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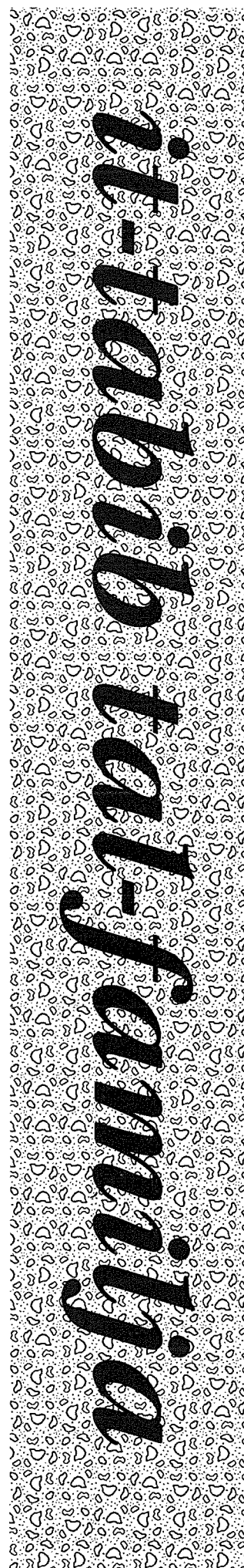
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Editorial

I wish to welcome our readers to the Christmas issue of our Journal, and I take this opportunity to wish all our readers a prosperous new year on behalf of all the members of the council.

It is not news that the college is drawing up a register of Family Doctors, and all of you will have received an invitation to register if you meet the criteria listed on the invitation itself. This is only the first step in an intensive programme to elevate the status of General Practice to that of a speciality. The full advantages of being included in this register may not be immediately apparent, but I must urge all eligible doctors to register at the earliest.

In the international field, the College continues to strive to increase contact with various international bodies, which can help us with advice and expertise in setting up training programmes for our registered members. I was recently involved directly in this regard when I attended the European General Practice Research Workshop in Slovenia, and I refer you to Dr. Anthony Mifsud's account published in this issue. The college and the EGPRW are both eager to build on this relationship, and in fact the EGPRW meeting in October 1996 will be held in Malta.

In conclusion, may I once again wish you my best of luck for the New Year, and hope to see you at the January CPD meeting!

Jean Karl Soler

CONTINUING PROFESSIONAL DEVELOPMENT 1995 PROGRAMME

Accreditation is to take the form of credit units and the system of credit allocation will take into consideration both active and passive involvement in Continuing Professional Development (CPD) activities, the former attracting more credit units than the latter. Each member of the College must accumulate 27 units annually to retain the right to membership. A CPD logbook has been distributed to all members to allow recording of credit units as they are accumulated.

SOURCES OF CREDIT UNITS

Informal (Active) Learning:

1. Presentation of lecture at College or 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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In the same way as medication has side effects, so also a visit to (or by) the doctor may have psychological "side effects", such as relief, worry, suspicion, guilt feelings or blame. Sometimes psychological factors are themselves the central issues behind the symptoms treated by the doctor, as in the case of psychosomatic illness and stress induced illness.

The doctor's role is not merely to diagnose and prescribe treatment, but also to advise patient on lifestyle, attitudes and preventive measures. How well a doctor's propositions are attended to and implemented by the patients and their caregivers depends heavily on how doctors put their message across and the nature of the doctor-patient relationship. What follows is a series of psychological skills that can enable doctors to notice these psychological "side" or central "effects", and to use these to arrive at an optimal working relationship with the patient. In medical jargon, this paper is a sure-fire prescription for an effective bedside manner.

I will be referring to four basic skills, which are:

1. **Listening and attending**
2. **Using the understanding response**
3. **Validation**
4. **Legitimation**

To illustrate my presentation of each I will be using two hypothetical case studies:

(a) an 18 year old young lady we can call Anna who consults her family doctor regarding an itch she has been feeling in her vagina, and

(b) a 38 year old man to be called George who has been diagnosed with a stomach ulcer.

Listening and attending

Telling the doctor what you have and what you are feeling is very important for the patient. It feels as if one is removing a heavy burden that could not be handled. By letting the patient talk and by paying close attention, the doctor can become aware of psychological factors, e.g.. the fact that Anna feels guilty about sexual encounters she should not have had and fears that perhaps she is being punished for her immorality, or in the case of George that he is in over his head with work commitments and his wife is not taking his over-involvement at work very well.

Listening and attending sounds deceptively simple as a technique. Important components of this skill are: facing the patient, maintaining eye-contact, an open posture, the assuming of encouraging non-verbal behaviour (e.g.. leaning forward, nodding) and the ability to focus and concretize patient expression. For example:

To Anna who tends to ramble in her nervousness: "You were telling me about your last date with your boyfriend before you began to talk about discos, let's go back to that shall we?"

To George: "You said that you have a lot of worries, perhaps you can tell me what exactly is worrying you".

The effect that listening and attending has on the patient is a sense that the doctor is thorough

and must really have a grip on the problem now that he or she knows so much. This boosts the patient's confidence in the doctor significantly. Also by the cathartic effect of unburdening oneself, the patient is relieved and in a better state to address the medical problem.

Using the Understanding response

This is a skill used extensively in counselling and psychotherapy. It can be loosely defined as showing the other person what you have understood. It can range from merely repeating what the person has said, to it's more advanced forms where the therapist senses the unsaid and shows the client that he or she has understood even that. A basic understanding response to Anna may be: "So if I understood what you said, you are worried about what caused this itching". To George the doctor may say: "From what you are telling me I can see that you are being bombarded by demands by everyone, your boss, your wife, your children..."

When the doctor uses such understanding responses, the patient is assured that the doctor understands. Once again this increases confidence and trust in the doctor and leads to the formation of a "working alliance" ensuring that the patient will listen to the doctor's recommendations and put them into practice. In addition the understanding response has the effect of leading the patient to risk more and reveal more. Anna may draw up enough courage to reveal that she actually had sex with her boyfriend and now feels terrible about it. George

may confide in the doctor by adding that the real source of his worries is the fact that he found out his company is embroiled in criminal activity and the police are closing in. These are facts that the doctor needs to know in order to give the right advice and prescribed treatment.

Legitimation

Many times persons are very self critical, and although their exterior may show that they are confident and sure of themselves, deep down they are very prone to condemning themselves, to dwelling on their mistakes and ignoring the mitigating circumstances. Although George is not a part of the criminal activity in his firm he feels so incapable and stupid for having been deceived by his colleagues. Anna is feeling that her worrying about sex will scare her boyfriend away and the blame for losing him will fall on her shoulders.

Legitimation is the skill whereby the helper shows the person what they are not to blame for and what they are justified in feeling without guilt or recrimination. In Maltese legitimation is better explained as "turihom fejn ghandhom ragun".

Using this skill, the doctor can tell Anna: "Any responsible person would worry if they had sex when they were unprepared for it. I think your worrying shows a certain maturity on your part".

To George, the doctor might say: "Our human senses are limited George, if someone wants to hide something from you and is cunning enough they could outwit even the most observant of persons".

These comments help the patient to gain a sense of perspective and to realize that they are not dealing so badly with the problem after all. The most important effect is that after this

patients are better disposed to hear what they would not like to hear, that is their shortcomings and irresponsibilities (fejn m'ghandhomx ragun): for Anna the risk of AIDS and STD's, for George the serious consequences of his worrying and lack of rest.

Validation

This skill has to do with raising the patients' valuation of themselves. It consists of recognizing the value of the patient, helping them feel that they are worthwhile persons and showing them their strong points.

The doctor can validate Anna by telling her: "Despite the fact that you gave in to your boyfriend, you seem to have certain values in your life which point out your mistakes to you. This is an important quality to have".

To George: "Well George, if you worry so much it must be that you must care a great deal both for your work and your family. If you did not care, perhaps you would not worry".

Validation has the effect of boosting patients' self-esteem and self-confidence. It increases and makes possible their resolve to comply with what are sometimes very difficult prescriptions of the doctor: to stop smoking, to lose weight, to change one's lifestyle, to have an operation, etc.

These are the basic skills that can be utilized in the doctor-patient relationship. There are others, such as Empowerment, where patients are encouraged to take responsibility for their health and be active rather than passive in their healing process. These skills stem from a patient-centred philosophy of medicine. Their disadvantage is that they are more time consuming than merely diagnosing and treating in an impersonal manner. Their advantage is that the patient leaves the consulting room with

hope and confidence, while the doctor has the satisfaction of knowing that he has not only treated the body, but also the mind and the soul. As a result of this the healing process will be that much more extensive and lasting.

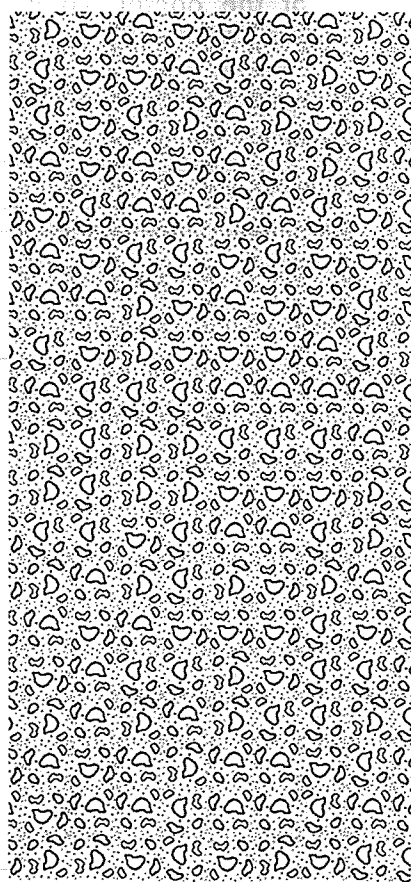
Empowerment

Your health is in your hands not mine. Turn passivity to activity (ensures that patient will not only take medication) but also take advice – a crucial part of treatment.

Research shows that the attitude towards illness is an important part of the cure.

How to empower:

Savoire model. Ultimately these are gimmicks until they become an attitude. Some attitudes behind these skills are: the practice of patient centred medicine, non-chemical treatment and preventive medicine, respect for human beings and their experiences.



My experience comes from three interlinked fields. That of a physiotherapist and manager of the World Class fitness centre, as well as an active sportsman.

Many people, even in today's age of constant bombardment, from the mass media on the various forms of exercise, still have the absurd notion that exercise is only done temporarily following a particular musculo-skeletal injury, to reduce weight, and sometimes to overcome boredom.

