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Family Medicine

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Journal of the Malta College of Family Doctors
The mission of the Journal of the Malta College of Family Doctors (JMCFD) is to deliver accurate, relevant and inspiring research, continued medical education and debate in family medicine with the aim of encouraging improved patient care through academic development of the discipline. As the main official publication of the Malta College of Family Doctors, the JMCFD strives to achieve its role to disseminate information on the objectives and activities of the College.

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The passing of two colleagues and pioneers

Prof. Pierre MALLIA

During July 2016 the College lost two important figures who advanced family medicine in Malta. Dr. Denis Soler served medical politics throughout his career. He was an avid GP and even co-started one of the biggest occupational health services organisations on the island. But he is mostly remembered as the President of the Malta College of Family Doctors and was very proud of saying that the first meeting was held in his own kitchen. I mentioned this a few years ago when, as President of the College for the second time, I felt it appropriate to award Denis with the first Honorary Fellowship of the MCFD. I asked him whether he was happy, given that whoever occupies the place of President knows the difficulties it carries and often the perception that no-one appreciates what you are doing. His reply came from the heart and I could see joy in his face. I am proud that as a College we appreciate the work of people during their lifetime. But Denis was also the founder-member of the first Department of Family Medicine in the Faculty of Medicine & Surgery at the University of Malta, with the help of then Dean, Prof. Mark Brincat and became the head of department until his retirement. I still remember an AGM we had which was hosted at St. Philip's Hospital when he described his plans and visions of a department within the Faculty of Medicine and of having a Master's Degree in Family Medicine. Although being involved in medical committees and politics brings with it a fair share of worries and conflicts which tax a person considerably, it is even for this we should all be grateful for having people like Denis who moved forward notwithstanding the silent suffering one feels; and it is for this that we will continue to recognise him for his invaluable work in family medicine locally.

We also mourn the passing away of Dr. John Howard, former International Chairman of the Royal College of General Practitioners who died peacefully in July following a year of illness. John encouraged the MCFD to pursue the post graduate training of doctors locally. He hosted Dr. Philip Sciortino at the Royal College in Princes' Gate for a teacher's course which subsequently led to a teacher's course for the MCFD in Malta several years later; this is where many of us got to know him. When I became President I got to know John very well and I was invited to attend an International Development Day at the RCGP. There I made a decision to move forward with MRCGP(INT). He said he would support me in any way. In fact I asked him whether, if I find sponsors for flights, he would host a delegation of five to seven people in London the following year. He did; not only for the following year but for several to come. His generosity went to sky-high levels. The AGM the following year approved that we would work towards MRCGP(INT) and more teachers courses. The rest is history. But without John's generosity I can honestly say we would not have made it so quickly. He was quick to move a memorandum of understanding and of appointing an International Advisor. Many of us have fond memories of John. The last time we saw him was last year during the Global Day at the RCGP. Joking and happy as usual, he concealed what he was going through. We only knew something was amiss when he politely refused to come as external examiner of the Dept. of Family Medicine due to health reasons. One of our External Advisors who visited our exam this year told us he did not speak about his illness and continued to come to work in his practice daily. We heard of his passing away on the last day of their visit.

A public health perspective for primary health care

Dr John M. CACHIA

The content and service goals of primary health care must reflect national public health priorities, if primary health care is to retain its traditional role as a relevant contributor to the national health system, as a reliable caregiver promptly responding to the evolving health needs of the Maltese population and as a trustworthy partner providing sustainable and cost-effective services.

THE OLD-OLD

The average life expectancy at birth of the Maltese population has increased by 25 years in the last 70 years reaching 82 years in 2013. The number of persons attaining age 75+ years (commonly referred to as the old-old) has swelled. However increase in life-expectancy among the old-old has only been 3.65 years over the same 70 year period with mean life expectancy reaching almost 87 years in 2013. The old-old aspire for a better quality life, not merely more years to their life. The number of old-old will rise exponentially over the coming 20 years from 32,500 in 2015, doubling to 65,500 in 2035. The care needs of our old-old population and their aspirations for a better quality life will be the outstanding feature of our health system in the coming 20 years. Primary health care must concentrate its efforts on the better health and wellbeing of our current middle-aged (40-59 years) and young-old (60-74 years) in order to have a healthier old-old population over the coming 20 years.

