

## Israel meeting presentation abstracts

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PRESENTATION 1: Friday 14th October, 1994  
9.45 - 10.15

TITLE: Cost and clinical effectiveness evaluation of using a C-reactive protein near patient test (Nycocard) in primary care.

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Objective: To evaluate the impact of a novel near patient test (NPT) for C-reactive protein (CRP), an inflammation indicator, in routine primary care practice. To compare the CRP with the erythrocyte sedimentation rate (ESR).

Methods: Prospective recording of Nycocard CRP values on intention to investigate, comparing results with the Beckman Array System.

Subjects: 177 patients identified during routine consultation in six primary care practices

in Birmingham, England.

Main outcomes: Changes in: local laboratory usage; characteristics of patients chosen for testing; use of quality control; comparison of NycoCard readings with results from the same sample sent to an independent laboratory; and cost benefit analysis.

Results: 181 NycoCard CRP assays were carried out during the 3 month intervention, with 146 (81%) to establish a diagnosis and the remainder for monitoring purposes. 67% of tests were performed by the physician, 61% during surgery consultations. The sensitivity of the NPT result was 97%, but the overall specificity 79% (this may have been partly a reflection of operator error, varying from 56% to 91% between practices). Costs for the CRP NPT were equivalent to ESR tests performed routinely in hospital laboratories.

Conclusions: CRP is currently a rarely used test in UK primary care and awareness of its value could be raised. This assay was not used on a daily basis, but demonstrated an overall efficiency of 84% in novice practices and displayed diagnostic advantages over the ESR.

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PRESENTATION 2: Friday 14th October, 1994  
10.15 - 10.45

TITLE: Managed health care to contain costs in the ambulatory sector of the health care system in Switzerland.

AUTHOR(S): Ueli Bollag

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Switzerland's private and public third-party payers are squeezed by health care costs that continue to soar at rates well above inflation. They are convinced that managed care plans will produce demonstrable savings as compared with the current trends of traditional fee-for-service medicine.

Several Health Maintenance Organisations (HMOs) are currently operating on an

experimental basis but plans have been made by different provider organisations to embark on a country-wide network of HMOs. SanaCare Inc is one of them and it runs five SanaCare Practices at present, the author being in charge of the centre in Bern, the capital of the country.

People insured with SanaCare Inc pay a premium which is around 20% less than in the conventional fee-for-service system. They are also exempted from cost sharing which is 10% of the bill and they do not have to pay the franchise which amounts to SFr. 150,= per year. We believe that four main aspects will help to curb costs. For one, all health care personnel including doctors are employed at a fixed salary . Second, practice outfit is relatively cheaper (capital investment and running costs) for a group of health workers than for a single-handed practitioner. Thirdly, referrals may be fewer due to the diversity of competences of a team of health personnel under the same roof. Fourthly, third party payers/sickness funds should be able to make considerable savings as they can pool the administrative expenditure for a network of centres functioning along the same lines.

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PRESENTATION 3: Friday 14th October, 1994  
11.00 - 11.30

TITLE: Cost-Benefit of Cindi programme in Slovene primary health care.

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In 1990 Ljubljana Primary Health Centre began with CINDI (= countrywide integrated chronic noncommunicable disease intervention) programme in Slovenia. All the work was done and managed by general practitioners. A survey study of a representative sample of 1692 Ljubljana inhabitants, aged from 25 to 64 years was done. The WHO methodology was used with a special attention on risk factors for chronic noncommunicative diseases (cardiovascular and cerebrovascular disease, chronic respiratory diseases and some cancers: lung, breast, cervix, colorectal and prostata).

The results of this survey showed that the distribution of risk factors (elevated blood pressure, elevated blood glucose, elevated serum cholesterol, overweight, unhealthy diet, physical inactivity, smoking and alcohol abuse) in Ljubljana was very high and that medical and non-medical intervention was needed, according to the WHO-CINDI protocol.

The non-medical intervention had been done with the support of Ministry of Health. There had been a general agreement, that the medical intervention should be carried out, too. Therefore a network of about 70 CINDI consultation offices was established in GP settings in Primary Health Centres all over the country with specially educated general practitioners and nurses to carry out the preventive programme. Medical intervention programme should include examination of the patient, identification of his eventual risk factors, evaluation of the risk, health education, follow up and control check-ups.

Approximately one third of CINDI consultation offices started in 1992. But on January 1st, 1993, a new way of payment was introduced by National Health Insurance. The CINDI programme was not included. As a result of that, all the preventive programme was entirely stopped, giving no specific reasons.

The imposed dilemma is whether to carry on CINDI programme only as a scientific research project that would be financed as all research projects in Slovenia or to go on working according to WHO-CINDI protocol, requiring new financial funds. Therefore National Health Insurance should acknowledge the necessity of financing preventive work and CINDI programme.

The lesson learned: making a good preventive programme had created huge new needs for medical services, which nobody was prepared to finance, so they had to fade. This shows that cost-efficiency analysis should be done before research studies and programme introduction.

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PRESENTATION 4: Friday 14th October, 1994  
11.30 - 12.00

TITLE: Home visiting in Andorra.

AUTHOR(S): Luis Burgués  
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Magie Verdaguer  
Oriol Ramis  
Juan Gérvas

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Background: Home visiting is greatest in Belgium (45,7% of consultation) and least in Finland (0,4%). The published figures show an association between reimbursement way of payment to general practitioners and high rates of home visits (and the opposite for the salary payment).