The No 1 factor which has always attracted people towards exercise is education. The process of education, i.e. promoting health and fitness, usually travels a determined course.

Unfortunately this course is very often side-tracked along the way. This often happens as the 'norm setters' vary with the age of the individual, from the coach or teacher in children and adolescence to the physician in many older adults.

This is an important point. Physicians have always been instrumental in prescribing exercise, and may on occasion even influenced, the outlook of some of your patients views towards exercise.

Doctors should be at the forefront in prescribing exercise to their patients. But does one feel confident enough when giving advice? Or do we just avoid mentioning it because we feel it may not concern us/or just play down its importance!

This has been highlighted by two separate papers, one which was published by the

A.M.J.PREV. MED 1991 and the other by the Canadian Family Physician 1992 showed that the physicians who had not actively participated in sport would not be as willing to prescribe exercise to their patients as those physicians who had done exercise regularly.

Out of the 63 doctors questioned in one of these studies, 62% felt the need for more knowledge about exercise and 54% felt some discomfort i.e. felt uncertain in making specific recommendations to their patients.

Professor RJ Shepherd who is a well known authority in the field of sports medicine, believes that even in a country like the USA, where people are so obsessed with good looking bodies, there is need for changes in medical and para-medical school curricula. So that especially doctors who are primary educators can tackle the elementary facet of preventive medicine effectively.

Hopefully some might decide in the near future, to set up a course in the form of a day course or workshop to help share ideas and keep abreast with what is going on in the field.

I am sure we all understand the physiological benefits of exercise, and also we must be very aware of the possible dangers of incorrect exercise prescription.

We are passing through an age where people have become obsessed in creating images for themselves, by trying to look like their favourite screen idols. I constantly meet people wishing to trim a few pounds off various placed in their bodies, as though Michelangelo was about to chisel

a famous sculpture. But we know very well that any form of drastic change can only be performed by means of just as drastic a measure.

Peoples opinion is strongly influenced by the general trends or habits and the persons ability to conform with those norms. E.g. I would not expect an elderly woman who has never done exercise in her life to start exercises at a gym just because it was trendy. For many people gymnasiums look like large metal jungles, full of self-centred people. I must say, in some instances they might be right!

How does one go about prescribing the right exercise?

First of all we are not about to give accurate advice to anyone, if we do not know:

- (a) what is available and suitable for the individual's lifestyle and habits
- (b) if we do not set the patient's sights on achievable goals
- (c) keep up to date with the latest advances in the field.

Motivation is the key to exercise prescription and it depends a lot on the individual's (physician/physiotherapist) initial advice. Many beginners, may either prefer to exercise alone i.e. walking, home exercise or swimming and this may be suitable for some individuals as well as being extremely useful. The good thing about this form of exercise is that one does not need any fancy expensive equipment and is easy to adhere to.

I find, I must constantly remind clients participating in team sports such as football (amateur level) or activities such as jogging,

that these activities should not be selected as routine exercise to lose weight or gain fitness. **One should not start jogging to get fit but rather one should get fit to go jogging.** I often explain the story of the chap who started the jogging craze to lose weight, Mr. James Fixx, who unfortunately died of a massive heart attack whilst jogging.

Although the benefits of exercise far outweigh the risks we must be realistic and inform our patients of the tests that should be done to prevent any unfortunate accident. At our centre we recommend anyone over the age of 35 who has no exercise background or might be in the high risk bracket, to have a complete medical done by their GP and possibly a stress test.

Most people young as well as old prefer to do exercise with a group of friends or people they can socialise with and share experiences with. We must not forget the social and psychological benefits as well as the physiological aspects of exercise.

One of the satisfactions I encounter in my work, very often, is when a client who might have reluctantly attended the fitness centre for the first time, who might have been forced by a nagging spouse or girlfriend or a patient whom I might have referred to the gym to do rehabilitative exercise, come to me after a few weeks and feel that the time spent in the centre helped the client/patient feel mentally refreshed and really relaxed. They feel they are able to concentrate more when at work, they are able to sleep better, are more aware of their eating habits, and most of all feel less general aches and pains.

Interestingly enough, it is not often that families join in exercising together. We often see a father and son doing exercise, playing football, riding a bike or a

mother playing a game of tennis whilst their children are taking tennis lessons and so forth, but rarely do we see a whole family group.

At my centre we do have a few families who come down together, especially on the week-ends. I must say I really admire those parents who 'make time' to join their children in some sporting activity. At World Class whilst the children are taking a swim in the indoor pool, parents may exercise. As the gym overlooks the pool, both parent and child can keep and eye on each other.

Besides the obvious advertising opportunity, I mentioned this, because I feel that if we really believe in the benefits of exercise, this behaviour is an ideal stimulus for our children's future. Children brought up in this way will most definitely find it easier to continue doing exercise as a way of life, as is going to work or school, rather than just a boring habitual chore to be done when one is stimulated by an overweight complex or injury problem.

In one instance, I organised two seminars on separate days. One was entitled 'exercise in children' and the idea was to bring together the Minister of Sports and Culture, sport educators, parents and sportsmen to discuss the difficulties encountered in this field. The turn out was extremely poor despite a good advertising campaign.

The other was Back Pain. I had invited a foreign lecturer to talk about the latest trends in the treatment of back pain. The turn out for this lecture was overwhelming. We had 130 people in a hall that should take about 80. This highlights the fact of the little importance we give to exercise education and prevention, in children. Strictly speaking we cannot expect a very healthy future if this remains the same.

I would like to say a few words on exercise prescription and injury, namely back pain. I really can't understand why, so many people are told that when one has a musculoskeletal injury whether it be an ankle sprain or back pain especially back ache without neurological symptoms they are told not to exercise. Most of the current literature on musculoskeletal injury shows that we may be causing irreversible damage by advising a patient to rest following a minor injury.

To conclude, a point of interest, and serious misconception. Abdominal Exercise. Studies carried out by M. Cumberford in Australia and Shirley Sharmon in America show that the most important muscle group for trunk stabilisation are the obliques. Owing to their origin and insertion they form the trunk's natural corset. Most of their work is done on the concept of muscle balance or imbalance which may be the case in injury.

Most abdominal exercise performed today have been shown to stimulate only the rectus abdominis and mostly the hip flexors namely iliopsoas. Therefore a person boasting of being able to perform 200 sit-ups a day in a crouch position may actually have weak trunk stabilisers (obliques). Therefore we should not be surprised that a seemingly fit athlete complaining of an acute back ache after just an hour of standing may really be suffering from muscle fatigue due to poor trunk control.

Also the method used to do these exercises mainly stimulate the muscles fast twitch fibres, when we know that postural muscles are predominantly, slow twitch fatigue resistant muscles.

Studies on back pain and the various treatments are numerous. One particular study done in Cologne in 1991 showed that initial strength analyses in various

age groups shows maximum strength is obtained in men up to the age of 20-29 years, and in women at 20 years of age.

An interesting note is that the back strength reaches its peak again at the age 40-49 years in men and 40-49 years in women this is followed by a rapid decline in torque. The reason for the rapid decline is strength at the ages between 25-35 years may be that at this age group most people are concentrating on their lives, their families, their work and studies and have little time for themselves. People still think that their physical capacity is that of a young person, when in fact the

degeneration process starts much earlier.

The relation between back pain and strength is relatively proportional i.e. the greater the pain the less the muscle strength as well as the mobility.

Sports such as jogging and football have little effect on back extension strength. This, because this type of sport does not particularly stimulate the back muscles.

Controlled exercise may improve these strength figures by 50% and reduce back pain by 70%. (The patients admitted to

these research where not suffering from neurological symptoms.) These results highlight the importance of exercise in the treatment of back pain.

Whatever the spinal alignment as long as there are no serious pathological changes, exercise together with the right advice and treatment, if necessary, is an important treatment and rehabilitative tool, as well as an important preventative measure in dealing with musculoskeletal and on occasion psychological stress. Thus, exercise can help us regain peace of mind, calm tempers and most of all like the proverbial apple keep the doctor away!



ROYAL COLLEGE OF GENERAL PRACTITIONERS

At a time when general practitioners are increasingly coming under pressure, it is particularly important for them to find time to "stand and stare". This major 'think-piece' by Dr Peter Toon, of St. Bartholomew's Hospital Medical College, offers just such an opportunity.

Dr Toon believes that the current debate about quality in general practice is being conducted on the wrong battleground – politics and science, rather than ethics and philosophy – and that the key is to be able to recognise the distinction between facts and values. To this end he defines three models of general practice: the biomechanical, the humanist, and the public health. He also tackles the problems of running a practice as a business and the concept of the family in family practice.

Those who expect a definitive answer to the question "What is Good General Practice?" will be disappointed. *Occasional Paper 65* is essentially a

work of medical ethics which seeks to resolve concepts and find a unified philosophy rather than promulgate practicalities. In doing so it will provide a welcome challenge to those who want to stand back and think deeply about the role of the generalist in medicine today.

What is Good General Practice?, Occasional Paper 65 is available from RCGP Sales, 14 Princes Gate, Hyde Park, London SW7 1PU. Tel: 071 823 9698. Price £10.00 (£11.50 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 071 225 3048.

Enquiries about the content of this *Occasional Paper* should be made to:

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Considering the work environment at a local shipbuilding industry, namely, Malta Shipbuilding. Here, I was employed on a five day week basis, visiting employees reporting sick at their homes. A total number of 2,000 employees were registered on their books during the period in question – namely, 19th October 1990, when I started work, up to the 11th October 1991 (52 weeks). I was only responsible for half the workforce – that is, 1,000 employees. During this 52 week period, there were 3 weeks of shutdown: from the 15th to the 30th August, and from 24th to 31st December. In addition, I was off work for four weeks during the whole year. So, I actually worked 45 weeks during the year and visited a total of 1,659 cases averaging 7 to 8 employees per day in a 5 day week.

