JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

ISSUE NO. 3 SEPTEMBER 1991

EDITORIAL

It is a pleasure to announce that the Malta College of Family Doctors has been accepted as a full member of W.O.N.C.A. Moreover, Dr. Dennis Soler, the President, has been nominated to sit on the Post Graduate Medical Committee representing the College.

The first six months of this year have proved to be busy and unfortunately this journal did not go to press in time. The coordinated organisation of an accredited system of meetings proved to be truly time consuming and dedicated work from council members was involved.

Since the December issue of this journal the M.C.F.D. has organised a Winter and Spring CPD meeting and has actively participated in six postgraduate symposia. This issue announces the programme for the Autumn CPD meeting and calls new doctor members to lead discussions for the coming winter one. Clearly for these ambitious programmes to be successful the council needs your active participation and the finance of pharmaceutical firms. In this regard a special word of thanks goes to Clinipath Laboratory Services and Associated Drug Ltd. for their sponsorship.

The months of May and June were evidently hallmarked by the Health Service Reform Symposium and the initiation of discussions on the 'Family Doctor Scheme' with medical unions.

'It- Tabib tal-Familja' will keep its eyes open, so as to maintain the standards of family practice within the concepts of this new scheme.

Godfrey Farrugia

CONTINUING PROFESSIONAL DEVELOPMENT — 1991 PROGRAMME

Accreditation is to take the form of credit units and the system of credit allocation will take into consideration both active and passive involvement in Continuing Professional Development (CPD) activities, the former attracting more credit units than the latter. Each member of the College must accumulate 27 units annually to retain the right to membership. A CPD logbook 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 newsletter are to be sent to
"It-Tabib tal-Familja", Malta College of Family Doctors, P.O. Box 70, Paola, Malta
Design and Typesetting: *a•r•t•w•o•r•k•s*

THE HEALTH OF THE FAMILY DOCTOR

ANTHONY PAUL AZZOPARDI

Doctors tend to have better physical health but poorer mental health than others. Their poor mental health may inevitably affect their care of patients and the epitaph of an Athenian physician reads:

"These are the duties of a physician: First to heal his mind and to give help to himself before giving help to anyone else."

However a survey amongst doctors showed that:

Almost 20% of doctors had not consulted a doctor when they would have liked to because they were doctors themselves. In addition,

- 30% would not seek advice from anybody for excessive tiredness;
- 20% for excessive alcohol consumption;
- 17% for dependence on drugs;
- 40% would not see anybody about sexual difficulties.

These are circumstances when one would strongly advise a patient to seek advice.

- Over 75% had treated themselves with antibiotics;
- 25% were not sleeping well and treated themselves with hypnotics;
- 5% treated themselves with anti-depressants;
- 3% treated themselves with opiate pain-killers.

Self-medication is common among doctors.

In addition many did not seek out preventative care:

- 75% had not talked to their GP about BP;
- 43% had not discussed their dietary habits;
- 84% had not talked about stress and their lifestyles.

Mortality and morbidity statistics show that GP's may be at considerable risk from diseases and other illness related to stress. For example, figures from the Registrar General (1978) have shown:

"...Medical practitioners have a higher risk than the general population of dying from three causes frequently linked to stress namely:

•Suicide;
•Cirrhosis;
•Accidental poisoning..."

A US study has shown that there the suicide risk for doctors was twice that of the general population with a higher proportion being psychiatrists. Most early studies were made on male doctors but recent evidence suggests that the rate among women doctors is just as high.

A letter in the British Medical Journal noted that in the United Kingdom the rate was three times that in the general population and the rate for women doctors was six times that of women who were not doctors.

A twenty year follow-up of college students (NEJM 1970) found that, compared with other professions, doctors were more likely to have poor marriages, to abuse alcohol, and to use sleeping pills, amphetamines or tranquillisers.

There are various hypotheses:

- Medical Associations do not act as support groups and leave their members to deal alone with ever-increasing demands — possibly predisposing to depression and suicide.
- Difficulty with diagnoses and treatment, death of children, impact of work on family life.
- Achievement-oriented compulsive people are attracted to medicine and this pre-selection of vulnerable individuals may contribute to the high incidence of mental illness, stress and drug dependence.

The main physical problems identified in the local scene would include:

- Long hours. Ours is not a 9 to 5 job.
- Poor working environment. Some surgeries are conducted from small pokey back rooms in a pharmacy. In this regard there might be subtle pressure from the pharmacist to over-prescribe or to prescribe particular brands. There might be sharing of the same consulting room with other GP's so that one cannot leave letters, prescription pads or instruments and be constrained by time-limits. Having said this this, one also has to acknowledge that over the years a personal friendship does develop with the pharmacist who also acts as a receptionist, telephone operator and, at times, an assistant.
- Weather conditions in Malta cannot be described as extremely adverse but carrying out house visits in the early afternoon in mid-summer is by no means easy.
- Poor communications system. The telephone system is in the throes of renewal and in the meantime you can easily spend fifteen minutes trying to get through to a single number with many wrong numbers, incorrect connections and simply no connection at all.
- Poor roads and driving standards — which are deteriorating by the day — with bumpy roads, dug-up roads, frequent inexplicable deviations, large volume of traffic on the inadequate roads.
- Working single-handed means that one is continuously on

call and this, apart from the stress it engenders, is physically exhausting.

- Large numbers of house visits expected by the Maltese patients even for minor complaints. The chart shows the proportion of house visits to surgery consultations in my practice during 1990. As you can see the winter months are worse. Three explanations come to mind:
  1. There is more illness in winter;
  2. People are less ready to leave their warm homes in winter and therefore expect the doctor to visit;
  3. The extreme heat of summer makes me use all my powers of persuasion to convince patients to call themselves.

  Overall the figure is 37.1% which is extremely high by any standard.

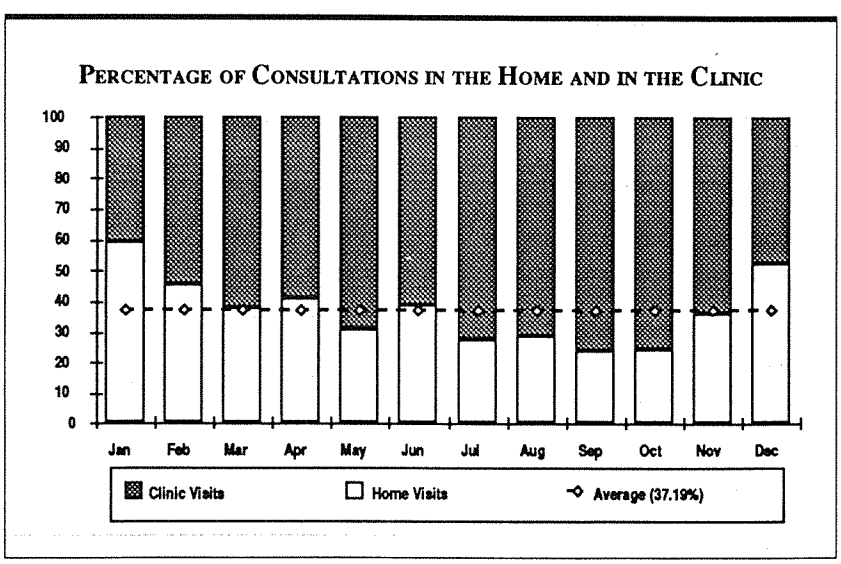
Increasingly we shall encounter problems with AIDS and drugs. The AIDS-mentality (i.e. consider every blood sample as potentially infected and every patient at risk as potentially a person with AIDS) has not yet crept into the local scene, but no doubt this varies from one practice to another and if not, eventually it will. Drugs seem to have by-passed the GP. Being a small country, every drug patient is taken, sent or goes to the central Detoxification Centre. The introduction of the Control Card and the green prescription form have severely limited our freedom to prescribe drugs of dependence so we are not approached by addicts for prescriptions. We are however called in by the drug addict's family in a panic when he is newly-discovered.