Research question: In Andorra general practitioners are paid by reimbursement, does this fact imply a high rate of home visits like in Belgium and France?

Method: We used data provided by the Andorran Social Security (July 1991-June 1992) and data provided for nine Andorran general practitioners, from a registration period of four weeks October-November 1992 (age, sex, consultation/home visits, reason for encounter, health problem, referral, use of laboratory test, prescriptions).

Results: During one year Andorran general practitioners attended 48,742 consultations (being 5,541 home visits, 11,4%). In the recording period the nine Andorran general practitioners attended a median of 77 encounters, being 8% home visits. More frequent health problem dealt at home were: flu, acute tonsillitis and acute respiratory infection.

Conclusion: In Andorra home visiting is a daily activity of general practice, but the rate is medium (from an European point of view).

Recording general practitioners: Antoni Berges Constanza, Josep Burgues Monserrat, Lluís Burgues Monserrat, Julia Martínez-Illescas Bermejo, Margarida Masardo, Pascal Morisset, Albert Pla Bureu, Jordi Verdaguer Ferre, Carles Vidal Vidal.

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PRESENTATION 5: Friday 14th October, 1994  
12.00 - 12.30

TITLE: Evaluation cost prescription in General Practice.

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Although the differences among the health care systems, the progressive increase on health costs is a world phenomenon

Some of the reasons are:

- the new technology and the new drugs and their costs,
- the increase on population demands,
- the increase of life expectancy.

In Portugal, the GPs are free to prescribe, but to prescribe is an act that costs money. More and more the doctors must know how much their activities will cost. They must be trained how to evaluate it. They also should be involved on direct and indirect costs evaluation, because they are important agents on cost reduction (without giving worse care).

During one month the author studied the prescription of 9 GPs working in a health centre in Porto. She compared the patient lists and the type of patients. There are differences among the doctor prescriptions. There is not a direct association between the number of prescriptions and the costs. The costs increase with the patient age. The anxiolytics is the first drug group prescribed. The second is the antibiotics, and the third is non-steroid analgetics.

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PRESENTATION 6: Friday 14th October, 1994  
14.00 - 14.30

TITLE: Assessing the relative efficiency of general practice.

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Introduction: Good practice dictates that doctors are sound in diagnosis and manages the patient's condition with appropriate use of investigations and treatments including medicines, other members of the primary health care team and hospital services i.e. uses resources properly and wisely. Assessing good practice and quality of service is problematic since performance indicators are poorly developed and methods of assessing efficiency of resource utilisation and cost-effectiveness of service delivery at practice level are lacking. Indeed current academic discussion examines whether it is justifiable and practical to compare general practices in terms of the conversion of resources into delivering patient services?

The paper will describe the methodology, the difficulties in defining appropriate and relevant resource and service factors, the results and conclusions of a study, conducted in England, undertaken to examine the efficiency of general practice work processes and to assess a multivariate analysis method.

Methods: Resource (inputs) and patient service (outputs) indicators were identified, proposed and selected or rejected. The practices were chosen as ten groups of three practice in order that confounding variables would be minimised within the groups where demographic characteristics were similar. Resource and services data were collected for one year in 30 general practices. Data were analysed using data envelopment analysis (DEA), a multivariate analysis technique, and the relative efficiency of each practice generated.

Results: The project demonstrated that a relative efficiency could be generated using DEA. Interestingly individual factor data were more revealing about resourcing, services and health care delivery than the relative efficiency.

Conclusions: DEA generated the practice's relative efficiency of converting resources into delivery of services. Demography was not shown to be an influencing factor in the efficiency of resource utilisation.

Discussion: Efficiency is not an indicator of effectiveness of health care services neither does it measure the competence and performance of practitioners. It should be argued that without additional evaluation of quality of care and standards of practice DEA relative efficiency figures are meaningless.

Efficiency of resource utilisation is being explored by governments' operations research departments as an indicator of good practice. It is important that clinicians develop their own performance indicators of good practice in order to avoid invalid and inappropriate assessment.

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PRESENTATION 7: Friday 14th October, 1994  
14.30 - 15.00

TITLE: Cost-effectiveness of joint consultations of general practitioners and orthopedic surgeons: a randomised controlled trial.

AUTHOR(S): André Knottnerus  
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Objective: Joint consultations by general practitioners (GPs) and medical specialists in the 'grey area between referral and non-referral' are actively promoted but their cost-effectiveness is not clear. We evaluated the outcome of joint consultations of GPs and orthopedic surgeons in a primary care setting.

Methods: 12 GPs had regular joint consultations with one of 4 orthopedic surgeons. Included were patients with locomotor disorders, for which referral to hospital was considered.

Exclusion criterion: compelling reasons for referral. In a randomized consent design 173 patients were assigned to joint consultation, and 166 to a usual care control group. Subjective and objective data on health and functional status were collected. Skills of the GPs were compared with a non-participating GP-control group. After one year of follow-up measurements were repeated, including patient examinations by an independent surgeon. Data on medical interventions and health care costs were obtained.

Results: In the intervention group significant reductions in hospital referrals (35% versus 68%,  $p < 0.01$ ) and laboratory and X-ray investigations were observed as compared with the control group, without any negative effect on health and functional status.

Intervention group patients were more often symptomfree after 1 year (35% versus 24%,  $p < 0.04$ ). The participating doctors scored better on skills. On a national basis the estimated annual cost reduction would be 23 million dollars (on 15 million inhabitants) for this specific domain only.