HEALTH LITERACY

The Malta Health Literacy Survey 2014 (HLS2014) has provided useful insights on the current level of citizen empowerment. 45.8% of our adults have problematic or inadequate health literacy. Although Malta's general health literacy level is comparable with the rest of Europe, our performance lags behind the best in Europe (the Netherlands) by 8 to 16 percentage points. In relation to delivery of care, HLS2014 has shown that more than 85% of adults in our population find it very easy or fairly easy to find out where to get professional help when ill (86.8%), to understand doctor or pharmacist instructions on how to take medication (92.4%), to use information from the doctor to take decisions about their health (88.3%) and to follow instructions from doctor or pharmacist (94.6%). The health care professional enjoys the trust of the population and primary health care must continue to build upon this trust. The situation concerning promotion of health and prevention of disease is less uniform. Health warnings about smoking, low exercise and excess alcohol were understood very well or fairly well by 92.5% of interviewed adults.

RISK BEHAVIOUR AND CHRONIC DISEASE MANAGEMENT

This high level of understanding of risk factors for chronic disease is not always being translated into concrete health behaviour at population level. Measured Body Mass Indexes reveal that 77% were overweight or obese in 2010 and this represents a net increase of 10% in the prevalence of obesity over 26 years (1984-2010). The population prevalence of diabetes has continued to hover at around 10% of the adult population despite decades of aggressive campaigns. On a more positive note, blood pressure control has improved with normal blood pressure being detected in 68% of adults in 2010 compared to 52% in 1984. This same trend can be observed with measured cholesterol levels with desirable levels being attained in 37% of adults in 2010 compared to 22% in 1984. Given the poor performance in lifestyle related risk factors, it is not unreasonable to assume that improvements in blood pressure and cholesterol control can be attributed primarily to the effects of medication. Primary health care must continue to work with citizens on lifestyle related risk factors.

CANCER SCREENING

88.3% of the Maltese adult population understand why health screening is necessary. The last available published figures indicate that for breast cancer screening, following very encouraging initial responses of 75%, uptake is now barely reaching 50% of the target population. Colon cancer screening levels have not reached 40% uptake. Uptake rates for the complete Human papillomavirus vaccine are not encouraging. Primary health care practitioners have a pivotal role in transforming this "understanding of the necessity of screening" into concrete health behaviour change at population level.

MENTAL HEALTH

Only 54.3% of adults know where to seek help for managing basic mental health problems such as stress and depression. Primary health care practice must take up the challenge of addressing this serious lacuna in the Maltese health system. Mental health and wellbeing is an integral part of health and primary health care is eminently placed to give form and substance to the concept that there is no health without mental health.

PERSONALISED MEDICINE

38% of the population is getting mixed messages from the media and this does not facilitate active participation in decisions on one's own health. This affects mostly those who are most vulnerable and those at risk of limited health literacy. These include persons with bad self-perceived health, persons with low self-assessed social status, those suffering from more than one long-term illness, persons aged 76+ years, and persons with pre-primary or primary education. The primary care practitioners must identify and tackle less resilient and vulnerable persons within our community. Care and advice must be personalised, taking into account the specific needs the more vulnerable groups.

WAY FORWARD

Better primary health care is an investment in the future of our society. Family medicine specialists need to sharpen and focus their skills and competencies on the public health challenges prevalent in the current health system scenario. The main role of primary health care is the reduction of the burden of ill health in our families and communities by identifying and targeting those behaviours that lead to chronic disease, by improving early detection of illness, by improving the delivery of health services in community settings, and by teaching patients, families, students, trainees, other health care professionals and educators. These are the four distinct areas of work around which primary health care action must develop and evolve in the interest of primary health care practice and the long term sustainability of our health care system.

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RESEARCH ARTICLE

Higher number of hospital admissions for bronchiolitis with lower mean ambient temperature

Dr Frank C CASHA, Dr Justine FARRUGIA PRECA, Dr Rebecca PISANI

ABSTRACT

Background

During our work as general practitioners (GPs) in Malta and during attachments in the Paediatric Department of the main hospital in Malta, we encountered children with bronchiolitis. Bronchiolitis has been described as a seasonal viral illness characterised by breathing difficulties, cough, poor feeding, irritability and lethargy and, in the very young, apnoea (SIGN, 2006). We speculated that there were more bronchiolitis-related admissions to hospital during colder temperatures, but could not find any literature on the local patterns of this illness. International literature described a specific seasonality of bronchiolitis in the northern hemisphere, with more admissions being recorded in the winter months (Centers for Disease Control and Prevention (CDC), 2010; Chen et al., 2014; Coffin, 2005; Grimprel, 2001; Grimwood et al., 2008; Hervás et al., 2012), specifically with colder temperatures (Chen et al., 2014). In a concurrent study, we established seasonality and recorded other epidemiological features of the condition (Casha et al., 2015).