Psychological problems

These would include:

- Worrying about patients' complaints. Allied to this is the fear that you might have missed something important. This is, of course, worse when one has a large number of patients to see.
- Unrealistically high expectations by others of your role.
- Coping with phone calls during the night and early morning. Allied to this is the pre-call tension. This comes on when the patient has already phoned once and you have given advice but lie there expecting him to call again.
- Night calls. This is the single most important source of stress experienced by GP's in their work.
- Dealing with problem patients. Here I would include the requests for unjustified certification to avoid school, work or to avoid attending court. The latter are frequently sent by their lawyer, another professional! Here we have the constant struggle to convince the patients without losing them. Another source of stress is when an unnecessary visit is requested. These unreasonable requests make the doctor angry because he cannot accept, and even angrier because the patient should not have put the doctor in a position of having to refuse.
- Daily contact with dying or chronically-ill patients and, in their bereavement, sometimes being blamed by the relatives for the patient's death.
- Dealing with relatives and friends as patients. If something goes wrong, you lose both a friend and a patient. Conversely, very often, patients end up as your friends.
- Inadequacy. A GP is by no means a specialist in all fields. One tries to be a good all-rounder, but there are instances when one is found lacking. One might note that as medicine becomes more effective, so what one misses or doesn't do becomes more critical.
- 24-hour responsibility for patients' lives, especially in our solo-practice set-up.
- Rankin et al (1987) have suggested that general practitioners derive pleasure from exercising their technical skills. However Mechanic (1968) has observed that: *"... the average doctor to his growing practice and increasing demands on his time ... by practising at a different pace and style. Such a pattern of work requires doctors to practise on an assembly line basis, which diminishes the unique satisfaction possible in general practice."*

The large number of patients waiting in a crowded waiting room has been described by one GP as a head of steam so



that the more patients there are, the faster one is forced to work.

- Another powerful source of anxiety/stress is the "Report of the Working Committee on the GP Scheme in the Maltese Islands". The "Charter for the Family Doctor Service" worked out by Sir James Cameron at Brighton in 1965 stated:
"That general practice must remain a family doctor service; that the GP must have adequate time for each patient; be able to keep up to date; must have complete clinical freedom; have adequate well-equipped premises; have all the diagnostic, social service and ancillary aids he needs; be encouraged to acquire additional skills in special fields; be adequately paid by a method acceptable to him and which encourages him to do his best for his patients; have a working day which leaves him some leisure."
Shall *we* have this? Our anxiety stems from our justified mistrust of our politicians, but it is also partly the fault of our Medical Unions who do not keep the rest of the profession informed of what is going on.

Social problems

1. Demands of the job on the family.
2. Dividing time between spouse and patients.
3. Demands of the job on social life.

Women who marry doctors may think it is going to be a glamorous life. This is possibly more so in the case of couples who marry soon after the husband graduates so that they do not really know what to expect. Then they find it a bit humdrum, the telephone is always ringing and they find it's a bit irksome. The children need you for their homework and you're still doing your surgery at 7.30 at night. You can't commute your children to school because you have a long list of patients to visit.

A DHSS study in 1980 that many men and women doctors were deeply unhappy in their chosen profession. Marriage and children were seen as obstacles to their career plans by both sexes. On the other hand many, including men, resented the way a medical career may diminish family life. The statement "I preferred to be at home playing with the baby than looking after somebody else's" was made by a man. All the family, especially the wife, frequently share in the patients' problems. All our children are trained from an early age to take intelligible and intelligent messages. The wife is expected to be able to give advice. It is not just the doctor that is part of the village life: the wife is always the doctor's wife, not Mrs. A., an entity in herself. This can cause problems in the beginning, especially when the wife is professionally qualified in her own right, and who used to work.

Welfare Issues

There is in Malta tremendous cohesion in the profession and even between doctors and paramedics. In the case of medical necessity one can within hours fix an appointment with a consultant most of whom we know personally. Special investigations, physiotherapy, hospital appointments and treatment for ourselves and for our families pose no problems.

Obtaining medication from Drug Reps again most of whom we know well is also easy.

Our patients are fortunately not yet given to litigation with us but the Medical Associations are ready with their experience to help the doctor concerned should this occur. Here one might remark that it is time the Profession as a whole started to think of Medical Defense Insurance because what is happening abroad is sure to happen here eventually.

Our College ought to work as a support group: For example in 1985, the British Medical Association announced a new service — a National Counselling and Welfare Service for Sick Doctors — where a concerned colleague may contact the centre and a National Adviser is appointed who can approach the sick doctor who, very often through lack of insight as a result of their illness or through embarrassment, may not have approached somebody "local".

Earlier On

Realistic advice must be given at schools so that pupils have some idea what a career in Medicine will mean.

Personal assessment and career advice should be offered throughout Medical School and before.

Women who have had a break in their career should have retraining.

In 1988, the World Federation of Medical Training recommended that:

"Medical Schools should use selective methods for medical students which go beyond intellectual ability and academic achievement to include the evaluation of personal qualities."

This might therefore help provide effective primary prevention, help reduce long-term unhappiness, stress and mental illness in the profession.

By providing CPD, journals, advice on the upgrading of our

surgeries, record-keeping and computerisation, the practice of medicine would become more efficient and the job easier.

On a psychological plane, the provision of CPD, opportunities to serve on committees, for research, for meeting with other professionals with interests other than medicine — for ourselves and for our spouses — this would provide the support which most of us who work in isolation badly need.

It is unfortunate that as self-employed professionals we have never been helped in any way by the State. We have instead been made the target of punitive taxation with unfair best of judgement assessments. We have been excluded from all forms of sickness or injury benefits. Whilst the employed category was entitled to a full pension at age 61, we had in many cases to wait until age 65 to get our due. To date this is still the case until the proposed new legislation is enacted. We have had legislation enacted prohibiting us from working in our traditional surgeries – the pharmacies, from working in any private clinics or hospitals and now we are faced with a great unknown – the proposed FD Scheme which we know very little about (and which we like less). Being such a vulnerable group I might lastly mention the various insurance options open to a self-employed GP in Malta.

We have BUPA with which the MAM has negotiated a very favourable rate. PPP also provides medical cover.

Then we have the Income Protection Insurances which will pay out a sum of money for the duration of periods of illness when we cannot work. We lastly have the Life Insurances.