Consultations: Joint consultations of general practitioners and specialists in a primary care setting can result in more cost-effective health care.

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PRESENTATION 8: Friday 14th October, 1994

15.00 - 15.30

TITLE: A trial of intervention in primary care for patients with fatigue.

AUTHOR(S): Paul Wallace

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Fatigue is a remarkably common condition, affecting up to 40% of patients in primary care. The number of these who present complaining of fatigue as a primary symptom is rather less but nonetheless account for around 2% of all consultations. A substantial number of patients with fatigue become chronic attenders, with a high consumption of primary care services, increased receipt of drug prescriptions and multiple referral to hospital out patient departments.

Having carried out a large study of fatigue in general practice, we are planning to develop a study protocol for a randomised control of intervention for fatigue in a primary care setting. It is currently envisaged that the intervention will be undertaken either by nurses or by counsellors with a training in cognitive behavioral therapy. A further intervention will consist of patients with a written manual for the management of fatigue. The propose of the trial will be to evaluate the relative cost effectiveness of these different interventions. Outcome measures will include the levels of fatigue in the study subjects, rates of GP consultation, receipt of prescriptions, referral to hospital, level of wellbeing and time off work.

As the study is still at the design stage, it is intended that the presentation should outline

the principle features of the study and highlight the methodological issues raised. If there is interest, it may be possible for the study to be extended internationally.

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PRESENTATION 9: Friday 14th October, 1994

15.50 - 16.20

TITLE: How to compare general practice in developed countries.

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Background: Cross-national comparison of health systems have a long history despite the difficulty in performing such studies. But it is no frequency to compare general practice in developed countries. In Europe, most studies have focused on anecdotal information.

Research question: Is there a set of useful characteristics in comparing general practice in developed countries?

Method: We review most international studies comparing developed countries (Western Europe, Australia, Canada, Japan, the USA) and we develop a framework of common and key characteristics.

Results: Nine questions are critical: 1)is there a universal/near universal public health insurance?, 2)is anyone eligible for coverage of medical expenses through the public health insurance plan?, 3)are consumers free to choose their general practitioner?, 4)is the general practitioner a gatekeeper to secondary care?, 5)is the general practitioner paid by salary?, 6)does the general practitioner work in a public health centre?, 7)does the general practitioner receive total payment from the patient?, 8)is the general practitioner paid by capitation? and 9)is the general practitioner paid by reimbursement?

Conclusion: General practice belongs to the health system. We have developed a set of questions which help to compare general practice in developed countries.

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PRESENTATION 10: Friday 14th October, 1994  
16.20 - 16.50

TITLE: Task profiles of general practitioners in Slovenia: an overview.

AUTHOR(S): Igor Svab  
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The WHO principles are based on the equal right of the individuals for access to a quality health service. The need for adequate data in order to achieve this goal has been emphasised. GP's work influences heavily the entire health care system. Several studies have already shown that there are big differences in the way general practitioners perform their daily work. A lot of variability has been found in referral rates, house visits and time per patient. All these differences suggest that there are differences in health care delivery between GPs, which could be in contrast with the main goal of the WHO strategy. This is especially emphasised in the case of the countries which are changing their health care systems and in the countries where these kind of questions have not been scientifically dealt with yet.

The study on task profiles of general practitioners was conducted in Slovenia in order to give an insight into work of general practitioners in this country. The study is the Slovenian contribution to the European study on task profiles of general practitioners, coordinated by the NIVEL-institute.

A random sample of 162 GP's, selected from the membership list of the Medical chamber have filled in a standardised questionnaire. The questionnaire included several areas (basic information, task description, problems, solved by a GP, preventive procedures, disease management, job satisfaction) and a diary through 14 days.

The data have been analysed using standard statistical methods. The data will show the

overview of the reported working style of general practitioners in Slovenia. This study provides a basis for research of general practitioner's task profile and task distribution among different PHC professionals in Slovenia.

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PRESENTATION 11: Friday 14th October, 1994  
16.50 - 17.20

TITLE: Alcohol drinking and drinking habits among elementary schoolchildren in Slovenia.

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Alcohol drinking is an important problem in Slovenia. The majority of Slovenians had their first drink at their childhood. It is important for the GP and for the Health authorities to know which are the protective and risk factors for children's alcohol drinking to prepare effective, preventive programs. There are some data for local communities from different parts of Slovenia but no data at national level about this problem.

Some years ago I prepared a study about children's alcohol drinking in my community of Litija. This year I prepared a study for three generations of Slovene elementary schoolchildren. I chose the 3 graders (9-10 years old), 6 graders (12-13 years old) and 8 graders (14-15 years old). A random sample of 1250 children for each generation (it's about 5% of the population in each generation) was chosen for the study. They were given anonymous questionnaires about their drinking habits, everyday life, family life, parents, friends, about their attitudes and patterns about alcohol. There were some dilemmas to be solved (before the questionnaires were made and given to the children) to get relevant data important for Slovenia as a whole. There will be still some dilemmas at the interpretation of the results.

There is no final result yet because the analysis of collected data is still going on. The results from the local study in community Litija (that were already published) are to be worried about, especially if they are compared with results of similar studies in other

countries:

among 919 pupils aged from 12 to 15 years there were only 5 who had never even try any alcohol beverage. 40% of pupils had tried alcohol before the age of 7 years. There were only 60 pupils - this is 6,5% - abstinent among them; 18,0% of children drank alcohol several times a week. 19,4% of pupils had been drunk more than once.

