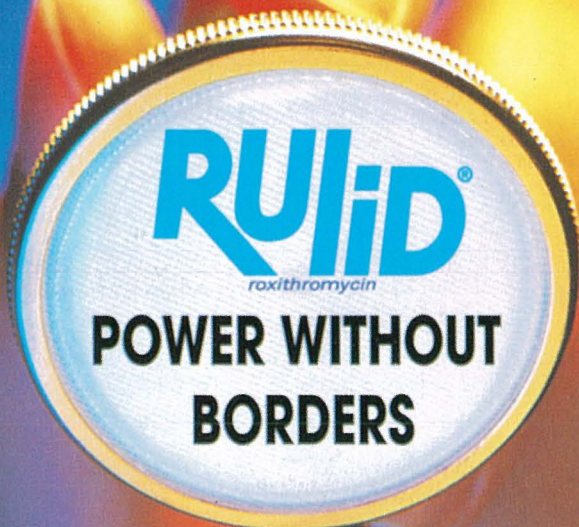




the family physician
it-tabib tal-familja

JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS • ISSUE No.19 • DECEMBER 2000

COMMUNITY ACQUIRED RESPIRATORY INFECTIONS



RULiD[®]
roxithromycin

**POWER WITHOUT
BORDERS**

RULiD[®] *First of the new macrolides*

roxithromycin

Contents: INN: roxithromycin - Presentations : Oral route : Tablets : 50, 100, 150 mg. Properties : Semi-synthetic macrolide antibiotic. Indications : Infections caused by susceptible microorganisms (e.g. upper and lower respiratory tract infections, genital non gonococcal infections, skin and soft tissue infections).

Posology and method of administration : Adults : one 150 mg tablet twice daily. Renal impairment : Severe hepatic impairment : one 150 mg tablet daily. Elderly :

It is not necessary to modify the dosage regimen. Children : The dosage regimen to be used is 5 to 8 mg/kg/day in two divided doses and treatment must not be pro-

longed beyond ten (10) days. Tablet forms must not be used in children below four (4) years of age. 12 to 23 kg : 50 mg twice daily 24 to 40 kg : 100 mg twice daily above 40 kg : 150 mg twice daily. Contra-indications : Hypersensitivity to macrolides. Concomitant therapy with vasoconstrictive ergotamine-type compounds. Adverse reactions. : Gastrointestinal : nausea, vomiting, abdominal pain, diarrhoea; in isolated cases, symptoms of pancreatitis. Hypersensitivity reactions, mainly mucocutaneous (rash, urticaria, angioedema), exceptionally systemic (bronchospasm, anaphylaxis). Dizzy sensations. Liver function tests abnormalities : rarely cholestatic or acute hepatocellular liver injury. Disturbances of taste and/or smell. Possibility of fungal overgrowth. Special warnings and special precautions for use : in severe hepatic insufficiency, the dose should be reduced by half (1 tablet 150 mg daily). Pregnancy : roxithromycin crosses the placental barrier; the safety of the foetus has not been established. Lactation : roxithromycin is minimally excreted in human breast milk. Abnormalities of the growth plate have been observed in young animals at unbound plasma concentrations 30 to 60 times higher than those observed in clinical use. No abnormalities were observed at unbound plasma concentrations 10 to 15 times higher than those observed in clinical use. It is therefore recommended that the dose level of 5 to 8 mg/kg/day be adhered to for no longer than ten days (for paediatric forms of roxithromycin only). Drug interactions : There is no clinically significant interaction with carbamazepine, ranitidine, aluminium or magnesium hydroxide, oral contraceptives containing oestrogens and progestogens. In healthy volunteers, a slight increase has been detected in plasma concentrations of theophylline or ciclosporine A levels but this does not necessitate alteration of the usual dosage. An in-vitro study has shown that roxithromycin can displace protein-bound disopyramide ; such an affect in vivo may result in increased serum levels of free disopyramide. Like other macrolides, roxithromycin may increase the absorption of digoxin. The effects of midazolam may be enhanced and prolonged in patients treated with roxithromycin, as with other macrolides antibiotics. Certain macrolide antibiotics are capable of a pharmacokinetic interaction with terfenadine, leading to increased serum levels of terfenadine. This may result in severe ventricular arrhythmias. Caution should be exercised if roxithromycin is co-prescribed with terfenadine. List 1 : Full prescribing information available on request.

Hoechst Marion Roussel

Editorial

Dear Readers,

Those more observant amongst you will have noticed that the title of the journal has changed, and that now the text "The Family Physician" appears on the front cover along with the traditional Maltese name. With this change, amongst others, this journal is being launched as an International Mediterranean Journal of Family Medicine. The new format Journal will also be distributed in other Mediterranean countries as from this issue.

The Editorial Board has been enlarged and a new Scientific Advisory Board created to accommodate colleagues from other countries who will co-operate with us in the internationalisation of our College journal. May I extend the College's welcome to our friends and colleagues from abroad, and in particular to Prof. Christos Lionis who has joined our Editorial Board.

In keeping with this project, we have begun accepting papers from other Mediterranean countries, and in this issue we have an excellent article on the utilisation of complementary medicine, from Israel.

Furthermore, all Family Medicine articles submitted for publication are being peer-reviewed. This task has been taken up by our illustrious colleagues Frank Dobbs, Igor Svab and Ruth Bridgewater, who many of you will remember from the EGPRW Research Methods Course held in Malta recently.

I would like to recommend readers a particularly good read in this issue. His Excellency Prof. Guido de Marco, President of Malta, has so kindly given his consent for us to reproduce his touching opening speech delivered at the opening of the 6th Mediterranean Medical Congress at the Cathedral in Mdina on the 7th September, 2000. The moving address was welcomed by all present, and made us all contemplate different aspects of our work and the challenge of "being the best and giving the best without fear."

By keeping abreast of developments in our field we hope to rise to the challenge.

Jean Karl Soler

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PREVALANCE OF *TINEA PEDIS* AND *ONYCHOMYCOSIS* IN MALTA - THE *ACHILLES* PROJECT

M.J. BOFFA, E. BORG, E. MIFSUD, J. PACE, L. SCERRI, D. VELLA BRIFFA

DERMATOLOGISTS

INTRODUCTION

The Achilles project was set up because of the general poor awareness of foot disease, especially of fungal foot infections. Foot diseases are often not viewed as a real problem, and the general public has limited knowledge of them. Most previous studies have involved small and specific population groups, such as school children, subjects visiting swimming baths, populations with specific occupations, or patients with underlying diseases like diabetes. Moreover, patients often had to diagnose the condition themselves. The results of these self-assessments, was an underestimation of the prevalence of foot infections.(1, 2)

The Achilles project was the largest epidemiological study ever to be carried out on foot health in Europe and other countries, related to the part of the body below the Achilles heel (e.g. foot, toes, toenails). Started in 1998, the aim of the project was to gain a better understanding of diseases affecting the feet and their prevalence among different patient groups with a view to improve the timely diagnosis and optimal treatment of this significant medical problem. The project also allowed an insight to be gained into the predisposing factors and quality of life in a large population, and to generate clinical data from a sample of the population. The data also served as the basis for epidemiological studies, allowing both medical professionals and patients to benefit from this knowledge. The ultimate goal is therefore to increase the chance for timely diagnosis and treatment of foot disorders.

Several European countries, including Austria, Belgium, the Czech Republic, Germany, Greece, Hungary, Italy, Luxembourg, the Netherlands, Portugal, Poland, Russia, Slovakia, Slovenia, Spain, Sweden, Switzerland and the United Kingdom (UK), have thus far participated in this foot-screening project, which was endorsed by the European Academy of Dermatology and Venerology (EADV) and the European Nail Society. Following the example of these countries, in 1999 Malta, Jordan and Cyprus implemented the Achilles project.

METHODS

Patients visiting the dermatologist for any condition unrelated to foot problems had a clinical evaluation of the feet. 186 patients were screened. Patients were included in the study irrespective of their age, sex, or medical complaints. Participating dermatologists examined patients' feet for seven working days during the last week of October 1999. Assessments were also carried out for demography, predisposing factors, diagnosis of foot disease, skin and nail examination, and quality of life measurements. The project investigated the effect of gender, age and several clinical factors, including diabetes, obesity, antibiotics, corticosteroids, immunodepression, vascular disease, trauma, osteoarticular pathology, and sports activity, on the prevalence of foot disease.

Four patient age groups were defined as follows: child, 0-17 years; adult, 18-39 years; medium aged, 40-64 years; elderly, 65 years and older. In assessing the nature of the foot disease, tinea pedis was defined as a fungal infection involving the plantar and/or interdigital side of the foot while onychomycosis was defined as a fungal infection

of the nail. The prevalence was calculated as the number of cases divided by the number of subjects in the corresponding population.

RESULTS

186 patients were screened, and 6 dermatologists practising in Malta took part in this project.

Onychomycosis

Onychomycosis was reported in 19.1% of individuals: (males 10.5% and females 7.7%). The risk of onychomycosis for males was approximately 1.30 times higher than the risk for females, and increased with each additional year of age by 1.02 times for both sexes. The prevalence of onychomycosis was higher among persons with diabetes, obesity, vascular disease, trauma, and those practising sports.

Tinea Pedis

Tinea pedis was reported for 16.1% of individuals, with prevalence being higher in males (20.0%) than females (12.1%). Tinea pedis incidence increased with age up to the age of 56.

Fungal foot infections

The percentage incidence of fungal foot infection was 23.7%, with an expected higher prevalence in males (28.4%) than females (18.7%). The risk increased by 1.65 times for males relative to females, and with each additional year of age by 1.28 times for both males and females. Practising sports was observed to be a predisposing factor for foot diseases, mainly in children and adults.

DISCUSSION

Table 1 compares the results for onychomycosis, tinea pedis, and fungal foot infections in Europe (1998 survey) and in Malta, Cyprus and Jordan (1999 survey). In Europe, 13,695 patients were included in the survey. In Malta 186 patients

	Patients	Fungal foot infections	Tinea pedis	Onychomycosis
Europe	13,695	35.0%	22.0%	23.0%
Malta	186	23.7%	16.1%	19.1%
Cyprus	1506	41.2%	28.2%	21.7%
Jordan	1287	27.3%	20.5%	11.5%

Table 1: Comparison of Achilles project results, adapted from Haneke (1999)

were screened (population 376,000), compared to 1506 in Cyprus (population 751,500) and 1287 in Jordan (population 936,300). Cyprus screened the largest percentage of their population, while Europe screened the least.

The prevalence of fungal foot infections as found in the Achilles project is much higher (3) when compared to other epidemiological studies. (1, 2)

However, it can be seen from the table that the incidence of all onychomycosis, tinea pedis, and fungal foot infections is comparable for all regions participating in the Achilles project. (3) The sex-dependency of onychomycosis remains a topic of discussion. The Achilles project data for Europe parallels the results obtained in Malta and firmly establishes the higher prevalence of clinically diagnosed fungal foot infections in the males of the total screened population. (3)

Because of their lack of knowledge of foot problems, patients do not seek treatment at the early stages of foot fungal infections and the condition often becomes very serious, affecting quality of life (itching, pain, discomfort in walking, embarrassment, limitations in work and other activities). This makes the disease more difficult to treat, and longer treatment duration is needed. It should be pointed out that foot problems are not due to poor personal hygiene, but that underlying causes may be related to a variety of predisposing factors which mean that some people are more likely to contract a foot problem like a fungal infection.

In the European study, for example, diabetes was associated with an approximately 50% increase in the risk of fungal foot infections, including tinea pedis and onychomycosis. (4) Among diabetic patients the prevalence of simultaneous tinea pedis and onychomycosis was more than two times higher than for non-diabetics, and most infections were caused by mixed fungi.(4)

The elderly (65 years and over) also had a predisposition for mixed infections, (5) and as expected practising sports increased the risk of fungal foot infections, especially tinea pedis. (6)

The family doctor is in a prime position to diagnose these conditions, and would be able to link any underlying factors. Moreover, both physicians and patients should be aware of effective therapy to treat these very common conditions. (3)

ACKNOWLEDGEMENTS

In Malta, this research has been made possible by an unrestricted educational grant from Janssen-Cilag, under the auspices of the Maltese Dermatological Association.

