres across. Occasionally lesions can be very extensive and cover a large area, for example a whole limb. Port-wine stains may involve any part of the skin surface but occur most commonly on the face and upper trunk and are often unilateral. Port-wine stains usually persist throughout life with the surface area affected remaining unchanged relative to body size. With increasing age they tend to become darker purple in colour and more noticeable. Raised, thickened and nodular areas may also develop. There is no association with skin cancer.

Complications and associated conditions

The main consequence of port-wine stains is cosmetic. Lesions are often unsightly and, especially when on the face, may cause profound psychological disturbance. Even small lesions at other sites may cause significant embarrassment and most patients who have port-wine stains would like to have them removed. Facial port-wine stains may be associated with abnormalities of the ocular vasculature including dilated conjunctival vessels and an increased risk of glaucoma. Glaucoma is more likely if both upper and lower eyelids are affected and such patients should have regular ophthalmic review. In the Sturge-Weber syndrome a unilateral facial port-wine stain is associated with ipsilateral encephalomalacic angiomatosis which represents a developmental malformation of the vasculature of the leptomeninges. Affected individuals may suffer from epilepsy, mental retardation and glaucoma. The rare Klippel-Trenaunay syndrome consists of the association of a usually extensive port-wine stain on a limb with soft-tissue swelling, with or without bony overgrowth.

Treatment of port-wine stains

Until recently management of port-wine stains has been very unsatisfactory. Treatment modalities which have been used over the years include excision and grafting, dermabrasion, tattooing, Thorium X, red phosphorus, radiotherapy, electrocautery and cryotherapy. Unfortunately none of these treatments produced acceptable results and for most patients the only option was cosmetic camouflage.

The situation has changed dramatically over past few years with the advent of pulsed dye lasers which are now the treatment of choice for port-wine stains. This is an exciting development which means that for the first time effective and safe treatment may be offered to affected patients. The term laser is an acronym for light amplification by stimulated emission of radiation. Laser light has certain unique properties which are responsible for its clinical effects. Laser light is intense, coherent, collimated (perfectly parallel beam) and monochromatic. Sophisticated technology allows the laser light to be emitted in brief pulses.

Treatment is based on the principle of selective photothermolysis whereby pulses of light are selectively absorbed by the target chromophore (in this case haemoglobin in the abnormal blood vessels of the port-wine stain) to produce selective, thermally-mediated
ated injury. By using short pulses, energy is deposited in the targets before they can cool off, producing extreme localised heating. This results in destruction of the target with minimal damage to intervening structures. The laser light is delivered in small circular spots commonly up to 10 mm in diameters. The parameters of the pulsed dye laser currently available locally include a pulse duration of 1.5 msec and four wavelength options - 585 nm, 590 nm, 595 nm and 600 nm. The longer wavelengths penetrate further into skin thus reaching vessels located more deeply. On the other hand because the longer wavelengths are further away from the absorption peak of haemoglobin (577 nm) a bit of selectivity may be lost and there may be more competitive absorption by melanin. It is important to note that there are several different types of laser with medical applications yet only a few are suitable for treating port-wine stains. Although the parameters mentioned appear to be the best available at present for treating port-wine stains no single laser is completely effective for all cases. The pulsed dye laser is a major advance over the argon laser which was used in the past to treat port-wine stains but which produced unacceptable scarring in many cases.

Pulsed dye laser treatment for port-wine stains is usually carried out as an outpatient procedure. Laser pulses are applied carefully with minimal overlap to cover all the affected area. With big lesions this may be quite time consuming. Each pulse produces some discomfort if large areas are treated. In selected cases topical anaesthesia e.g. EMLA® cream may be helpful. Infants and young children require general anaesthesia.

Hazards, precautions and complications

In general, the pulsed dye laser has a low incidence of reactions and can be used even in infants and children. Nevertheless it is a powerful energy source which has to be handled carefully. The laser should be used only in properly controlled sites with precautions taken to protect operators and patients from accidental exposure. In particular, laser light can damage the eyes if these are unprotected during treatment. Special protective eyewear must therefore be worn by both operators and patients during treatment to prevent the laser light from entering the eyes.

