NEWSPAPER POST

JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

ISSUE NO. 4 JUNE 1993

EDITORIAL

It is my pleasure as the new editor to welcome members of the College to the first issue of "It-Tabib tal-Familja" for 1993. I hope to follow in the footsteps of my predecessor whilst at the same time improving the journal's image and content. I therefore welcome comments and constructive criticism, and solicit more contributions from members to allow this aim to be achieved.

I have been asked to remind all members to settle membership fees due at the earliest, as those who have not paid their fee shall not be eligible to contest or vote in the forthcoming College elections. Members who have not returned their 1992 accreditation logs are urged to do so promptly so as to facilitate the updating of relative records.

In conclusion, I refer readers to the College news *(page 23)* and ask those of you who have not responded to the Lombard Bank questionnaire to do so soon.

Jean Karl Soler.

CONTINUING PROFESSIONAL DEVELOPMENT — 1993 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**

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Design and Typesetting: *a·r·t·w·o·r·k·s (411885)*

"And you shall know the truth, and the truth shall make you free." (John 8:32)

One of the dilemmas that any practitioner attending a seriously sick/terminally ill patient experiences is whether he should tell the patient all the truth about the seriousness of his illness or not.

For physicians throughout the ages, one of the weightiest questions has centred on their responsibility in informing a dying patient about the seriousness of his condition.

There is no one universal formula which can be applied in all instances. Contrary to much of the doctor's work, there is no routine he can fall back on. Rather his experience will guide him in determining what a particular patient's needs are.

The doctor as an expert, is expected to provide thorough information by explaining to the patient the diagnosis, the prognosis and the treatment options, and this goes beyond giving out simple information. In this manner the doctor is creating the basis of autonomy for the patient, the ability to make informed choices as finally the patient has a sacrosanct right to actively participate in the management of his health. I personally always have serious doubts as to what "free" really means and whether the patient would rather be free in that sense.

In this regard there are two major philosophical schools of thought:

1. Utilitarian – for whom the overriding moral principle is to maximise welfare and minimise harm; however the principle of respect for autonomy is still a crucial moral one.

2. Kantian – who believe that respect for people and their autonomy is itself the overriding moral principle.

AGAINST TELLING PATIENTS THE TRUTH

One of the main reasons given by those who advocate this attitude to a patient with serious or fatal disease. It is also generally thought that a seriously ill patient is not psychologically equipped to receive news of a certain nature.

Truth telling goes far beyond providing mere information. Truth is not just the opposite of a lie, not just the sum of correct statements; it is a reciprocal state in the doctor-patient relationship which is established on the basis of mutual responsibilities.

In this context failing to respect patients' autonomy by denying them adequate information for rational deliberation amounts to "deception".

The case for "deception" of patients is usually based on 3 major arguments elegantly dissected among others, by Sissela Bok in her book "Lying".

1) The first argument in favour of deception is that doctors' Hippocratic obligations to benefit (principle of beneficence) and not harm (non-maleficence) their patients override any requirement of not deceiving people. People with serious illness are already distressed and the doctor may aggravate their condition by giving them distressing news; their prospects of recovery which very often depend on their morale and some placebo effect the doctor's attention has on the patient may be hindered.

2) The second argument in favour of not telling the truth is that it cannot really be communicated, both because a doctor is rarely sure of the prognosis and also because the patient is very rarely educated and informed well enough to fully comprehend the wide range of technical nuances divulged by the doctor.

Another view is that patients can never acquire enough knowledge to enable them to fully and appropriately participate, distant figure exercising unilateral decisions on the basis of knowledge that is assumed incommunicable. There is a tendency on the part of the doctor to adopt a paternalistic attitude and dictate what, to their mind is best for the patient.

3) The third argument against telling the truth is that patients do not wish to be told the truth when it is dire, particularly when they have a dangerous or fatal condition.

This is an important argument as it implicitly presupposes that doctors ought to respect their patients' wishes.

FOR TELLING PATIENTS THE TRUTH

1) Deception is morally unacceptable unless there is strong reason to believe that in a particular case overall welfare would be maximised be deception. Furthermore, honesty and frankness on the part of the doctor generates a stronger doctor-patient bond and this in turn can only increase the patient's welfare. Medical paternalism should not take over as patients are probably in a position to judge whether knowing the truth about unpleasant facts would or would not improve their welfare.

Doctors can master this difficult medical art by offering to answer questions and giving adequate time for this. There is probably no other instance in one's life which requires so much of a doctor's time; and a good doctor will know how much time and attention a particular patient requires. Denial by patients of serious problems is a natural defence mechanism which could indicate to doctors what, when and how much to divulge to a particular patient.

2) Impossibility of communicating the truth. Truth is beset with epistemological, logical and semantic problems and these 3 issues are of central importance in philosophy. What exactly constitutes the truth? Can anyone opining a personal opinion, often based on empirical data, tell the whole truth? Communication skills vary from person to person, so is it always possible to communicate the truth? Truth implies that the information passed on to the patient reflects exactly a particular state of affairs, but how sure can a doctor be that he is presenting a true picture of the patient's condition?

In actual fact the problems mentioned above have little to do with the question of what to do with such knowledge as finally the crucial moral question is "What are the doctor's intentions?" In particular does the doctor intend to discover what the patient would wish to know and try to meet such wishes when they concern the transmission of information he believes to be both true and distressing to the patient, or does he intend to deceive the patient?

3) Patients' wish not to know. Various studies indicate a varying proportion of patients who want to know the truth and an equally varying number of doctors who are prepared to tell patients all the truth. So rather than generalise one must consider what a particular patient wishes in the circumstances. Quite commonly too, relatives try to persuade the doctor not to tell the patient the truth and a ritual usually ensues composed of sotto voce conversations between the doctor and the patient's relatives, usually outside the patient's room: "Doctor, don't speak too loudly".

Doctors should heed what relatives have to say but must, in the end make some judicious decisions regarding what to tell the patient as finally the relatives' wishes may not reflect those of the patient.

4) Patients may have vitally important duties e.g. that they could carry out only if they were given such information. This could e.g. take the form of settling outstanding accounts, making a last will or finding final spiritual solace. Real harm rarely results from honesty in response to patients who want reliable information about their condition.

In America it is an ethical duty of doctors to provide patients with essential information. Truth telling and respect for autonomy have become virtual moral absolutes in that country.

In Italy the Italian Deontology Code written by the Italian Medical Association used to include the following statement:

"A serious or lethal prognosis can be hidden from the patient, but not from the family". It was revised in 1989 to read as follows: "The physician has the duty to provide the patient – according to his cultural level and abilities to understand – the most serene information about the diagnosis, the prognosis and the therapeutic perspectives and their consequences; in the awareness of the limits of medical knowledge, in the respect of the person's rights, to foster the best compliance to the therapeutic proposals. Each question asked by the patient has to be accepted and answered clearly. The physician might evaluate, specifically in relationship with the patient's reactions, the opportunity not to reveal to the patient or to mitigate a serious or lethal prognosis. In this case it will have to be communicated to the family. In any event, the patient's will, freely expressed, should represent for the physician an element to which he will inspire his behaviour".

In Spain a study among health workers showed that 71% would want to know the diagnosis should they suffer from cancer in the future. Apparently there is a phenomenon, which owes its roots to cultural traditions, a so called cancer taboo which is not conducive to a mandatory uniform disclosure of the true diagnosis at present.

A study from Greece showed that the answer to the straightforward question "Do the Greeks wish to be informed of the nature of their illness?" was a no qualified by a cautious "It depends". Factors determining willingness or otherwise for receiving such information, included age, education, family status, occupation and whether a person was deeply religious or not. Males and females were equally divided in their opinion. The author highlights the importance of good communication between doctors and patients and concludes that doctors should not lie, but should disclose to their patients the part of the truth they are ready to accept.

What is the situation in Malta? It appears that there are no official guidelines on the subject of truth telling. There is however, no doubt that doctors in Malta would welcome, and probably benefit from some form of guideline issued by a competent body. In view of the fact that to date neither the Medical Council nor the Medical Association of Malta have tackled the problem may I take this opportunity to urge the College to put this subject on its agenda as it is very often the family doctor who coordinates terminal care and the

person charged with divulging information to seriously sick patients.

Is medical ethics a cultural artefact such that a universal medical ethic is not possible?

I must stress that I believe ethics are inevitably connected to cultural values and therefore vary in different societies. What may be considered beneficial in one country may seem maleficent in another. This contrast in moral perspectives requires an implicit understanding of the dichotomy between believing in absolute values and respecting the pluralism of different cultures.

The situation everywhere is evolving rapidly, with malpractice lawsuits in other countries increasing and public scepticism of physicians on the rise.

For now, when I deal with seriously ill patients, I try to tell them the complete truth. But there are times when this is not easy. In all instances I make an effort to listen to them and respect their need for information. Since I believe that the suffering person knows the truth, I think the only way to respect all ethical principles is to let the patient know that there are no barriers to communication and the truth.