The workforce at Malta Shipbuilding comprises skilled labourers like shipwrights, painters, grinders, carpenters and crane drivers together with their chagemen, foremen and managers. The industry has only 60 managers but a bigger number of administration clerks,

Considering breakdown of figures in terms of certified illnesses. (A)

	AETIOLOGY	NO. OF CASES	%
1	URTI	330	30.5
2	GIT	195	18.0
3	BACKPAIN	105	9.6
4	TRACIMA	80	7.4
5	E.N.T.	72	6.6
6	LOWER RTI	70	6.5
7	MALINGERING	65	6.0
8	CVS	32	2.9
9	POST OP+HOSPITAL	30	2.8
10	OPHTHALMIC	25	2.3
11	OTHERS	79	7.4
	TOTAL	1086	100

Considering breakdown of figures in terms of Injuries on duty (B):

1	OPHTHALMIC	263 CASES
2	LOWER LIMBS	101 CASES
3	UPPER LIMBS	95 CASES
4	BURNS AND SCALDS	59 CASES
5	BACK AND NECK	27 CASES
6	HEAD INJURIES	19 CASES
7	CHEST AND ABDOMEN	7 CASES
	TOTAL COMPLAINTS	573 CASES

This averages 8.81 days absence per worker per year due to injury on duty. A graph representing number of injuries versus complaints may be read in ANNEX (B). A graph representing number of injuries versus month by month may be read in ANNEX (B1).

JOURNALS REPORT

- (i) Suratman A and Lai C.S. from Ann. Acad. Med. Singapore 1984
- (ii) Sadaragani C from Ann. Acad. Med. Singapore 1984

I would like to thank the following:

Josef Micallef – final year Medical Student for his great dedication and enthusiasm.
Malta Shipbuilding – Personnel Department (re statistics quoted).

Considering individual cases in decreasing order of frequency:

1	URTI	included influenza – illnesses, tonsillitis, sinusitis, pharyngitis, and laryngitis.
2	GIT	included gastritis, gastric flu, gastro enteritis and abdominal colic.
5	ENT	included autitis externa and media, vertigo and labyrinthitis.
6	LOWER RESPIRATORY TRACT INFECTION	incorporated bronchitis and asthma.
7	MALINGERING	these cases included people not found at home, patients examined and found fit for work and no reply on ringing the doorbell.
8	CVS	included chest pain due to angina, M.I. and hypertension.
9	POST OP+HOSPITAL	included hip replacement, LIH, SMR, Gastroscopy Gallstones op. and FIA.
10	OPHTHALMIC	included conjunctivitis and foreign body.
11	OTHERS	included psychiatric cases (24), skin (15), renal (11), generalised allergy (9) and dental complaints (8).

A graph representing Aetiology versus no. of Cases may be read in ANNEX (A).

This gives a total of 1086 cases seen, corresponding to 4329 working days lost, averaging 3.67 days sick per man per year.

draughtsmen and store officers. The average age of the shipyard worker is roughly 28 years.

The average absence due to sick leave amounted to 3.67 days per employee per year. In addition injury on duty at said work place amounted to 8.81 days per employee per year. Thus the total days lost amounted to 12.48 days per employee per year.

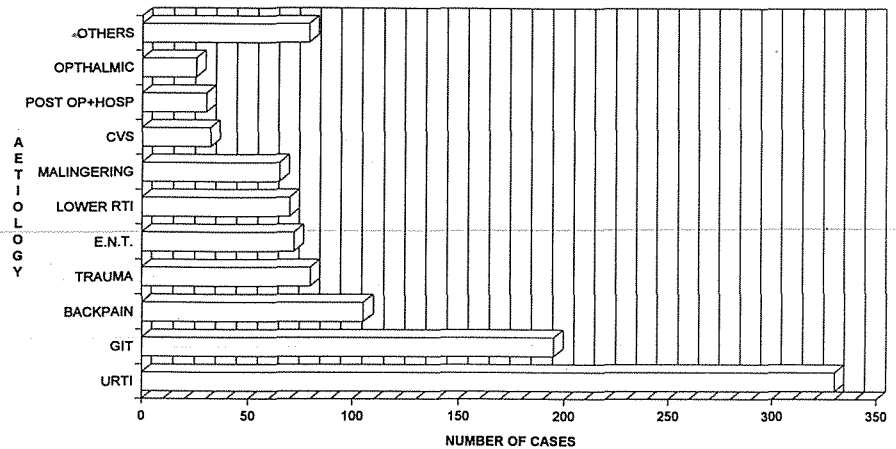
These figures were arrived at by considering absence from work due to sickness where there were 4,329 days lost and 1,086 cases seen. This gives a figure of 3.99 days absence on average. However, there were 1,000 employees on the books of Malta Shipbuilding giving 3.67 days loss from work due to sick leave per employee per year.

Considering days lost from injury on duty when there were 2,895 days lost and 573 cases seen, one arrives at the figure of 5.05 days absence due to injury per employee per year. The workforce of Malta Shipbuilding was 1,000 giving a figure of 8.81 days lost per employee per year. The total figure for days lost from work per man per year amounted to 12.48 days.

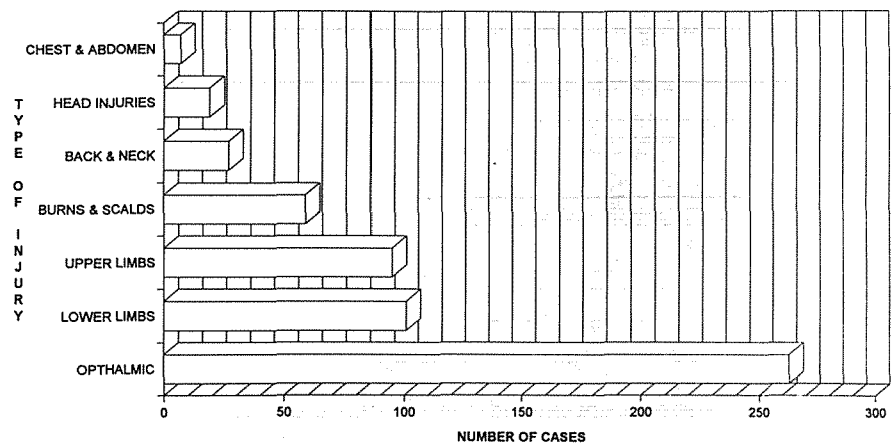
From a report in a journal (i) an oil company in Singapore gives 7 days loss from work due to sick leave per man per year for 1982. This rate compares to that for two shipyards in Singapore. Another report (ii) gives 4 days sick leave per employee per year in a Kuwait company for the year 1982. This journal quotes that the rate for Britain is 19 days sick leave whereas that for Germany is given as 12 days sick leave for 1978.

Considering the above reports the Maltese shipyard worker compares remarkably well with his European counterpart. On the other hand, he is not lagging far behind with his Asian colleagues. One must take into account the work environment, climate and advanced technology of his Asian colleagues.

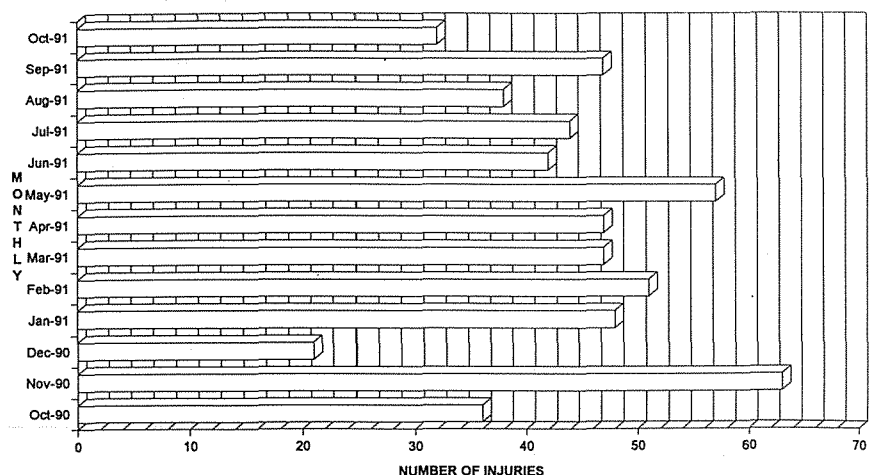
CERTIFIED ILLNESS (ANNEX A)



INJURIES (ANNEX B)



MONTHLY INJURIES (ANNEX B1)



The year 1994 has been declared by the United Nations as the International Year of the Family, indicating the social importance vested in the Family. This investment would be a complete failure if the active members of this same society do not act upon the idea and use the family as the fulcrum for general social improvement.

One way of ameliorating society through the family has been acted upon by the Health Promotion Department. What the department has done is that it has changed from the thematic approach that is from themes such as smoking, AIDS, nutrition to the settings approach. This approach is basically looking at society as a number of different settings namely workplace, schools, and families/communities.

This is really a more advanced approach than the thematic one as it encompasses most of society and meets people wherever it is most convenient for them. This, however, does not mean that the themes have been left out, on the contrary, these have been expanded and adapted according to the needs of the different target populations.

What is Health Promotion?

Health Promotion is rapidly establishing itself as an important force within the "New Public Health", itself an important feature of contemporary approaches to health and health care provision. Health promotion is a multi-disciplinary endeavour. Different forms of expertise inform both practice and research. The academic roots of health

promotion lie in what might be called the primary feeder disciplines, that is, psychology, education, epidemiology and sociology. More recently, secondary feeder disciplines such as social policy, communications theory, marketing, economics and philosophy have also made substantial contributions. Underlying previous development in health education and to a large extent evident in health promotion also are the medical disciplines. A medical contribution has often been and still is present in the form of an underlying influence. In fact, the object and focus of much of health promotion work rests, certainly at practice level, on a medical perspective, though more often from a social medicine viewpoint.

A central theme of health promotion is to develop interventions that do not resort to institutional medical forms of care. As such it fits in with more general moves away from state welfare provision and within a new public policy environment. It is possible to consider health promotion as a frontier of contemporary policy and cultural change (Beattie, 1991).

Health Promotion is now a growing part of industrialized health care systems, and is increasingly an integral part of primary care provision. It is representative of fundamental shifts in the relationship between the state and citizens.

Central to health promotion is a commitment to multi-sectorial action. To be successful, collaboration in theory must be matched by collaboration in

practice. This can be done only by taking multi-disciplinarity seriously. A step in this direction is to bring together contributions from different disciplines to health promotion.

Health promotion has emerged in the 1990s as a unifying concept which has brought together a number of separate, even disparate fields of study under one umbrella. It has become an essential part of the new public health movement. Health promotion now forms an important part of the health services of most industrially developed countries and is the subject of a growing number of academic activities.

Adoption of a multi-disciplinary approach to health promotion could avoid a blinkered approach and may be more appropriate to the health issues of the late twentieth century.

Why the Family?

The family is usually the most immediate potential support to individuals and thus their first line of defence. The family can make a major contribution to health promotion through role-modelling, adopting healthy lifestyle patterns, and developing appropriate attitudes to health and use of health services. Alternatively, in some cases family relationships may not be conducive to good health and can result in physical and mental abuse. Hence the acute need for interventions.