The participating dermatologists were: Dr. M.J. Boffa, Dr. E. Borg, Dr. E. Mifsud, Dr. J. Pace, Dr. L. Scerri, and Dr. D. Vella Briffa.

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PRIMARY HEALTH CARE SERVICES IN MALTA: PROVISION, UTILISATION AND REFORM

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FAMILY DOCTOR

INTRODUCTION

The Alma-Ata Declaration defines **primary health care** as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination." The declaration goes on to specify that "it is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (Declaration of Alma-Ata, 1978).

HISTORY

The origin of primary health care in Malta has been traced back to the 16th century when the Order of St John set up a system of prescription and provision of financial relief, food and free medicines for poor and needy sick women in the main towns. Then, under British rule, Physicians for the Poor were appointed with clinical, administrative and sanitary responsibilities; the first government dispensary in fact was opened in 1832, followed by others usually attached to the local police station. The physicians later were incorporated into the Executive Police, becoming known as Police Physicians until 1879, when they were made accountable to the Department of Charitable Institutions as District Medical Officers. The DMO system remained till the late 1970's, responsible for treating patients in their district who qualified for a Medical Aids Grant based upon income thresholds. Today's state primary health care system developed from a free emergency polyclinic service that was introduced in 1980 by the government during the ten-year doctors' dispute which had commenced 3 years earlier (Azzopardi Muscat, 1999).

CURRENT ORGANISATION AND SERVICES PROVIDED

Primary Health Care in Malta is provided by the state and the private sector as shown in Table 1:

Primary Health Care	
State	Private
<ul style="list-style-type: none"> • Health Centres <ul style="list-style-type: none"> General Practitioner Service (also in Local Clinics) Specialist & Paramedical Services Investigative Services Preventive Services • Community <ul style="list-style-type: none"> Domiciliary Nursing School Health Services 	<ul style="list-style-type: none"> • Solo General Practitioners • Company Doctor Groups • Nursing and other Health Care Professional Services

for 1 to 3 hours, once to five times a week, on weekdays only. These clinics also provide a postal service of free medicines to those entitled to such.

Besides the GP Service, most

State Primary Health Care Services

The backbone of the State Primary Care Service is the **General Practitioner Service**, which is available on a 24-hour basis in five of nine **health centres** in Malta and Gozo. Due to a shortage of doctors, Cospicua, Qormi and Rabat Health Centres only provide a GP service between 8 a.m. and 5 p.m. on Monday to Friday, and 8 a.m. to 1 p.m. on Saturday, while B'kara Health Centre provides just a local clinic service. A GP and nurse also attend **local clinics** in some 40 localities - these open

health centres also provide **Specialist and Paramedical Services** during office hours as follows:

- Acupuncture Clinic (Floriana Health Centre only)
- Dental Surgeon Clinic
- Dental Hygienist Clinic
- Diabetes Clinic
- Gynaecology Clinic
- Medical Consultant Clinic
- Mental Out-Patients Clinic
- Nursing Treatment Service (24 hours)
- Ophthalmic Clinic
- Pharmacy Service
- Physiotherapy Clinic
- Podology Clinic

- Psychology Clinic (Qormi Health Centre only)
- Schedule Five Clinic
- Speech Language Pathology Clinic

These services are complemented by **Investigative Services**, which include:

- ECG Service
- Laboratory Investigations Service (through the St Luke's Hospital Laboratory)
- Pregnancy tests (within the Gynaecology Clinic)
- X-ray Service

Preventive Services too are available in the major health centres, as follows:

- Ante-Natal Clinic
- Cervical Smear Screening Service as part of the Gynaecology Clinic
- Glaucoma Screening Clinic
- Immunisation Service
- Smoking Cessation Clinic
- Weight Reducing Clinic
- Well-Baby Clinic

Community Services include a **Domiciliary Nursing Service**, which is contracted out by the state to a private company (the MMDNA - Malta Memorial District Nursing Association), and **School Health Services**, both medical and dental (Dipartimento tal-Kura Primarja, 1997).

Private Primary Health Care Services

With the exception of just a couple of group practices, private **general practitioners** work on a solo basis from rooms in pharmacies or from specific clinics. Besides, a number of **groups of company doctors** provide a service of verification of sick leave for local companies. There are also **nurses** and **other health care professionals** (dentists, dental hygienists, physiotherapists, podologists, psychologists, speech language pathologists, etc.) who provide their services on a private basis, either individually or in groups.

Customers and Methods of Payment

As health-care providers in health centres are civil servants paid by salary, the state primary care service is offered free-of-charge at the point of use to all types of customers, direct or indirect (patients and relatives), and also potential (the whole population), be they Maltese citizens, refugees or tourists (the latter for emergencies only). However, clients must buy prescribed treatment from private pharmacies against out-of-pocket payment. The only exceptions are medicines on the Schedule Five list of chronic diseases (which are provided free from government pharmacies), and drugs, glasses, hearing-aids and dental services for Pink Card holders who fall below a certain income.

On the other hand, all private GPs (and other professionals working individually) operate on a fee-for-service basis, while the main groups of company doctors (and nurses) are paid by capitation. As such, services in the private sector are open to all those who can afford to pay the fees, and also to a growing sector of the population which has private health insurance.

UTILISATION OF PRIMARY HEALTH CARE SERVICES

Utilisation of primary health care services is reflected by the level of activity of such health

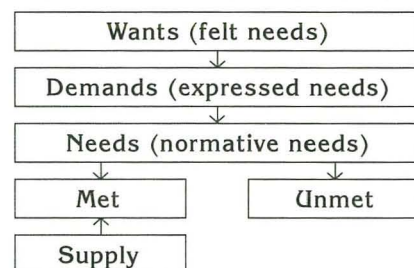


Figure 1: Different aspects of needs (Wright et al, 1998)

services. Such activity results from a process through which need becomes demand and then supply: this process is illustrated in Figure 1. Therefore, just as a doctor systematically assesses the needs of a patient before prescribing the effective treatment, the optimal utilisation of the resources of primary services depends on a systematic assessment of the healthcare needs of the population (Wright et al, 1998). Only then can inequalities in health and service-access be identified, following which priorities may be set for resources to be utilised effectively.

An effective and efficient health service should have as large an overlap as possible between need, demand and supply: see Figure 2, the original

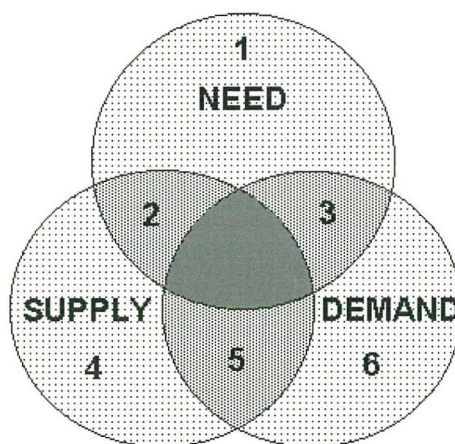


Figure 2: Relation between need, supply and demand: overlapping central area shows ideal relation (Wright et al, 1998)

Examples:

1. Treatment of child abusers
2. Health promotion; some screening; psychiatric treatment
3. Abortion; waiting lists
4. Hysterectomy
5. Vitamins; over-the-counter antibiotics
6. Cosmetic surgery in the public system

version of which was adapted by Wright et al (1998) from Stevens and Raferty (1992). The latter have defined **need** as the capacity to benefit from an intervention. There are a number of factors that affect the development of an *unfelt need*, through a *felt but unexpressed need*, to an *expressed need* or **demand** for a primary care service. These factors pertain to illness behaviour.

Illness behaviour of client

Mechanic (1978) defined illness behaviour as "the ways in which given symptoms may be differentially perceived, evaluated and acted upon (or not acted upon) by different kinds of person". Consciously or unconsciously, a patient would in fact ask a number of questions and consider different alternatives before seeing a doctor or another health care professional in primary care:

- *Are symptoms normal or abnormal?*

A client would consider prevalence ("there's a lot of it about at this time"), normalisation (a headache arising out of tension), and earlier events (a bruise after a fall) to decide whether a symptom is serious or not.

- *Should a doctor be visited?*

This decision depends on a sufficient number of social triggers (Zola, 1973). These include the perception of interference with a vocational or physical activity (a painful knee for a professional soccer player) or with social or personal relations (pressure by relatives to see the doctor); the occurrence of a personal crisis (family bereavement); and temporising of symptomatology ("it will soon pass") or sanctioning (a hangover after too much to drink).

- *What are the alternatives?*

Any alternatives to seeing the doctor could also be considered, such as ignoring the

symptoms (if previous episodes settled on their own), self care (analgesics for aches and pains), lay referral (taking the advice of a neighbour), or visiting an alternative health practitioner (an aromatherapist for eczema).

- *What are the costs/benefits of seeing the doctor?*

Finally, the patient would also weigh the benefits versus the costs of seeking a doctor's advice. Thus the benefits could be therapeutic (the prescription of treatment to cure an illness), the legitimisation of the sick role (the issue of a sick-leave cer-

The unfortunate truth is that in Malta clients abuse the state primary care system by attending health centres at all hours for minor ailments (two out of three GP encounters between 8 p.m. and 8 a.m. are for non-urgent cases - see Table 2) and by calling out the doctor for unwarranted house calls (as much as one in six of all calls are performed between 8 p.m. and 8 a.m. - see Table 3) (Department of Primary Health Care, 2000). This has affected clinicians' attitudes, and consequently staff resources, as described in the next section.

Night-time (8 p.m. - 8 a.m.) GP encounters during Jan-Sep 2000	Non-urgent (seen in GP Clinic)	Urgent (seen in Treatment Room)	Total
Number	35166	18094	53260
Percentage	66.0%	34.0%	100%

Table 2: GP encounters between 8 p.m. and 8 a.m. in health centres in Malta during January-September 2000 (Department of Primary Health Care, 2000)

House calls done during Jan-Sep 2000	Day-time (between 8 a.m. and 8 p.m.)	Night-time (between 8 p.m. and 8 a.m.)	Total
Number	22531	4387	26928
Percentage	83.7%	16.3%	100%

Table 3: House calls performed from health centres in Malta during January-September 2000 (Department of Primary Health Care, 2000)

tificate), or simply a dose of the doctor (where the doctor-patient relationship is strong enough for just a talk with the doctor making the patient feel better). The costs of visiting the doctor could include payment (unless use is made of the state services), time off from work (a self-employed person depends on his work to survive), travel (if the doctor's clinic is a long distance away - unless a house-call is requested), commitments (need to find someone to look after the children), the doctor's approachability (depending on his character and availability), trusting an outsider (with problems of a personal nature), fear (of the diagnosis of a serious disease) and pain (from surgery).

Clinicians' attitudes and resources

Once the illness behaviour of a client allows a need to be transformed into a demand, two categories of factors determine the **supply** of the necessary health care: clinicians' attitudes and resources. In spite of the state service in Malta being free, it has been estimated that two-thirds of primary health care is provided by private GPs. Although it has been said that the availability of good medical care tends to vary inversely with the need for it in the population served (Tudor Hart, 1971), this private-public disparity in utilisation in Malta may be due to different reasons.

Resources

Although there are adequate *facilities* (health centres, clinics and equipment), there is a lack of GP *staff* (in November 2000 standing at only two-thirds of the complement) working in the state primary care services due to poor employment conditions. As a result of this, doctors in health centres have to see a disproportionately large amount of clients, and often can only dedicate the minimum time necessary to see to a client's complaints. Moreover, health centre doctors are disheartened by the poor *conditions of work* and their low *income*, with a yearly basic salary during 1999 starting from Lm 4640, which is not even double that year's national income per head of Lm 2596 (Central Office of Statistics, 2000). This unfortunately has resulted in the development of a 'laissez-faire' attitude among a few doctors. Others are making the decision to switch to private practice when their income from the latter reaches a sufficient level, with the shortage of doctors thus being exacerbated further.