I don't think that Maltese society should borrow the American, English or Italian way but it should learn from all these to perhaps, find a better Maltese way. I will endeavour, along with other medical colleagues to contribute towards a positive change in our society.

"IN MUCH WISDOM IS MUCH GRIEF; AND HE THAT INCREASETH KNOWLEDGE INCREASETH SORROW" (Ecclesiastes i, 18)

How true this must be, especially when the patient happens to be a doctor.

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COMPUTERS IN GENERAL PRACTISE

HUGO AGIUS MUSCAT

This is a brief overview of personal computing as it affects the Maltese GP of the 1990s.

INTRODUCTION.

Computers have become ubiquitous in today's world. Computers are important, sometimes essential, tools for the handling of information. They are useful because they accept and store large volumes of data in a structured manner; these data can be manipulated, sorted and retrieved accurately, rapidly and consistently. However, a Health Warning is in order: the benefits of computerisation only accrue if you have the right computer and program for the task at hand, and if you feed the computer properly!

Persons convinced of the usefulness of computers often ask: "What computer should I buy?". The correct reply to this remains: "What exactly do you want a computer for?".

You should:

1. Determine the job to be done,
2. Find a program that does exactly the job,
3. Buy a computer that runs the program that does the job.

Having said this, what uses does a GP have for a computer?

- Like everyone else, a GP may simply need the computer for general data processing e.g. word processing, databases.
- A GP may also wish to computerize his/her clinical records, or other specific functions within his/her practice.

SPECIAL USES FOR COMPUTERS

Specific areas for which computers have already been used in general practice include the following:

- ❑ Patient registration (age/sex register)
- ❑ Repeat prescriptions
- ❑ Immunisation/screening call and recall
- ❑ Surveillance records (eg hypertension, diabetes)
- ❑ Protocols for history / diagnosis / management
- ❑ Opportunistic screening
- ❑ Drug interactions monitoring
- ❑ Automation of referral letters
- ❑ Pathology records
- ❑ Patient literature / instructions
- ❑ Educational / CPD packages
- ❑ Research / audit
- ❑ Communication with (to/from) remote databases:
  - ❒ hospital departments
  - ❒ Primary care centres
  - ❒ Libraries / research centres

THE DESIRABLE ATTRIBUTES OF A GP INFORMATION SYSTEM

When considering the computerisation of various facets of general practice, we would do well to consider the desirable attributes of a GP information system, as compiled by the Royal College of Practitioners of the UK in 1980, and which are still perfectly valid today:

1. The information system must be readily acceptable by doctors so as to facilitate and encourage the provision of a high standard of patient care.

a. The system should assist the primary care team to apply good community medicine to the practice population. To do this it is desirable to identify groups of patients at risk, so that health education, screening, immunisation, and other techniques of preventive medicine can be economically applied. For this purpose the team will require, for example, lists of patients of particular age ranges and sex; with particular illnesses; those undergoing treatment with particular drugs; or any combination of these specifications.

b. It should be so structured that it prompts the doctor to undertake or avoid particular actions that he might otherwise overlook. This is especially important in the long-term surveillance of chronic illnesses, in preventive medicine, and in the avoidance of drug interactions and allergies.

c. The record should remind the doctor at the time of the consultation of up-to-date practice in the diagnosis, treatment and management, relevant to the patient's needs.

d. The system should provide a record of clinical material structured in a form which can be used for undergraduate, vocational, and postgraduate teaching, including self-assessment by the doctor.

2. The records must be stored in a manner which fully satisfies the demands for confidentiality.

3. The method of storage and transmission of the record must ensure that there is negligible risk of losing it temporarily or permanently.

4. The contents of the record must be readily accessible, legible, and easily updated by a doctor working under pressure.

5. It must be possible to remove redundant information and, if desirable, to summarize it quickly and easily during normal use of the record.

6. The system must be of adequate capacity for the storage of a lifetime record of relevant information for every patient.

7. The whole or appropriate parts of the record should normally be easily available whenever required.

8. With the total exclusion of any patient identification particulars, the system should be capable of providing accurate data for health service management at district, area, regional, and national levels.

9. Similarly, the system should facilitate clinical and organisational research.

10. A record must be rapidly and securely transferable when a patient registers with a new doctor. There must be no possible access to the clinical data during the transfer process.

11. The record system should assist practice management, including the most economical and effective deployment of staff. This would require the monitoring of variations in worload, and the efficiency of the appointment system. Financial management should be facilitated, including stock control, payment of salaries, and other expenditure, and the calculation of the optimal relationship of working capital, cash flow, and profitability. Maximum income must be ensured with a quick and accurate submission of claims for payment of fees and allowable reimbursement of costs.

12. The system must be capable of adaptation to provide new functions.

13. It must be capable of use throughout the National Health Service, including linkage with systems used by family practitioner committees.

THE USER INTERFACE

If a particular program seems to suit your needs, it is a good idea to go through the following checklist in order to judge the quality of the "user interface" (the look and feel) of the program:

- *Is text laid out in a clear way?*
- *Are there menus or function keys for most commands, and is their pattern consistent?*
- *Are clear and unambiguous user instructions given at each decision point in the program?*
- *Are there "help" facilities for the user at various points in the program?*
- *Is the software foolproof (is the entry of nonsense data prevented or reduced by automatic data validation)?*
- *Does the program have built-in "data dictionaries" (e.g. medical terms, names of drugs)? Will updates be available?*
- *Can entry mistakes be corrected easily?*
- *Is there good integration, i.e. is it possible to move easily from one part of the program to another?*
- *Does the system have a fast response time, e.g. when sorting and retrieving records?*
- *Is it possible to escape from the program at any point without losing data?*
- *Are there password / screen blanking facilities?*

THE HARDWARE AND THE SOFTWARE

Let us assume that you have decided on the computer programs you need, and you have set out to buy personal computer hardware which will run the program. What would you actually need to buy?

The heart of a personal computer system is the microcomputer. At the time of writing, this would typically be an IBM or compatible, or an Apple Macintosh. If one were to buy an IBM-compatible, the minimum specification that would be advisable for the standard software (including Windows) being published at present would be an 80386SX processor-based machine, with at least 2 Mb of Random Access Memory, a 40 Mb hard disk, and a mouse. The current standard for a Visual Display Unit (VDU) to go with the microcomputer is VGA; colour is important for graphics-based programs.

A printer is a sine qua non in any personal computer system. You would typically consider a 24-pin dot matrix printer or perhaps a laser printer. Think of speed, noise, print quality, stationery size, stationery loading and cost of printer ribbons/ toner cartridges before deciding.

Data security is important, so consider investing in a surge protector, and perhaps a tape streamer (for rapid frequent backup of data) and/or an uninterruptible power supply. If communications are high on your agenda, a modem will be required to connect the computer to the phone system.

Networking of several microcomputers is an ambitious step ... and an expensive one. Apart from the pricey networking software, this would involve the installation of network interface cards, cabling, connectors, terminators, and possibly ducting.

The last, but not least, item of capital expenditure is the software. Typically, today, you would require MS-DOS, MS-Windows, a word-processing package, a database package, possibly a spreadsheet package, and, of course, specialized GP software. The cost of original, licensed software can be very substantial, but needs to be met. Software piracy is illegal and immoral. Moreover, it is short-sighted and dangerous to build your practice (i.e. your business, your livelihood!) around a computer system that relies on incomplete and unsupported software.

RECURRENT EXPENDITURE

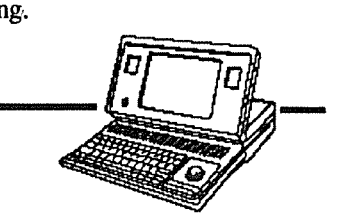
You should plan for any ongoing costs of a personal computer system. The most substantial are those associated with maintenance agreements (usually 8 to 10 percent of the initial equipment outlay per annum). Then, there is the cost of floppy diskettes, of computer stationery, and of printer ribbons or toner cartridges. If you are into communications, keep an eye on the cost of annual subscriptions to databases, and, if relevant, the tariffs of overseas telephone calls.

SUPPORT FROM THE COMPUTER HARDWARE/SOFTWARE SUPPLIER

When it finally comes to buying the system, it is a good idea to purchase the equipment from a well-established supplier, with a proven track record (this may be judged from the number of systems he has marketed). Both the hardware and the software should come with proper documentation and user manuals. Desirable items in a hardware maintenance agreement are: hotline telephone support, guaranteed rapid response to emergency calls, and the supply of replacement equipment during repairs. A software maintenance agreement should take into consideration the possibility of amending or upgrading the program, and the feasibility of transferring data to other programs.