Objectives

The aim of this retrospective study was to identify the temperature range in which most hospitalizations for bronchiolitis occur, and to determine if there is a significant difference between the number of admissions and the set mean ambient temperature categories (arbitrarily set as below 10°C, between 10.1 and 15°C, between 15.1 and 20°C, between 20.1 and 25°C and between 25.1 and 30°C). The null hypothesis is that there is no significant difference in number of hospital admissions between each mean ambient temperature group and the alternative hypothesis is that there is a difference. This was done with a view to providing a better understanding of the condition to guide both clinical and policy decisions.

Method

The four-year period January 2008 to December 2011 was chosen. Statistical data was obtained from the Department of Health Information and Research to define the dates of admission for all recorded episodes of hospital admission for bronchiolitis among infants or children under two years at Mater Dei Hospital, the main Maltese hospital, for this period. Temperature records for the same period were obtained from the Maltese Meteorological Office. Appropriate statistical tools were used to assess the relation between admission rate and temperature. The diagnosis leading to the classification of the admission as one for bronchiolitis was validated by examining a significant sample of doctors' notes in the relevant patient files and matching these against clinical criteria for diagnosis (SIGN, 2006).

Results

Our findings show that the majority of admissions occur between 10.91°C and 18.61°C. The nonparametric Kruskal-Wallis equality-of-populations rank test proved that there is a statistically different admission frequency between different mean ambient temperature categories.

Conclusions

In Malta, a higher number of hospital admissions for bronchiolitis among infants or children under two years occurs when mean ambient temperature is lower. This is in keeping with international literature.

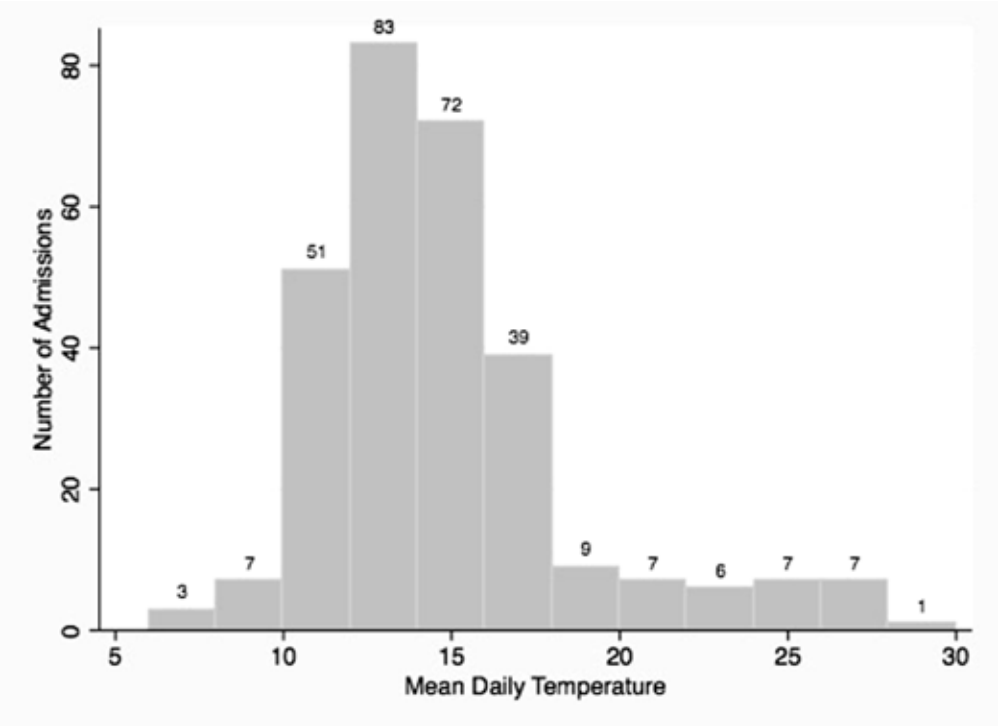
Key Words

Bronchiolitis, Malta, temperature.