Attitudes

Another factor in the disparity of utilisation is the poor continuity of care provided by the state GP service. As there is no patient registration in Malta, a client can walk into a health centre at any time to see the doctor who happens to be on duty, this resulting in a poor doctor-patient relationship. Moreover, as most clients attend for trivial reasons, entries are hardly ever made in the health centre files that were introduced in 1997.

On the other hand, while medical-record keeping in private practice cannot be said to be optimal and formal registration is non-existent, private GPs still have a core of patients who consult them most of the time

for all their health needs, with satisfactory continuity of care and doctor-patient relationships. In private practice, the item-of-service system of payment also acts as an *incentive*, as opposed to the salaried system in the state service. Clinicians' continuing medical *knowledge* and *fashions* of care are only minor factors in the private-public equation.

As a result, it has become the *culture* for a typical client to attend a health centre doctor for trivial and run-of-the-mill complaints (e.g. colds, BP checks, repeat prescriptions, sickness certificates), but to then seek his private GP's advice regarding more serious medical problems.

REFORM FOR QUALITY CONTROL IN PRIMARY HEALTH CARE

Quality is the degree or grade of excellence. **Quality control** involves the supervision and control of all operations involved in a process, usually involving sampling and inspection, in order to detect and correct systematic or excessively random variations in quality. Quality control was introduced in the health care sector in order to make better use of resources and improve the overall quality of care (WONCA, 1995).

Health **policy** may be defined as a series of activities with their intended and unintended consequences on health. In some languages, there is actually no difference between the words 'policy' and 'politics'! Walt (1994) has described a framework for health policy analysis, with **actors** of a health policy in the centre of a triangle made up of the content, **context** and process of such policy.

Context

The political system in Malta is democratic, with general elec-

tions where the people's representatives are elected to parliament. The latter is led by a cabinet of ministers from the main political party in government, which takes liberal and egalitarian decisions based on the recommendations of permanent secretaries and directors made through their respective ministers.

Such decisions should normally be based on societal values, with cognisance being given to technological factors, environmental and international influences, and within the constraints of the legal system. However, the overriding factor that affects all decisions is the difficult economic situation in which the country finds itself today. There is no better example of this than the proposed reform for quality in primary health care: the efforts of the various actors towards this goal are described below.

Actors

The importance of the provision of quality in primary health care, both academically and organisationally, was first highlighted in the late 1980's. Regarding the academic aspect, a 9-month intensive course for family physicians was conducted in 1987-88 by Prof. D Johnson of the University of Toronto, under the auspices of the **University of Malta** and with the support of the **Ministry of Health**. As declared by a former Dean of the Faculty of Medicine and Surgery, it is a pity that the competent authorities at the time did not respond to a detailed report on the development of family medicine in Malta left for them by Prof. Johnson (Grech, 1998). However, as an indirect result of such course, the **Malta College of Family Doctors (MCFD)** was founded in 1989, with an emphasis in its statute on the College's primary responsibility 'to encourage, foster and maintain the highest

possible standards in family medicine in Malta' (Malta College of Family Doctors, 1990, 1996).

As regards the organisational quality of primary care, in August 1988 the **Minister of Social Policy** (then responsible for Health) wrote to the two doctors' unions at the time, the **Medical Association of Malta** (MAM) and the now-defunct **Union of Government Medical Doctors**, announcing that "this administration intends to provide a truly comprehensive national health scheme, in which a key factor is that of the right choice of the patient to his own general practitioner", and inviting them to make submissions in this regard (Galea, 1988). Here, as described in the WHO publication 'Health Care Systems in Transition - Malta' (Azzopardi Muscat, 1999), 'a major change to the (primary care) system was attempted. The government at that time wanted to introduce a scheme whereby patients would be registered with a GP of their own choice. GPs were to be remunerated on a capitation basis and allowances. The scheme was to be voluntary, (and) not all GPs would be obliged to join.' However by 1991, as the report continues, 'due to a series of problems, the initiative never materialized, the project was abandoned and an opportunity to make a difference to the primary health care service was lost.'

Two years later, the **Medical Association of Malta** (1993) took the initiative in organising a conference entitled "Quality of Health Care in Malta - the Way Ahead", and the following were the main consensus points following the session on Family Practice:

- Continuity of care needs to be restored so that a doctor or more likely a small group of doctors are identified as the patient's carers.
- Immediate consideration is

given to the formulation of an adequate medical record in the health centres.

- The time has come to institute specific training for Family Medicine ... and CME should be actively promoted.
- Peer review: one of the possible steps could be the formulation of sets of clinical guidelines for common conditions seen in general practice.
- Pathology practice - a quality assurance programme should be made available for anyone performing laboratory tests outside hospital.

Then, in 1995, the **Department of Health Policy and Planning** (1995) of the Health Division published 'Health Vision 2000: A National Health Policy'. This recommended that 'the Primary Health Care Services will need to be strengthened in ways that will allow for the development of sound doctor-patient relationships and continuity of care, and will evolve from one exclusively providing medical care to clients at time of illness to one of advising, counselling, educating and coordinating all such activities that will help people adopt lifestyles conducive to better health and better quality of life'.

In May 1998, the **Malta College of Family Doctors** (1998 [1]) approved its 'Policy Document on Family Medicine in Malta', drawn up in line with recommendations from the World Health Organisation (WHO) (1998), and presented it to the Minister of Health in the Labour government then in power. In July 1998, the College sent the Policy Document with a Memo to Political Parties entitled 'Recommendations for the Future Development of Primary Care in Malta' (Malta College of Family Doctors, 1998 [2]). The memo concluded that "any future changes in the primary health care field should include these priorities:

- The homogenization of private and state-provided primary care services;
- Full professional autonomy of family doctors;
- The establishment of a chair in Primary Care within the Faculty of Medicine;
- Vocational training, ongoing education and specialization opportunities for family doctors."

'The betterment of primary health care in the community' is the title of section 161 of the 1998 Electoral Manifesto of the **Nationalist Party** (1998), which states: 'We commit ourselves to the betterment of primary health care in the community. This means the service provided by family doctors, health centres, pharmacists, nurses and paramedics, team-working at the local level. Reform here is essential. The biggest setback is that patients do not always meet the same doctor when visiting healthcare centres, and so continuity and the personal touch are lost. We will work at finding ways of promoting cooperation between the private health sector and that of the state, to the greater satisfaction of doctors and patients.'

In November 1998, following the election of the Nationalist Party to government, the **Malta College of Family Doctors** (1998 [3]) wrote to the Prime Minister (in reference to the Nationalist Manifesto) as follows:

- Organisational improvement of structural conditions

"The College agrees that continuity of care and teamwork are two of a number of cardinal characteristics of Family Medicine, together with systematic record-keeping and a cost-effective referral system, working within well-organised practices. International experience consistently shows that those health systems with a comprehensive and strong general practice set-up go hand in hand with relatively low national spending on

health care (ref. World Bank Report, 1990). Unfortunately, while huge financial resources are allocated for the development of secondary/tertiary care in Malta, primary care remains the Cinderella of medicine and is afforded scant and insignificant attention”.

- *Professional development*

“The College believes that education of the family doctor should be reviewed, both at undergraduate level (which at present is practically non-existent), and at postgraduate level through the introduction of vocational and specialist training (in addition to continuing medical education presently provided by the College). Such activities can only be maintained by an Academic Department of Family Practice within the Faculty of Medicine and Surgery at the University of Malta. In fact, this ties up with Malta’s aspirations to become a member of the European Union, where specialist training in Family Medicine is a requirement for family practice by doctors qualifying after EU accession (ref. EC Council Directive 93/16/EEC of 5 April 1993)”.

On this point of professional development, the **University of Malta** finally re-entered the field in February 1999. During a meeting that month with the Prime Minister, the President of the Malta College of Family Doctors (1999 [1]) announced that the setting-up of a long-overdue University Department of Family Medicine had been included in the Faculty of Medicine & Surgery’s Strategic Plan for 1998-2000. In fact, in May 1999, the Faculty Board of Medicine and Surgery unanimously approved the setting up of a **Department of Family Medicine**, and this was subsequently confirmed by the University Senate in November 1999, and by the University Council in February 2000 (Malta College of Family Doctors, 2000). However, GPs re-

plying to a call for applications for Academic Part-time Posts (T2) in Family Medicine issued on 26th April 2000 (University of Malta, 2000) had yet to be interviewed by November 2000.

During the above-mentioned meeting with the Prime Minister in February 1999, the College President also urged that the Cabinet favourably considers a report outlining ‘Proposals for Reform in the Primary Health Care Services’ prepared by the College with the Department of Primary Health Care and the Medical Association of Malta (Department of Primary Health Care et al, 1999). This report was finalised in January 1999 by the Working Group set up on the initiative of the **Ministry of Health** through the **Department of Primary Health Care**, and called for a realistically planned and costed comprehensive primary care scheme. As described in the World Health Organisation report ‘Health Care Systems in Transition – Malta’ (Azzopardi Muscat, 1999), these proposals ‘seek to address the rift that exists between the public and private systems of health care provision and take Malta’s historical, cultural, social and economic context into account. The principles underlying the reform will be similar to those proposed in 1991, but the details differ having learned from previous experience’. This WHO report agreed that ‘the present system of primary care is inefficient and reforms in this sector are urgently required. These must occur in the wider context of health care reform with particular attention to community support services and an emphasis on health promotion and disease prevention.’

Unfortunately, in May 1999, the **MAM** and the **MCFD** were given the disappointing news that the **Cabinet** had sent back the above recommendations to the Working Group with the message ‘think again’, apparently due to

the country’s financial constraints. In reply, both organisations reconfirmed their “readiness to participate in discussions leading to a reform in primary health care ... but requested that the Cabinet provides the Working Group with an indication of the financial resources that would be available for any proposals made.” (Malta College of Family Doctors, 1999 [2]). To date, no answer has been forthcoming to such offer and request.

The Maltese health care system was critically analysed in February 2000 during a three-day consensus conference entitled ‘A National Agenda for sustainable Health Care’ organised by the **Foundation of Medical Sciences and the Forum Group**. Prime Minister Dr E Fenech Adami, who opened the conference, outlined three priorities for discussion, the first of which being the need to decentralise care from the hospitals to the community care system (Fenech Adami, 2000). Moreover, in the conference’s concluding report entitled ‘Getting it all together’, Jonsson and Bannister (2000) emphasised resource allocation as a priority, pin-pointing primary health care as the sector which needed to be given adequate resources.

Therefore, despite:

- initiatives from professional interest groups (the Malta College of Family Doctors, the Medical Association of Malta and the Forum Group) on the
 - recommendations of international organisations (the World Health Organisation, the European Union and the World Bank), and the
 - provision of the necessary support from government and non-government organisations (the Health Division, the Ministry of Health, the University of Malta, and the Foundation for Medical Services),
- the cabinet of the present gov-

ernment has so far failed inexplicably to implement its own recommendations made when still a political party in opposition. In October 2000, however, it was revealed that an ad-hoc committee set up by Health Division was examining proposals made by three private entities interested in the running of the general practitioner service from the health centres (Deguara, 2000 [1]).

CONCLUSION: DEEDS NOT WORDS!

In his closing address at the February 2000 conference 'A National Agenda for sustainable Health Care', the Minister of Health, Dr L Deguara, declared that "*the days when health policy is dictated by political gains are over. It is high time to practice what we preach if we truly believe that the welfare of our nation surpasses any partisan political scoring. We are at the crossroads. If we really want a better future, long-term solutions are a must, even at the expense of short-term pains*". (Deguara, 2000 [2]). Fine words indeed; but will they be followed by the promised deeds? In this country we seem to have great difficulty in converting words into deeds, as evidenced by the sequence of events (or lack of them) in the primary health care sector over the past ten years or so (Sammur, 2000). As asked by Fenech (2000) in the Sunday Times published a few days before the conference, "will our politicians act together now, forgoing narrow political interests in the defence of the sick and suffering, both present and future?" Only time will tell.

During a symposium organised by the Ministry for Social Policy (1991) entitled 'Reforming the Health Services', the Workshop on Primary Health Care concluded that the most important and urgent recommendation in this area was a comprehensive educational

campaign for the public to make effective use of primary care services while avoiding abuse. Nearly a decade later such educational campaign has still not materialised.