After getting the results of my study among schoolchildren in Slovenia it will be possible (among many other important conclusions) to find out if the community of Litija with such alarming figures is something special or children's drinking in Slovenia as a whole is a special problem.

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PRESENTATION 13: Saturday 15th October, 1994  
9.00 - 9.30

TITLE: The Danish reform in "Out of Hours' service and its implications for epidemiological research.

AUTHOR(S): Frede Olesen  
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Introduction: 'Out of hours' service covers more than 75% of the time in a normal week. This service provision represents a substantial workload for general practitioners and a considerable cost for society.

Aim: The aims of this presentation are, firstly, to describe a very big reform in the Danish organisation of 'out of hours' service which was implemented on 1.1.92 and its consequences for numbers and types of patient contact with the service and, secondly, to describe the principles in different county based epidemiological research projects in out of hours service.

Method: The historical reasons and the principles in the reform are reviewed. National

statistical surveys before and after the reform are used as sources of statistical data. In addition data from actual research projects, providing evidence of practical experiences, are used to review the possibilities for epidemiological research.

Results: The new system has meant a considerable reduction in the 'on call' period for doctors so that the general practitioner now have a maximum of 2 evening duties and one night duty per month. The typical length of an 'on call' duty period is now 8 hours. The total number of 'duty' calls to the doctor has fallen, and the results are presented. The reform has meant that many calls which previously would have required home visits are now dealt with over the telephone or through consultations.

The out of hour organisation is now typical organised on a county basis where 50.000 to 600.000 inhabitants are covered by the same system. The doctors in most counties have computer record systems allowing automatic feed back to patient's own doctors following 'out of hours' contact. In one of the biggest counties we have developed special additional research computer software the features of which will be described along with two ongoing research projects.

Discussion: The provision of 'out of hours' service is a subject of international debate. Doctors in many countries discuss whether it is necessarily to have the heavy workload it entails. This project demonstrated that change is possible. The project also confirmed that a change in organisation can reduce the number of 'out of hours' calls.

Despite the importance of the 'out of hours' service little research has been done in this field, but we have shown that it is possible to make the doctors cooperate in this type of research if they have sufficient technical support.

International comparative studies in the provision, organisation and effect of 'out of hours' services are recommended.

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PRESENTATION 14: Saturday 15th October, 1994  
9.30 - 10.00

TITLE: Hepatitis C Virus seropositive patients: evaluation of the follow-up protocol.

AUTHOR(S): Ferran Gali-Gorina  
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Objective: To describe the main clinical features and their evolutive tendency. To evaluate the most useful parameters in the clinical follow-up and as bad prognosis features.

Patients and methods: Prospective study which has included a half-yearly control of analytical parameters and liver ultrasonography. Seventy nine seropositive patients (2nd generation anti-HCV EIA) have entered the study, coming from five general practitioners. The study began in March 1993, and an active research of cases was carried out, based on the risk factors for HCV.

Statistical analysis: Analysis of T student.

Provisional results: We have found a HCV seropositivity prevalence of 0,94%. From the early 79 patients, 55 (76%) have reached the second half-yearly control and 10 (13%) the third one. Among individuals younger than 45 years old, there is a male predominance (70%); about a 77% of them are intravenous drug users. Among those from 45 to 64 years old (35%), there is a female predominance (61%), and from 65 years old on (43%), there is no sex predominance. Laboratory tests: Initially, AST (SGOT) levels were increased in 77% cases; half a year later it was so in 82% cases and one year later in 90% of them. ALT (SGPT) levels were increased in 71%, 80% and 90% in the respective half-yearly controls. Alpha fetoprotein (AFP) levels were initially higher than 10 ng/ml in a 7% cases, to reach to 22% of them one year later. The rest of hematometric parameters had a few variations. None of the patients became HCV seronegative. There were 8 cases who had other viruses coinfection: 3 HBC and 5 HIV seropositive. There were initially 30 patients (37%) who showed abnormal ultrasonography. This test was not carried out in 20 patients (25%). Three patients developed a hepatocarcinoma. Four patients were treated with alpha-interferon. It is been observed a positive relationship according to the estimated infection's onset antiquity, based on the increasing levels of serum enzymes and the liver changes detected by ultrasonography.

Conclusion: The HCV seropositivity prevalence in our area is equivalent to that described by other studies. It stands out the high morbidity percentage and its progressive evolution along the study's time period, and the positive relationship, related to the evolution's length of the disease.

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PRESENTATION 15: Saturday 15th October, 1994  
10.00 - 10.30

TITLE: EGPRW participants: what they do?

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The EGPRW is european reseach meeting with some special characteristics: the participants meet in an informal way, discuss general practice/family medicine and research, and go home with research ideas (sometimes), new friendships and/or collaborative studies.

The authors, after being present in several meetings, but not always meeting the same persons, decided to do a small questionnaire to the EGPRW participants in Copenhagen in autumn spring meeting in 1993.

43 persons from 20 countries answered it.

The average of age was 43 years. The youngest was 27 (from UK) and the oldest 69 (from Spain). 69.8% (N=30) were male and 30.2% female. Only 32.6% attended more than 5 meetings.

After the meetings sessions 93% stay talking.

On average the participants sleep at home 6.8 hours/day (in percentage women sleep less than men), but 69.8% sleep less during the EGPRW meetings.