CONCLUSION

Much of this article was taken up by "caveats" intended to protect you, the GP, from the dangers of a hasty, uninformed entry into the world of computing. It is necessary to emphasize that beyond the nasty pitfalls there lies the immense power that computerised information processing can give you. For GPs as for everyone else in the 1990s, the power is there for the taking.



INTRODUCTION

The problem of infertility is not a new one. Much of the improvement that has taken place in the investigation and diagnosis of patients has not been paralleled by improvements in pregnancy rates. The management of infertility therefore remains a time-consuming, often costly exercise which can end in further frustration.

Infertility is best defined as the inability to concieve after one year of unprotected intercourse. Changes in life-style, family structure and particularly in the female role have led to a greater proportion of women postponing childbearing to the later reproductive years.

As a rule one would avoid an aggressive approach to infertility before 3 years (e.g. IVF) but if the women is 35 years or older, this may be considered earlier.

About 10-15% of couples have been estimated to be infertile (Pepperell RJ 1984)

The increased incidence of infertility with age is shown in Table 1.

Infertility is commoner in negro populations when compared to ewhite; 18.1 % vs 9.4 % the difference being mainly due to an increased incidence of tubal disease in blacks.

TABLE 1 – INFERTILITY WITH AGE

Age (in yrs)	*% incidence of infertility*
15 - 19	2.1 %
20 - 24	6.4 %
36 - 39	12.5 %
40 - 44	15.9 %

TABLE 2 – INFERTILITY vs PARITY

Para 0	10.1 %
Para 1	12.4 %
Para 2	6.0 %
Para >3	7.9 %

It also decreases with increasing parity up to para 3 and over when it increases slightly.

Infertility is more common in patients who do not reach high school education (14.0 %) compared to those who do (9.4 %) and those who go further (8.7 %).

After the first year of unprotected intercourse, only 75% of perfectly normal couples would have achieved a pregnancy, and only 90% after 2 years.

With these figures in mind, it is unusual to investigate infertility before a year of unprotected intercourse has elapsed.

SCHEME OF MANANGEMENT OF INFERTILITY

It is an essential aspect of infertility that the couple be seen together, at least for the first visit.

Initial assessment begins with the interview at the first visit. The female patient will be considered first.

The first factor to consider is the age of the patient: at 35 years, the chances of conception are half those at age 25 while at 40 they diminish further to one-fifth (20%).

The duration of infertility and the age of the patient will indicate the pace with which investigation and what therapeutic approach is to be offered.

Menstrual history: nobody has a 28 day cycle, the regularity being as important as the cycle length. It is more worrying if the cycle is short rather than if it is long (N.B. Oligomenorrhoea is defined as a cycle longer than 42 days).

The presence of dysmenorrhoea must be classified. Primary dysmenorrhoea is defined as pain beginning on the first day of menstruation and as menstruation proceeds, the pain improves. It is associated with ovulation. Secondary dysmenorrhoea is pain beginning 1 - 5 days prior to the onset of menstruation and is relieved by menstruation. The latter is considered to be related to pelvic disease e.g. endometriosis, fibroids, PID, Mid-cycle pain and vaginal discharge are biological markers of ovulation. Only 30% of patients will admit to recognising ovulation at the initial visit.

The method of contraception previously adopted by the patient may be associated with infertility. This is especially so for IUCD's.

The pill is not a cause of infertility. Pill takers have lower pregnancy rates in the first three months after stopping the pill but by 1 year pregnancy rates similar to people coming off natural forms of contraception are achieved.

Galactorrhoea is uncommon. Though hyperprolactinaemia is a frequent cause of infertility (about 5%), only 30% of patients with high prolactin levels will also have galactorrhoea.

The past obstetric history including any spontaneous or therapeutic termination of pregnancy, ectopic gestations and complications of any deliveries are particularly relevant to infertility.

The occupation of the patient and other aspects of her lifestyle will provide information regarding risk factors for infertility (e.g. PID).

The frequency of sexual intercourse must be determined, this being usually related to age. At age 20 years, a frequency of five times a week is average while at 40 years this would be closer to once a week, if that. It is not uncommon, however to receive false information regarding the frequency of sexual relations.

Since conceptions occur through a 3 day window a frequency of four times a week does not bind conception strictly to day 14. The presence of dyspareunia may indicate the presence of pelvic disease or it may simply be positional (Hawton K., 1982). It may also be a complaint used to mask deeper sexual problems. While on the subject, the male partner should be asked whether there is any difficulty maintaining an erection whether there is any premature ejaculation and whether penetration occurs properly.

Past Medical And Surgical History

Any past endocrine abnormality or pelvic surgery of any type must be recorded in detail. Vaginal surgery is also important as for example, with a cone biopsy; when too large a cone is excised. This restricts the production of cervical mucus and sperm transport cannot occur appropriately. This may also follow laser ablation.

The past and present weight of the patient are recorded (Ponderal Index WHG^2, aneroxia nervosa, gymnasts) and the treatment is to get the patient back to the normal weight range when menstruation should occur spontaneously.

As previously stated, the social and occupational history of the patient is important. Smoking >10 cigarettes a day will interfere with tubal function. Nicotine interferes with cilial action in the tube as it does with those in the chest.

Examination

A basic general examination with particular attention to height and weight, body hair, thyroid and breasts is performed. The presence of galactorrhoea should be demonstrated. A thorough gynaecological examination is mandatory with due care being given to the appearance of the external genitalia. A cervical smear, if indicated, is taken.

Any suspicion of an abnormality of the genitalia or mullerian tube defects should be excluded by appropriate investigation i.e. karyotyping if intersex is suspected or HSG/ Laparoscopy if mullerian tube agenesis is suspected.

The male partner should also be examined. Intersex e.g. Klinefelter's must be considered and a genital examination performed with particular attention to normal anatomy such as varicocoele, hydrocoele and abnormalities of the penis.

The presence of spermatozoa in an urinalysis specimen should alert the physician to the possibility of retrograde ejaculation.

Male Partner

It is estimated that in approximately 30% of infertile couples the cause lies partly or wholly with the male. (Hull Mr. et al, 1985)

The age of the patient is not as important as in the female; normal sperm counts can be maintained up to 50 - 60 years. A history of a past pregnancy with another partner confirms fertilisation capacity. Exposure to radiation (X-Rays), a hot environment, chemicals or drugs (eg salazopyrine) must be excluded.

Long stressful hours may suggest a low frequency of intercourse. A past history of inguinal hernia repairs, testicular tumours or orchido-pexy and any chemotherapy must be sought.

Past unirary tract or genital infection, especially mumps orchitis are recorded.

Sperm agglutinating or immobilising antibodies have been estimated to occur 3 - 13% of infertile men. Corticosteroids decrease the antibody titres but do not increase the pregnancy rates.

Endocrinological abnormality accounts for only 1-3 % of cases including the hypogonadotropic males and hyperprolactinaemia (which is associated with reduced androgen production).

All of the treatment options for male infertility including anti-

oestrogens, gonadotrophins and androgens have proved disappointing. (Schill W.B. 1986)

Artificial insemination with husband's semen (A.I.H.) is largely unsuccessful when applied to the oligoosthenospermic male (pregnancy rate 2% per cycle). AIH may be particularly successful in patients with relative oligospermia due to a high semen volume and patients with retrograde ejaculation; while IVF can be expected to have good results (pregnancy rate 60%/ cycle) in patients with asthenospermia only.

B. AIH using especially prepared 'washed sperm' and intrauterine insemination is more successful especially if the woman has had some form of ovulation induction or even superovulation. This latter procedure does however carry the risk of multiple pregnancy and ultrasound monitoring of the number of follicles needs to be carried out before insemination.

The ultimate solution the Male Factor problems is Artificial Insemination by Donor. Great care in counselling the couple needs to be taken before embarking on this course of therapy. AID should only be carried out in centres where established sperm banks exist. Donors need to be carefully screened and in accordance with current recommendations frozen sperm only used. The advent of the HIV risk has made the use of fresh sperm not recommended. Unfortunately this has led to a lower pregnancy rate since frozen sperm results have consistently failed to be as good as results with fresh ones.

Disorders Of Ovulation

1. Ovarian Failure

This may be either primary, presenting with primary amenorrhoea or secondary causing oligomenorrhoea or secondary amenorrhoea.

The Resistant Ovary Syndrome presents with secondary amenorrhoea and very high gonadotrophin levels. Primordial follicles are present on ovarian biopsy, but also FSH and LH receptors are absent. The condition is associated with universally unsuccessful treatment - the only option remaining is oocyte donation (Bromwick P., 1990)

Other types of ovarian failure may be treated with oral contraceptives for 3 months in order to down-regulate the hypothalmic-pituitary and ovarian axis; on withdrawing a rebound phenomenon may stimulate ovulation.

2. Polycystic Ovary Syndrome

This condition previously known as Stein-Leventhal is characterised by oligomenorrhoea (cycles longer than 42 days), obesity and hirsutism.