On a more positive note, we know that the family is the first positive point of contact with society. We also know that the

family doctor would already be playing a very active role in the health of the family. This central role needs to be acted upon and utilised to the benefit of the individual, the family and society. What we are actually highlighting is the fact that the family doctor is also a health promoter. One who already carries credibility and who himself plays an important social role.

The family itself is the most important educator. So important that habits internalised at the early years are ever so difficult to wipe out. Most of these habits are basically family habits but parents are always ready to offer their offspring a better chance in life. The doctor can monopolize on this inclination and offer better information and advice.

However, no formal set-up for the education of people who are capable of forming a family has ever been established. The responsibility of disseminating health promoting information and other relevant information falls squarely on the many disciplines who, through the execution of

their professional work, come in contact with families. The medical profession is one such profession.

The term 'family' is used here to include non-conventional families and households as well as the traditional woman-man-child unit. One parent families are on the increase and present their own special needs. Health Promoters need to be well aware of these needs and cater for them.

Evidence on the positive and negative effects of families on health is now available in many countries. A study carried out in 1989 by Health Promotion Authority Wales named The Welsh Youth Health Survey demonstrated the important influence parents have on the development of health attitudes and behaviours. It also highlighted that children of smokers were more than twice as likely to smoke than the children of non-smokers. This is just one example.

The family also acts as an important care-giver for sick or disabled family members. A high percentage of the care provided

to the elderly living in the community is provided by informal careers – normally female family members. Therefore it is not just primary health promotion that we are considering!

The development and maintenance of 'healthy' families have traditionally been a focal point for the support services and the church. Based on experience, more support services and policy measures that support family life and family health can be developed. This point towards the political commitment that health promotion demands. However, this cannot be the bottom line. More support may simply mean further dependence. Education including information and role-modelling means empowerment – an enrichment to all concerned. Empowerment is the crux of health promotion.

How does this relate to family doctors?

In the local situation, the family doctor is a central figure, so central that people do not go to him/her for medical advice only. This central position can have a



ROYAL COLLEGE OF GENERAL PRACTITIONERS

Emotional problems form a very large part of the work of the general practice and some forms of mental illness are the commonest of all diseases in the British population. The Health Service has always devoted a great proportion of its expenditure to mental illness and with new developments taking place in community care, the time is right for a complete rethink about the provision of these services and how they relate to primary and secondary care.

Psychiatry and General Practice Today is the first book to be written jointly by two medical Royal Colleges. Both the editorship and authorship were shared equally between general practice and psychiatry and together they tackled many of the

PSYCHIATRY AND GENERAL PRACTICE TODAY

major issues on this subject. The book therefore represents a landmark in co-operation and comes at an appropriate time when services are being so radically reviewed.

Psychiatry and General Practice Today, published by the Royal College of Psychiatrists, can be obtained from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £17.50.

If ordered from the Sales Office at Princes Gate at the same time as *Psychiatry In General Practice*, by Arthur and Betty Watts, the price for the two books is £29.00.

considerable influence on the potential health promotion activities of the families. Family doctors can do much to encourage healthy lifestyle. Such advice should not only be positive, sensitive and timely, but should also acknowledge and address barriers that patients may come across when adopting new or altered health behaviours. These barriers may be apparent only to those close enough to be able to see through the social screens.

The family doctor is many times seen as a friend – he is not simply asked questions relating to health and lifestyle but he is watched and seen as a role-model too. Patients tend to look up to their doctor and rightly so but it is important for one to realise the responsibility of actually living a healthy lifestyle.

In Health promotion one cannot not mention the preventive aspect. In fact a particular model discussed by Tannahill (1987) sees the preventive side of health promotion as one of its integral parts. This aspect focuses very much on the knowledge, information given. The family

doctor is definitely a source for this kind of information. Such topics as physical exercise, smoking, alcohol and drugs, physical development, safety measures, food and stress control are in line with healthy lifestyle. One must not at this stage forget screening programmes. The family doctor is in an ideal position to guide those of his patients who need specific screening!

In case one feels that discussion may not always be possible due to other pressures on the family doctor – a supply of leaflets on these topics should enhance every waiting room although it can never replace one-to-one communication. Development of such material may be a means of different professions coming together.

In short, when we look at health promotion in the family, we see the family doctor as a very important protagonist.

- He/she is an important source of information
- Can help his/her clients increase their self-confidence by adopting a more open

attitude towards discussing health issues

- Educate on parental skills, healthy lifestyles
- Teach first aid measures
- Be informed on and refer to self-help groups
- Use the clinic as an educational outlet

The family doctor is an important point of contact between society and health promotion. Recent research has highlighted the fact that in developed societies about 80% of any given population have contact with the family doctor at least once a year. If this doctor is well versed in health promoting messages, then the vital link can be established, if on the other hand, health promotion does not rate high on his/her agenda, then an important opportunity may be lost for ever.

My last point is a simple question. Are our doctors willing to be health promoters? If the answer is yes, then let us apply our messages further. But if the answer is no, then another question follows: What are you/we going to do about it?



ROYAL COLLEGE OF GENERAL PRACTITIONERS

1952 was a special year in the history of general practice, as it saw the foundation of the College of General Practitioners. The result was the release of a vast amount of intellectual energy among leading general practitioners. Among these were Arthur and Betty Watts, founder members of the College, who produced their book *Psychiatry in General Practice* in that same year.

The College has republished this book for three reasons: first as an important historical marker, as it was one of the earliest clinical books from general practice; secondly, because the volume of depressive illness remains the same today as it was forty years ago, and the principles of care still apply; and

thirdly, to contribute to the "Defeat Depression" campaign already distinguished by the publication of the first joint book by two Royal Colleges, details of which are enclosed.

Psychiatry in General Practice is available from RCGP Sales, 14 Princess Gate, Hyde Park, London, SW7 1PU. Tel: 071 823 9698. Price £15.00 (£16.50 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 071 225 3048.

If ordered from the Sales Office at Princes Gate at the same time as *Psychiatry and General Practice Today*, by the Royal College of General Practitioners and the Royal College of Psychiatrists, the price for the two books is £29.00.

PSYCHIATRY IN GENERAL PRACTICE

1ST ASIA PACIFIC TRAVEL HEALTH CONGRESS • HONG KONG

"AGENDAS FOR THE FUTURE"

Invitation

At the very successful World Congress on Tourist Medicine and Health held in Singapore, January 1993, the Asia Pacific Travel Health Association selected Hong Kong as the venue for the next international meeting. Entitled the **1st Asia Pacific Travel Health Congress**, this conference will focus on the health of travellers in general, and especially those whose business or journeys take them in and out of the Asia-Pacific region.

The Congress will feature a range of topics of central interest to both the medical professional and those in the travel and tourist industry who wish to ensure the optimal health and safety standards for their clientele. Our objective is to bring together the latest information on travel health to benefit all concerned in this quickly emerging field.

The opportunity to visit Hong Kong in the historic run-up to the change of sovereignty is not without historical significance. In addition, pre- and post-conference tours offer the opportunity to visit some of the most interesting countries in the world.

We hope you will join us in Hong Kong in March 1996.

*Dr Ian B Marshall, Chairman
Congress Organising Committee*

DATES TO REMEMBER:

DEADLINE FOR EARLY REGISTRATION	30 SEPTEMBER	1995
DEADLINE FOR RECEIPT OF ABSTRACTS	30 SEPTEMBER	1995
ACCEPTANCE OF ABSTRACTS	30 NOVEMBER	1995
DATE OF CONGRESS	4-8 MARCH	1996

PROGRAMME EMPHASIS

Travel Health Management
 Future directions in travel health
 Impact of travellers on government resources
 Special considerations for travel in Asia
 The business and frequent traveller
 Information and communications to consumers
 Education and training for professionals

Medical
 Hepatitis A and B
 Vaccinations for travel
 Malaria, prevention & drug resistance
 HIV-related health risks
 Sexually transmitted diseases
 Other viral infections
 GI infections/diarrhoea
 Allergic reactions/skin problems
 Other tropical diseases
 (TB, dengue plague, cholera, melioidosis)

Travel Industry
 Pre and post travel health services
 Safety issues and accidents
 Health problems in air travellers
 Medical assistance and evacuation
 Reducing risk to travel service providers
 Advice from/for food handlers, hoteliers,
 tour providers, removal companies
 Travel health insurance

Keynote speaker:

Professor Robert Steffen, MD
 President, International Society of Travel Medicine

ABSTRACTS

Abstracts are invited for free papers and poster presentations. Abstract forms can be obtained from the Congress Secretariat and will be sent with second announcement. Authors whose abstracts are accepted for presentation will be permitted to register at the reduced (members') rate.

Background:

The European General Practice Research Workshop (E.G.P.R.W.) is an academic group composed of general practitioners all over Europe, who are involved in research in General Practice. Workshops are held twice a year in different European Countries.

The Malta College of Family Doctors is a member of the E.G.P.R.W. and in order to stimulate research in general practice, two members (Dr. Anthony Mifsud and Dr. Jean Karl Soler) have participated in the recent E.G.P.R.W. workshop held in Ljubljana Slovenia from the 13th to the 16th October 1994.

Report:

This workshop dealt with

evaluation of cost effectiveness in General Practice. During the two and a half days of the workshop a number of theme and free standing papers were presented and discussed. During this meeting one is impressed by the informality and cordiality of the participants, which stimulated us to make valuable contacts with colleagues from all over Europe who are readily willing to help our College to initiate research in General Practice.

Before the workshop, we had a meeting with the E.G.P.R.W. executive board. During this meeting we proposed that a future workshop should be held in Malta. After discussion, our proposal was accepted and an **E.G.P.R.W. workshop will be held in Malta in October 1996.**

Conclusion:

The papers presented were very stimulating and the ideas aired could easily be used to set up similar fruitful research projects in Malta. This fact together with the useful contacts made with other European colleagues rendered our participation worthwhile and I suggest that attendance to such meetings should become a regular part of the M.C.F.D. activities and urge college members to participate.

I, together with Jean Karl Soler would like to give special thanks to our sponsors who made our participation possible. (1. M.C.F.D., 2. N.S.T.S., 3. Drug Firms: Associated Drug Co Ltd., C. Degiorgio Ltd; A. Gera & Sons; Galea Pharma; and Pharmacos).