67.4% of participants bring homework, but only 62.1 of them worked on it. The work is not the responsible for sleeping less, because 55.6% of the participants who work on it sleep the same.

What the EGPRW participants enjoy more in the meetings is:

- to set ideas for research (76.7%)
- to establish new relationships (67.4%).

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PRESENTATION 17: Saturday 15th October, 1994  
11.20 - 11.50

TITLE: Which costs? Which effectiveness?  
A philosophical analysis of costs-effectiveness measurement and its relevance for general practice.

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Aim: To discuss the various meanings that can be and have been attached to the apparently straightforward terms costs and effects (effectiveness) and to present an alternative approach, which I consider relevant for general practice.

Method: Literature search, concept analysis.

Results: Cost-effectiveness analysis is a part of medical technology assessment (MTA). In this area of study, a wide definition of technology is used, comprising devices and machines as well as procedures and even organizations. A computerized search of the literature in this field from its inception (around 1972) until the end of 1993 shows that the initial definitions of its area of study were very large: costs, and, notably, effects were defined, in the beginning of MTA, as financial, social, ethical, and organizational. Some definitions speak of the study of all conceivable secondary effects of medical technology. Gradually, the scope of research has been restricted to clinically and economically defined effectiveness.

Various costs-effectiveness analyses concerning the treatment of asthma/COPD will be discussed as examples of this restriction of the aims of MTA, and more specifically of the definition of costs and effects. I argue that these studies would have been more interesting for general practice had ethical and social effects and costs been taken into account.

Special attention will be paid to the philosophical underpinnings of the concept of quality of life, which is an important element in many costs-effectiveness studies. I will argue the apparently trivial thesis that quality of life should not only be studied using quantitative, but also using qualitative methods. Especially approaches that consider the meanings of medical innovations (but also of existing technologies and procedures) both for patients and physicians will be important. A method to study the meanings of techniques and procedures, developed within the field of social studies of science and technology (SST),

will be presented and its advantages for studying costs and effects in primary care will be clarified.

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PRESENTATION 18: Saturday 15th October, 1994

11.50 - 12.20

TITLE: The relative costs and accuracy of two methods of establishing the social class of patients in the U.K.

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Many aspects of health care including morbidity, resource usage and lifestyle are linked to the socio-economic status of patients. In the U.K., a regular census every ten years establishes socio-economic status using "social class". In primary care the social class of groups of patients is often needed to establish their health needs and to assist in targetting care.

Very few practices record the social class of individual patients and those that do often use an incorrect methodology. There is a belief that, as caring holistic doctors, we know the social circumstances of our patients. This presentation will start by dispelling that fallacy by showing that doctors and staff do not know their patients' social class.

Two methods were used. One was direct questioning of a cohort of patients. The other was to use the patients address (postcode) to identify the census enumeration district in which they resided. The patients were given the social class distribution of their enumeration district and these distributions were aggregated for all the patients. The relative costs of the two systems were established.

The census derived data was as accurate and much cheaper for measuring the social class of a cohort of patients than direct questioning.

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PRESENTATION 19: Saturday 15th October, 1994

14.00 - 14.30

TITLE: Palliative care at home or in the hospital: a research of the costs of care of terminally ill cancer patients at home and in the hospital, and a comparison of their experience of the Quality of Life.

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This research makes a comparison of the quality of life and the costs of care of terminally ill cancer patients at home (outpatients) and in the hospital situation (inpatients). One of the reasons to start this research was the observation that throughout the years a shift has taken place from the extramural to intramural treatment of patients although the majority of the patients prefer to die at home. Government believes that extramural care is a much cheaper alternative than intramural care.

17 seriously ill cancer outpatients and 24 inpatients were questioned about their perceived quality of life and about the costs of care.

The quality of life questionnaire consists of four parts:

1. a general question about quality of life;
2. 6 questions about the functional abilities of the patients;
3. 33 items of the Rotterdam Symptom Checklist;
4. 1 open question.

The costs of hospital care are gathered through the accounts. The costs of home care are gathered by cost diaries. No significant difference between quality of life of outpatients and inpatients could be determined. Notable is the fact that, regarding to 8 symptoms of the RSCL, almost 40% of the patients suffer from periods of depressiveness. The average

costs of hospital treatment are significantly higher than the average costs of home treatment. Striking is the fact that, although the total costs of hospital care are higher than the total costs of home care, the costs for the patients themselves when cared at home, are higher than the alternative, and this, as said, for the same perceived quality of life.

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PRESENTATION 20: Saturday 15th October, 1994  
14.30 - 15.00

TITLE: The law of health insurance in Romania.

AUTHOR(S): Constantin Pandeli

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Any system induces a conduct for the components of the system.  
Changing the system leads to changes in the conduct of the components. Now, in Romania, we are moving from centralized medical assistance system (Semasko) to a new type of medical assistance - free, public, private, non profit.

The components of this new system (people, the doctors, and F.N.A.S. and the National Fund of Health Insurance) should change their attitudes and to accept new conducts, related with the following new parameters of the system:

- relation between doctor to the patient,
- relation between the doctor to the National Council of Health Insurance (N.C.H.I.),
- relation between the patient to the (N.C.H.I.).

To be realistic, all these above mentioned relations should be related with the interest of the components and with the financial results (the profit).

The very dear slogan for the former Communist Regim - "The Man most precious Capital" - should be changed into the maxim - "The Health most precious Capital" -. It becomes evident and recognized by all that the Health costs, should not be granted free. How much does it cost? Not to much, not to less but exactly as should it be. All these elements, new for the Romanians, are the main points to be pointed out by the present work.