Hormone analysis will reveal a raised LH/FSH ratio in the order of 3:1 (Bair d C.T. et al 1977). The sample should be repeated during menstruation when a raise in FSH is expected in order to provoke subsequent follicular menstruation. In PCO the FSH/LH will again be found to be elevated.

The pulsatile secretion of FSH and LH is abnormal in PCO. The high level of LH can interfere with chromosome division from Metaphase I to Metaphase II at the time of ovulation. If the ovum is not realeased in Metaphase II then the ova are not suitable for ovulation. This accounts for the high percentage of spontaneous abortion in PCO patients.

3. Anovulatory cycles: abnormal follicular growth and corpus lutem function.

The ovary as an endocrine organ is responsible for the production of oestrogens for which 17ß oestradiol is specific for the follicular growth. A single sample is not enough to confirm normal follicular growth and 2 or 3 samples in the first half (follicular phase) of the cycle may be necessary. Ovulation is confirmed by a progesterone assay-evidence of corpus luteum formation. This needs to be done 7 days prior to menstruation in day 21 in a 28 day cycle.

Uterine Causes Of Infertility

Disease of the endometrium will prevent implantation and establishment of a pregnancy and the commonest causes are endometrial attrophy eg as a result of pelvic Tb and Asherman's Syndrome (intra-uterine synechae).

The diagnosis may be suggested by a hystero salpingogram but is best made by hysteroecopy.

For patients with mullerian tube abnormalities, metroplasty can

CAUSES OF FEMALE INFERTILITY
(Hull M.R. et al 1985)

1. Disorders of ovulation (20%)
2. Tubal factors (15%)
3. Cervical factors (3%)
4. Endometriosis (6%)
5. Unexplained infertility (30%)

render someone infertile. The incidence of infertility after metroplasty is in the region of 20-30%. This is because it may be associated with the development of Asherman's syndrome.

Cervical stenosis may cause infertility from a lack of mucous. Fibroids only cause infertility if they occlude the tubes; they are a cause of recurrent abortion rather than infertility.

Mymectomies are associated with very high rates of tubal disease.

Assessments Of Ovarian Activity

1. Changes in cervical mucous

Pre-ovulatory cervical mucous is plentiful, clear, acellular and with a low viscosity. Spirbarkeit can be demonstrated and it ferns on drying.

On the day of ovulation threads as long as 15-20cms long can be formed without breaking.

The cervix opens slightly at the time of ovulation.

2. Endometrical Biopsy

The presence of secretory endometrium simply confirms the presence of progesterone but is not confirmatory for ovulation e.g. luteiniseal unruptured follicle (LUF cycle) (Mudge T.J., 1982).

3. Basal Body Temperature

On average a patient gets bored of keeping a BBT chart after 2 months. Mistakes in the charting are common. This method identifies a shift in temperature which points out when progesterone is produced rather than when ovulation occurs. It does however give an idea of the length of the luteal phase and it is therefore advisable to keep a BBT for a short while.

4. Laparoscopy

This needs to be done in the luteal phase in order to confirm ovulation but if performed in the follicular phase, the developing follicle should be identified.

5. Ultrasound

Sequential ultrasound examination will demonstrate growth of the dominant follicle and in addition to oestradiol levels will confirm whether growth is appropriate.

A rising LH level is a sensitive indication of ovulation but in the case of the LUTEINISED UNRUPTURED FOLLICLE ovulation will still occur.

6. Hormone Levels

Assessment of reproductive hormones, FSH/LH, prolactin, oestrogen and day 21 (18-25) progesterone are an essential part of the diagnostic work up of infertility.

Testosterone levels are useful in the diagnosis of PCO's though only 20% of the PCO's will have raised levels.

Treatment Of Anovulatory Infertility

1. Clomiphene citrate

This compound is oestrogenic and anti-oestrogenic at the same time. It should not be given to patients who are ovulating because it will interfere with estradiol receptors in the endometrium and with the production of cervical mucus

Clomiphene can be started in a dose of 450mgs only for five days from D3 to D7 of the cycle. the serum progesterone should be assessed and if no ovulation occurs the dose is raised to 100mgs and then to 150mgs. There is however no benefit in going above that level.

Treatment should continue for at leasyt 9 - 12 months unless the patient concieves.

If this does not occur at a does of 150mgs, follicular growth should be monitored in the next cycle and oestradiol checked on days 10 and 13 and progesterone on day 21.

If the oestradiol rise in consistent with the presence of a follicle but a low level of progesterone, then the patient is not releasing an ovum. In the absence of an LH surge, HCG can be given along with clomiphene. If both oestradiol and progesterone are flat, then gonadotrophins should be used. Pergonal therapy must however have good monitoring facilities.

2. Gonadotrophins

Pergonal is a mixture of FSH/LH having mainly an action of FSH i.e. follicular growth. Ovulation induction can be achieved by HCG.

TABLE 3 - RELATIONSHIP OF OVULATION TO CONCEPTION IN PATIENTS WITH OVULATORY DISORDERS AFTER TREATMENT.

	% ovulation	*% conceived*
1. Primary Amenorrhoea	0	0
2. Secondary Amenorrhoea	56	34
3. Oligomenorrhoea	74	51
4. Anovulatory cycles	85	62

The regimen for Pergonal is to give on days 1,3,5,... to stimulate follicular growth, in a dose of 150i.v. by i.m. injection. A pure FSH preparation (Metrodin) may also be used.

On days 10 or 12, if the follicular response is adequate, HCG may be given and the couple advised to have sexual intercourse.

If the response is not adequate the dose is increased to 300 and to 450 subsequently.

Monitoring with oestradiol levels only will not indicate the degree of follicular development i.e. two small follicles will produce as much oestradiol as of one large one.

It is best to monitor with a combination off oestradiol levels and ultrasound examination on alternate stages. The main complication to be avoided with this treatment is Hyperstimulation Syndrome.

3. LHRH pumps

LHRH pumps secrete LHRH in a particular manner, simulating the natural process. It may be administered subcutaneously or intra-venously. The pump stimulates normal pituitary function, by substituting the hypothalamus and the thereby stimulating normal follicular growth.

In theory there is no need to monitor follicular response but hyperstimulation does occur and therefore the need to monitor as with gonadotrophin therapy is necessary.

Pregnancy rates in hypothalmic, hypopituitary syndrome are good but no better than with pergonal. LHRH pumps are better physiologically but there are no data to confirm that pregnancy rates are superior.

LHRH has been applied successfully for cases of hypergonadotrophic hypogonadism (e.g. Kellman's Syndrome), multicystic and polycystic ovaries. (Armer M.A. et al, 1968)

4. Bromocryptine - Dopamine agonists

Anovulation due to hyperprolactinaemia is associated with very favourable results after treatment: 90% will get pregnant within 3 months. Bromocrytine,, a dopamine agonist, reduces the level of prolactin and reduces the size and growth of prolactin-secreting adenomas. It is considered the treatment of choice with recourse to surgery being rarely necessary.

Bromocriptine is usually started in a dose of 2.5mgs b.d. and continued in a maintenance dose of 1.25mgs bd.

In cases of borderline levels of prolactin, bromocryptine will not work.

(to be continued in the next issue)

cpd

The Epidemiology Of Blood Transmissible Disease In Malta

Hugo Agius Muscat

There are two serious blood transmissible conditions that a health worker may come in contact with: Acquired Immunodeficiency Syndrome (AIDS) and Hepatitis B.

AIDS in Malta
– the epidemiological situation

The Acquired Immunodeficiency syndrome (AIDS) is caused by a retrovirus known as the Human Immunodeficiency Virus (HIV).

The following statistics refer to persons who have suffered from AIDS. Further to these, there are an estimated 50 to 100 Maltese residents who carry the HIV virus but have not (so far) developed AIDS.

By the end of 1991, 22 cases of AIDS had occurred in Maltese residents; all the persons who developed the disease before 1991 have died.

Sex distribution *(Figure 2)*

Of the 22 cases by the end of 1991, 21 were males, while 1 was female. The reason for the male preponderance is explained by the routes by which the disease has been transmitted.