Once the local Government Legislation is about to be changed to permit self-employed professionals to qualify for benefit, I might here point out too the importance of paying the correct National Insurance contribution. Furthermore, a recent amendment to the Law which has come into effect in 1988 lays down that if one pays at a lower rate than one should, currently one-sixth of the annual income up to a maximum of LM 13.60 per week, one might be asked to pay the underpaid contributions in arrears and still not qualify for the right pension. ◆

cpd

Developmental Screening in Family Practice

Sarah Portelli

Paediatric screening is an important area of medical practice because, in the words of Dr Mary Sheridan, "There is general agreement that the younger the age at which children with physical, mental, emotional or social disabilities are discovered and fully assessed, the more hopeful is the prognosis for amelioration or complete rehabilitation. " Family Doctors have many paediatric consultations, and they know the parents and therefore the family and social background, so they are in a good position to integrate personal preventive medicine with curative medicine. In the past the emphasis was on dealing with individual paediatric problems as and when they presented themselves to the medical profession, but nowadays the trend is to try and look at the whole child.

The reasoning behind attempting to screen *all* the children in a particular community, e.g. Malta, is to detect a relatively small number of conditions for which extremely effective treatment is available to prevent complications.

Examples of such physical conditions are congenital dislocation of the hip, deafness, squint and undescended testes. The simple test for a click in the hips if applied to every newborn and six week old baby can prevent CDH completely. If we could check the hearing of every 7 to 9 month-old baby in Malta routinely, by very easily applied distraction hearing tests, we could identify deaf babies early enough to give them a hearing aid and give the parents guidance on how to stimulate the child. Early intervention of this kind should increase the child's chances of acquiring a reasonable amount of speech, of education, and of life opportunities, and prevent behaviour problems due to the frustration of a young deaf child who cannot communicate. Early intervention in the case of any handicap will certainly help the parents in their difficult role. Lack of detection and action in the case of a squint may result in blindness in one eye. Undescended testes should be treated because, apart from any psychological and/or fertility problems which may develop later in life, the undescended testis is more likely to develop malignancy.

Other conditions such as phenylketonuria and hypothyroidism require biochemical screening of blood; and genetic screening is another increasingly important aspect of paediatric screening. These specialised areas of paediatric screening deserve to be the subject of further lectures. However, in this article, I want to concentrate on developmental screening in the first two years of

life. I would like to convince you that this method of screening normal child development is relevant to you in your practice, and that it is worth spending a few hours to familiarise yourselves with the simple technique I shall be showing you with the aid of a simple protocol.

First of all I would like you to look at the developmental screening chart (reproduced overleaf). You will notice that it is divided into four areas of development: motor, social, hearing and speech, and eye/ hand. These four areas correspond to four main features which distinguish man from other animals: upright posture, highly developed social structure, language, and sophisticated eye/hand co-ordination resulting in the developmental and use of tools, writing and so on. The age of the child is listed in the left-hand column, and for each age one appropriate ability is listed for each age in the four separate areas of development. Thus if you look at the age six months you will see that you have listed:

Rises onto wrists .....*Motor*

Turns head to
person talking .....*Social*

Babbles or coos to
voice or music .....*Hearing/ speech*

Takes cube from table ....*Eye/ Hand*

The implication here is that *most* babies of six months of age will be doing these four things — amongst many other achievements of course. If a baby of six months attends your clinic for any reason, it would be quite possible whilst he is there to screen him for normal child development by checking a few items across the page. In most cases the child will be able to do these things. In a small number of cases you will find he cannot, and will either be able to identify straight away where the problem lies e.g. no babbling, but all other areas normal may alert you to a deaf child. Or else you may find a child who is well behind in all four areas, and he would be said to be suffering from developmental delay which would require further investigation and could possibly indicate mental retardation. In many cases you might just be a little suspicious that development is not up to expectations, and arrange to see the child again in a month. Very often the diagnosis of developmental delay is made by "increasing suspicion" after two or three visits. The difficulty is of course that child development is so variable. Most of these abilities follow a normal distribution curve so that e.g. one child may walk unaided at 8 months, another at 16 months and they both be within normal limits. All these factors must be considered, but I think you will agree that with this method you can be guided.

This is how to score on the chart:

- When you observe a child succeeding in an item put a tick in the narrow column beside the item
- When the child fails in an item put a cross
- When you are relying on the mother's report and not your own personal observation put your tick in brackets
- If the child goes some way to attain an item, but does not complete it put "1/2"
- If you are uncertain put "?"

Go on scoring until you have found three items in a row in each field which the child is unable to do. Then draw a line across the chart to show the child's approximate level of achievement given as an age. You can see if a child is seriously behind in one field compared to other fields, or if he/ she is late in all fields.

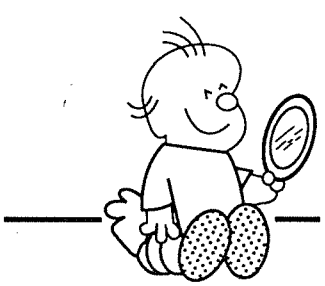
To summarize, may I suggest that in an ideal situation we would be able to go through general practice and well baby clinics to encourage developmental screening for all children. This could be combined with post natal checks at six weeks, immunisation schedules, and the concept of "Birthday check-ups". If we were able in Malta to train our doctors to identify handicap early by following a simple standard procedure such as the correct use of this chart. If we were able to encourage family participation by the use of the media and a booklet to all new parents. If we were able to have available a Child Development Unit where parents would have easy and early access to the most highly qualified professionals on the island in the field of handicap from not only the medical field but perhaps even more importantly from the fields of Education, Psychology and Social Welfare. If we were able to achieve all these things, then I think we could be very proud indeed of our services for young children and their families. ◆

REFERENCES

Court S D M, The report of the Committee on Child Health Services, "Fit For The Future", (1976), HMSO London

Sheridan M, "From Birth To Five Years" (1973), NFER-NELSON

The General Medical Services Committee of the British Medical Association and the Royal College of General Practitioners, Handbook of Preventive Care for Pre-School Children, (1984)



Date	Mth	MOTOR	SOCIAL	HEARING & SPEECH	EYE & HAND
	1	Head erect for few seconds.	Quieted when picked up.	Startled by sounds	Notices bright objects close to.
	2	Head up when prone(chin clear)	Smiles	Listens to bell or rattle	Follows ring up, down & sideways
	3	Kicks well	Alert. Follows person with eyes	Searches for sound with eyes	Glances from one object to another
	4	Lifts head and chest prone	Returns examiner's smile	Laughs	Clasps and retains cube
	5	Holds head erect with no lag	Frolics when played with	Turn head to sound	Pulls paper away from face
	6	Rises on to wrists	Turns head to person talking	Babbles or coos to voice or music	Takes cube from table
	7	Rolls from front to back	Friendly with strangers	Makes four different sounds	Looks for fallen objects
	8	Tries to crawl vigorously	Shows toy	Shouts for attention	Passes toy from hand to hand
	9	Turns around on floor	Helps to hold spoon	Says "Mama" or "Dada"	Manipulates two objects at once
	10	Stands when held up	Rings bell in imitation	Listens to watch Responds to talking	Clicks two bricks together
	11	Pulls up to stand	Finger feeds	Understands 'No'	Pincer grip
	12	Walks or side-steps around pen	Plays 'Pat-a-cake'	Three words with meaning	Points with index finger
	13	Stands alone	Waves 'Bye Bye'	Looks at pictures	Picks up small object
	14	Walks alone	Uses spoon	Knows own name	Makes mark with pencil
	15	Climbs upstairs	Shows shoes	Four or five clear words. Point to familiar toy	Places one object upon another
	16	Pushes pram, toy, horse, etc.	Curious	Knows "give", "show", "get"	Scribbles freely
	17	Climbs onto chair	Manages cup well	Babbled conversation	Watches from window
	18	Picks up toy without falling	Takes off socks and shoes.	Enjoys pictures in books	Constructive play with toys
	19	Climbs stairs up and down	Knows one part of body	6-20 words	Tower of three bricks
	20	Jumps	Imitates activities	Echoes words	Removes wrapper from sweet
	21	Runs	Puts on garment	Two word sentences	Circular scribble
	22	Walks upstairs	Tries to tell experiences	Listens to stories	Tower of five or more blocks
	23	Seats himself at table	Knows two parts of body	Demands by pointing	Copies perpendicular stroke
	24	Walks up and down stairs.	Knows and names four parts of body.	Names four toys.	Copies horizontal stroke.