**ROYAL COLLEGE OF GENERAL PRACTITIONERS**

Diabetes is an important disease and one that is increasing in prevalence. Its impact is such that people with diabetes face shortened expectation of life and the risk of serious complications, and it therefore poses a tremendous challenge for care.

Essential for good care are good working relationships between patients and professionals. The fact that specialists cannot on their own provide personal care for diabetic patients and that diabetes, like most long-term chronic diseases, is best managed by multidisciplinary primary health care teams has led to the development of shared care arrangements between patients, general practitioners and specialists.

**PSYCHIATRY IN
GENERAL PRACTICE**

In this new *Occasional Paper*, Dr Patricia Greenhalgh, Clinical Lecturer in Primary Health Care, reviews a whole variety of shared schemes in the UK and concludes that whatever the merits of sole hospital care, shared care or sole general practitioner care, it is systematic, organized care that counts.

Shared Care for Diabetes, Occasional Paper 67 is available from RCGP Sales, 14 Princes Gate, Hyde Park, London SW7 1PU. Tel: 071-823-9698. Price £9.00 (£9.90 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 071-225-3048.



EVALUATION OF THE WINTER CPD MEETING

5-7 OCTOBER 1994

Day 1: Wednesday 5th October 1994

Pitfalls of the C.X.R. – Dr M. Crockford

“How I manage ...” – Dr J.K. Soler

Doctors present: 40
Forms returned: 27

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

Disagree: 0
Undecided: 3
Agree: 24

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

Disagree: 0
Undecided: 1
Agree: 25
No reply: 1

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

Disagree: 1
Undecided: 9
Agree: 14
No reply: 3

The best feature of today's seminar was:

- Pitfalls of the C.X.R. (x14)
- Visual aids of the pitfalls of C.X.R.
- Follow up of pitfalls of C.X.R. needed
- Reading a C.X.R. properly
- Punctuality and not too long
- A lesson I've learned (x1) important from a general practice point of view

Today's seminar would have been better if:

- Pitfall of C.X.R. should have been spread over 2 to 3 sessions
- C.X.R. taken bit by bit
- 2nd speaker spoken more clearly and had better transparencies
- If seminar was better attended
- Better quality transparencies of 2nd talk (x6)
- Time too restricted (x2)
- Less rushed through

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

Dr. Julian Mamo

Epidemiology in General Practice
Consultation Skills, Medical records,
Counseling skills, Sexual counseling.

Day 2: Thursday 6th October 1994

Well woman clinics – Dr Scerri

A lesson I've learned – Dr Philip Sciortino

Doctors attending: 41
Forms returned: 25

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

Agree: 22
Undecided: 3
Disagree: 0

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

Agree: 22
Undecided: 1
Disagree: 1

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

Agree: 17
Undecided: 8
Disagree: 0

The best feature of today's seminar was:

- Dr Sciortino's presentation (x5)
- Dr Scerri (x7)
- Both talks (x2)
- Dr Sciortino was precise
- Dr Scerri was very well done (x2)
- Good lesson learned from Dr Sciortino's talk
- The wider aspect of the well woman clinic
- Systematic approach (both speakers)
- Visual aids (Dr Scerri)

Today's seminar would have been better if:

- Better audio visual aids
- Started earlier
- Questions for each topic immediately after each lecture and not lumped together in the end leading to confusion
- Offer tea and lemon (Dr David Sciberras)

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

Dr Julian Mamo
Epidemiology in General Practice

Day 3: Friday 7th October 1994

Promoting Health in the Family – Forum

Mrs S. Bugeja – Health Promotion Manager
Dr S. Scicluna Calleja – Psychology Lecturer
Mr A. Zammit – Physiotherapist
Dr G. Farrugia – Family Doctor and Local Council Mayor

Doctors attending: 45
Forms returned: 23

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

Disagree: 0
Agree: 22
Undecided: 1

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

Disagree: 5
Agree: 17
Undecided: 5

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

Disagree: 3
Agree: 17
Undecided: 3

The best feature of today's seminar was:

Promoting exercise
The psychologists presentation was very pertinent (x10)
Dr Alan Zammit's presentation (x5)
Both (x5)

Today's seminar would have been better if:

1st and 2nd talk have been done away with
Specific instructions as how to exercise different muscle groups
The physiotherapist and family doctor were more specific and less general in their lecture
Speakers topic more closely related
Less reading of previously prepared papers

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

Nil

WINTER C.P.D. MEETING

MAIN CONFERENCE HALL, MEDICAL SCHOOL,
G'MANGIA • STARTING TIME 8.30 P.M.

Wednesday, 18th January 1995

Sensible Prescribing in Family Practice – Prof. F.F. Fenech
A lesson I've learnt – Dr. J. Portelli Demajo

Thursday, 19th January 1995

More Pitfalls of the Chest X-ray – Dr. M.P. Crockford
How I Manage ... – Dr. M. Schembri

Friday, 20th January 1995

The Role of the Community Nurse in Family Practice
A Video-Forum Presented by the Malta Memorial District Nursing Association
Reception
Meeting Kindly Sponsored by Galeapharma Ltd.

REGISTER OF FAMILY DOCTORS

The College reminds eligible doctors to apply in writing to be included in the register of family doctors.

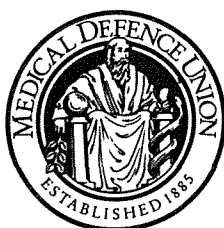
Eligible applicants should practice family medicine for more than 50% of their time. Family medicine is the provision of primary, continuing, comprehensive whole patient care to individuals, families and the community. The family doctor accepts unreferral patients presenting to his practice, and provides service at all time and at location, away from his practice. He provides continuing as well as episodic care.

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The Malta College of Family Doctors commemorated the fifth anniversary of its foundation on the 7th November 1994. The occasion was celebrated with a dinner at the Southern Bliss Restaurant, Marsascala on the 3rd December 1994. Guests of honour were the Hon. Prof. John Rizzo Naudi and Dr Joseph L Pace, respectively Chairman and Convenor of the Postgraduate Medical Committee of the University of Malta.

After the delicious meal, Dr Denis Soler, College President, summarised the College's history as an academic body for family doctors. The first college of its

sort in Malta was started among much scepticism among university academics, suspicion from politicians, curiosity in the profession (especially family doctors), and with much anxiety to the three founder-members, Denis Soler himself, together with Wilfred Galea and Ray Busuttill. But, above everything, the College was established with the blessing and the help of Prof. Rizzo Naudi, who believed in its value from the outset.

The College distinguished itself from other organisations in Malta by providing an academic culture for the family doctor. Through its activities, a new

environment was created where the family doctor could emerge from his/her shell to participate actively in writing papers, making presentations and attending purposely-organised courses. What distinguished the College from other international bodies was the system of accreditation through which College membership was confirmed on a yearly basis.

Looking back over the past 5 years, the College organised 13 meetings, during which 43 family doctors gave presentations; six issues of the Journal of the Malta College of Family Doctors were issued; a week-long Trainers'



ROYAL COLLEGE OF GENERAL PRACTITIONERS

Of all the problems associated with inner cities, deprivation and its implications for health override all others. The College has already demonstrated its commitment to raising standards of care in inner cities through previous publications and by running a Conference in 1990 with the support of HRH The Prince of Wales.

In 1991 the College set up an Inner City Task Force, now under the chairmanship of Dr Iona Heath, with instigated a nationwide survey of inner city general practitioners. The results, supported by a comprehensive review of the literature and wide consultation with those involved in both the provision and planning of health care, form the basis of this new *Occasional Paper*. Having identified the problems, the authors offer practical solutions and make recommendations for action.

Occasional Paper 66, which has been welcomed by the Council of the College, marks the College's continuing commitment not only to patients but to those who work where the burdens are heaviest.

REPORT OF THE INNER CITY TASK FORCE OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS OCCASIONAL PAPER 66

Enquiries about the content of this *Occasional Paper* should be made to:

Dr Maria Lorentzon
Department of General Practice
St Mary's Hospital Medical School
Lisson Grove Health Centre
Gateforth Street
London NW8 8EG
Tel: 071 723 7169

OR Dr Iona Heath
Caversham Group Practice
Kentish Town Health Centre
2 Bartholomew Road
London
NW5 2AJ
Tel: 071 267 4411

Copies are available from:

RCGP Sales
14 Princes Gate
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Tel: 071 823 9698

Price £10.00 (£11.00 non-members)
including postage.

Access and Visa are welcome, 24 hour answerphone.
Tel: 071 225 3048.

Course in Family Medicine was attended by some twenty doctors in 1993; another twenty doctors participated in a Training Course in Community Psychiatry in 1994; and a Policy Document on Training in Family Medicine was presented to the authorities in 1993.

Dr Soler finally outlined the College's plans for the future. These include the organisation in 1995 of a National Conference on "The Future of Medicine in Malta", the hosting of the European General Practice Research Workshop here in Malta

in October 1996, and the development of a Speciality Retraining Course in Family Medicine with the ultimate aim of the drawing-up of a Register of Specialists in Family Medicine.

Prof. Rizzo Naudi, after congratulating the College and auguring it well for the future, then distributed Certificates of Accreditation 1991-1993, awarded for three consecutive years of regular participation in the College's Continuing Professional Development Scheme, to the following College members:



Dr Anthony P. Azzopardi, Dr Alfred Baldacchino, Dr Louis Bonello, Dr Michael A. Borg, Dr Costant Caruana, Dr Jean Pierre Cauchi, Dr Michael Cordina, Dr Godfrey Farrugia, Dr Peter A. Fenech, Dr Bryan Flores Martin, Dr Patrick Frendo, Dr Wilfred Galea, Dr Maurice Gatt, Dr John Gauci, Dr George Grech, Dr Anthony Mifsud, Dr Tania J. Mizzi, Dr Joseph G. Pace, Dr Jacqueline Padovani, Dr Carmelo Palmier Cecy, Dr Leo Portelli, Dr Joseph Portelli Demajo, Dr Raymond Sacco, Dr Anna Marie Said, Dr Joseph Saliba, Dr Carmen Sammut, Dr Mario R. Sammut, Dr John J. Schembri, Dr Marcel Schembri, Dr Denis Soler, Dr Joseph L. Zammit, and Dr Christopher Zarb.