BACKGROUND

Bronchiolitis is a respiratory infection which is very common in the very young (Coffin, 2005). It is characterised by breathing difficulties, cough, poor

Figure 1: Histogram showing the number of admissions per mean daily temperature



feeding, irritability and lethargy and, in some cases, apnoea (SIGN, 2006). The pathogen is usually a virus, most notably the respiratory syncytial virus, and is transmitted through direct contact with respiratory secretions and indirect inoculation from surfaces. It generally presents as a one to two-day history of upper respiratory tract infection (URTI) followed by moist cough, respiratory distress and feeding problems once the lower airways are involved. Treatment is mainly supportive and varies from treatment at local clinics intermittently to continuous inpatient treatment and at times intensive therapy unit (ITU) care (Centers for Disease Control and Prevention (CDC), 2010; Coffin, 2005; Fitzgerald and Kilham, 2004).

Bronchiolitis shows a seasonal variation, being most common during the winter months (Coffin, 2005; Fitzgerald and Kilham, 2004; Grimprel, 2001; Hervás et al., 2012; Marlais et al., 2011; Tang and Loh, 2014). This has been described in a number of international studies (Marcone et al., 2013; Munywoki et al., 2014; Riese et al., 2014; Salomão Junior et al., 2011; Vidaurreta et al., 2011), and recently, by the authors in Malta (Casha et al., 2015). However the authors could not find any local literature relating mean ambient temperature with the number of admissions for bronchiolitis among infants, and hence proceeded to try to establish whether there was any such correlation.

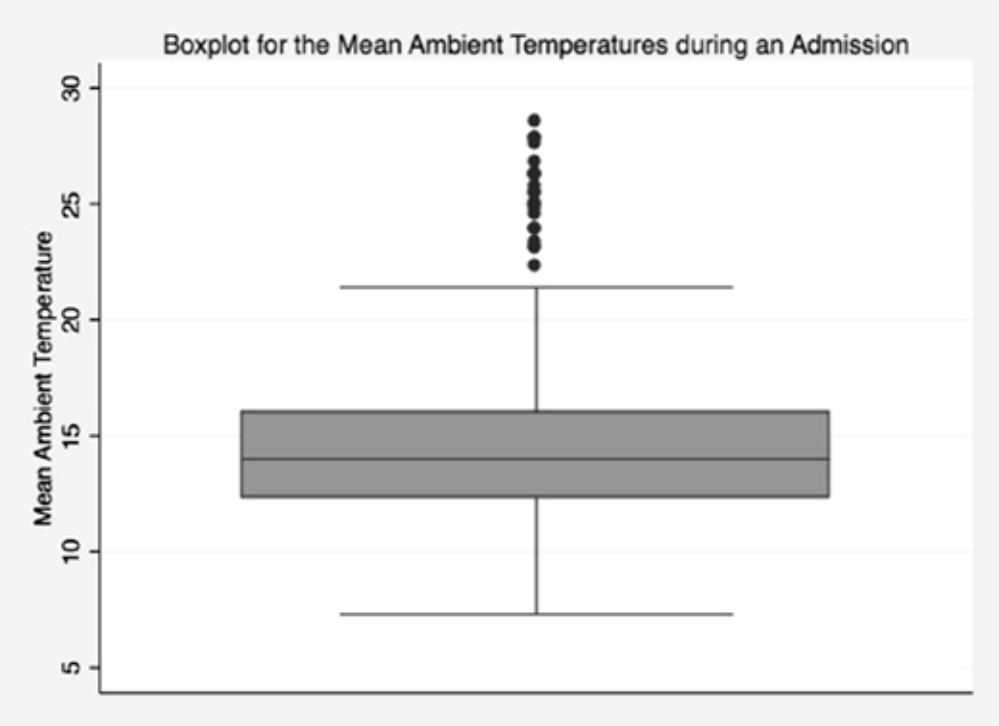
OBJECTIVES

The objectives of this study were to identify the temperature range in which most of the hospital admissions due to bronchiolitis takes place and to determine whether there is any significant difference in the number of hospital admissions due to bronchiolitis vis-a-vis the mean ambient temperature. For convenience, the mean ambient temperature was categorised into five groups: group 1 (mean ambient temperature less than 10°C); group 2 (mean ambient temperature between 10.1 and 15°C); group 3 (mean ambient temperature between 15.1 and 20°C); group 4 (mean ambient temperature between 20.1 and 25°C) and group 5 (mean ambient temperature between 25.1 and 30°C). The null hypothesis is that there is no significant difference between the number of admissions to hospital due to bronchiolitis and the mean ambient temperature groups. The alternative hypothesis is that there is a significant difference between the number of admissions to hospital due bronchiolitis and the mean ambient temperature groups.