Family Doctor-Consultant Relationship

John Gauci

The relationship between the Family Doctor and the Consultant is of necessity moulded through the various encounters that take place in the course of their work and leisure and which are listed in Table I.

They are encounters that each one of us is so familiar with but perhaps has never stopped to think how they affect our perception of one another.

Medical Student – Consultant Teacher Interaction (The Socialisation Process)

It is not simplistic to assume that the doctor is profoundly influenced by his consultant teachers who not only impart knowledge and skills but also consciously or subconsciously attitudes, emphasis, sentiments and values vis-a-vis the professional work for which he/she is being trained.

I graduated in 1975 with 39 others. 65% of us are working in a consultant capacity either in Malta or abroad. My impression is that in the past there was a tendency to foster the value of specialised care and let those students who want to go into general practice to do so by default.

Times, circumstances and needs have changed drastically since then but have our consultant teachers adjusted their emphasis and attitudes to match the needs of the future Family Doctor?

Related to this, is the undergraduate curriculum providing medical students with significant primary care experiences which compete fairly with specialised care for time, people, space and money?

To become a principal in general practice, having spent almost 10 years in hospital medicine is a situation demanding redress, as M. Keith Thompson pointed out in his discussion paper appearing in the Journal of the Royal Society of Medicine (Dec '86) under the name "A Concept of Disease to Educate the New Type of Doctor". He goes on to say in his concluding remarks: "Doctors in their early training should no longer waste a decade away from normal human communities where they can become observers of human development."

I shall not discuss in any depth this aspect but I think it must be mentioned first in order to reflect its chronological placing and underscore its importance in influencing the shaping of the relationship between consultants and future family doctors.

Hospital Practice and Family Practice

It is at this interface that most communication takes place between the family doctors and consultants, whether directly or indirectly and I dare say that this is the area where it seems both parties are dissatisfied.

The interaction concerns individual patients and arises from decisions, often complex in origin, to seek consultant advice. Family Doctors vary in their referral rate and the same family doctor may himself vary over certain periods for various reasons (Table II).

None of these factors should be regarded as fixed entities and in any referral more than one factor can operate simultaneously e.g. the coping capacity of the family doctor can fluctuate and can be undermined for a time by an unnerving professional experience such as the unsuspected sudden death of an elderly diabetic patient from a silent infarct.

The salaried doctor dealing with demanding, sometimes disrespectful, patients in a system that is not personalised or does not cater for continuity of care is not motivated to refer frugally and appropriately.

The quality of service available from hospital may vary over time e.g. a particularly

Table I Family Doctor-Consultant Encounters

- Medical Student – Consultant Interaction
- Hospital Practice and Family Practice
- The Domiciliary Consultation
- Post-Graduate Medical Education
- Family Dcotor – Patient – Consultant Relationship
- Social Encounters

TABLE II FACTORS INFLUENCING REFERRAL RATES OF FAMILY DOCTORS TO HOSPITAL

- THE FAMILY DOCTOR'S MOTIVATION TO TAKE RESPONSIBLE DECISIONS.
- THE FAMILY DOCTOR'S SKILLS OF DETECTION, INTERPRETATION, REASSURANCE AND TREATMENT.
- THE COPING CAPACITY OF THE FAMILY DOCTOR, PATIENT AND FAMILY.
- THE PATIENT'S BELIEFS AND EXPECTATION THAT A PARTICULAR SYMPTOM IS A MATTER FOR HOSPITAL.
- THE DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF THE PRACTICE POPULATION.

sympathetic usually new consultant may attract more consultations.

Patients and relatives are greatly influenced by the media. We all have experienced a sudden increased demand for mammography following some programme on breast cancer on TV or even after it is revealed that one of the actors in a popular TV series develops a lump in the breast.

Unless the consultation takes into account all these factors operating on the Family Doctor in making a decision for referral there is bound to be misguided criticism if not downright obstructive behaviour from his side.

I will hasten to add that this does not exonerate the Family Doctor from communicating sensibly to the hospital doctor or consultant. Indeed it underscores the need for clear communication.

There is an old medical joke about the GP's letter that said "Dear doctor, Please see this patient, ?chest" and got the reply "Dear Doctor, chest present".

I am aware that hospital doctors grumble about Family Doctors' letters of referral which are sometimes regarded as largely irrelevant, lacking in structure or seriously incomplete. Inevitably there is a cultural divide between doctors who have a long term relationship with patients and are mainly interested in human behaviour and doctors to whom selected patients are referred, ideally for a specific clinical problem to which the consultants have an answer. These differences are reflected in the data each provides for each other.

However, serious mistakes can be committed if junior doctors in hospital do not take the Family Doctors' letters of referral seriously and take it upon themselves to decide whether to keep a patient who was referred for admittance to hospital by the Family Doctor without consulting themselves with a consultant beforehand.

I am sure that several Family Doctors have had the unfortunate experience of having a patient refused admission by the junior staff with disastrous consequences. I believe that when this happens the consultant involved should take the necessary disciplinary action and before this happens Consultants should impress on their staff that most GP's have a good reason for referring.

CONSULTANT'S COMMUNICATION WITH THE FAMILY DOCTOR

What does the Family Doctor receive by way of a discharge letter from the consultants? I have great respect and gratitude for those consultants who compose the summary of a complex case for the Family Doctor. How can one plead for cognitive as well as sophisticated skills if those who have the most skills undervalue them by delegating them to their juniors?

Discharge letters consisting of an interminable list of negative investigations without an opinion as to the diagnosis or a mention of the prognosis are of no use to anybody least of all to the patients.

It is also not good practice to delay issuing a discharge letter until the results of investigation are all available which can take weeks if not months. The doctor needs to be kept informed ideally pari passu with the development of the case and this not merely to keep the doctor informed but also to be able to pass on suitable information in the comfort and familiarity of one's surgery to the patient. Very often the patient comes out of the hospital bewildered and full of doubts and questions which he expects to be answered and explained by the Family Doctor. Whenever there is dual care, the danger of confusion from poor communication is always present. It is sometimes forgotten that what the hospital doctor and the Family Doctor say to the patient is at least as important as what they prescribe and seldom do the two doctors know what the other one has said.