Perhaps the time has come for better use to be made of the media to inform the ordinary citizens of the dire needs of primary care in Malta, and persuade them to lobby their local parliamentary representatives on the matter, for the good of the country's health care system and, ultimately, that of the Maltese patient.

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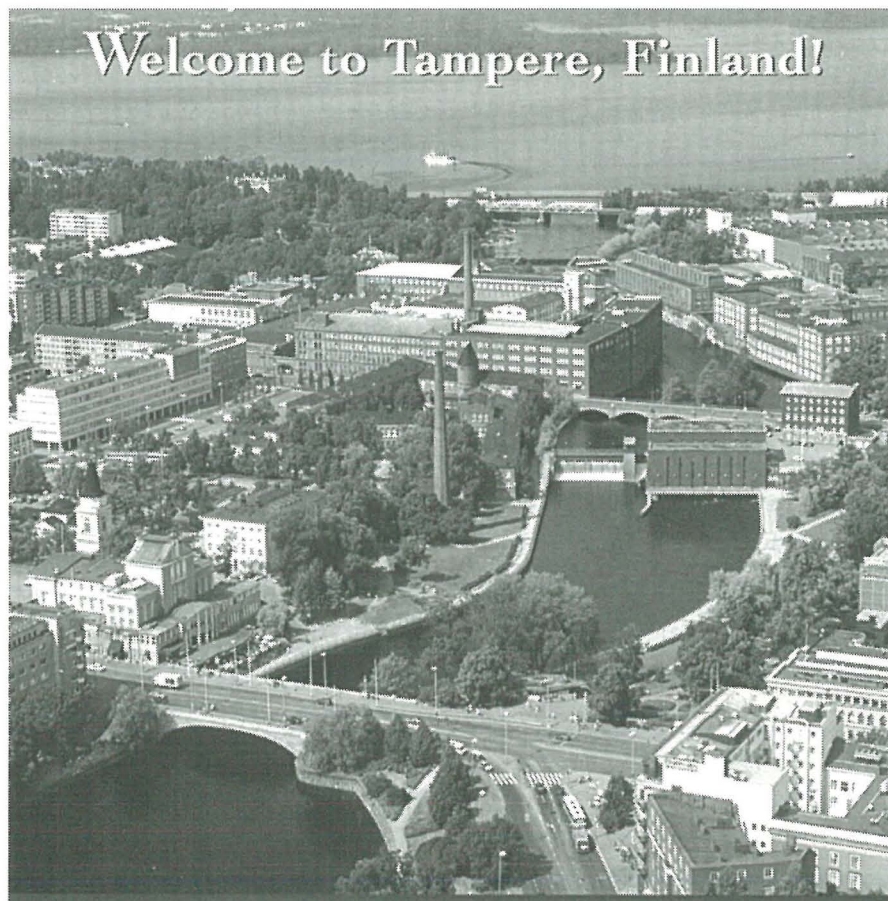
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ACNE VULGARIS IN MALTA A DERMATOLOGIST'S PERSPECTIVE

LAWRENCE SCERRI

DERMATOLOGIST

INTRODUCTION

Acne vulgaris is an inflammatory disease of the pilosebaceous units characterized by oily skin, and the formation of comedones, papulo-pustules, and less frequently nodulo-cystic lesions. Permanent scarring which may have profound negative psychosocial effects in the short and long term is a real risk¹. Varying degrees of acne affects at least 85% of 16 year old boys and girls, with a tendency towards natural resolution by the age of 25². Acne may less commonly affect older age groups, particularly in females. Exacerbating factors include psychological stress, pre-menstrual state, and oily applications including cosmetics. The alleged role of diet constitutes a common misconception among acne sufferers¹. An extensive array of topical and oral medications are nowadays available for effectively treating acne of any severity³. Treatment needs to be tailored according to the type and severity of the acne, and must be administered with the least possible delay if scarring is to be minimized or prevented. Other than the mild forms of acne which may respond to over the counter (OTC) applications, acne treatment falls squarely within the competence of the prescribing physician. Health education can go a long way towards helping the public to better understand this common affliction, and to provide general guidance that will in turn aid to keep acne related morbidity to the lowest acceptable levels.

SURVEY

Objectives and methods

A dermatologist-based questionnaire survey was carried out by the author, with a view to evaluating various aspects of the problem of acne vulgaris in Malta. The questionnaire was designed to elicit the following information:

- sources of patient referral to the dermatologist (author)
- acne care prior to referral
- acne medication received by patients prior to referral
- incidence of 'spot picking'
- patient knowledge of perceived acne-exacerbating factors and natural history of acne
- correlation of acne severity with the degree of embarrassment it produces
- acne severity and degree of scarring according to gender
- correlation between acne medication received in the 6 months prior to referral and acne severity
- correlation between oral acne medication received more than 6 months before referral and the extent of acne scarring

RESULTS

Demographic data

One hundred consecutive patients with acne, newly referred to the dermatologist (author), were recruited in the survey. Recruitment took place in the year 1999, both from the public hospital dermatology department (14 patients), as well as from private practice (86

patients). The sources of private referral were: 66 self-referred; 14 referred by family doctor; 4 referred by pharmacist; 2 referred by beauty therapist/hairdresser. Gender distribution was equal with 50 male and 50 female patients. The age distribution was: 31 patients below the age of 16 years; 63 patients aged 16 to 25 years; 6 patients over 25 years old.

Acne duration, previous acne care, and patients' perceptions

The duration of acne at the time of referral was: less than 3 years in 47 patients; 3 to 6 years in 40 patients; over 6 years in 13 patients. Inquiry on previous care for acne revealed the following pattern: 62 patients made use of OTC applications; 46 patients attended a beauty therapist (58% of females, 34% of males); 36 patients had been to a dermatologist; 27 patients had seen a family doctor; 5 patients received no previous care.

The medical acne treatment received in the 6 months prior to referral was as follows: topical medications (antibiotic, benzoyl peroxide and/or retinoid) in 43 patients; oral antibiotic in 22 patients; oral hormonal therapy (oral contraceptive pill combined with cyproterone) in 2 patients; none in 51 patients. Worth noting is the fact that one male patient who had severe acne with scarring, was on an anabolic steroid prescribed in connection with an infertility problem. The intake of oral acne medication before the 6 months prior to referral consisted of: antibiotic in 22 patients; hormonal therapy in 6 patients; none in 77 patients. In addition, none of the patients had received oral isotretinoin prior to referral.

Inquiry about the harmful habit of 'spot picking' produced an affirmative reply in 71 patients. An assessment of the degree of embarrassment experienced as a result of acne was performed by means of a linear visual analogue scale, the score ranging from 1 to 10 (mild embarrassment : score 1-3, moderate embarrassment: score 4-7, severe embarrassment: score 8-10). Mild embarrassment was recorded in 12 patients, moderate embarrassment in 36 patients, and severe embarrassment in 52 patients. The patients' replies to perceived acne-exacerbating factors are summarized in **table 1**. Moreover, **table 2** summarizes the patients' responses to questions relating to infectivity, natural disease duration, the risk of scarring, and the influence of timely treatment on the incidence and degree of eventual scarring.

Table 1. Response to questions on possible acne-exacerbating factors (Right answers are denoted as bold underlined figures)

	Yes	No	DK
Chocolate (n=100)	56%	28%	16%
Fried food (n=100)	68%	23%	9%
Foundation (n=37)	73%	19%	8%
Hair gel (n=70)	60%	29%	11%

Table 2. Response to questions on nature and complications of acne (Right answers are denoted as bold underlined figures)

	Yes	No	DK
Acne is contagious	14%	78%	8%
Acne lasts several years	93%	7%	0%
Acne can cause scarring	97%	3%	0%
Early treatment minimizes scarring	93%	1%	6%

Acne clinical characteristics and correlations

In 76 patients, acne affected only the face, whereas the face and trunk were both affected in 24 patients. The predominant morphology of the acne lesions was as follows: mixed (comedones and papulo-pustules) in 49 patients; papulopustular in 32 patients; nodulocystic in 14 patients; comedonal in 5 patients. The clinical severity of the acne was considered to be mild to moderate in 44 patients, and moderate to severe in 56 patients. Acne scarring was absent in 59 patients, whereas 34 patients had mild to moderate scarring, and 7 patients demonstrated moderate to severe scarring.

Table 3. Association between clinical severity of acne and related embarrassment

Acne severity	Mild embarrassment	Moderate embarrassment	Severe embarrassment
Mild to moderate (n=44)	16%	39%	45%
Moderate to severe (n=56)	9%	34%	57%

Table 4. Acne scarring according to gender

Degree of scarring	Male (n=50)	Female (n=50)
None	58%	60%
Mild to moderate	28%	40%
Moderate to severe	14%	0%

Moderate to severe embarrassment was commonly experienced in connection with all levels of acne, being somewhat more pronounced in the more severe acne cases as outlined in **table 3**. Acne severity was found to be slightly greater in males, with 60% of males compared to 52% of females having moderate to severe acne. The degree rather than the incidence of acne scarring was also found to be greater in males as may be seen in **table 4**. Moreover, the incidence and degree of scarring was observed to be directly proportional to the duration of acne as per **table 5**.

It was more likely for patients with more severe acne to have received medical acne treatment in the 6 months prior to referral as shown in **table 6**. Finally, **table 7** demonstrates that a substantial proportion of patients with established acne scarring had not received oral acne medication before the 6 months prior to referral.

Table 5. Degree of scarring according to duration of acne

Acne duration	No scarring	Mild to moderate scarring	Moderate to severe scarring
< 3 years (n=47)	70%	23%	7%
3-6 years (n=40)	57%	38%	5%
> 6 years (n=13)	23%	61%	16%

Table 6. Medical acne treatment received in the 6 months prior to referral to dermatologist according to clinical acne severity

Acne severity	Topical agents	Oral antibiotic	Hormonal therapy	None
Mild to moderate (n=44)	39%	14%	2%	57%
Moderate to severe (n=56)	46%	29%	2%	46%

Table 7. Degree of scarring according to oral acne therapy received more than 6 months before referral to dermatologist

Degree of scarring	Antibiotic	Hormonal	Isotretinoin	None
Mild to moderate (n=34)	29%	9%	0%	68%
Moderate to severe (n=7)	29%	14%	0%	57%

Discussion

To the author's knowledge there exists no recent published data regarding the problem of acne in Malta. The pilot survey being reported, despite not permitting statistical analysis, reveals important trends that are worth documenting, and some of which warrant further investigation and intervention.

The fact that 86 out of 100 consecutive patients with acne recruited in the survey, opted for private rather than national health service (NHS) specialist care, lends itself to various interpretations. The waiting time for routine referrals to be seen in the NHS dermatology department is currently 3 to 4 weeks, which is not unreasonable by today's standards, and considering that acne is not an acute condition. Possible reasons for acne patients predominantly resorting to private specialist care include an even faster access to a specialist with the added option of self-referral, the private health care setting often being perceived as more patient friendly, and reluctance to taking a morning off from work or school to attend an NHS morning specialist clinic when a specialist may be seen in the evening albeit having to pay a fee (bigger incentive for private medical insurance holders).

As much as 77% of private acne patients were self-referred, in contrast to only 16% being referred by a family doctor. Moreover, only 27% of all the patients, private and public, admitted to having received acne treatment from a family doctor in the past. Given that a family doctor is expected to be competent in treat-

ing patients with mild to moderately severe acne, which constitute 44% of the survey's sample, the above figures therefore imply a lower than expected contribution by family doctors towards overall acne care. This may be due to endemic cultural trends, as well as to the anomalous local primary health care set up whereby the family doctor does not, by right, play a central role in the management of the patient's overall health.

As much as 62% of the patients admitted to making use of readily available OTC acne products in the past. In second place came beauty therapists to whom 46% of the patients, around two thirds of females and one third of males, had resorted at some stage during their acne problem. Beauty therapy practice today, incorporates a bewildering range of skin care techniques and applications that are acceptable and appealing to the public at large, and indeed does occupy a prominent position in today's cosmetic culture. However limits of practice should be clearly defined, adhered to, and enforced. The management of inflammatory skin conditions including inflammatory acne falls outside the field of competence of the beauty therapist. It is therefore in the interest of the patient, that appropriate regulatory restrictions to this effect are incorporated in the Health Care Professions Act which is currently being re-drafted.