Distribution by transmission category *(Figure 3)*

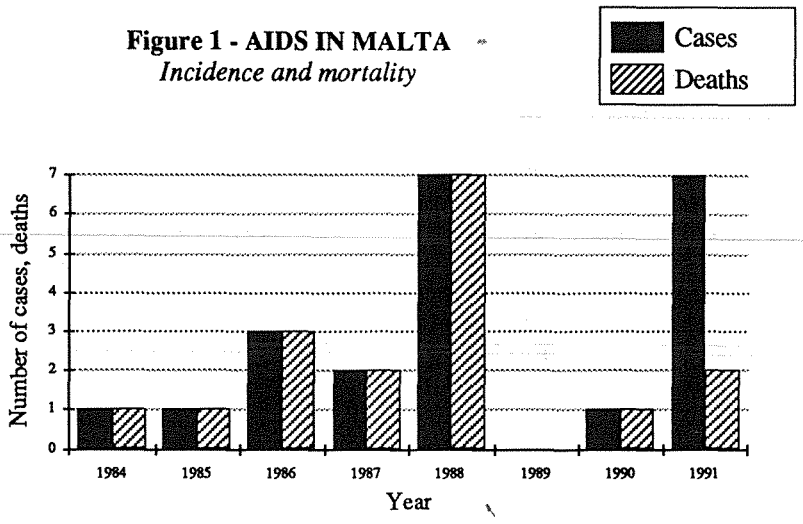
A number of Maltese haemophiliacs were accidentally infected with the HIV when they received blood products that were essential for the treatment of their haemophilia. This happened at a time when no one recognised the existence of the HIV. This route of transmission is now completely blocked.

In practically all the other cases of AIDS, the HIV was transmitted sexually. In 12 cases this was the result of a male homosexual relationship.

There have been no cases of AIDS in intravenous drug users (IDUs). If IDUs share needles there is a risk of rapid spread of HIV within this group of persons, and those who have sexual contact with them.

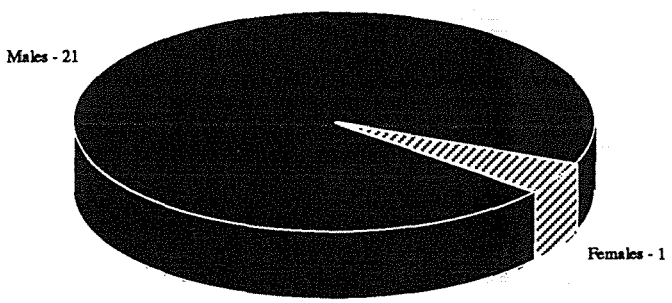
If IDUs develop AIDS, one may also expect to have cases of transmission of HIV from mother to child (transplacental or "vertical" transmission). This would eventually lead to babies and young children developing AIDS.

Figure 1 - AIDS IN MALTA
Incidence and mortality



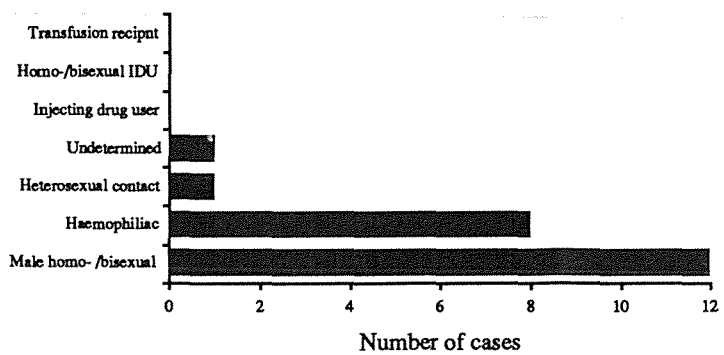
Situation as at 31.12.91

Figure 2 - AIDS IN MALTA
Sex Distribution



Situation as at 31.12.91

Figure 3 - AIDS IN MALTA
Transmission Category



Situation as at 31.12.91

The age distribution of AIDS cases reflects the way HIV was transmitted:

Age group *(yrs)*	Number
10-14	1
15-19	2
20-24	0
25-29	7
30-34	2
35-39	5
40-49	5

1992 update

So far (4th February 1992), there has been one new case of AIDS reported this year. It is not possible to release more details at this stage, other than to say that the person is male.

Hepatitis B in Malta
- the epidemiological situation

The annual incidence of "infectious hepatitis" has been published in the Malta Demographic Review since 1967 *(Figure 4)*. This figure appears to cover viral hepatitides A, B and non-A non-B. The spike in 1975 was almost certainly due to an outbreak of Hepatitis A.

Number of cases

It is only since 1987 that separate statistics are kept for cases of Hepatitis B infection, and that a clear distinction has been made in records between Hepatitis B infection and Hepatitis B virus positivity. The number of reported cases of Hepatitis B infection has tended to increase in the past five years. *(Figure 5)*.

Regional distribution of cases

It has been suggested in the past that there is a preponderance of Hepatitis B infection in the south of Malta. The available figures were analysed by the three Medical Officers of Health (MOH) regions. It was found that, although there is a slight excess of cases in the Southern region, there is no statistical difference from the incidence in the Central and Northern regions *(Figure 6)*. The number of cases, however, is small, so it cannot be excluded that a significant difference could emerge with greater numbers.

HBV positivity

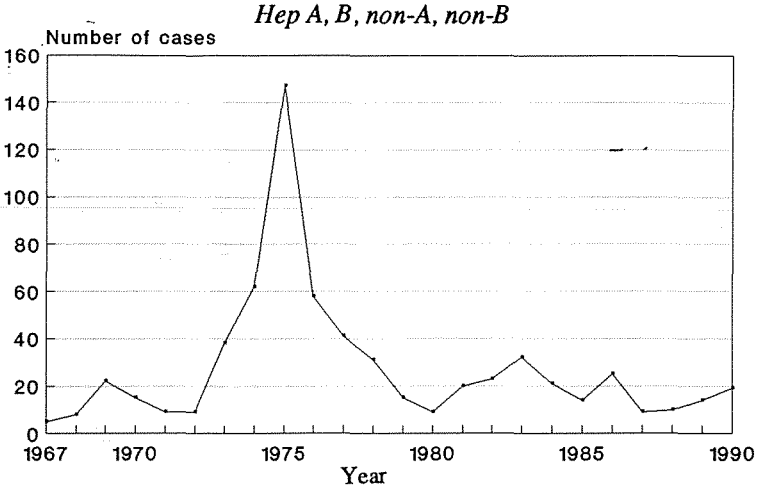
Information on HBV positivity is scarce. Moreover, little research has been carried out on the modes of HBV transmission in Malta. Recently (January 1992) medical staff at the Health Information Systems Unit studied a random sample of 23 records relating to investigated cases of HBV positivity. The suspected transmission categories are depicted in Figure 7. In almost half of the cases, no mode of transmission could be indicated. Sexual activity, stick injuries, tattoos, shaver sharing, blood transfusion, and perinatal body fluid contact were considered to be the likely risk factors in the rest. The factor in this list which is relevant to health care delivery is, of course, stick injury.

Transmission of HBV and HIV from patient to health-care worker

Hepatitis B virus (HBV) spread

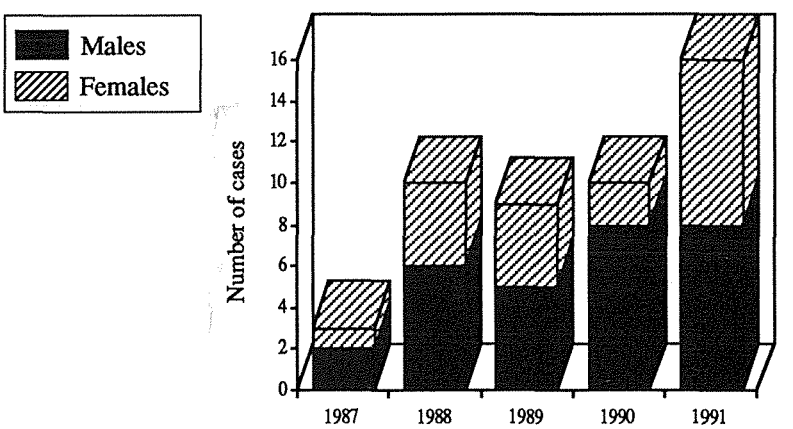
The spread of HBV is proportional to the degree of blood exposure. For highly exposed workers, e.g. surgeons and laboratory personnel, the lifetime risk of HBV infection reaches 30 to 50 percent.