Dr Gino T. Abela, Dr Martin Borg, Dr Tonio Bugeja, Dr Anna Busuttil, Dr Raymond Busuttil, Dr Ramiro Cali Corleo, Dr Frank Paul Calleja, Dr Stefan Camilleri, Dr Anthony Felice, Dr Taygeta Firman, Dr Joseph F. Grech, Dr Mark Mangion, Dr Mario Saliba, Dr Anthony Schembri, and Dr Joseph Scicluna were awarded the certificate in absentia.

The first accompanying photograph shows the Hon. Prof. John Rizzo Naudi being presented with a memento of the occasion by Dr Denis Soler, with Dr Joseph L Pace looking on.

The other commemorative photograph was taken after the dinner, and shows, from left to right: Dr J.L. Pace (guest), Dr M.A. Borg, Dr J. Gauci, Dr J. Padovani, Dr W. Galea, Dr J.G. Pace, Dr A. Mifsud (council members), Prof. J. Rizzo Naudi (guest), Dr D. Soler (president), Dr G. Galea (associate member), and Dr M.R. Sammut (honorary secretary).

Letter to the Editor

The Department of Family Practice of the University of Limburg, held its first summer school on Quality Assurance in General Practice between the 28th August and the 2nd September 1994 in Maasticht, The Netherlands.

The Malta College of Family Doctors was represented by Dr Anthony Paul Azzopardi and the visit was generously sponsored by the Lombard Bank (Malta) Ltd.

There were 22 participants from 13 countries and the course was divided in five modules spread over five tightly packed days – on more than one occasion ending at 11 o'clock at night.

The topics covered were: Development of Guidelines, Assessment and QA, Introduction to technical aspects of data collection and analysis, Quality improvement and change, with the importance of Peer influence in the process of change. In all these topics, exercises in subgroups were held to provide hands-on experience in planning how to proceed once one returned to one's country.

Examples from, and the experience of different countries provided an insight as to how GP's in various countries attempt to improve the quality of their service and the hurdles which had to be overcome before the concept was accepted.

"It takes several years to go from conviction through conversion but improvement escalates from the day the process begins".

It is salutary to note that if doctors themselves do not make the effort to introduce QA this will be eventually forced upon them.

Dr Anthony Paul Azzopardi



ROYAL COLLEGE OF GENERAL PRACTITIONERS

JACQUELINE V. JOLLEYS BA, MD, MRCP, MBA

Continence services have been made a priority by the NHS Management Executive for 1994/95 so the publication of this text by Dr Jolleys is particularly timely.

Much still remains to be done to remove the stigma associated with incontinence and to get across the message to the three million sufferers that a great deal can be done to help them. To this end Dr Jolleys shows that the traditional approach of taking a careful history, and performing relevant clinical examinations and investigations, can often lead to discovering causes which are amenable to treatment, much of which can be undertaken in general practice.

There is no doubt that general practitioners who are willing to apply the knowledge contained in this book to everyday clinical practice may well increase their own job satisfaction – they will certainly

CLINICAL SERIES – INCONTINENCE- DIAGNOSIS AND MANAGEMENT IN GENERAL PRACTICE

earn the undying gratitude of their patients and families.

For enquiries about the content of the book please contact: Dr J.V. Jolleys, Country House, Stoney Lane, Coleorton, Coalville, Leicestershire LE67 8JJ; Answerphone/fax 0530 811893.

Copies are available from:

RCGP Sales
14 Princes Gate
Hyde Park
London SW7 1PU
Tel: 071 823 9698

Price £14.00 (£15.40 non-members) including postage.

Access and Visa are welcome, 24 hour answerphone.
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Information Desk

INTERNATIONAL COURSE IN GENERAL PRACTICE

The 5th International Course in General Practice is organised within the University of London by the Departments of General Practice and Primary Care of the Royal Free Hospital School of Medicine, The University College London Medical School and St. Mary's Hospital Medical School.

Venue: Sheila Sherlock Education Centre,
The Royal Free Hospital
Date: 17th to 28th July 1995
Course fees: Sterling 676.00
Accommodation: Sterling 15.75 dly
Enquiries: Jane Fleming-Willcox
The Sheila Sherlock Educ. Centre
The Royal Free Hospital
Rowland Hill Street
London NW3 2PF

GENERAL PRACTICE AND CANCER PREVENTION IN EUROPE

Proceedings of the Wonca Satellite Conference - The Hague 12 to 15 June 1993

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THE EUROPEAN JOURNAL OF GENERAL PRACTICE

Initiated by WONCA Europe, SIMG, EGPRW, EQUIP and the National Colleges for General Practice

Call for Papers

The European Journal of General Practice is a new journal which will initially be published quarterly and will be launched at the beginning of 1995.

The journal reflects the increasing significance of General Practice/Family Medicine in Europe as a scientific discipline.

The journal which will be published in English, will present: peer reviewed scientific papers on research, teaching and learning, quality assurance and review papers; background information on many aspects of GP/FM in Europe; a communication section with newsletters from the participating European organisations and national colleges, and summaries and conclusions of congresses and workshops.

It will also contain a time-table for important events in GP/FM.

Papers should be submitted to:

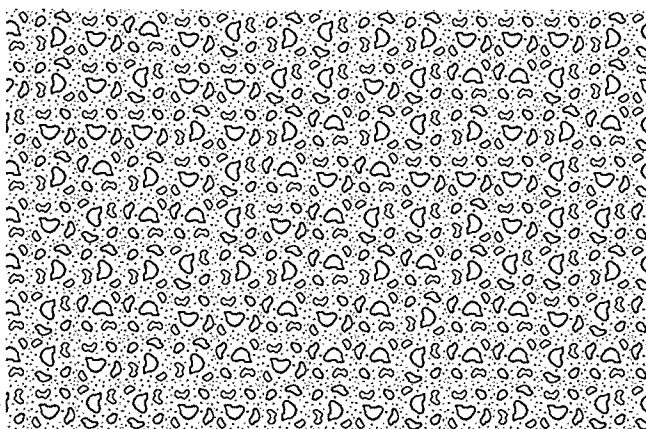
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'Guide for Authors' and subscription information may be obtained by writing to the above address.

CONSULTATION IN GENERAL PRACTICE

The 4th International Workshop

Organisers: EURACT
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Date: September 5 to 9, 1995
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Institute of Public Health
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REASONS FOR ILL HEALTH RETIREMENT AT THE VALLETTA DOCKYARD, MALTA 1975-1989

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Summary

The reasons for ill health retirement ("boarding out") for employees of the Malta Drydocks Corporation were examined from 1975 up to the end of 1989. The purpose of this research was to see whether there had been any dramatic changes in the importance of different pathologies as seen in similar British industrial units over a similar period. During this period 462 retirements were noted in Valletta, cardiovascular and locomotor pathologies being the main causes of boarding out. However, differences from similar British Units were seen especially with respect to diabetes and visual and psychiatric problems, which were great in the Valletta dockyards. There are many cultural and occupational reasons for this as well as the fact that the results would be influenced by the retirement age in Malta being 61 years of age.

Introduction

Ill health retirement is a useful endpoint for the study of industrial morbidity with a high diagnostic accuracy¹. Studies at British Steel in the '70's demonstrated that the major causes of early retirement in order of precedence were cardiovascular, respiratory and musculoskeletal. However more recent unpublished studies

undertaken within British industry reveal a decreased importance of respiratory, pathology which is believed to be due to the decreased prevalence of smoking seen over the last decade.

Background

Malta's excellent natural harbour, together with its strategic position has predestined its history from the Phoenicians to the present.

The British presence led to the full development of the Grand Harbour into a major ship building and repair yard suitable for the heavy units of the Royal Navy. The prolonged run down of the Royal Navy up to the final British withdrawal in 1979 cut the number of employees until by the mid '70's only 4600 were employed. At the end of December 1989 there were 3838 employees. Shipbuilding as well as shiprepair are still practised.

Method: The results were obtained by reviewing the records of the National Insurance Medical Board, which consisted of three medical practitioners of consultant status. This was founded in January 1972 in order to board out employees either at their own request or at the request of the Malta Drydocks Corporation. A memo of October

1977 defined the criteria for inclusion as; "... they should have been sick, hurt or unable to attend work for the last three months".

Only data from 1975 is included as the records before this time are incomplete.

In Malta, most male dockers retire at 61 years of age, this being legally enforced. For females the age is 60 years; however there are very few women employed within the dockyards.

Results

Table 1 below shows the results that were obtained. A table of the number of retirements by year can be drawn.

As we can see from the dramatic difference between the 1979 and 1980 figures, ill health retirement, "boarding out", is dependent on the degree of work, with increasing numbers being processed when there is less work available.

If we now consider the reasons for retirement in terms of pathology for five year groups we see the following Table 2. The incidence of each pathology for each five year age group can be drawn thus. Tables, 3, 4 and 5.

Table 1: Number of retirees/year

YEAR OF RETIRMENT	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
NUMBER OF RETIREES	5	13	16	24	4	80	64	46	58	22	22	41	18	30	21

Discussion

Ill health retirement is not a modern phenomenon. Indeed the first ill health pension was granted in 1684 to Martin Horsham, a land waiter in the Port of London, whose pension was paid by the Treasury Warrant because in their words he was "so much indisposed by a great melancholy that he is at present unfit for business."

The first paper on ill health retirement concerned 1781 British Steel workers retired over a two year period in the '70's¹. For the male group the total incidence was 0.518% per annum, with 31% expressing multiple pathology.

The main causes were circulatory (35.6%), respiratory (18.8%) and musculoskeletal (16.4%). Retirements over 45 years of age maintained this order. However, below 45 years, musculoskeletal pathology predominated (20% of the total), followed by circulatory (19%), nervous (14.5%) and respiratory (8%).

90% of the respiratory pathology was due to chronic bronchitis. Several studies were commissioned by British Steel to determine the cause of this high incidence and smoking was determined to be the main aetiological factor.¹ The incidence for all pathologies increases with age.

Other more recent studies,² suggest that with the decreased prevalence of smoking, the importance of respiratory pathology has fallen from second to third place.

How do the Valletta results compare over the same period?

The overall incidence is of the same order of magnitude as UK plants on average, being under 1% per annum. The number of retirees below 45 years was too

small for accurate analysis. The incidence rapidly increases above 45 years and by the age of 50 years² the final order is settled.

Although there has been some fluctuation in the relative percentages over the fifteen years, the principal causes and order of pathology remain unchanged. The principal causes are cardiovascular 49.6%, locomotor 29.1%, vision/central nervous system 25%, psychiatric 23.7%, respiratory 14.7%, endocrine 12.1%. The relative fall in endocrine pathology needs to be reviewed in the future to determine whether this is sustained, or is an aberration.