Purpura commonly appears in the treated area immediately after treatment. This may appear alarming but is harmless. It is caused by haemorrhage from the targeted blood vessels in the port-wine stain and typically resolves within 7-10 days. Blistering and crusting may also appear in the treated area especially if high fluences are used.

Potential cutaneous complications of pulsed dye laser treatment for port-wine stains include scarring and pigmentedary changes (hypo- and hyper-pigmentation). There is a risk with every treatment and it is important to note that lack of scarring or pigmentedary changes with previous treatment does not completely exclude this risk in future. Nevertheless the incidence of significant texture or pigment change following pulsed dye laser treatment is less than 5% in most published series and the local experience appears to be in keeping with this or better. The laser machine available locally has a recently developed feature called dynamic cooling whereby a spurt of cryogen is sprayed on the skin just before the laser pulse. This reduces discomfort while protecting the epidermis and superficial dermis by selective cooling allowing safe use of higher laser fluences. There is evidence that laser treatment with dynamic cooling is safer and more effective than with earlier lasers which did not incorporate this feature. The risk of pigmentary changes is greater in patients with darker skin types and those with sun-tanned skin. Treatment should therefore be avoided in those with tanned skin and patients instructed to protect the skin from sunlight before and after laser treatment. If blistering or crusting develop in the laser-treated area this may increase the risk of scarring and should be treated with a topical antibiotic ointment to reduce the chance of infection.

At what age should patients be treated?

Port-wine stains may be treated with the pulsed dye laser at any age. Ideally however treatment should start in infancy or early childhood with a view to completing it before school age and thus minimising psychological consequences of disfigurement. This is especially important with large, visible lesions on the head and neck. Early treatment has other advantages in that lesions usually respond better and require fewer laser treatments than those in older patients and furthermore fewer laser pulses are required because the area to treat is smaller. However advantages of early treatment have to be balanced against the risk and inconvenience of general anaesthesia which is required to treat young children.

Results

It is usual to treat a small test area first to assess response. Most lesions require multiple treatments, usually 6-10, for maximum improvement. Treatments are repeated every 6-8 weeks until maximum clearing becomes evident. In practice the first treatment produces proportionately most improvement. Response to treatment varies according to which particular laser equipment and parameters are utilised and therefore results in published studies are not always comparable. In general however more than 80%
of port-wine stains can be expected to lighten by at least 50%\textsuperscript{14}. Not all lesions respond equally well\textsuperscript{14}. Several studies have demonstrated a better treatment outcome in younger patients and those with smaller lesions. Body site is also important - for example port-wine stains on the midface involving the medial cheek, upper lip and nose (corresponding roughly to the distribution of the second branch of the trigeminal nerve) usually respond more slowly and less completely than other facial areas. In addition there may be structural differences in microvascular patterns in different port-wine stains which could also contribute to differences in treatment outcome\textsuperscript{17}. The presence of associated glaucoma, Sturge-Weber or Klippel-Trenauney abnormalities are not contraindications to treatment however it should be emphasised that the laser will correct only the cutaneous component.

Pulsed dye laser treatment for port-wine stains has now been available in the Malta Health Service since 1999. The laser machine is installed at St Luke’s Hospital. Several patients have been treated and results so far are encouraging. Although by no means all port-wine stains will disappear completely it should be possible in most cases to at least lighten the colour and thus produce worthwhile cosmetic improvement. Patients should be referred to the Dermatology Department in the usual way. It is important to note that the pulsed dye laser is effective only for vascular lesions. Pigmented birthmarks and other pigmented disorders do not respond to treatment with this laser.

REFERENCES


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References should be at the end of the text, and numbered according to the order in which they are referenced from the text. They should not number more than ten. References should be in the 1997 Vancouver style (Ann. Intern. Med. 1997; 126: 38-48 and http://www.wame.org), with names and surnames of all authors when six or less, when seven or more list the first three and add et al., title of article, name of journal abbreviated according to Index Medicus style, year, volume, first and last page numbers.

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Qed tahseb biex twarrab xi ftit flus għal xi ħaġa speċjali jew biex isserrah mohhok f'każ ta' bżonn?

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