There are almost five years since Romania, one of the Eastern European countries (with a

population of 23 million people) is trying to escape of Communism and to be integrated in Europe.

Now by adopting the Law of Health Insurance our country will make a new step, a positive one.

The new law changes the old system but will induce new behaviours as regards medical assistance.

These changes are to be taking into consideration by Romania neighbours and why not by the Central and Western European countries.

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PRESENTATION 21: Saturday 15th October, 1994  
15.00 - 15.10

TITLE: Duration of the first visit - a standard of the patient's satisfaction with the medical examination?

AUTHOR(S): Dean Klancic  
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Duration of the first examination is important as well as for a patient as for a physician and notably affects the procedure of it, the establishment of mutual relations and the efficacy of the further treatment. This is the common goal of both and it is conveyed as a mutual satisfaction.

By measuring the duration of the first visit and with the anonymous questionnaire a group of trainees in general practice tried to find out the length of the visit in the GP office with the patients of 15 years and above, and the correlation between patient's satisfaction and the duration of the first examination.

The first visit was defined as the first visit of a patient for a specific illness in the current calendar year. This research was carried out by seven physicians; 554 patients were

questioned, 471 questionnaires were correctly filled in. Median of the first visit was 7,4 minutes, 65,6% of patients indicated as the appropriate length of visits 5-10 minutes. Duration of the visit grew with the age of patients, and with the older age grew also the number of patients who voted for visits longer than 10 minutes. 94,5% of all patients were satisfied with the length of the visit, even though the satisfaction was not in proportion to the length of the visit. The opinion of patients about the appropriate length of the visit did not correspond to its actual duration. Satisfaction of patients was greater with female doctors than with male doctors although these visits were shorter.

It can be also concluded that satisfaction of patients depends notably on other factors besides time.

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PRESENTATION 23: Saturday 15th October, 1994  
15.20 - 15.30

TITLE: The medical visit for driving license as an opportunity for health promotion and prevention in General Practice.

AUTHOR(S): Meritxell Fiter  
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Background: Andorra is a country with a health system based on fee for service in which prevention and health promotion is not covered by the system.

The population contacts the health system only in illness situations, so no health data are available about the population who "don't use doctors".

In order to obtain a driving license a medical certificate, provided in Andorra by the GP, is compulsory. This medical visit has a periodicity of 10 years and is regulated by the law of 4 October 1993.

Objective:

- To exploit this visit for purposes other than the purely administrative;
- To collect epidemiological data from this population and do follow ups at 10 year intervals;

- To detect risk factors that may influence the accident rate;
- To take advantage of an opportunity for prevention and health promotion.

Method:

- Design and use of a new certificate model for data collection;  
This new certificate permits centralization of data and interfaces with other data bases such as those of hospitals, emergency services etc.;
- Offering a workshop to all Andorran GPs in which the model was evaluated and a protocol for the visit was established;
- Publication of a manual containing the agreed upon guidelines for this visit.

Discussion: The traditional system of the medical visit for the driving license has not brought sufficient benefits in the reduction of the accident rate.  
The authors present a new procedure, implemented in Andorra, that strengthens the role of the GP in this certification process and provides a broad range of benefits.

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PRESENTATION 24: Saturday 15th October, 1994  
15.30 - 15.40

TITLE: Health problems of the elderly - a trainee project in general practice.

AUTHOR(S): Iztok Tomazin  
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There have already been a few studies concerning the health status of the elderly in Slovenia. A majority of them were dealing with the illnesses of the elderly and their treatment. The role of the general practitioner is to take into account all the problems of the individual and not only the disease. This aspect is often neglected by the medical profession. Therefore it is important to stress it during the education of general practitioners. A trainee project has been initiated during the vocational training of general practitioners. The aims of the project were the following:

- to make an overview of the health related problems of the elderly in a sample of Slovenian trainee practices;
- to test the usefulness of the questionnaire, developed by the trainees;
- to make the trainees aware of the complexity of the health related problems of the elderly.

The questionnaire was made on a basis of the questionnaire developed by Maes. It has been tested by GP trainees on over 400 people, older than 65 in the GP practices.

A majority of the elderly have had at least 2 important health problems. The main recorded problem of the elderly was pain (a majority of the elderly had pain at least in 1 localisation). The problems with relatives and neighbours, emotional and economic problems were also important. They deserve special attention of the general practitioner. The questionnaire proved to be too complicated for the routine use in general practice, but it has proved to be a good educational exercise. For the routine use in general practice a simplified version of the questionnaire should be developed. The satisfaction of the elderly was high.

The research also shows the research potential of the trainees in general practice.

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PRESENTATION 25: Saturday 15th October, 1994  
15.40 - 15.50

TITLE: Motivation to choose general practice.

AUTHOR(S): Zaida de Aguiar Sa Azeredo  
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In Portugal, after finishing the general post graduate training the doctors must do an examination, if they want to become specialists.

Not always they get the right mark to choose the speciality they wish.

The authors decide to study which are the main reasons why doctors choose general

practice. They compare with internal medicine.

They required 173 doctors: 85 GPs and 88 doctors of internal medicine.

63,5% of GPs choosed general practice as 1st option. 84,1% of internal medicine doctors choosed internal medicine as 1st option.

There are differences on the motivation reasons to choose these specialities.