Acne sufferers constitute a very vulnerable and exploitable patient sub-group, and hence need proper guidance. They should be protected from being lured into non-validated, non-medical practices that only serve to delay the institution of effective medical therapy. In the case of moderate to severe acne, lost time translates into avoidable permanent scarring. In the author's opinion, the Maltese Department of Public Health is becoming increasingly efficient in curbing misleading health-related advertising in the media. This department ensures that the contents of proposed health-related adverts in the media are routinely scrutinized and censored by medical experts in the respective field before approval is granted.

The mistaken notion that diet plays an important part in the causation of acne is still very much prevalent amongst the public at large. In fact, only 28% and 23% of acne patients rightly believed that chocolate and fried food respectively do not influence the course of acne. Another commonly quoted acne-related dietary misconception concerns the ingestion of dairy products. The level of awareness of the comedogenic, and hence acne-exacerbating potential, of oily cosmetics such as foundation and hair gels was encouragingly high at 73% and 60% respectively. Moreover, the vast majority of patients knew that acne is not contagious and that its course spans over several years. Virtually all the patients knew that acne can cause scarring and that early effective treatment minimizes or prevents scarring.

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1. Perry CM & Brogden RN. *Drugs* 1996; 52(1): 125-158.
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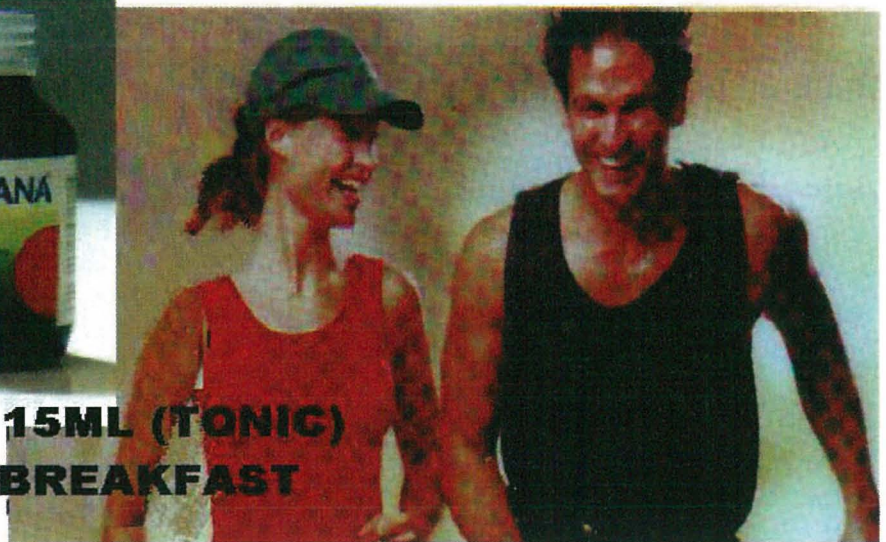
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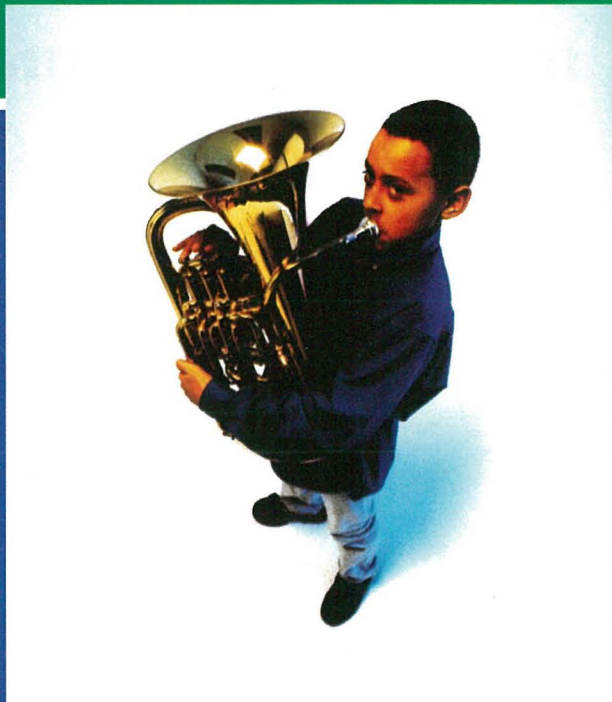
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Abbreviated Prescribing Information

Uses 'Accolate' is indicated for the treatment of asthma. **Dosage** Adults and children aged 12 years and over: One 20mg tablet twice-daily by mouth. 'Accolate' should be taken continuously. As food may reduce the bioavailability of zafirlukast 'Accolate' should not be taken with meals. Higher doses may be associated with elevations of one or more liver enzymes consistent with hepatotoxicity. The clearance of zafirlukast is significantly reduced in elderly patients (over 65 years). Clinical experience is limited and caution is recommended. **Contraindications** Hypersensitivity to the product or any of its ingredients. Moderate or severe renal impairment. Hepatic impairment or cirrhosis. Children under 12 years of age. **Warnings/Precautions** 'Accolate' should be taken regularly and continued during acute exacerbations of asthma. 'Accolate' does not allow a reduction in existing steroid treatment. As with inhaled steroids and cromones 'Accolate' is not indicated for use in the reversal of bronchospasm in acute asthma attacks. 'Accolate' has not been evaluated in labile (brittle) or unstable asthma. Elevations in serum transaminases are usually asymptomatic and transient but could represent early evidence of hepatotoxicity. If clinical symptoms or signs suggestive of liver dysfunction occur, serum transaminases should be measured, and appropriate action taken (see full prescribing information). Cases of Churg-Strauss Syndrome have been reported in association with 'Accolate' usage. A causal relationship has neither been confirmed nor refuted. If a patient develops a Churg-Strauss Syndrome type illness 'Accolate' should be stopped, a re-challenge test should not be performed and treatment should not be restarted. **Interactions** Possible pharmacokinetic interactions with warfarin (prothrombin time should be monitored), acetylsalicylic acid ("aspirin"), erythromycin, terfenadine, theophylline and smoking. During post marketing surveillance there have been rare cases of patients experiencing increased theophylline levels. **Possible Adverse Reactions** Headache and gastrointestinal disturbance may be associated with 'Accolate' administration. These side effects are mostly mild and do not necessitate withdrawal from therapy. Hypersensitivity reactions, including urticaria and angioedema, have been reported. Rashes, including blistering, have also been reported. Infrequently in clinical trials, with an incidence equivalent to placebo, elevated serum transaminase levels have been seen. Rarely the transaminase profile has been consistent with a drug-induced hepatitis which resolved following cessation of 'Accolate' therapy. Increased incidence of infection (usually mild, mainly of the respiratory tract) was observed in elderly patients in placebo-controlled trials. **Pregnancy and Lactation** Safety in pregnancy has not been established. 'Accolate' should not be administered to breast-feeding mothers (see full prescribing information). **Presentation** 'Accolate' tablets containing 20 mg zafirlukast. Based on 8/IH/1035706 'Accolate' is a trade mark of Zeneca Limited. Consult the full Prescribing Information before prescribing. Further information is available on request. AstraZeneca, Silk Court, Silk Road Business Park, Hulley Road, Macclesfield, Cheshire SK10 2NA, England. www.asthma.zeneca.com password: asthma

AstraZeneca 

CECLOR

means compliance for both
Mothers and Children

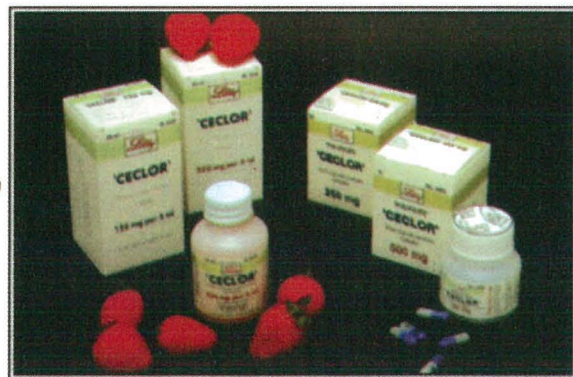
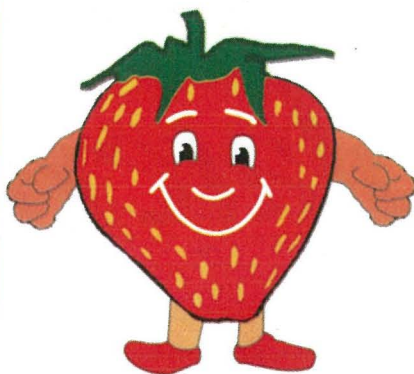


TWICE-A-DAY

“for otitis media and pharyngitis the total daily dosage may be divided in two and administered every 12 hours”

GREAT STRAWBERRY TASTE

“Only CECLOR received > 99%
taste acceptance in children”



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Notwithstanding this knowledge, 41% of the patients had varying degrees of visible scarring. This rate of scarring is worrying when one compares it to the substantially lower rate of scarring in the UK which is seen in around 17% of cases of acne¹. The local high rate of acne scarring is probably largely due to the late institution of effective medical treatment in patients with moderate to severe acne. Another likely contributing factor is 'spot picking' which is unfortunately a common habit among patients. Along the same lines and being just as damaging is the lancing and squeezing of acne lesions, which is allegedly practiced by a number of beauty therapists locally. One may argue that this being a dermatologist-based survey gives rise to skewed data which would hence explain the higher rate of acne scarring, since patients with more severe acne are more likely to visit a dermatologist. However this is not the case since as many as 44% of the patients coming to the dermatologist according to this survey suffered from mild to moderate acne.

Another interesting statistic that emerged from this survey is that males had more severe acne and acne scarring than females. However, the world literature on acne does not imply that the severity of acne and related scarring is generally influenced by gender. It is therefore probable that additional female patients with more severe acne and associated scarring do exist locally but were not captured by this survey, possibly because these are seeking alternative, non-medical therapies. One may also speculate that local female acne sufferers may be generally less aware of the benefits of medical treatment compared to their male counterparts.

Scarring is likely to complicate moderate to severe forms of inflammatory acne, and normally takes at least 6 months to develop. Patients with such acne severity require oral therapy in addition to topical agents in order to achieve clinical control. In this survey, 66% of the patients with visible scarring had never received oral treatment going back to more than 6 months before referral. It is therefore likely that undertreatment as well as a delayed treatment are responsible for the high local incidence of acne scarring. This survey confirmed that the incidence of scarring increases with increasing duration of acne. Moderate to severe inflammatory acne is usually effectively controlled by courses of oral antibiotics and hormonal therapy, but the recurrence rate is high and repeated courses are required. Given that therapy with oral isotretinoin is associated with a very high cure rate without the need for repeat courses (with very rare exceptions) one should consider this treatment option more often⁴. The long term savings in financial and 'scarring' terms certainly outweigh the apparent short term high cost of the drug⁵. It is noteworthy that none of the patients entered in the survey had previously received oral isotretinoin.

Conclusions

- The negative psychosocial impact of acne at all levels of the disease should never be underestimated.
- There is evidence to suggest that acne in Malta is undertreated, and this is reflected in the high incidence of associated scarring.
- Public education campaigns may help convey the important message that acne is a skin disease which responds to medical treatment, the timing of which is crucial in minimizing consequent scarring. Health education should also aid to dispel popular misconceptions related to acne.
- Family doctors should be given the opportunity to update their knowledge of acne management, as well as to become more involved in the management of at least the milder forms of acne.
- The limits of practice of beauty therapists should be clearly defined, and there should be appropriate legislation to ensure proper regulation of such practice. In particular, it should be clearly laid down that the management of inflammatory skin conditions including inflammatory acne is solely the responsibility of a medical practitioner.

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UTILIZATION OF COMPLEMENTARY AND ALTERNATIVE MEDICINE IN PRIMARY CARE - WHAT ARE THE RELATIONS BETWEEN IT AND CONVENTIONAL MEDICINE?