Figure 4 - "INFECTIOUS HEPATITIS"
Hep A, B, non-A, non-B



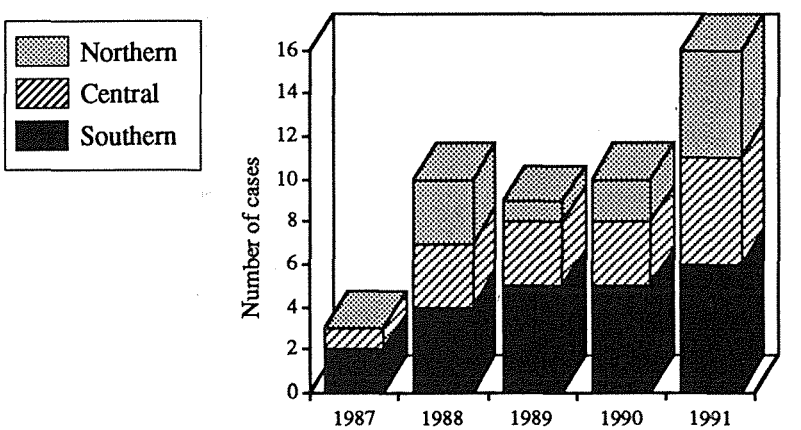
Source: Malta Demographic Review

Figure 5 - NOTIFIED CASES OF HEPATITIS B
Number and Sex Distribution



Source: HISU

Figure 6 - NOTIFIED CASES OF HEPATITIS B
Distribution by MOH Region



Source: HISU

Human immunodeficiency virus (HIV) spread

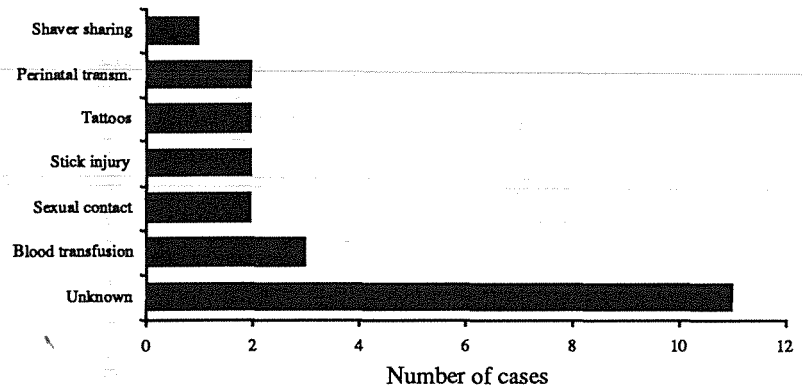
HIV circulates in the blood at much lower concentrations than HBV, ans is not able to survive as well as HBV outside the body. It is therefore uncommon that HIV infection is acquired through health care.

Immunization and Universal Precautions.

Nowadays, health care workers can be immunized against HBV, and therefore no longer need to run the risk of having Hepatitis B.

"Universal precautions", i.e. precautions that are taken at all times, are the cornerstone of the prevention of blood transmissible disease in general. They are particularly important for the prevention of AIDS, as immunization against HIV is not available. Universal precautions are based on the assumption that all blood is potentially infectious, regardless of its source, and of results of tests on it.

Figure 7 - HBV POSITIVITY
Risk Factors for transmission
(A sample of 23 cases)



Source: HISU

Components include:

- Handwashing
- Careful handling of sharps
- Proper sterilization, disinfection or disposal of instruments after use
- Appropriate use of gloves, masks, gowns, etc.

Readers are referred to the "Report on the Consultation on Prevention of HBV/HIV Transmission in the Health Care Setting", published by WHO (Geneva), which includes specific

cpd

News From The Rotary Doctor Bank

New Hospital in Desert Soon Ready

"A terrible experience."

That was the reaction of the representatives of the Rotary Doctor Bank, when they visited Wajir, a 'town', although we would more consider calling it a hole, out in the desert in northeast Kenya.

The worst was arriving at the hospital, built by Italian prisoners of war during the Second World War and in an attrocious state of disrepair. To carry out any kind of meaningful medical work there was practically impossible.

Now everything has changed. Enormous work has been carried out with Swedish money, one million Swedish Crowns from SIDA through the Erik's Help Fund and 300,000 Swedish Crowns from Lions, and soon a new hospital will stand ready. The Doctor's Bank 'specialist' on this desert area by the frontiers to Somalia and Ethiopia, Doctor (and University lecturer) Carl-Axel Ekman will inspect the result, together with Bernt Einarsson from the Erik's Help Fund who is responsible for the project. After this doctors will be sent there, primarily surgeons and orthopedists.

Economical Difficulties

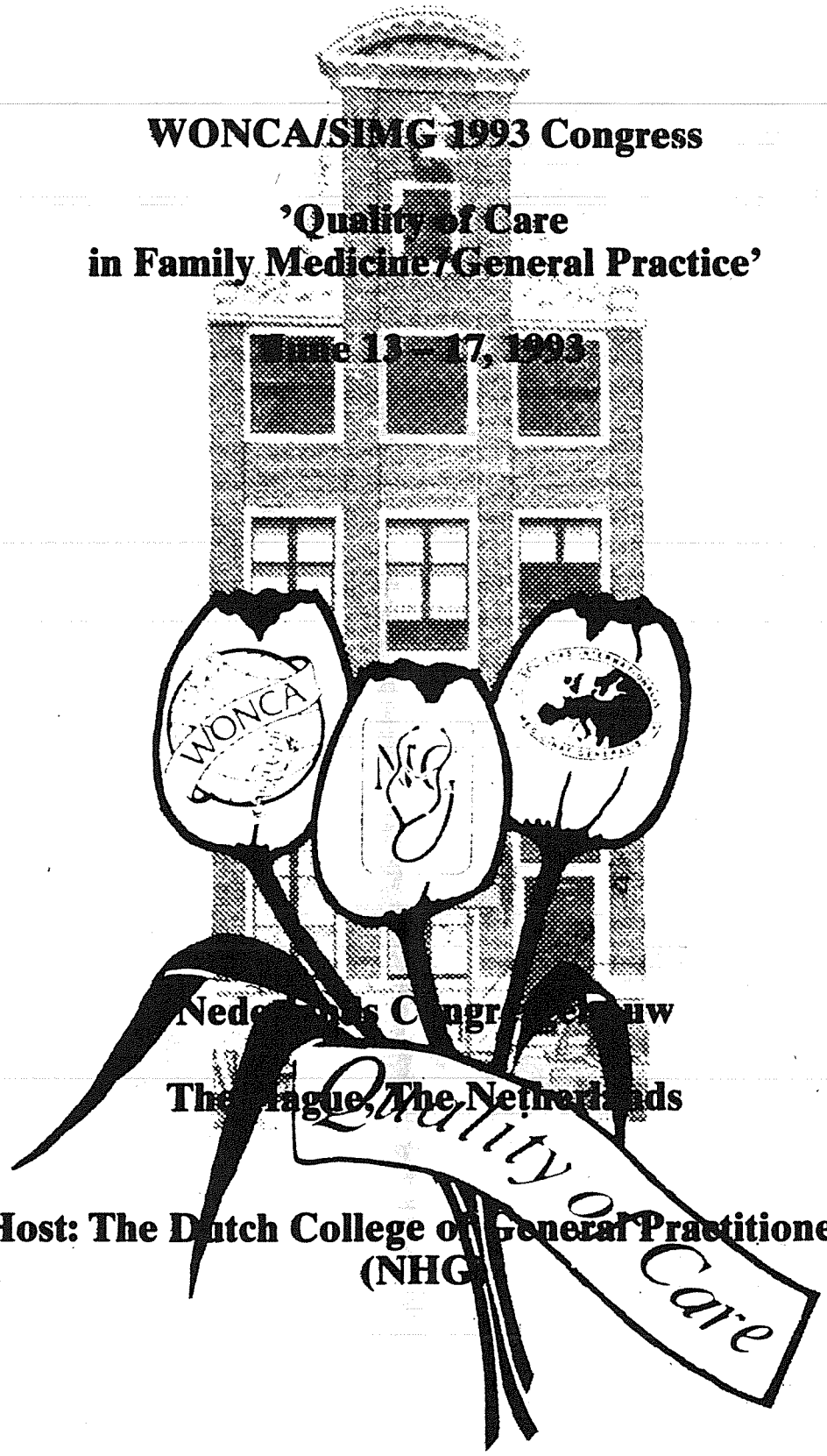
Maseno Hospital in Kenya was built by the British in 1906 and had for a long time a good reputation. After Kenya achieved independence it started to fall into disrepair. However, attempts were made to make it functional again, in part by the Doctor Bank sending surgeons and other doctors there.

"The big problem for the hospital is the economy," write the Danish doctors Thomas Castberg and Eric Thing who have worked there for the Doctor Bank.

WONCA/SIMG 1993 Congress

'Quality of Care in Family Medicine/General Practice'

June 13 – 17, 1993



Nede[illegible]s Congr[illegible]uw

The Hague, The Netherlands

Host: The Dutch College of General Practitioners (NHG)

WONCA/SIMG CONGRESS
THE HAGUE, NETHERLANDS
13 - 17TH JUNE 1993

At one time a prize was awarded in medical quizzes for knowing the meaning of the initials WONCA. Today, happily there is an understanding of both the purpose and function of the World Organisation of National Colleges and Academies of General Practice. SIMG (Societas Internationalis Medicinae Generalis), in association with the Dutch College of General Practitioners is organising the largest gathering of general practitioners to have taken place in Europe for many years. The theme of the conference is "Quality of Care in Family Medicine" reflecting the present state and future needs of health care in many countries and particularly those in Eastern Europe.

Has Western European medicine anything to offer the Eastern Europeans? What can we learn from them? High on the list of priorities will be the problems of the ageing population, growing demands for health care, increase mobility of the population in a changing continent. How can change be achieved? Are guidelines, protocols and a GP syllabus with a defined core of knowledge the way ahead? If we set standards, how can they be met?