Smoking

The prevalence of smoking in Malta is far higher than in the UK. In the UK, cigarette smoking has decreased over the last decade.³ Although the statistics on the number of cigarettes smoked annually are not published by the Maltese Government, figures are published on private consumption, which increased consistently throughout the '70's and '80's. This, together with the increase in tourism, seem to suggest that cigarette smoking has at least remained static. Other statistics state that for 1984, overall 54% of Maltese males smoked, as did 21% of females.

Table 2: Showing Percentage of Pathology within Five Year Age Groups

	1975 - 1979		1980 - 1984		1985 - 1989	
	No.	%	No.	%	No.	%
Cardiovascular	30	48.4	146	55.2	60	45.4
Respiratory	9	14.5	33	12.2	23	17.4
Gastrointestinal	5	8.1	19	7.0	12	9.0
Locomotor	14	22.6	91	33.7	41	31.0
Carcinoma	1	1.6	7	2.6	5	3.7
Psychiatric	13	21.0	70	25.9	32	24.2
Genitourinary	2	3.2	6	2.2	3	2.2
Endocrine	9	14.5	41	15.2	9	6.8
CNS / Vision	15	24.2	76	28.1	30	22.7
Total number	62		270		132	
Total employed	4782	1975	4833	1980	4429	1985
Total Incidence (% per annum)		0.26		1.11		0.60

The pathological events can be tabulated within five year age groups thus. For the sake of convenience the results are taken from the age of 45 years onwards.

Table 3: Group 1 • 1975 - 1979

AGE	45 - 50		51 - 55		56 - 60	
	No.	Incid.	No.	Incid.	No.	Incid.
Gastro	1	0.05%	-	-	1	0.06%
Cardiovascular	4	0.20%	7	0.34%	14	0.88%
Respiratory	2	0.10%	2	0.10%	4	0.20%
Locomotor	2	0.10%	5	0.25%	8	0.50%
Carcinoma	-	-	-	-	1	0.06%
Psychiatric	2	0.10%	3	0.15%	5	0.31%
Genitourinary	2	0.10%	-	-	1	0.06%
Endocrine	2	0.10%	3	0.15%	2	0.13%
CNS / Vision	1	0.05%	4	0.20%	6	0.38%

The reasons for continued high levels of smoking are many, ranging from their relative cheapness to the dependence of the economy on the duty raised.

Conclusion

For the majority of studies cardiovascular disease consistently remains the major cause of ill health retirement. The causes of this are manifold and in the UK even with decreased smoking, there is no sign as yet of a fall in the importance of cardiovascular disease. Locomotor pathology increases in importance for all groups. The level of respiratory pathology has fallen in Britain but maintains a constant level in the Maltese workers. Endocrine pathology is far greater in importance and in incidence in the Maltese workers. This could be due to the predominantly carbohydrate Maltese diet of pasta. Another key difference is the increased incidence and importance of visual problems causing premature retirement in the Maltese workers. There are many possible reasons for this. Firstly because of the nature of their work, any deterioration in eyesight would become apparent earlier on. This would be especially so with undue glaucoma in welders for example. Also the environment of a shipyard is such that the eyes would be exposed to injury (i.e. from the welders' arc - classically transient and painful), foreign bodies and also to the fact that in hot weather protective wear is uncomfortable and may not be worn. Also, the Mediterranean climate, the outdoor nature of the work and the higher infra red radiation would render the workforce more susceptible to ptygion. The higher prevalence of diabetes in Malta also makes itself present with impaired vision. Thus this demonstrates the flaws in comparing different workers from different countries and climates doing different jobs.

Medicine and its history rest on the foundation of studies undertaken to determine the changing nature and importance of disease so that in the words of Ramazzini's "De Morbis Artificum Diatriba" of 1700; "Medicine like jurisprudence, should make a contribution to the well being of workers, and see to it as far as is possible that they should exercise their callings without harm."

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- 2 Ill Health Retirement at Cowley 1986 - 1988 by A.N. Williams. Oxford Medical School Gazette Hilary 1991.
- 3 "Annual Abstract of Statistics" editor Dennis. Her Majesties Stationary Office 1987.
- 4 Hansard; 8th January 1990, page 716, concerning the speech made by the MP. for Newport West Mr Paul Flynn during the debate on the Pensions (Miscellaneous Provisions) Bill.

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Dr Cacciottolo	Consultant Physician, St Luke's Hospital

Table 4:

Group 2 • 1980 - 1984

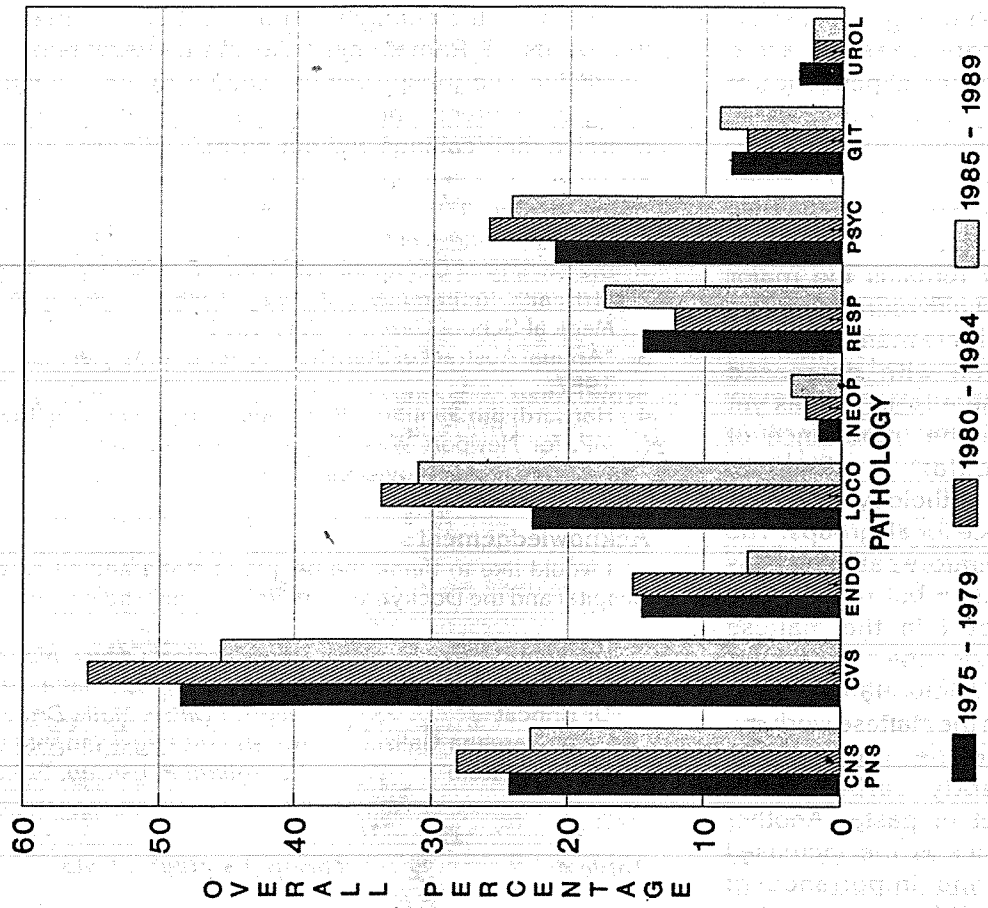
AGE	45 - 50		51 - 55		56 - 60	
	No.	Incid.	No.	Incid.	No.	Incid.
Gastro	2	0.09%	4	0.22%	12	0.62%
Cardiovascular	13	0.59%	41	2.26%	76	3.90%
Respiratory	2	0.09%	12	0.66%	13	0.67%
Locomotor	8	0.37%	20	1.10%	56	2.87%
Carcinoma	-	-	2	0.11%	4	0.21%
Psychiatric	8	0.37%	13	0.72%	36	1.84%
Genitourinary	-	-	3	0.16%	2	0.10%
Endocrine	1	0.04%	8	0.44%	26	1.33%
CNS / Vision	7	0.32%	21	1.16%	38	1.95%

Table 5:

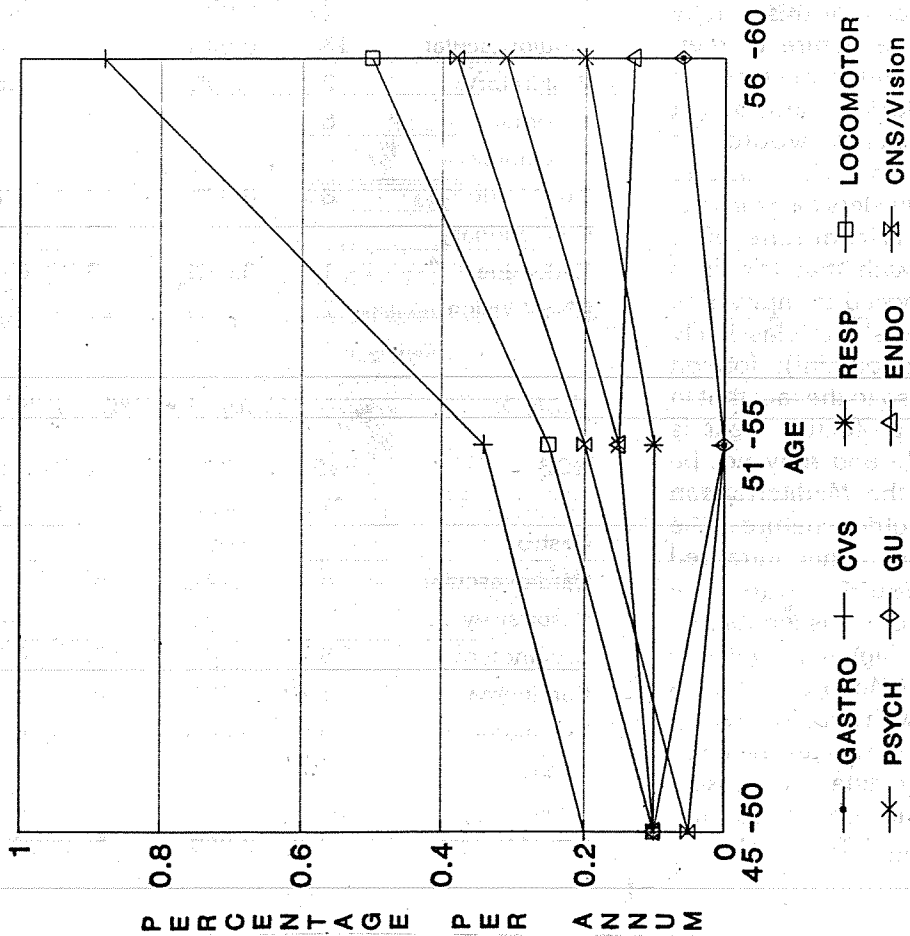
Group 3 • 1985 - 1989

AGE	45 - 50		51 - 55		56 - 60	
	No.	Incid.	No.	Incid.	No.	Incid.
Gastro	1	0.05%	2	0.12%	9	0.57%
Cardiovascular	8	0.42%	16	0.92%	30	1.90%
Respiratory	1	0.05%	8	0.46%	15	0.95%
Locomotor	5	0.26%	10	0.58%	21	1.33%
Carcinoma	1	0.05%	2	0.12%	2	0.13%
Psychiatric	5	0.26%	9	0.52%	14	0.89%
Genitourinary	-	-	-	-	2	0.13%
Endocrine	1	0.05%	2	0.12%	6	0.38%
CNS / Vision	7	0.36%	5	0.29%	11	0.70%