E. KITAI, S. VINKER, A. SANDIUK, Z. ZELTZER, A. GAVER, M. HERZ*

FAMILY DOCTORS

ABSTRACT

Background: Complementary and alternative medicine (CAM) utilization among various groups of patients in western countries is increasing.

Objectives: To describe the utilization of various CAM methods in parallel with conventional primary care medicine and the relations between it and conventional medicine.

Study Design: Four hundred and eighty patients in two primary care clinics participated in the survey. The participants answered a structured questionnaire, which included socio-demographic information and details of CAM therapy utilization.

Results: Eighty percent of those seeking CAM therapy received conventional medical treatment for the same complaint as well. When asked if CAM should be funded 69% agreed, 14% disagreed and 8.3% were undecided. The most frequent causes for using CAM therapy were insufficient improvement by conventional treatment (36%), a reluctance to take medications (19%) and willingness to try a new modality (13%). Most of those who received CAM therapy felt it was beneficial and claim they would return to use it in the future under similar circumstances.

Conclusions: We found that the term complementary is more appropriate as most patients use CAM in parallel to conventional medicine. Patients using CAM are satisfied and intend to use CAM in the future.

INTRODUCTION

Surveys in western countries have shown an increase in CAM utilization among various groups of patients¹⁻⁴. In a telephone survey in the United States, one in three of those surveyed had used a non-conventional medication in the previous year, and one third of these had consulted a CAM therapist¹. In another survey of CAM utilization in a representative sample of the US population, 8.3% used CAM in the previous year. Wolthers, et al³ found that 31% of the children surveyed in Denmark had received a non-conventional medication sometime in the past. We have found that 19% of primary care patients had consulted an alternative medicine therapist at least once⁵.

There is little information on the inter-relationships between conventional primary care medicine and CAM utilization, especially where medical insurance is universal but does not include CAM. In a multinational study, Borkan et al⁶, found that 60% of primary care physicians had referred some patients to a CAM therapist, but the study did not show how many pa-

tients were treated by CAM therapists and what were the treatment results. Druss et al², found that most CAM users were using it in parallel to conventional medicine as complementary therapy and only 20% of CAM users used it as an alternative to conventional medicine. The complicated web of communication and interaction between the patient, conventional care physicians, CAM therapists and other informal cares were the issue of a recently published reviews^{7,8}.

The rate of the utilization of various CAM methods simultaneously with conventional primary care medicine for the same complaint is not known. It is not clear why CAM therapy is initiated and whether a CAM consultation means that the patient is unhappy with conventional treatment. These important questions were addressed in a study among primary care patients in Israel.

* Unfortunately, since contributing to this article, Dr. Herz has passed away. (Editor's Comment)

METHODS

The survey was carried out in two urban family practices in Israel, affiliated with the General Sick Fund Health Maintenance Organization.

Patients' enrollment was via telephone interview or direct contact in two primary care clinics. In clinic A, randomly assigned patients who consulted the doctor in a given two-month period, were asked to answer a questionnaire at the end of the encounter. In clinic B, a sample of 250 patients was randomly selected from the clinic register, of these 205 were located and contacted. These patients were interviewed by telephone and asked to fill-in the same questionnaire.

The participants answered a structured questionnaire, which included socio-demographic information and details of CAM therapy utilization, whether their family physician or another conventional physician had treated the same problems as well. They were asked if they think CAM should be funded in the national health insurance, are they satisfied with the CAM therapy and are they intending to visit again the CAM therapist. The methods used for patients enrollment and the detailed questionnaire were presented in a previous publication⁵.

The following methods were defined as CAM modalities:

- Physical alternative methods: reflexology, chiropractic, osteopathy, shiatsu.
- Acupuncture.
- Other methods: naturopathy, herbal medicine, aromatherapy, color therapy, homeopathy.

Data analysis: Data was analyzed using descriptive statistics.

RESULTS

In clinic A 313/344 patients agreed to participate and completed the questionnaire (response rate 91%). In clinic B, 167/205 patients completed a telephone interview (response rate 81.5%). The data regarding 480 patients was available for further analysis. Altogether 90 patients (90/480, 19%) made 107 self-referrals for CAM therapy. The most common single method chosen was homeopathy (37%). 28% of the patients chose physical alternative methods, of this group, the most commonly used was reflexology (74%). 12% of the patients used acupuncture.

When asked if CAM should be funded 332 (69%) agreed, 67 (14%) disagreed and 40 (8.3%) were undecided. Answering the question "Why did you use CAM therapy for this complaint" the most frequent causes were insufficient improvement by conventional treatment (36%), a reluctance to take medications (19%) and willingness to try a new modality (13%). Eighty percent of those seeking CAM therapy received conventional medical treatment for the same complaint as well. 48% of those who received CAM therapy felt that the treatment was beneficial and another 35% found it was partially beneficial. When asked if they would return to use the same therapy under similar circumstances in the future, 56% of patients who used CAM stated that they definitely would and another 17% stated that they may do so.

DISCUSSION

About one fifth of the participants in this survey had received CAM therapy at some time in the past. This is concurrent with results of other surveys^{1,2}. The socio-demographic characteristics of CAM users were presented in detail in a previous publication⁵.

We found that almost 70% of the patients think that CAM should be funded. As we did not include a question of willingness to pay higher monthly dues in order to enable this funding, this conclusion should be taken with caution. On the other hand, in health systems where CAM was included in its services, satisfaction was reported to be lower⁹. Some favorite effects of CAM therapy may stem from it being mainly "private medicine"⁸.

Druss et al², noted that CAM users had used more types of conventional medicine preventive services. This interrelation between CAM utilization and preventive medicine utilization is important and may reflect special "health needs" of this sub-population. Ernst¹⁰ has suggested a series of advantages of CAM over conventional medicine including: more time spent with each patient, empathy, individual attention, hope of cure from chronic disease states and the attention given to health rather than disease. In our study those seeking CAM care were mainly motivated by the subjective failure of conventional treatment and the attempt to avoid medication. These reasons were not mentioned in other studies.

Eighty percent of the patients who received CAM therapy received conventional medical care for the same complaint, similar to the findings of Eisenberg et al¹, and Druss et al². This may suggest that most patients seeking CAM therapy had not stopped using conventional medicine, but were using both, implying that the term "complementary medicine" is more accurate than "alternative medicine". The conventional physician may feel concerned about CAM utilization⁷. He may feel that the CAM therapist is unqualified, major diagnoses could be missed or delayed, compliance with conventional therapy may be reduced, and dangerous adverse effects may occur^{11, 12}. Considering the fact that both treatments

are often used simultaneously, the family physician should be aware and actively inquire about CAM use.

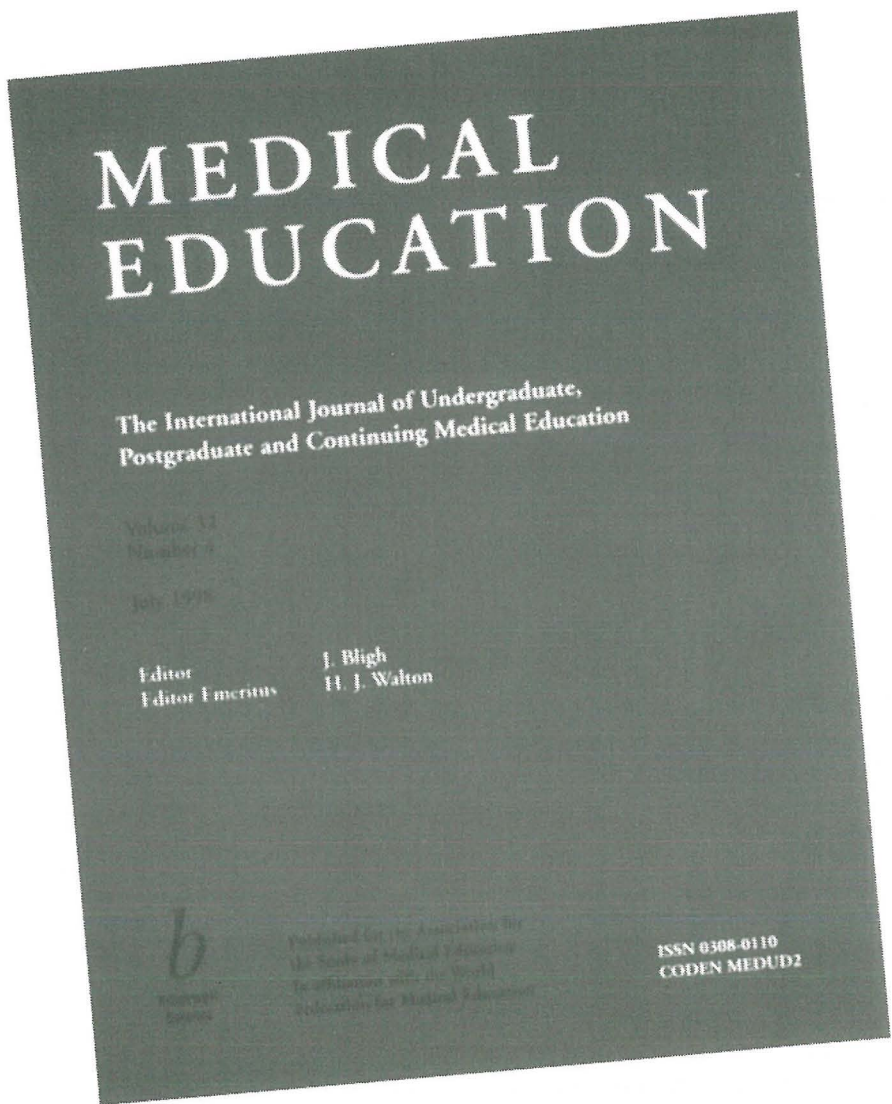
In surveys of CAM users, about 80% are satisfied with the treatment they received, not always in concordance with an improvement in their presenting complaint⁸. Over two thirds of patients who seek CAM return to further courses of treatment and almost all thought they might use CAM in the future⁸. This is also in concordance with our findings in an Israeli primary care population.

In conclusion, we found that CAM is popular. The term complementary is more appropriate as most patients use it in parallel to conventional medicine. Patients using CAM are satisfied and intend to use CAM in the future. Many others think that CAM should become funded.

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MALTA COLLEGE OF FAMILY DOCTORS

HON. SECRETARY'S REPORT OF COLLEGE ACTIVITIES 1999-2000

MARIO R. SAMMUT

FAMILY DOCTOR

1. Council meetings:

In the first Council meeting after the AGM of 29/4/99, Dr F P Calleja was welcomed to the College Council. Dr W Galea was proposed, and accepted, to return as International Secretary instead of Dr Busuttil.

Nineteen meetings were held since the last AGM of 29/4/99. Eleven of these meetings (1st May, 9th June, 30th June, 5th July, 14th July, 27th July, 4th August, 23rd September, 21st October 1999, 3rd January 2000, 29th February 2000) were devoted to the 6th Mediterranean Medical Congress. Council members' attendance was as follows:

M R Sammut	19	J G Pace	17
F P Calleja	19	W Galea	17
D Soler	18	J K Soler	16
M A Borg	18	A Mifsud	14
A P Azzopardi	18	J P Gauci	7
P Sciortino	18		

2. 6th Mediterranean Medical Congress:

A Preliminary Announcement was distributed at a College stand during the WONCA 1999 Meeting in Mallorca, Spain, during May 1999. On the 9th June 1999, after presentations by two conference organisers, the College Council decided to provisionally select Howard's Travel, confirming such decision on the 5th July. On the latter date, the Westin Dragonara Resort was chosen as the conference venue. On the 27th July, Dr D Soler presented the signed agreements with the Mediterranean Medical Society and with Howard's Travel. On the 30th July, the University Rector, Dr R Ellul Micallef, was invited and

accepted to be a keynote speaker. On the 4th August, the design of the Congress poster was presented and accepted by Council, who also accepted a proposal by Webcraft to host the Congress website. On the 21st October, Dr J G Pace was appointed Senior Chairman of the Congress, and Dr J K Soler was confirmed as Chairman of the Organising Committee, with Dr P Sciortino, Dr M A Borg and Dr A Mifsud as Chairmen of the Scientific, Hospitality and Finance Committees respectively. The 2nd Announcement was published at the end of March 2000, and subsequently distributed.