The wide variety of speakers, delegates, symposia, workshops, and demonstrations will ensure that no one will leave the conference without new ideas, increased motivation and a greater understanding of the problems of others.

Needless to say the academic programme will be complimented by a rich social programme offering a variety of entertainment in a relaxed and beautiful setting.

WONCA EUROPEAN REGION
VICE PRESIDENT REPORT

1989-1992

The past three years have seen dramatic changes in the geopolitical structure of Europe, changes which have had a profound effect on health services. I feel fortunate to have been in a position, as a consequence of my WONCA role, to have been able to participate in the promotion of General Practice/ Family Medicine in Europe during this epochal moment in history. General practice/family medicine have a vital and central role in primary health care services of these countries. The first 18 months of my activities with WONCA were focused on facilitating the incorporation into WONCA of new and existing Colleges/Associations of General Practice/Family Medicine in particular those in the former eastern block countries.

At the end of my term we have applications to WONCA in various stages from Italy, Hungary, Yugoslavia, Czechoslovakia, Romania, Estonia and Russia.

While the application from the German Democratic Republic (GDR) terminated with the fall of the Berlin wall and the unification of the Germany, it is hoped that the positive aspects of Family Medicine/General Practice in the former (GDR) are not lost as a consequence of reunification.

The Estonian Society of General Practice was created in December, 1991 under the leadership of Dr. Kermes. In Russia, the first chair of General Practice is being established under the mentorship of the College of the Family Physicians of Canada. It is our hope that the founding chairman of the Russian department, Professor Vladimirtcev, will be attending the Vancouvcer meeting of WONCA.

The most prominent European organisation involved in General Practice/Family Medicine became an "organization in collaborative relations with WONCA". It includes S.I.M.G. (Societas Internationalis Medicinae Generalis, N.L.G. (New Leeuwenhorst Group), E.G.P.R.W. (European General Practice Research Workshop). The Italian CSERMG (Centro Studi and Ricerche in Medicina Generale) became an associate member of WONCA. The application from France UNAFORMEC is being processed.

The N.L.G. is responsible for the establishment of "The European Academy of Teachers in General Practice". This will be announced at the European Conference on General Practice in Scotland, in March 1992 and will also be on our agenda at our meeting in Vancouver.

The first WONCA European Regional Conference on Family Medicine – Barcelona – December 10-14, 1990. This conference was a product of a very active Host organising Committee headed by Dr Juan Gene Badia. It was very well attended by almost 1300 General Practitioners/Family Physicians from all over Europe and other parts of the globe. The scientific program was well presented and facilitated discussions in the true spirit of General Practice/Family Medicine. Social programs enabled new and old friendships to flourish.

Prior to the Barcelona conference we held the meeting of the European Member Organizations of WONCA (December 9 - 10, 1990 Castelldefelds). This meeting, which facilitated the co-ordination

of the various activities around Europe, was well attended and included observers from Eastern Europe. The minutes of the meeting were distributed to the member organisations and the up-dating chapter was published in WONCA News.

During that meeting we formed EQUIP, the WONCA European Working Party of Quality Assurance in Family Practice, under the chairmanship of Professor Richard Groll. The Working Party had already met in Utrecht on December 5-7, 1991 at the invitation of the Dutch College of General Practice. The product of this working party looks very promising and is planned for presentation at the 2nd European Conference of General Practice/ Family Medicine in den Hague 1993

In November 1991 the Royal College of General Practitioners in U.K. organized a conference on General Practice in "new Europe" with overview papers on the current situation of General Practice/Family Medicine in Europe.

The last 18 months of my term were focused on strengthening links with the European office of the World Health Organisation (WHO). WONCA, as a non-governmental organisation, has official relations with WHO. Joint WONCA-WHO activities include:

a) Formal WHO-WONCA consultation with the government of Greece on April 28, 1991 Porto Carras Greece concerning PHC and the promotion of Family Medicine as a speciality.

b) A WHO meeting on PHC development in Southern Europe April 21-24, 1991 Greece.

c) WHO Working Group on the contribution of Family Doctors/General Practitioners to health for all. Perugia Italy May 22-25, 1992. The report of this meeting will be included in the agenda papers.

d) WHO Working Group on the Development of General Practice in countries of Central and Eastern Europe – Czechoslovakia, April 22-24, 1992.

At present the WHO European office is proposing a "Charter on General Practice". We will be discussing this proposal at our meeting in Vancouver including the possibility of involvement by the European Member Organizations in the development of the charter.

In conclusion the past three years, which included the Gulf War, were very intense and dramatic years for me personally and professionally. I found it a great challenge to meet and collaborate with many colleagues and colleges. I deeply thank you for the co-operation and the friendship you have shown to me and the opportunity to work with you.

GioraAlmagor MD, FRCGP
(Visiting Professor)

SFAT-AM Short Family Therapy In Ambulatory Medicine

Alon

"My experience as a family medicine resident exposed me to the new horizons of the biophychosocial model. Despite my good intentions, I was doubtful that my patients could benefit from this model within the constraints of the 10 to 15 minutes available for a consultation. Exploring mew possibilities, I discovered the ideas of Milton Ericson, Michael Bal;int, Ian McWhinney, Dorothy and Baird, Sawa Medalie, Susan McDaniel and Tom Campbell which helped me to change.

"I was fortunate to be assisted by a clinical psychologist who specialized in family therapy and medical psychology, Isaschar Eshet. We became good friends and have enjoyed a collaborative professional relationship."

Isaschar

"For many years I sought ways to exploit my psychology skills outside the citadel of academia. Fortunately, I was able to bring my experience in family therapy to good use in primary health care teams in the community.

"Three years ago, in a memorable telephone conversation, Alon and I discovered each other! Alon and I work together as co-therapists with his patients at the community clinic. I have been impressed by the family physician's skill in effectively combining medicine and family therapy in a 10-15 minute patient encounter. It seems that our shared collaborative approach offers a unique example of handling patient encounters.

It is the art of medicine!"

Lately Giora Almagor who is Alon's first trainer in Family Medicine and acts today as Senior Officer in WONCA (World Organisation of Family Doctors) joined our team. Giora contributes with his clinical, as well as organizational experiences. Giora is now spending his sabbatical year as a visiting professor to the Department of Family Medicine at McMaster University.

GIORA

"As a result of my experience with many different family medicine teaching programs in different countries, I joined Alon and Isachar with a realization that this approach offers a better way to practise and teach Family Medicine. We discovered SFAT-AM (Short Family Therapy in Ambulatory Medicine) through a course of watching video sessions which we taped during regular doctor patient family consultations. We are convinced that these are effective techniques for family therapy in the family practice setting for 3-6 sessions of 10-15 minutes duration.

"On all of the above we have learned the importance of dividing the consultation's session with the "difficult" patient and family, in a stepwise strategy. This method creates opportunities to find appropriate tools for each of these steps. This stepwise strategy can be learned by the family physician.

"We teach the method to our senior residents and family physicians and we got enthusiastic, encouraging feedback."

A year ago Alon visited 12 Family Medicine Departments in the USA and Canada. He lectured and showed a videotape demonstrating SFAT-AM techniques. The observers showed interest and willingness to co-operate in research and developing the teaching aspects.

Giora presented SFAT-AM as a video in conferences on General Practice / Family MEDicine in Florence, Barcelona and Paris. With feelings of great satisfaction and achievement, we began to write a monograph as a professional and experimental book with some review articles. The monograph describes in detail the doctor patient family encounter. It includes: interpretation through our case presentations, narration, and protocols from the fields of family therapy, behavioral and strategic oriented thinking. With the help of Hava Katz - Senior Family Therapist, author with others of "Doctors and their feelings", and supervisor of the on-going peer supervision tutor group in our Family Medicine program, we adapted the original video to the various levels of knowledge for teaching.

We have developed a series of courses in this field to be run in Israel and various places in the world. The course creates an opportunity for Family Physicians / General Practitioners to see the day to day work in a new and refreshing light. The participants will get a "cookbook" at the end of the course.

All three of us receive a lot of support from our teaching colleagues in the Vocational Training Family Medicine program in Israel. We search for international co-operation and opportunities to develop research to establish SFAT-AM.

We presented our experience at the WONCA world conference in Family Medicine in Vancouver in May 1992 and other occasions. During these we distributed a booklet which contains the abstract of our work and some practical examples. We hope to publish the complete monograph this year.

For more information you may wish to contact:

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FURTHER NEWS FROM THE ROTARY DOCTOR BANK

EXHAUSTED DOCTORS FINALLY GOT A VACATION

"The mission hospital Nkinga in Tanzania has 200 beds, has annually 3500 operations and 67,000 visits by patients. If this had been a Swedish hospital some 100 doctors would have been working here. At Nkinga there are four doctors!