VALLETTA 1975 - 1989

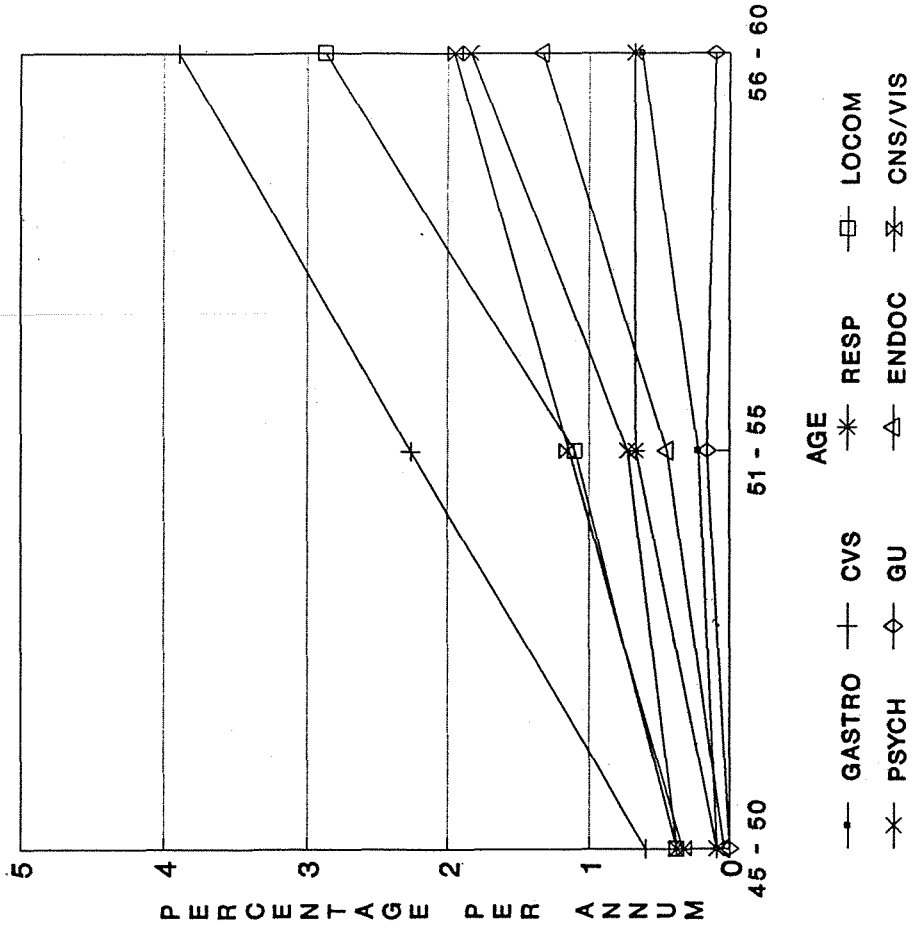


ILL HEALTH RETIREMENT MALTA DRYDOCKS 1975 - 1979



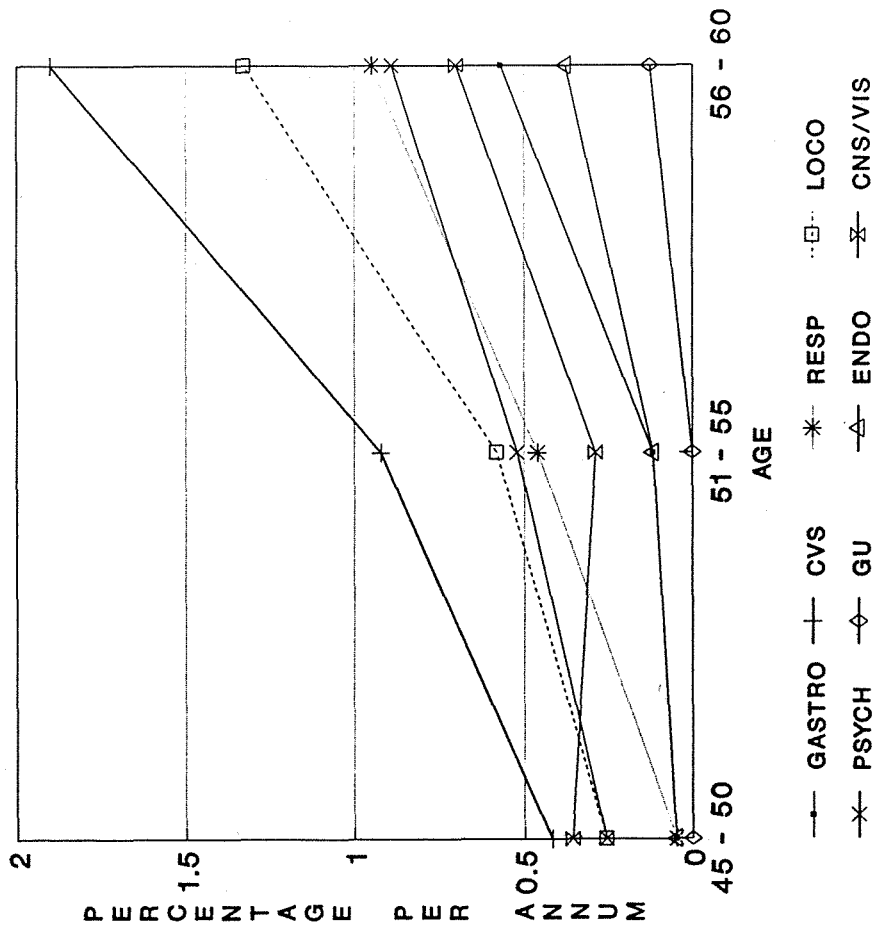
VALLETTA MALTA DRYDOCKS

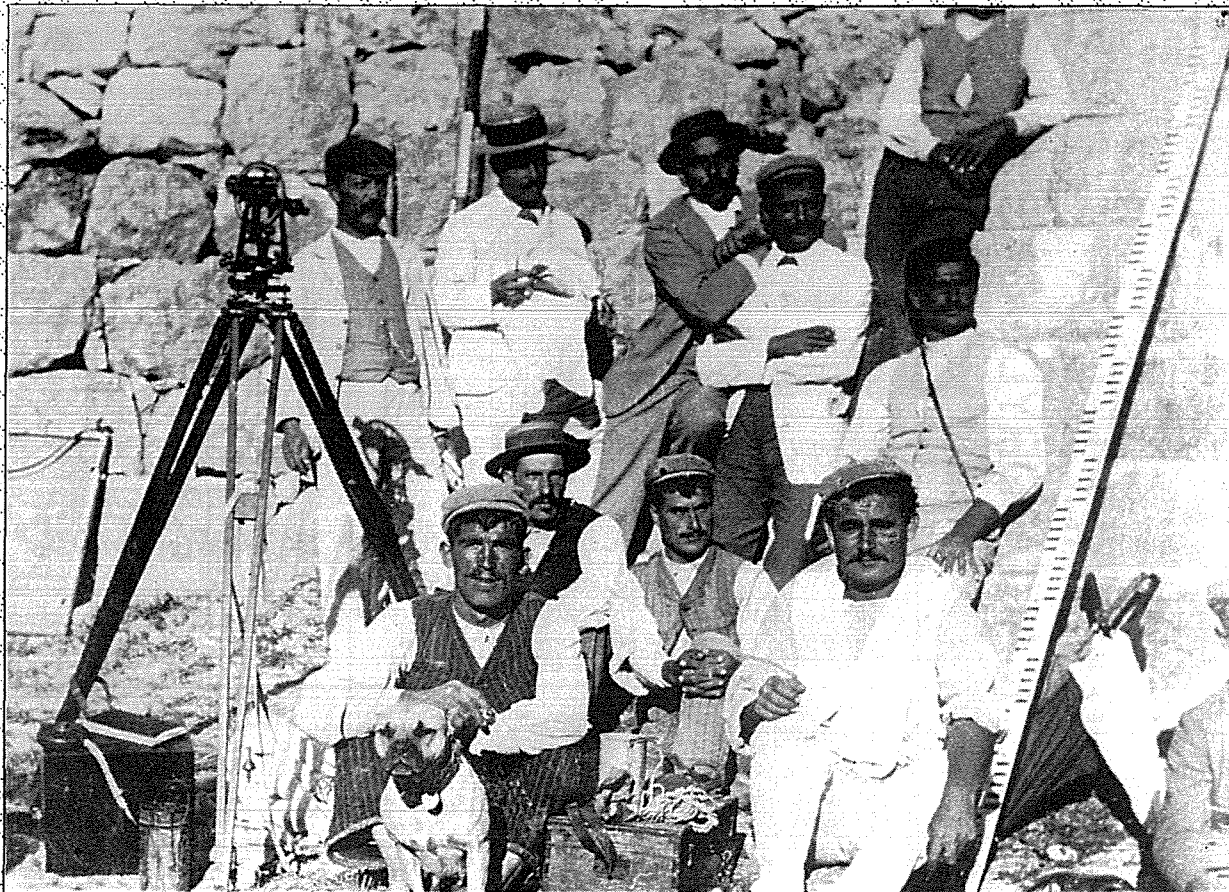
1980 - 1984



VALLETTA MALTA DRYDOCKS

1985 - 1989

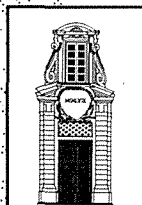




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