3. CPD Activities:

- **Autumn 1999 CPD Meeting (6-8 October 1999): Information Technology in Family Practice:**
 - *Wednesday 6th October:* Information Technology in Medical Education - Dr P Sciortino;
 - *Thursday 7th October:* The Use of the Internet in Family Practice - Dr H Agius Muscat & Dr W Galea;
 - *Friday 8th October:* TRANSHIS - a Computerised Medical Record for Family Practice in Malta - Dr J K Soler.Sponsors: Biosphere and Servier.
- A CPD meeting was held in collaboration with the Malta Hospice Movement on the 3rd

November 1999, entitled '**When not to use morphine**' with Dr Victor Pace, Consultant in Palliative Care, as speaker.

- On behalf of the College, Dr P Sciortino introduced the afternoon workshop for family doctors at the **First Maltese Conference on Infection Control and Antibiotic Therapy** on 6th November, which was held in association with the College (which also provided accreditation).
- The College granted accreditation to a **Conference on Bioethical Issues** held on the 24-26/11/99 at the Medical School, G'Mangia.
- A **Sports Medicine Seminar on Lower Limb Biomechanics and Associated Injuries** was held by the Medical Commission of the Malta Olympic Committee on 26th - 28th November 1999 in association with the Malta College of Family Doctors, with appropriate accreditation granted for participating family doctors.
- The **Winter CPD Meeting** was held on 26-28 January 2000 at Farsons, Mriehel, with refreshments kindly sponsored by the latter. The meeting was entitled '**The Evolving Role of Occupational Health in Malta**', with the programme as follows:
 - *26th January 2000:* An Overview of the Work of a Company Doctor - Dr D Soler
An Overview of the Work of a Company Nurse - Ms N Caruana
An Engineer's View of Occupational Health - Ing. J P Sammut

- *27th January 2000:*
Sickness Leave Parameters - Dr J G Pace
Review of a Database of Company Visits over 3 years - Dr J K Soler
- *28th January 2000:*
An Economic Evaluation of a Company Occupational Health Service - Dr P Sciortino
The National Occupational Health Structure: An Official View of the Role of the Company Doctor - Dr M Gauci
- A **Workshop on Computer Literacy**, which was to be organised for the College by Mr Anthony Sultana at De La Salle College on the 29th January 1999, had to be cancelled due to lack of participants.
- A lecture on **medical anthropology** was held at the Medical School on March 28th 2000 by Prof. Murray Last in collaboration with the University of Malta and the College.
- The **Spring CPD Meeting** on 'Fertility Issues in Family Medicine' was held on 10-12 May 2000 with the following programme:
Wednesday: The oral contraceptive - Mr D Felice, Case presentations & discussion - Dr P Degabriele.
Thursday: Contraception without the OCP - Mr G Buttigieg, Case presentations & discussion - Dr M Rizzo Naudi.
Friday: The childless couple - Prof. M Brincat, Male Infertility - Dr J Vassallo.
Sponsors were Pro-Health and Synthelabo.
- In April 2000, the Sports Medicine Subcommittee of the Malta Spots Council requested the College's collaboration and accreditation for a **Sports Medicine Conference** due to be held on the 9-11 June 2000.

4. Local news:

- In May 1999, the Faculty Board of Medicine and Surgery

unanimously approved the setting up of a **Department of Family Medicine**. This was subsequently confirmed by the University Senate on the 11th November 1999, and by the University Council on the 17th February 2000.

- The **EGPRW International Course on Research Methods in Primary Care** was hosted successfully by the College on 3-7 June 1999 at the Forum Hotel, St Andrew's.
- In June 1999, it was announced that the **Patients' Charter** had been translated into Maltese and put up on the College website. A leaflet with versions in Maltese and English was printed through a sponsorship by BUPA (Malta) in February 2000 and publicised by a press release.
- In June 1999, Dr M R Sammut was invited to represent the College in a parliamentary sub-committee discussing "**Mental Health: policies, structures, services and legislation**". Dr Sammut explained the College's opinion that, for the Mental Health Reform in the Community to succeed, primary care needs to be reformed in line with the College's Policy Document.
- Dr P Sciortino and Dr M R Sammut held an initial meeting on 17th August with Dr R Busuttil, Director General (Health), regarding the introduction of a 3-4 year course in **Vocational Training in Family Medicine**. Dr R Busuttil subsequently prepared a draft memo on the subject and referred it to the College for its comments before submission. Such programme was approved with amendments during a subsequent meeting on 28/1/2000 between the Director General (Health), the Medical Association of Malta and the College (represented by D Soler, M R Sammut and P

Sciortino). During this meeting the DG(H) accepted that the Health Division sponsors a **Trainers' Course** organised by the College as part of such programme.

- In a letter dated 16th September 1999, Dr Frank Portelli, CEO and Director of **St Philip's Hospital**, agreed to renew the hospital's support and commitment to the College for 3 years commencing on the 1st January 2000.
- Dr M R Sammut represented the College at a follow-up **Seminar on the Draft Mental Health Act** held by the National Mental Health Commission on the 26th October 1999.
- Dr M R Sammut and Dr A Mifsud represented the College at a **meeting** organised on the 28th October 1999 by the Medical Association of Malta regarding **issues related to EU accession**. Dr A Mifsud and Dr F P Calleja were subsequently nominated to represent the College on an Academic Associations' Committee for EU Accession.
- In November 1999, the Council agreed that the **College membership fee** be raised (for the first time in 10 years) to Lm 15 as from 2000.
- The College **10th Anniversary Dinner** was held at the Coastline Hotel, Salina on the 9th December 1999, with the Minister of Health, the Director General (Health), the Dean of the Medical School and the CEO of St Philip's Hospital as the College's guests.
- The College was invited by the Director General (Health) in December 1999 to nominate a representative to a working group being set up to plan a **National Antibiotic Campaign**. Dr A Mifsud was chosen as such representative.

- **Transhis** was launched during a one-day workshop on the 5th February 2000 at the Forum Hotel, St Andrew's, with 12 doctors prepared to use the programme. Another 5 doctors accepted to use the programme after a second workshop on the 26th February. Prof H Lamberts and Dr I Okkes are to visit in June 2000 to assess progress and provide advice on the programme's use.
- Dr J G Pace chaired a workshop on 'Health Care in the Community' during the conference organised by the Foundation for Medical Sciences and the Forum Group entitled '**A National Agenda for sustainable Health Care in Malta**' on 18-20 February 2000.
- During March 2000, the College Council recommended that a peer-review system be introduced for the **College Journal** 'It-Tabib tal-Familja'.
- In March 2000, the College wrote a letter of congratulations to the new President of the **Medical Council**, and requested that GPs have a dedicated representative and that voting be performed by postal ballot. On 12th April, Dr D Soler announced that the Medical Council had rejected the College's two recommendations.
- Dr J G Pace, Dr P Sciortino and Dr A Azzopardi represented the College at a meeting on the 24th March 2000 set by the Director General (Health) with various associations to discuss **legislation changes to the Medical and Kindred Professions Act**.
- Dr F P Calleja was appointed in March 2000 as College representative to the **Breast Care Support Group** committee.
- In March 2000, the Council accepted an invitation through Dr M R Sammut from

EUROPREV to participate in a **study on GPs' views re health promotion**, and accepted Dr Sammut's suggestion that this be held in collaboration with the Health Promotion Department for support with mailing.

- In April 2000, the College collaborated with the Health Promotion Department in this year's **Quit & Win 2000** smoking cessation campaign, by means of a joint letter to family doctors.

5. International news:

- A College delegation made a strong showing at the **WONCA Meeting in Palma de Mallorca**, Spain on 19-22 May 1999, with Dr D Soler and Dr M R Sammut representing the College in a WONCA Europe Council Meeting; Dr M R Sammut making a presentation on 'Tobacco Control in Malta', co-chairing a workshop on cardiovascular diseases and representing the College in a EUROPREV Closed Meeting; Dr J K Soler participating in an ICPC Meeting and reviewing posters for EGPRW; Dr A Mifsud representing the College in a EGPRW Closed Meeting; Dr P Sciortino representing the College in a EURACT Closed Meeting; and Dr W Galea actively participating with Dr J K Soler in a Medical Informatics Meeting. Moreover, Dr C Sammut and Mrs M Soler took care of a College stand promoting the 6th Mediterranean Medical Congress to be hosted by the College in September 2000.
- On 5-6 November 1999, Dr M R Sammut, the College delegate to EUROPREV, participated in the **First Closed Meeting of EUROPREV Delegates** in Barcelona, and was appointed to the **Coordinating Board of EUROPREV**.
- Dr P Sciortino represented the College in a **EURACT Meeting** in Israel during March 2000.

- In March 2000, the Council chose College President Dr D Soler and Secretary for Ethics Dr A P Azzopardi as its representatives to the **WONCA Europe Meeting in Vienna** during 2-6 July 2000.
- During a **EGPRW Meeting** in Maastricht in May 2000, Dr A Mifsud represented the College and Dr J K Soler presented a paper.
- Dr M R Sammut will be representing EUROPREV as a WHO temporary advisor in the above **WHO CINDI Programme Directors meeting** due to be held in Malta on 9-10 June 2000. The meeting will be discussing the area of smoking prevention in health professionals.

6. Membership and Accreditation:

- Seven College members failed to pay their 1999 subscription fee by the end of October 1999 despite repeated reminders. As such, these were **deleted from the College register** as per Council decision of 13/9/94.
- **Membership at present stands at 126.**
- **45 College members were accredited for 1999**, 20 of which have maintained their accreditation status for the nine consecutive years since 1991.

7. College Journal and Newsletter:

- Three issues of the College Journal (December 1998 and June & December 1999) were published since the last AGM. The Newsletter continues to be sent on a regular basis exclusively to College members, with local and international news of special interest to family doctors.

18th May 2000

These days more and more Maltese Family Doctors are using information technology in their practices. Electronic medical records offer many advantages over paper-based systems, including fast and efficient data retrieval and professional presentation of patient data as problem lists and medication lists. This has been the experience of many colleagues who chose to use the program Transhis for their clinical records, and this has the added advantage that data is classified with ICPC and can be used for research purposes. More details were given in the article about the project published in the June issue of the Journal.

Other colleagues use electronic information systems to assist them in providing optimal care for their patients. Sources include the vast on-line databases available, many times for free, on the internet. One may get accurate and very much up-to-date information, but the vast expanse of information makes retrieval complicated for the uninitiated. Also, one has to be online to use these resources, and this may be impractical for doctors practicing from clinics in pharmacies. An alternative approach is to use data collected on a CD-ROM which can be used by the doctor with access to a computer or laptop in his clinic, without the need for an internet connection. The data on CDs designed for Family Doctors is specific to the discipline and presented in a way which is more efficient to use in front of a patient. However, updates are necessary to keep the information current, and the user must make the effort to keep his system updated.

In this short article I would like to review a few such CD ROMs, and hopefully whet the reader's appetite and encourage him to try the programs out himself.

EVIDENCE-BASED MEDICINE GUIDELINES

Participants at the recent World Organisation of Family Doctors (WONCA) conference in Vienna were given a copy of the EBM Guidelines CD ROM published by the Finnish Duodecim Medical Publications Ltd. The CD ROM collects and summarises sets of guidelines which relate to the core clinical knowledge essential in general practice. It is the most extensive collection of guidelines for primary care, with more than 900 headings, and includes problem-based guidelines relating to a number of symptoms encountered in primary care, as well as disease-specific guidelines including even rare diseases. Various techniques and minor surgical procedures are included,

and all guidelines are supported by concise summaries of the underlying scientific evidence. The evidence is based on Cochrane reviews and DARE abstracts on the Cochrane Library as well as on other recent systematic reviews.

The idea of the project emerged in 1987 from the obvious need for a handbook discussing the diagnosis and treatment of the wide range of diseases and conditions encountered by the Family Doctor. The CD ROM is prepared by a team of experienced, practicing primary care physicians working in close co-operation with 20 specialist co-ordinators and 300 authors. The contents are updated three times a year.