This brings me to the point of when a patient is discharged from hospital. I am glad to recognise the increasing tendency of many consultants to discharge patients from outpatient quite early on, if the case allows it, to the Family Doctors' care. Apart from unloading the OP clinics there really is no point in extended review of the patient by progressively more junior members of the hospital team.

The Domiciliary Consultation

The Domiciliary Consultation has a long history in Malta as in UK the place we emulate most in matters medical. It had attained a quasi magical aspect with an aura surrounding the Consultant, his knowledge, behaviour and powers. There was a way the GP attended to the Consultant and a way the patient's relatives attended to and addressed the Consultant and the GP.

Although this form still survives in a less melodramatic setting, certainly the number has diminished for various reasons. I firmly believe it should stay, however, for it still serves a very valid purpose in our local scene. To mention some advantages of the Domiciliary Consultation:

1 The intimacy of the setting. It provides the opportunity for a specialist opinion to be given at the patient's home and for the consultant to experience on a personal level the social and personal environment in which the patient lives.This often colours important decisions in short and long term management.
2 It often avoids unnecessary admissions to hospital.
3 It is a learning experience for the consultant and GP alike.

Postgraduate Medical Education

The family doctor in Malta has up till recently played the passive role of a listener on most activities of a medical educational nature. Subjects discussed and lectured on have been heavily biased towards hospital medicine and understandably so. I dare say that the setting up of the College has been the first significant step tangibly taken by the local Family Doctors to foster continuing medical development and raise standards from our end. The College's participation in the post graduate CME programme should hopefully be the beginning of a more active interaction and cooperation between hospital medicine and family practice, which has been until recently sadly lacking.

It is my impression and I'm sure of many of us Family Doctors that a good number of Family Doctors would welcome the opportunity to keep in touch and participate in the hospital care of patients, on a part time basis. This can take the form of attendance at Out Patients sessions of some particular speciality. This form of Family Doctor participation in Hospital care, I believe, would be beneficial to the Family Doctor and Consultant alike since

1 It is one way for the Family Doctor to keep *au courant* with Hospital Medicine
2 It bridges the sometimes diverging paths taken by hospital medicine and general practice. Because of the direct and personal interchange that constantly takes place between the Family Doctor and consultant, the right milieu is created to help iron out lingering prejudices, cooperation is enhanced and mutual understanding of each other's problems is fostered.

Maybe the possibility of such participation is explored in a more serious manner in the near future by the parties concerned.

Family Doctor-Patient-Consultant Relationship

By this I am mainly referring to the way the patient understands or perceives the role of the Family Doctor and Consultant. I believe that the present local medical and paramedical scene sometimes leaves the patient in a wilderness of confused indecision. I sense a lack of direction in people's ideas of good medical care. Roles are confused and in this maelstrom of misconceptions are caught the Family Doctor and the consultant. To whom does a patient with a painful knee refer himself, directly to hospital, to his GP, to a bone specialist, to a physiotherapist, to an acupuncture clinic or to a faith healer? How does a doctor be it a GP or consultant react to the oft requested 'good check up'? While a lot can be done to educate the people through the media the Family Doctor and Consultant are in a prime position to do their part of education provided each keeps to his role.

Patients go to their Family Doctor either because they fear that they may have a disease, in which case reassuring is what is needed, or because they actually have a disease when they expect to be treated quickly, efficiently, and certainly with the least hassle and at home or near their home.

However these two functions can be achieved ONLY if the Family Doctor is seen by the patient to be clinically competent and to have the authority to reassure. If the patient does not fully trust his doctor he frequently finds himself looking over his shoulder for further investigations or a second opinion.

After all, Consultants find themselves in a similar position. They depend on their clinical skills and appropriate selection of patients and so they need competent and reliable family doctors in the community who refer appropriately and not just to get rid of problem patients. Understandably, consultants resent diluting their specialist experience with cases that can easily be dealt with by the Family Doctor. An important achievement of specialist medicine is the shortening of hospital admission times, but early discharge depends on the consultants being able to refer the patient to a competent Family Doctor. Day care surgery depends on a good domiciliary service.

To complete the triangle, like they say that GP's get the patients they deserve, also perhaps Consultants get the GP's they deserve.

Social Encounters

I still remember, from my Lyceum days, an over-enthusiastic Religion teacher who in his zeal claimed that one can convert a person to Christianity over a cup of tea. In our context it is more like 'in vino veritas'.

> *Surgeon and apothecary. Prescriptions and family medicines accurately compounded. Teeth extracted at one shilling each. Women attended in labour, two shillings and sixpence each . Patent medicines and perfumery. Best London pickles. Fish sauces. Bear's grease. Soda water. Ginger beer. Lemonade. Congreve's matches and Warren's blackening.*
>
> **Notice over an apothecary's shop in Manchester in 1940's.**

Family Doctor/Consultant Roles

We can look back with complacency at this blurring of the boundary between medicine and grocery. This chap was extracting teeth and delivering babies and selling London pickles and lemonade etc. But I feel that sometimes we doctors, by our pattern of work, do blur our roles of Family Doctors and Consultant's.

Underlying all these encounters between the Family Doctor and Consultant that determine the nature of the relationship is the role that both doctors play in caring for the patient.

The basic features of Primary Medical Care or General Practice are essentially first contact and continuing care of individuals and families over long periods of time: whereas the consultant's is organised to provide short term episodic care often in artificial communities. The Family Doctor is involved with whole-person relationship developed within a formative society. He is often faced with an undiagnosed and unselected mass of health problems which are brought to him when the patient considers it necessary to consult him. The hospital consultant deals more with highly selected and biased case material which has been pre-sorted and pre-diagnosed by the GP.

In many health care systems, access of the patient to the consultant is by referral from the Family Doctor. In Malta it often does not work that way and one main barrier of choice between the Family Doctor and the consultant is a pecuniary one. Should the situation remain like this or should there be a better delineation of roles. Certainly a complete demarcation of roles and function is impractical and undesirable but should the paediatrician dilute his skills and see the stuff that the Family Doctor should be dealing with and vice versa? How far should the Family Doctor embark in taking on the full management of difficult cases? With the easy availability of investigative means at the desk top the temptation is greater: but if we Family Doctors keep in mind that family practice is not the sum of a series of specialities practiced at a superficial level we avoid the trap of acting as consultants ourselves.

I STRONGLY BELIEVE THE FAMILY DOCTOR CANNOT BE A FAMILY DOCTOR AND A SPECIALIST SIMULTANEOUSLY AND CONSULTANTS SHOULD NOT ADOPT A FAMILY DOCTOR PATTERN OF WORK. To summarise the Family Doctor/ Consultant relationship should be one of mutual respect and understanding based on the role and competence in one's field. Nourished by frequent exchanges of information and close working relationships and last but not least on the appreciation of the fact that we are destined to work together for the good of the patient for the rest of our active medical life. ◆

References:

Dr. Gillian Rice – Understanding Doctors –Getting the Best Health Care. (Michael Joseph. 1990)

Merton et al (1957) The Student Physician

Becker et al (1961) Boys in White – Student culture in Medical School

Fox R (1957) Training for Uncertainty

Stanley Ian. The Practitioner: August 1987 p.1051

John Fry. General Practice International (1977) 6.2. 83-86.