This is what the surgeon Lennart Sjoholm, Jonkoping writes, sent out by the Doctor Bank as a relief doctor. He goes on to say:

"It's no wonder if the doctors at such a hospital get tired and need relief. Thanks to the Doctor Bank supplying a relief doctor, all four doctors have had three weeks of vacation, and another hospital Mchukwi, has recieved help during these three weeks."

One of the basic ideas was just this when the Doctor Bank was started, to relieve doctors who work under difficult conditions in developing countries, and this concept has meant much to many other hospitals.

Day 1: **15 January**
Number of evaluation forms returned: 1

Today's seminar was relevant to family medicine/general practice:	Agree - 1
Today's seminar increased my knowledge and/or awareness of issues:	Agree - 1
My patient care will be modified as a result of this seminar:	Disagree - 1

- No other remark.

Day 2: **16 January**
Number of evaluation forms returned: 17

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

Agree strongly:	9
Agree:	8
Undecided / Disagree / Strongly disagree:	nil

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

Agree strongly:	7
Agree:	8
Undecided:	1
Disagree / Strongly disagree:	nil
No comment:	1

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

Agree strongly:	5
Agree:	9
Undecided:	2
Disagree:	1
Strongly disagree:	nil

Today's seminar would have been better if:

- Specialist views on Rx of depression

The best feature of today's seminar was:

- Talk on haematuria (*6)
- Talk on depression (*2)
- Both features (*3)
- Good presentations
- The strong relevance to general practice

Day 3: **17 January**
Number of evaluation forms returned: 15

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

Agree strongly:	2
Agree:	10
Undecided:	nil
Disagree:	2
Strongly disagree:	nil
No comment:	1

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

Agree strongly:	2
Agree:	9
Undecided:	1
Disagree:	3
Strongly disagree:	nil

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

Agree strongly:	nil
Agree:	11
Undecided:	1
Disagree:	2
Strongly disagree:	1

The best feature of today's seminar was:

- Only one (talk)
- Only one topic!!
- The number of questions asked showed that the subject of social security was an interesting topic since it [...] everybody's [p..]

Today's seminar would have been better if:

- Slides, please
- Variety
- Better presentation of rather boring subject

Please suggest topics for our future CPD meetings:

- Irregular vaginal bleeding
- Anxiety in general practice
- Paediatric cardiology
- ENT problems
- Ophtalmological problems.

RENEWAL OF SUBSCRIPTIONS
CALL FOR SPEAKERS

Members are reminded to pay their subscription for 1993 and to come forward and volunteer to deliver a paper at one of the College's CPD programmes

College News

1. This issue of the Journal as well as all the issues of the coming four years are being sponsored by **Lombard Bank**. Mr Alfred Mallia, Chairman Lombard Bank, accepted to sponsor the College Journal after being approached by the College President Dr Denis Soler. Preparations are also in hand for the Bank to provide College members with special banking facilities in the near future and in this connection members should have received a questionnaire.
   The response to this questionnaire has been rather poor (approximately 30%) so we take this opportunity to urge members to return their completed forms immediately. In the event that the form has been misplaced, kindly contact one of the Council members for a replacement.

2. **BUPA Ltd** are also sponsoring the College, along with the **Medical Defence Union** with their adverts in this and future publications of the College Journal.

3. A week long **Course for Trainers in Family Practice** was conducted for the first time in Malta by Dr Peter Bennet, an experienced UK trainer and Dr Michael Price, London Regional Advisor in General Practice and Dr Ray Busuttil, College Secretary and Qualified Trainer. In all 16 doctors participated in the week long course held between 22 and 26th March. There was an interesting array of ages, experience and talents among the participants, but all agreed that the course was of the highest order and professionally rewarding. An end of course dinner was held at the Union Club where the course organisers presented certificates to each participant. A big thank you goes to Dr Marcello Cherubino for offering the conference facilities for free and for hosting a reception, and to Air Malta for sponsoring the flights of the UK trainers. Thanks also go to the CGMO for granting one week study leave to those participants employed in Government Health Centres.

4. The College President and Secretary recently had talks with Dr Louis Galea, Minister for Social Development and Prof John Rizzo Naudi, Parliamentary Secretary for Health on the need to have doctors wishing to follow Family Practice as a carreer undergo an orientation programme as part of their pre-registration period, before being allowed to join the Government Primary Health Care Scheme. The concept was received favourably and the College is now engaged in formulating a Policy Document on Vocational Training at the request of the Minister. Another meeting on the subject was held with the Academic body which also reacted positively (but rather sceptically) to the idea.

MCFD Spring CPD Meeting

Wednesday, 5th May, 1993

1. **Managing Sports injuries in Family Practice**
   Dr Martin Borg
2. **A lesson I've learnt**
   Dr A Felice

Thursday, 6th May, 1993

1. **Dietary Advice to Patients**
   Nutritionist
2. **How I Manage**
   Dr A M Said

Friday 7th May, 1993

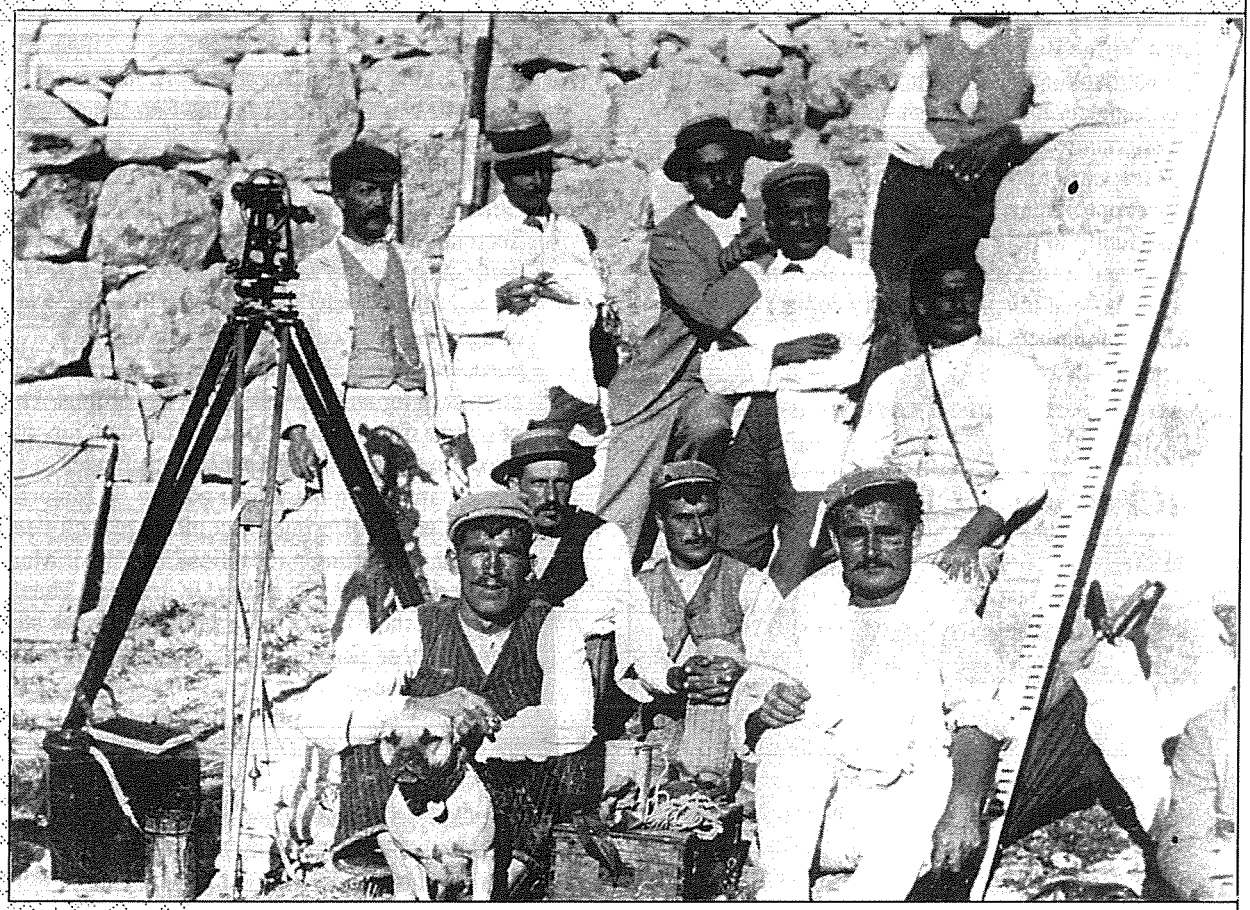
Recent advances in the treatment of common cancers
Dr V Muscat

Computers In General Practise

Hugo Agius Muscat Pgs. 5 - 7

References

RCGP (1982) Computers in Primary Care
RCGP (1985) Trends in General Practice Computing
Preece J (1990) The Use of Computers in General Practice
Javitt J (1986) Computers in Medicine - Appicatons and Possibilities



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