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PRESENTATION 26: Saturday 15th October, 1994

15.50 - 16.00

TITLE: Self-traction: a new attempt to help patients with pains in lumbal and cervical spine.

AUTHOR(S): Janez Svoljšak

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Painful conditions connected with cervical and lumbal spine damage are the most often problems which we melt in the ambulance of general practice.

The means of treatment are various but the results of the treatment are not often sufficient.

One of the forms of treatment is the so-called traction. It can be executed by using various instruments, numerous methods of autotraction have also been developed but the effect of these methods varies. The methods of autotraction developed op till now did not get to be used in common practice.

In the year 1993 I developed and described a new method of traction which is performed by the patient himself. I named the method self-traction.

This method can be used for traction of cervical and lumbal spine areas. The patient can perform it either in a standing, sitting or lying position and he does not need to use any additional instruments, by the results of calculations and measurements on the model, the powers of traction are very alike to those, achieved by using traction instruments.

155 patients participated in my research and they all had troubles with cervical and lumbal spine areas. They have been performing the self-traction for at least 14 days. Before and after the treatment the patients were examined.

The patients estimated the effects of self-traction regarding to their problems, 128 patients (82%) stated that the pains after the treatment have reduced ( $p = 0,001$ ), 163 patients considered the method as good.

The research shows that self-traction reduces the pain coming from the cervical and lumbal areas of spine. The results can be compared with the results of other methods of extension.

For this is the first research of the effects of this method it ought to be developed even further. If the following results were as sufficient as the present, the doctor in general pedical practice would get a hold of a new way to help his (or hers) patients.

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PRESENTATION 27: Sunday 16th October, 1994  
9.30 -10.00

TITLE: Utilization of antiulcerous drugs in general practice.

AUTHOR(S): MaMar Valero Marcet  
Maria Vernet Vernet  
Carles Valero Garcia  
MaMontserrat-Urena Tapia  
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Background: Antiulcer treatment for dyspepsia alone is not justified; however persistent dyspepsia may require a medical work-up for gastrointestinal pathology.

Objectives: 1. Describe the therapeutic manoeuvres in peptic symptomatology in a primary care centre.  
2. Investigate the methodology applied in the diagnosis of peptic disease in patients that have received antiulcer treatment in primary care centre.

Methods: Subject: all the patients from five general practitioners that had received

antiulcerous treatment during the period from 1st of February to 30th of April in 1992.  
Study design: transverse and retrospective study.  
Statistical methods: description of frequencies.

Results: Overall, 171 patients were taking antiulcerous drugs (histamin H2-receptors antagonists, inhibitors of the proton pump, and cytoprotectors) during these period. 42 of them (25%) took antiulcerous drugs for protection against potential gastroduodenal damage by anti-inflammatory therapy. The other 129 (75%) took them for peptic symptomatology, with the next diagnosis: 29 (22%) oesophagitis, 25 (19%) duodenal ulcer, 9 (7%) hiatus hernia, 8 (6%) gastric ulcer, 5 (4%) other pathologies, 4 (3%) without pathology, and 31 (25%) without diagnosis. Just one case had microbiological study of *Helicobacter Pilory*.

24 (19%) patients with peptic symptoms were studied by the digestive specialist. The rest of patients, 105 (81%), were studied by general practitioner with the next diagnostic methods: 77 (73%) esophagogastroduodenoscopy, 8 (8%) barium contrast radiography, 1 (1%) chest X-ray (hiatus hernia) and 10 (18%) patients had not diagnostical exploration. About the drugs used: 84% of duodenal ulcer, 100% of gastric ulcer and 48% of oesophagitis were treated with H2-blockers; the rest received omeprazole.

The therapeutic criteria was correctly noted down in the patient's history in 55% of cases. The beginning of the treatment was during the first month after the diagnostic in 63% of cases and the length of it was from one to six months in 66%.

Conclusions: 1. The antiulcerous criteria of treatment in our primary care centre was rather acceptable due the number of previous diagnostics.

2. Endoscopy was the most used method for diagnosis but it must be mainly used in all the cases of peptic disease.

3. The prevalence of *Helicobacter Pilory* infection in this study is really low. It would be justified by its time-period when *Helicobacter Pilory* wasn't systematically investigated.

Actually, endoscopy with biopsy and microbiology analysis are necessary in the study of persistent dyspepsia; the new line treatment in order to eradicate the *Helicobacter Pilory* infection and the pressure for earlier cancer diagnosis always require them.

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PRESENTATION 28: Sunday 16th October, 1994  
10.00 - 10.30

TITLE: Organisation and analysis of qualitative research data by means of a PC-database.

AUTHOR(S): Jan Mainz

Frede Olesen

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Introduction: Last year one of us (FO) presented a small computer programme for simple statistical analysis of quantitative research data.

Many research questions in primary health care could best be answered by qualitative methods based on interviews. The analysis of this type of data material is often done with the Grounded Theory approach. That is, the information is divided into themes and sub-themes and the relationship between the themes is investigated and finally new theories and understanding are proposed. Interview information is transcribed to paper or the analysis is conducted by repeated listening to taped interviews.

Many researchers have experienced considerable difficulties in retaining an overview of the information obtained. Some computer programmes have been developed to assist with the analysis of transcribed data, but they are difficult to use in an efficient way.

Aim: The aim of this presentation is to show how we use a database (PARADOX) in the analyses of qualitative data.