Dowson S. Maynard A. (1985) General Practice

McLean A.L.J. BMJ July '87; What makes a good consultant?

M. Keith Thompson. Journal of the Royal Society of Medicine. "Not the Mackenzie Lecture". Dec. 86.

Cammock D.W. Lee F.H. (1966) Dual Care. Lancet 1 . 482-483.

Loudon I.S.L. (1976) A question of numbers. Lancet 1 736-737.

D.J. Pereira Gray. Just a G.P. Journal of the Royal College of General Practitioners (JRCGP) Apr. 1980

Higgins. P.M. (1979) The GP/ Hospital Interface. Journal of the Royal College of Physicians of London. 13 No 3. 132-138

Horder J.P. (1977) Physicians and Family Doctors. A New Relationship. JRCGP 29. 24-32.

Rosenberg C.L. (1975) How much general practice by specialists? Medical Economics 52. 131-5.

John P. Geyman Family Medicine as an Academic Discipline. The Journal of Family Practice. Sept. '90.

Draper P. Smits HL: The primary-care practitioner- specialist or jack of all trades. N. Engl. J. Med. 1975: 293; 903-907.

cpd

MANAGEMENT OF HYPERLIPIDAEMIA — A PROTOCOL

EDWIN E. J. MARTIN

A protocol is an agreed method of dealing with a process that relates to medicine which is written down, worked to by a group of people and which is regularly reviewed.

1. One needs a protocol to ensure consistent management between doctors;

2. One also needs a protocol to guide fellow paramedics about what one needs them to do.

3. A further reason to have a protocol is that if one is working as a team say in the care of diabetics, if everybody involved in the care — the specialist, the GP, the nurse and the health educator have all been involved in the drawing up of the protocol they will all feel committed to it and they will all know what other members of the team are doing.

4. Having drawn up a protocol, one can then assess what skills are needed by every-body involved in the care. If needed, further education can be given if anybody involved lacks the necessary skills.

5. If one has a protocol, one has defined exactly what one is aiming to do and if good records are kept after a few months one can go back and assess whether one has kept to one's protocol and what standard of care has been given to the patients. This is practice audit.

TYPES OF PROTOCOL

In general, in family medicine, there are two types of protocol:

1. **Operational protocols**: These govern the way in which patients are able to contact the doctor, the way in which medical care is delivered and the management and finance of the practice.

2. **Clinical protocols** cover the principles for management of specificdiseases. As an example of a clinical protocol I would like to offer our protocol for the management of hyperlipidaemia. It is based on an outline protocol produced by the British Heart Foundation. ◆

---

1 Management of elevated blood lipids will only be carried out in the context of an integrated strategy for CHD risk factor management. Thus in every patient an enquiry will be made about smoking, alcohol intake and exercise. Family history will be recorded and blood pressure and weight will be measured. Action will be taken concerning these factors at the same time as managing lipid levels.

---

2 Every patient on the list will be offered a general health check every 3 years. As part of this test a lipid measurement will be carried out. In Bedford we do not have the facility to measure lipid fractions so total cholesterol measurements are used. We accept that triglycerides are rarely independent risk factors for CHD.

---

3 Patients with cholesterol less than 5.2 mmol/litre (40% of the population in the UK) will be reassured, but encouraged to maintain an ideal body weight. Any other CHD risk factors will be dealt with i.e.smoking, high alcohol intake, poor diet.

---

4 Where patients have total cholesterol 5.2-6.5 mmol/litre they are referred to the practice dietician for a low total and saturated fat diet with an increased percentage of unsaturated fat. They are encouraged to attain an ideal body weight and any other risk factors are dealt with.

5 Where patients have a total cholesterol of 6.5-7.8 mmol/litre this requires more specific and vigorous lipid lowering dietary advice. The dietician will follow these patients up every 2 months. Where other risk factors are present and where lipid levels do not fall with diet and loss of weight, lipid lowering drugs are sometimes considered. With serum cholesterol over 6.5 mmol/litre the patients' families are screened.

6 Lipid levels of more than 7.8 mmol/litre requires special attention particularly in males, postmenopausal women and those with other risk factors. Such problems as diabetes, hypothyroidism and alcohol abuse are excluded. Failure of dietary advice to lower lipid levels after 3 months indicates drug treatment.

7 At all levels of serum cholesterol dietary advice and weight reduction is always the first treatment. In many cases it will be all that is required.

8 Drug treatment if necessary is started with a resin. If triglycerides are also high a fibrate with or without a resin is used. The statins are very effective but their long term safety has not been proven so we use them as third line drugs.

9 In all cases patients under dietary or other treatments will be given booklets and the nature of their problem will be repeatedly discussed with them.

10 The aim is to reduce the cholesterol levels of patients under 55 to below 6.5 mmol/litre and those over 55 to below 7.00 mmol/litre. Ideally patient's cholesterol should be reduced to below 5.5 mmol/litre but this is not always possible.

11 Every year the list of patients whose cholesterol was over 6.5 mmol/litre and who are under treatment will be considered. Any patients who have not been seen and reviewed within the year are recalled.

12 The doctor will work closely with the dietician and the health screening nurse and have regular meetings with these colleagues to ensure that advice given to patients does not differ according to whom they see.

13 When lipid levels have been controlled patients will be reviewed twice a year.

14 When lipid levels cannot be controlled, or when there is evidence of accelerated arteriosclerosis the patients are referred to a specialist colleague.

15 Every 2 years the patients with hyperlipidaemia will be audited and the following will be measured

a The number not reviewed within 1 year
b The average level of cholesterol at which dietary advice is given
c The average level of cholesterol at which drug treatment is started
d How many patients are in which drugs
e The average fall in cholesterol on dietary treatment
f The average fall in cholesterol on drug treatment
g How many patients have not had other CHD risk factors addressed

A plan will then be made for the next 2 years.

"We may praise communication, but in the human species non-communication might seem to be the more striking feature of our way."

Robert Ardley (1970)

We know this to be true politically, in unhappy marriages and in many other spheres of life. However there is evidence that this is just as true in the medical setting as it is in ordinary life. The area of medicine where we communicate or try and communicate with our patients is the consultation.

Spence in 1960 wrote "The essential unit of medical practice is the occasion when in the intimacy of the consulting room or sick room a person who is ill or believes himself to be ill seeks the advice of a doctor whom he trusts. This is the consultation and all else in the practice of medicine derives from it."

So if the consultation lies right at the heart of all that we are trying to do as doctors it is right that we look at it, analyse it, study where we fail in it and try and do it better.

There are several ways in which we can look at the consultation — several models which we can use to analyse it. First of all there is the medical model.

MEDICAL MODEL

In this model we see a patient bringing in

1. **A complaint**
   This complaint is then considered to elucidate it.
2. **An investigation takes place.**
   Following the investigation and due consideration
3. **A diagnosis is made** — we have decided what is going on
   Having decided what the diagnosis is —
4. **A prognosis is made** — we decide what the outcome is likely to be for this problem. Finally, having decided what the problem and the likely outcome are —
5. **An intervention is planned** either to remove the cause of the problem or at least to minimise the effects of the problem.