The interface is a simple form, where one enters simple text terms such as "asthma" or "hypertension" and the program returns a list of articles and guidelines with the word in the title or in the actual text of the article as specified by the user. The user can construct advanced searches with logical operators such as AND and OR. The program includes a thesaurus function, a hierarchical MeSH of terms and the facility to browse the database, all included to help constructing searches.

The guidelines are designed to be used at the bedside, and help the physician to choose the best course of action in the evaluation of symptoms and treatment of diseases, according to the best available scientific evidence.

There is no doubt that this CD ROM is a very useful addition to the desktop, and its simple interface makes it so easy and intuitive to use. The guidelines are short and focus on practical points, and can be read quickly during the consultation. A nice feature is the inclusion of pictures of common and less common conditions which help to refresh one's memory in case of doubt.

For more information, the reader should go to the website, at www.ebm-guidelines.com

MENTOR PLUS

Mentor Plus, from Oxford University Press, is a leading diagnostic aid for medical professionals. The CD ROM provides instant access to expert information on over 2,000 diseases and 26,000 commonly used medical terms. It includes text from the acclaimed Oxford Handbooks of Clinical Medicine and Clinical Specialities, multimedia material to support descriptions of diseases and procedures, and can link

directly to the Oxford Textbook of Medicine and British National Formulary CD ROMs. It also incorporates over 200 patient leaflets and details of over 500 self-help groups in the UK.

The interface is based on Microsoft's Internet Explorer, and all documents are indexed and hyperlinked, which makes it familiar to those used to browsing the internet. At the left of the Explorer window is a navigation bar which allows users to skip between sections. The articles are indexed by speciality (e.g. anaesthesia, ENT, general practice), alphabetically by title, and by drugs, making it very easy to find information via a few mouse clicks. Multimedia files (audio, video and pictures) are indexed alphabetically and by media type.

A very useful feature of the program is the collection of patient information sources. These include simple anatomical diagrams to help in educating patients, charts (such as a menstrual diary and peak flow diary), lists of self-help groups, and patient leaflets to be printed out and handed to patients.

In summary, Mentor Plus is an extensive collection of data sources, including patient information

leaflets, which has been indexed for easy and efficient use during the consultation. For more information, the reader should access the Oxford University Press website at www.oup.co.uk

REFERENCE CDS

Many other CDs are available commercially, and may be useful to the Family Doctor. For example, the entire Illustrated Merck Manual is available on CD, along with The Merck Manual of Geriatrics. The text is useful as a reference, and the search functions are much superior to the index of the printed version. In fact you can search the entire manual for single terms. Another well known resource is the Cochrane Library, which spans two CD ROMs. The database is a collection of reliable evidence of the effects of health care, and original research is graded as to the strength of evidence and indexed for searching purposes.

Readers with an interest in acquiring these and similar CDs are advised to contact the editor for more information.

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The Editor reserves the right to edit, style and, if necessary, to shorten material accepted for publication. Articles relating to Family Medicine will be submitted for peer review, and may be returned to the author for modification if suggested by our peer reviewers. Articles from Mediterranean countries other than Malta may be reviewed by members of our Scientific Advisory Board before being submitted for peer review.

The article should have a title that appears at the top of the first page. The names of the author/authors should be clearly indicated at the beginning of the article, below the title. The area of expertise of the author should also be indicated. An address and telephone number should be included for forwarding any proofs if required.

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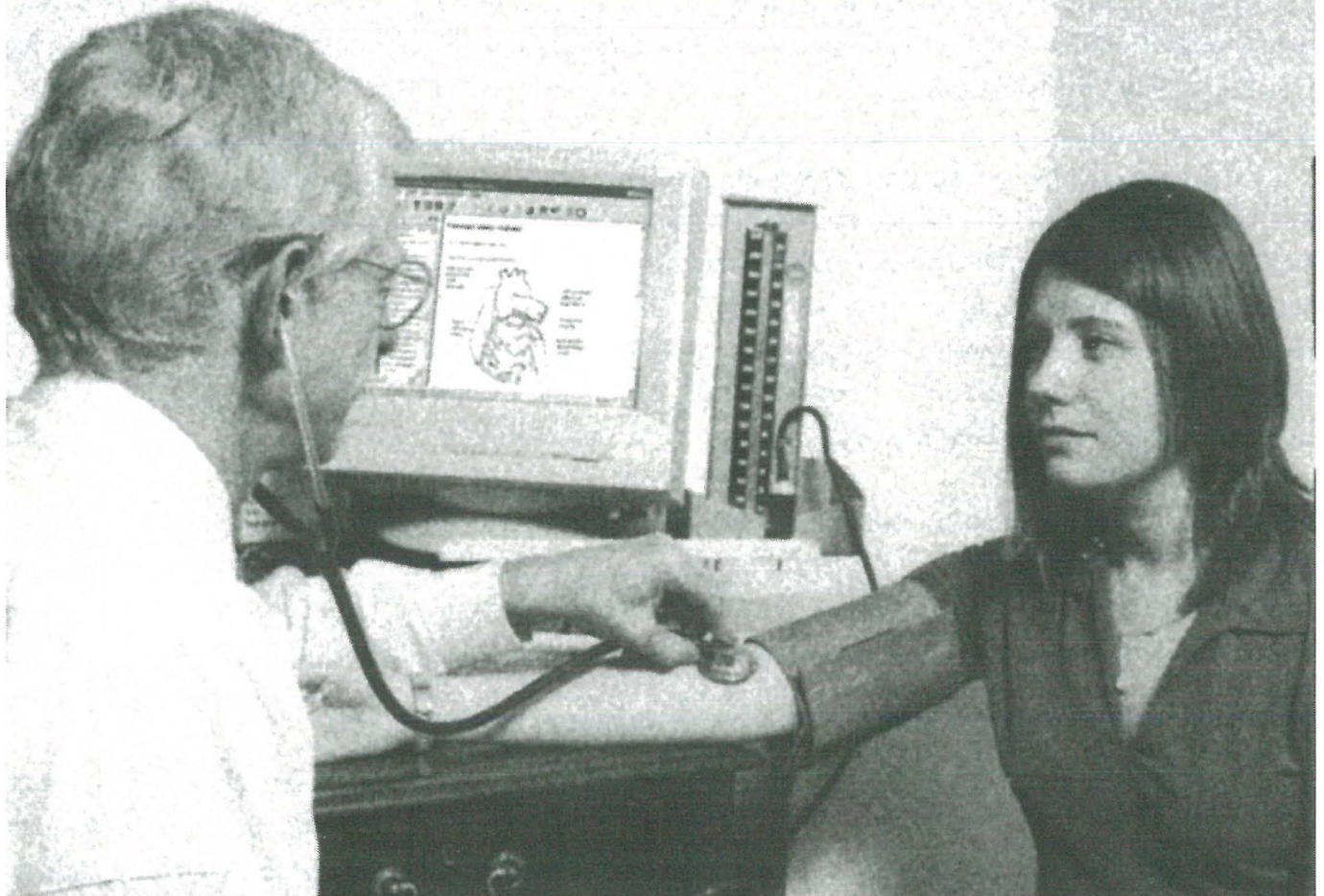
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SPEECH DELIVERED BY H.E. PROF. GUIDO DE MARCO, PRESIDENT OF MALTA, AT THE OPENING OF THE 6TH MEDITERRANEAN MEDICAL CONFERENCE AT MDINA, 7TH SEPTEMBER 2000

Ladies and Gentlemen,

Medicine, much like religion, has always had a magical mystique about it. The medical practitioner, like religious practitioner provides a bridge and helps the laymen to rationalize the unknown and reduce it into known terms. The patient, often sick and in pain, seeks the advice of the one person, the doctor, who can deliver him from the misery of suffering. In the vast majority of cases it is family doctors such as you gathered here today, whom patients first consult about their symptoms. It is at this point that the family doctors face a mayor challenge - that of communication.

In this era of globalization, communication may take on several forms: Internet, interactive television, radio..., but in dealing with clients, the family doctor has to rely on that most basic form of communication - - words. Talking to a patient, taking time out of a busy schedule is part of a process which the medical profession cannot with impunity, ignore.

By talking to the patient, the doctor is administering the first therapy, that of giving the patient importance and hence making him feel that he and his feelings count. Talking this approach needs courage and sensitivity. Courage in the face of difficult or upsetting diagnoses. Sensitivity, because in the balance between schedules, family and the patient in front of him, the doctor must always empathise with the patient to be able to give him optimum advice.

It is from this challenge to communicate effectively, that another, in my opinion more important challenge, springs. This is the challenge of demystifying medicine. Earlier, I referred to the doctor as being perceived to be a form of magician, the purveyor of health and well being when illness strikes. In the past this aura of reserved information to the initiated few was carefully preserved. It gave prestige. It gave authority, and, if one might dare acknowledge, it discouraged the patient from asking questions, which the doctor, for any amount of reasons, might not be in a position to answer. In fact, this situation led to a distinction between the haves and have-nots of knowledge. More importantly, it led to an increasing helplessness on the part of the patients who became prone to leave even the simplest issues to the doctor, or even, the consultant. Patient empowerment is a dual challenge.

It involves hard work in educating the people and spreading knowledge so that the gap between the Info-haves and the Info-have nots is substantially decreased. It involves a more professional approach by family doctors themselves. For the doctor who disseminates is one who is sure of his status, of his knowledge, of his ability to heal. No one is in a position to empower anyone else if his own power-base, in this case knowledge, is threatened.

This brings us to another point, the need of doctors to keep abreast of information and discoveries. No mean feat this, when one considers the vast amount of knowledge constantly being updated on several aspects of medicine. Several factors keep doctors from updating themselves as often and as thoroughly as they would like. Among these factors one must mention discrepancies in standards of development reached by the countries in which the doctors operate.

Mediterranean counties may resemble others geographically and climatically but they find also similarities in the problems they face. Lack of resources leads to frustration among doctors who know that they can do more but may not because the country's resources are perhaps mis-directed. In this respect Malta, has achieved much. Perhaps because of its size, its lack of resources, Malta has had to exploit to the utmost its resource to be able to give the best health care it can afford.

Malta's effort was recognized in the report published last April by the world health organization in which it placed fifth in the world as a country making the best use and providing the best care relative to the resources available to it. States must ensure that access to knowledge is not hampered because now, even more than before, the process of developing knowledge from available data makes all the difference between good and excellent treatment of the patient. Conferences of this kind also serve as an impetus for research in fresh woods and pastures new.

Doctors have the assurance of belonging to a profession but increasingly, the world is moving away from professions and more towards professionals.

This change is indicative of changing times. The family doctor must not rely only on the medications so easily prescribed. Psychological therapy

often translated into listening and explaining helps to foster serenity in the patient, laying the foundations for speedy recovery.

Patient empowerment and increasing doctor - patient communication lead to a different field of medicine - Family and Community medicine. Studies abroad have shown that more than 90% of also contacts by patients start at the level of primary care. Not only minor illnesses such as colds, but chronic illnesses such as asthma and more serious illnesses. The range of treatment which falls under the jurisdiction of the family doctor is vast and the clinical decisions made by them are critical to subsequent diagnoses and treatment. Family treatment is increasingly being recognized as a specialization in itself.

At the moment in Malta primary health care is provided both by the state and also by the private sector. Perhaps the time is approaching when this area is harmonized so that the service is optimized while leaving ample space for choice. One principle is paramount: Medicine is not a commodity available only to those who can afford it. Treatment and cure are not dependent on health insurance. The only health insurance that a patient needs lies in the fact that he is a human being wor-

thy of every respect and dignity whose life must be cherished and respected as an image and likeness of the Creator.

I want to stress an important principle: a person belonging to the profession owes his first duty to his client. Any other consideration whatever be its relevance, including financial remuneration, is subject to this basic principle.

Ladies and gentlemen

These are only few of the challenges which face the medical profession and it is up to the medical professionals like you to deal with them to the best of their abilities in their daily work. The greatest challenge however lies within each and every one of us: to be the best and to give the best without fear.

A final word, I think that the family doctor is one of the most respected persons in our community. In my personal experience, the family doctor is an advisor, a healer and always a friend, a family friend. May I take therefore this occasion to publicly thank our family doctors - our family friends.

Thank you and good work.

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