Method: Following initial analysis a list of themes is developed and a database screen is set up with the following fields: interviewee identification, theme, sub-theme, free-text and eventually other ad hoc fields.

The themes, sub-themes and eventually additional information on each of these are stored in a reference file, which can be further developed throughout the research process. A database record is generated for each quotation from the material, and the researcher then record the background information followed by the free-text field, which start with identification of the source of the interview data (for example tape number and place on the tape or transcription reference including the page and line reference). Then the researcher writes the quotation and finally eventually a personal comment.

Results: The real strength of the programme is in the final analysis, where the stored data can be sorted and printed out so that either all data for one interviewee or all data relating to a particular theme are produced. The researcher hereby get a quick and comprehensive overview and the 'datadeath' is more likely to be prevented.

Discussion: We have used the programme in two comprehensive qualitative projects with excellent results. The programme has proved much faster than other computer programmes for analyses of qualitative data. We can give a sample file on request to those of you who have access to the software.

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PRESENTATION 29: Sunday, 16th October, 1994  
10.30 - 11.00

TITLE: Glicemic control of diabetics II at primary care.  
Associated factors.

AUTHOR(S): Ma Montserrat Urena Tapia  
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Background: Primary Care is the suitable area either for control, or detection, and care progress of long-term complications in diabetic patients. This, together with high prevalence specially in eldest people, makes primary care centres put more effort in dealing with this illness.

Objectives: Describe the main factors associated to the glimecic control of diabetic patients in a primary care centre.

Subjects and methods: Diabetic II patients included in the diabetes program of our center. Demography variables, risk factors, and associated diseases are analyzed, and also other variables, like progression of diabetes, diabetic education and drug therapy, obtained from our diabetes program.

The glicemic control is given by HbA1C.

Statistical analysis: analysis of variance, chi-square analysis, and regression analysis.

Study: transversal.

Results: All adult diabetic II patients attended at our primary care centre are included. We identified 382 patients. Of which 63% are women, 47% of them have arterial hypertension 80% of them have body mass index (BMI) >25, 61% of them have blood

cholesterol > 220 mg %, and 16% are smokers. The disease has more than ten years progress in 33% of them. ECG alterations were found in 25% of all them, proliferative retinopathy in 6% and malb > 30 mgr/minute in 22%.

Men have a better glicemic control, regardless of age. There are not any differences in the glicemic control in the matter of smoking, obesity, hipercol., HTA, and in any kind of hipotensors drug therapy used. The patients with proliferative retinopathy have worse glicemic control than patients without it. No differences have been found about ECG variations, yalb, years of disease progress, selfmonitoring of glycemia and glycosuria, exercise and diet compliance. Patients whose only therapy is diet, who also have less years of disease progress, have a better control. Among the studied variables, the percentage of "non listed" varies from 10% to 30%, being higher in ECG, malbuminury and fundoscopic view.

Conclusions: 1. In our study, the factors associated to the glicemic control in DMII are: sex, proliferative retinopathy and diabetes drug therapy.

2. In our results, no significant relation was found between diabetic education and glicemic control, so we will have to make a profound study of intervention methods in order to obtain better results.

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PRESENTATION 30: Sunday 16th October, 1994  
11.20 - 11.50

TITLE: Respiratory illness and mortality in England and Wales.

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The possible relationship between the incidence of respiratory diseases as reported to general practitioners and numbers of registered deaths in England and Wales has been examined. Morbidity data from sentinel practices for the period 1986-1990 (population covered increased from 220.000 to 470.000) were used to calculate weekly rates of aggregated respiratory disease for persons of all ages and for elderly persons (ages 65 years and over).

The elderly respiratory disease rates and numbers of deaths were aggregated into 4-week periods; secular and seasonal trends were removed from each series and the two sets of residuals were examined graphically and cross correlation coefficients calculated. There was a very strong positive association between the respiratory disease rate and number of deaths in the same 4-week period, and there was also a significant but less pronounced association between respiratory disease in one 4-week period and deaths in the next. After prior separation of weeks according to temperature into four bands, weekly rates for respiratory disease were also strongly associated with the number of weekly deaths for each temperature band.

The synchronisation of peaks and troughs in the two series throughout the year supports the hypothesis that a cause and effect relationship exists between respiratory disease in the elderly and number of deaths. Other climatic and meteorological variables besides temperature may play a part in determining the spread of a respiratory disease. There is a need for further research to identify the micro-organisms responsible for acute respiratory infections in the elderly.

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PRESENTATION 31: Sunday, 16th October, 1994  
11.50 - 12.20

TITLE: Prescribing in Europe - How united are we?  
(European prescribing comparisons).

AUTHOR(S): Jacqueline Jolleys  
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At the last meeting of EGPRW in Copenhagen we distributed copies of a questionnaire which sought a range of information relating to prescribing in individual European countries including:

- Do primary care prescribers receive feedback?  
If yes, what are the details of the system?
- How many preparations are licensed for prescribing?
- Have there been government initiatives to restrict prescribing and are any planned for the future?
- How much do patients pay for their drugs?
- Which classes of patients are exempt from payment?

EGPRW participants and their colleagues from 16 european countries returned completed questionnaires. It was possible to check the reliability and validity of the information in 62% cases since more than one completed questionnaire was returned from 10 of the 16 countries. The data were analysed.

We would like to share the very interesting results with EGPRW participants, invite general comment and in particular feedback on our interpretation of the results, debate the issues raised and seek suggestions about how further progress the study.

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*This page was last updated on **June 7, 1998***