Now I doubt if anybody will challenge the fact that this pattern has some validity or that it describes what goes on in many consultations. However this description of the consultation is really of little practical use because although it describes what is going on it does not give any indication of how it happens. It is rather like talking about making a cake and saying that one buys the ingredients, mixes them up, bakes the cake and puts it in a tin — all true but one is none the wiser about how to make a cake.

PROBLEM-SOLVING MODEL

In this model of the consultation:

- A **problem** is presented.
- The patient, or whoever is presenting the problem makes a **statement** about what is troubling them.
- The doctor then **clarifies** what is going on and makes sure that all the information is fully understood.
- The problem is then **defined** and agreed between the patient and the doctor. Having defined the problem, **solutions** are then considered. Usually a range of solutions are **generated** i.e. for a tennis elbow: you could just wait for it to get better; you could rest the arm; or you could have an injection of methylprednisolone and lignocaine into the extensor tendon insertion. Having generated the possible solutions, the doctor and patient need to **clarify** what is involved in each and finally a **selection** is made of which solution will be tried.

This model is a little bit more than the previous one because at least it does define some of the tasks to be carried out to complete the stages of the consultation which we described in the first model. However even this model is very mechanistic and does not say anything about the interaction between two people, the doctor and the patient, both of whom are individuals with their own personalities and life experiences. Thus the consultation is a social as well as a medical encounter.

SOCIAL MODEL

Now there are certain rules of social encounters whether they take place in the setting of ordinary life, or in the setting of a medical consultation.

In any **encounter** there is an **ostensible reason** for the contact between two people.

The ostensible reason provides an **acceptable context** which allows a **social transaction** to take place. The acceptable content provides most of the **overt content** of the meeting. There is also a **covert content** which stems from the **expectations** of the two people concerned and reflects their **role perception** and their personalities and attitudes.

Now all of that may sound like doubledutch and may seem totally unrelated to the medical consultation. However I would like to put that concept first of all into

the context of the traditional Hollywood setting of boy meets girl at a dance, then into the setting of a medical practice.

First of all then, the dance.

A boy and a girl separately go to a dance. The boy likes the look of the girl, so goes up to her and says "Is the seat beside you free?" — he can already see it is free, but he is establishing an **encounter.** The **ostensible reason** for the encounter is that the boy wants to sit down. The **acceptable or overt content** of the encounter may then continue by the boy talking to the girl about how good or bad the band is. All the time there is **covert content to** the encounter involving thoughts such as "Does she like me?" "Will she dance with me?": this covert content stems from the **expectations** of the boy and the girl, for instance, they may be confident that at such encounters they usually can make girls (or boys) like them. Who eventually asks whom to dance depends on the **role perceptions** of the boy and the girl. In America it might well be the girl, in Italy it would rarely be so.

In the Medical Setting

When a patient goes to see a doctor, he or she establishes an **encounter** with an **acceptable content** for instance: "I have a sore throat". However the patient may have a **covert content** to his consultation. This may vary from "I want antibiotics for this complaint whatever the doctor believes about the treatment of sore throats" to " I am sad and lonely and I want this powerful figure, the doctor, to respect me and give me lots of sympathy". Whether this covert or hidden part of the consultation comes into the open or not depends partly on the **expectations** of the two parties of the consultation and partly on the **role perceptions** of the two people.

It is these last two factors, expectations and role perceptions, within the consultation that I would like to consider now. To the extent that we are familiar with a role, we each have expectations of the person who fills that role. So as the patient gets to know a doctor he or she likes to know what role that doctor likes to play. If the doctor likes to play the role of the dominating professional, the patient will have few expectations that he will be able to discuss with the doctor why he should do what the doctor suggests. Much of the underlying worries of that patient will never surface and his covert concerns and problems will not be brought to the doctor's notice. Instead they will probably frequently be presented as physical ailments. However if the doctor takes a more flexible role the patient may be able to discuss the covert as well as the overt reason for his encounter with the doctor and develop enough confidence to manage his own minor illnesses and anxieties.

Relationship Model

So the social factors which we have discussed vary the way that the doctor and the patient interact. These differences in relationships affect the progress of the consultation.

Szaz and Hollender 1956 recognised three sorts of relationships between patients and doctors:

1. Active/Passive or Authoritarian

In this case, the doctor obtains information from a largely passive patient. He then makes a decision about what should be done — the doctor generates the solutions and the patient is expected to carry them out. This may be a relevant model for certain life-threatening conditions but with other conditions, the solutions are doctor-generated and the patient may well not feel committed to them. There is no real reason why the patient should carry them out. Doctors who practice in this way often complain about ignorant and rude patients without realising that the reason why patients don;'t carry out their instructions is that they have not been themselves involved in working out the solutions to their own problems.

2. Guidance/Cooperation

This second style of consultation is where the doctor acts as guide to the patient. The doctor is still in the dominant role, but rather than acting as a dictator he collects information, makes a decision then persuades the patient about his view of the problem and about his view of a solution. Rather than demanding obedience from the patient, the doctor tries to persuade the patient to accept the doctor's view of the situation.

3. Counselling

In this third style of consulting, the doctor tries to get the patient to define the nature of their own problem using the doctor only as an information resource. The patient is then encouraged to define the options for resolving the problem, again using the doctor as an information resource. Once having decided what they are going to do in this sort of consultation, on the whole patients feel that the solution reached is theirs and they are committed to it and compliance with treatment is usually very good. However this sort of consultation is much more difficult for the doctor to carry out. It is much easier for us to define a way out of a problem as we see it and then impose this on the patient than it is for us to help the patients find their own way out of their problems, simply giving them the information with which to make their decisions. Many doctors reject this way by saying that patients are too stupid, ignorant or dependent to make up their own minds when really these doctors mean that they, the doctors, are too rigid to learn this style of consulting.

Mediums of Communication

So far we have looked at patterns of communication in the consultation. We have not looked at the actual mediums of communication within the consultation.

1 Verbal communication

The easiest form of communication is verbal communication. Words convey meaning. However even with verbal communication there are ways of transmitting messages other than by words, for instance:

a) Tone of voice can indicate depression, elation, shyness, aggression etc. and many other things.
b) The language used i.e. formal language or slang can indicate what role the patient perceives the doctor to be taking.
c) The cadence of the speech i.e. the stumbling speech of the shy person with a poor self image or the slurred speech of the drunk or the person with CVA can tell a lot about what is going on in a particular patient.

2 Non-verbal communication

This is possibly the most powerful form of communication. There are people who say that 60% of all communication is non verbal. Quite apart from the obvious forms of non verbal communication such as the patient who breaks down in tears, or who thumps the desk, the slumped immobility of the severe depressive, the stiff posture of the person with the bad back and the restlessness of the patient who has not yet plucked up the courage to tell you what they have really come to see you about tells you more than many words.

So far we have considered various models of the consultation and the mediums of communication within the consultation. I would now like to consider what the pattern of the consultation should be and what tasks have to be carried out in a consultation.

Pattern of a Consultation

What then should be the pattern of a consultation? What is the broad spectrum of what should go on in each consultation? Stott and Davis have claimed that four main tasks should be carried out in each consultation. These tasks are as follows:

1 The presenting problem should be addressed with the patient and dealt with.
2 Every meeting with the patient is an opportunity to continue the management of what patient's long term problems. For instance if a patient comes in with an itchy scalp and you know that they are an asthmatic it is important that you also enquire about the patient's symptoms of asthma, check their inhaler techniques and do a peak flow estimation as well as dealing with the itchy scalp.
3 Every consultation with a patient for whatever reason is an opportunity to practice opportunistic health promotion. A patient comes in with tinea pedis. As well as dealing with their presenting problem one should ask form other things. Are they a smoker, are they overweight, what is their alcohol intake? If one doesn't know it is important to enquire and to give any necessary advice and help.
4 Finally when a patient consults it is important to consider whether they are using the health service intelligently. Do they think that we can cure colds and flu? Do they need some help with managing their own minor illness by themselves without using us? Some gentle advice and education may give them the confidence to take responsibility for their own health and change their help seeking behaviour.

We have seen then that the consultation is not a simple procedure but a very complicated process right at the heart of our professional life. So what tasks do we have to carry out within the consultation?

Consultation Tasks

1 Create the right atmosphere to establish rapport
2 Encourage the patient to volunteer information and feel involved in his own care
3 Tolerate emotionally disturbing things which this patient may say
4 Interview the patient logically and systematically
5 Use a style which is appropriate to each patient at each stage of the interview
6 Recognise when a consultation is going wrong and make appropriate adjustments
7 Avoid medical jargon and explain the meaning of medical terms
8 Understand and use non-verbal communication
9 Right at the heart of the consultation come to a joint decision about diagnosis and solutions with the patient.

To carry out these tasks we need to be able to do several things-

1 Ask open ended questions
2 At times ask focussed questions
3 Clarify inconsistencies in what patients say
4 Define the meaning of what a patient is saying- this may involve bringing out covert or hidden meanings.
5 Summarise what patients have said
6 Notice non verbal clues that patients give us
7 We need to be able to listen to what the patient is saying, not what we want them to say
8 Remember what has been said and heard

9 When a patient is rambling we need to be able to interrupt them and bring them back on course.

10 We need to enable patients to say things they are shy or scared of saying

11 We finally need to challenge patients when they are practising denial. i.e. the wife who will not face to the fact that her husband is dying.

In Conclusion

It would seem that we need to be supermen and women to be skilful at consultation. This of course is nonsense. Many of the skills we use in consultation we also use in our ordinary social lives. However where we are using these professionally we have to identify them, develop them and learn any that we are not good at. Skill in consultation is the first hurdle in a medical man or women's life. If we have not jumped this hurdle really we have not started to practice high quality medicine however long we have been qualified. I have not considered the continuing nature of family medicine consultations. I have not considered the outcomes of consultations, nor have I considered 101 other aspects of consultations. However you have given me one of the largest subjects in medicine to speak on and I hope you will excuse me in being selective. ◆

Evaluation of the Winter and Spring CPD Meetings

Hugo Agius-Muscat

The response to the second and third CPD meetings organised by the College was even more encouraging than the response to the first. On average, over 50 evaluation forms were returned after each session; these were a good source of feedback from Members. On Day 1 of the Winter Meeting, Dr Cacciottolo's contribution on the Family Doctor/ Consultant relationship was received particularly well. On Day 2, Dr Sarah Portelli's talk on paediatric screening was rated very highly. The speakers on Day 3 (The Family Doctor's Health/Welfare/ Local Scene) were uniformly appreciated. Moving to the Spring Meeting, the feature on Day 1 concerning Consultation Skills went down especially well. On Day 2, Prof Fenech's talk on the management of myocardial infarction received much favourable comment, while on Day 3, Dr Martin's talk on protocols was very well rated. In all the six seminars, the vast majority of Members agreed that the Seminar was relevant, that it increased their knowledge/awareness of issues, and that their patient care would be modified as a result of the seminar. Several constructive comments have been received, all of which are being considered by the Council. ◆

MCFD Autumn CPD Meeting

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

Wednesday, October 16th, 1991

1. **Drugs in Pregnancy**
   M. Brincat
2. **Obstetrics and Gynaecology in Family Practice**
   G. Vella

Thursday, October 17th, 1991

1. **Death Certification**
   H. Agius-Muscat
2. **Bereavement — The Doctor's Role**
   P. Muscat

Friday, October 18th, 1991

1. **Problem Patients in Family Practice**
   E. Martin
2. **Community Services & Private Practice**
   M. A. Borg

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

Accreditation for Research

College Members are reminded that they may be awarded up to ten accreditation points a year for carrying out research that is relevant to General Practice. Until the end of 1991, the College Council will consider research that is currently under way or has been completed this year. From 1992, Members will be required to submit their research protocol in advance to the Council in order to be considered for accreditation. If a Member requires help in the preparation of a research protocol, the Council, through the Research Subcommittee, is ready to offer its advice.

Thanks to Janssen Pharmaceuticals,
represented in Malta by
Vivian Commercial Corporation Ltd.
for providing the College with a subscription to Medicine Digest and Medicine International.

'Doctor of Your Own Choice'

As you might have heard, a document entitled 'Family Doctor Scheme' as proposed by the Ministry for Social Policy was officially handed to representatives of the medical profession. Joint MAM and UGMD discussions have started with representatives of the Ministry early in June.

It is evident from this 82 page document that the Malta College of Family Doctors has a leading role in monitoring the quality of care and in enhancing continued professional development of family doctors.

This report nominates one person from the M.C.F.D. to sit in the Family Doctor Scheme Council, an autonomous body responsible for the overall management of the scheme. Moreover, the Council acting on the advice of the M.C.F.D. together with the Postgraduate Medical Committee will accredit a minimum number of hours of postgraduate meetings, courses or lectures in claim for the Continuing Medical Education Allowance.

The report also envisages a Good Practice Allowance as an incentive for excellency in one's work. The accrediting panel consisting of three members will again include a nominee of the College together with a representative of the council and the Institute of Health Care of the University.

These major representatives of the College within the scheme undoubtedly further strengthen its academic position and evidently increase doctor representation in the workings of the Family Doctor Scheme Council.

This column augurs that the claims put forward by the doctor colleagues representing us are listened to and implemented by the Ministry.

Call for Speakers

MCFD Winter CPD Meeting: The 3-day Winter meeting is a free-standing seminar. Any doctor or group of doctors interested in leading a conference on any new theme for discussion may contact any member of the College Council or phone 465359. All those interested are asked to submit their notice by September. Remember, under the accreditation scheme, leading a discussion at a CPD activity attracts 5 credit units.

Thanks to the sole sponsor of this issue of our Journal:
The College would like to thank the following for their support through a financial donation:
Pharmasud Ltd,
agents for Scandrug and Ratiopharm

it-tabib tal-familja

Journal of the Malta College of Family Doctors
P.O. Box 70
Paola
MALTA

TO:

Dr Sammut Mario R. MD
'Santa Marija'
Triq Salvu Curso,
Siggiewi.

NEWSPAPER POST