METHOD

A list of all episodes of admission of children under two years of age to the paediatric medical wards at Mater Dei Hospital for bronchiolitis with International Classification of Disease (ICD) 10 classification

Figure 2: Boxplot for the mean ambient temperature during an admission



J21.0-J21.9 between January 2008 and December 2011 was obtained from the Department of Health Information and Research (DHIR). For each of these episodes, the date of admission was noted. The mean ambient temperature for each day for the four consecutive years was recorded. The mean temperature values were provided by the Meteorological Office of Malta.

For validation purposes, the identity of all admissions fitting the criteria described above was obtained from the DHIR, after obtaining ethics approval and approval from the Head of Department of Paediatrics, the Data Protection Officer and the hospital CEO at the time of the study.

'Bronchiolitis' is a clinical diagnosis, based on history and examination (SIGN, 2006). In order to determine that the criteria for the diagnosis of bronchiolitis made during each episode of admission were correct, a significant number of incidents of hospitalisation for bronchiolitis were randomly sampled and the corresponding patient records (hospital files) were examined to check if the clinical features noted during the hospital stay were compatible with a clinical diagnosis of bronchiolitis as defined in the SIGN guidelines for bronchiolitis (SIGN, 2006). Random selection of the files entailed listing all the admissions chronologically, then calling for 1 in 15 files. In the sample taken, 60% had both nasal discharge and cough, 36% had a cough without nasal discharge while less than 0.05% had nasal discharge without cough. Fine inspiratory crackles were present in about 20% of the sampled population while high pitched wheeze was present in 64% of the sampled population. Presence of these features was interpreted as correct clinical diagnosis.

During the study period, there were 292 admissions. For each of this admissions, the mean ambient temperature on the day of the admission was recorded. The mean ambient temperatures recorded on the day of admissions were then plotted, and the histogram shown in Figure 1 was obtained. The average of the mean ambient temperatures recorded on the day of admission and the corresponding standard deviations (SD) were then obtained, and a box plot was then drawn, as shown in Figure 2.

In order to better illustrate the relationship of mean ambient temperature with the number of admissions, the study period between January 2008 and December 2011 was divided into weekly intervals, with a total of 208 weeks, numbered week 1 to week 208. The number of admissions due to bronchiolitis during each week, and the mean ambient temperature during that week, were obtained. The values were plotted on a scatterplot as shown in Figure 3. Even though no easy linear relationship between the number of admission per week and the weekly mean ambient temperature was found, the number of admissions was visibly higher during the

low temperatures. To determine that low temperature results in a significant higher number of admissions then higher temperatures, five temperature categories were set, and the number of admissions per week during each temperature category listed. The temperature categories were as follows:

- Group 1: mean ambient temperature less than 10°C;
- Group 2: mean ambient temperature between 10.1 and 15°C;
- Group 3: mean ambient temperature between 15.1 and 20°C;
- Group 4: mean ambient temperature between 20.1 and 25°C;
- Group 5: mean ambient temperature between 25.1 and 30°C.

The nonparametric Kruskal-Wallis equality-of-populations rank test was then used to determine if there is a significant difference between the admission numbers in each temperature category.

RESULTS

Figure 1 illustrates a histogram showing the number of admissions due to bronchiolitis vis-a-vis the mean ambient temperature. As shown, most of the admissions occur between 10°C and 18°C. The highest mean ambient temperature recorded on the day of an admission was 28.5°C and the lowest mean ambient temperature recorded was 7.3°C. The mean was 14.76°C with a standard deviation of ±3.85°C. The boxplot shown in Figure 2 illustrates the measurements of central tendency described above.

The scatterplot shown in Figure 3 plots the number of admissions per week vis-a-vis the mean ambient temperature for that week. The scatterplot shows a nonlinear relation between the number of hospital admissions and mean ambient temperature. In view of this, the Pearson's product-moment correlation coefficient could not be obtained.

In order to determine that the number of admissions to hospital is significantly different in each mean ambient temperature category, the Kruskal-Wallis equality-of-populations rank test was used to rank the number of admissions in each of the mean ambient temperature category. The results obtained are shown in Figure 4. The figure shows the number of observations in each group with the corresponding rank sum. The Kruskal-Wallis test gave a chi-square of 87.2 with four degrees of freedom and a *p*-value of 0.0001. Setting the *p* at 0.05, the null hypothesis was rejected and the alternate hypothesis was accepted. Therefore, the results show that there is statistically significant difference between the numbers of admissions occurring in each temperature category.

Figure 3: Scatterplot of the number of admissions per week against the mean weekly ambient temperature

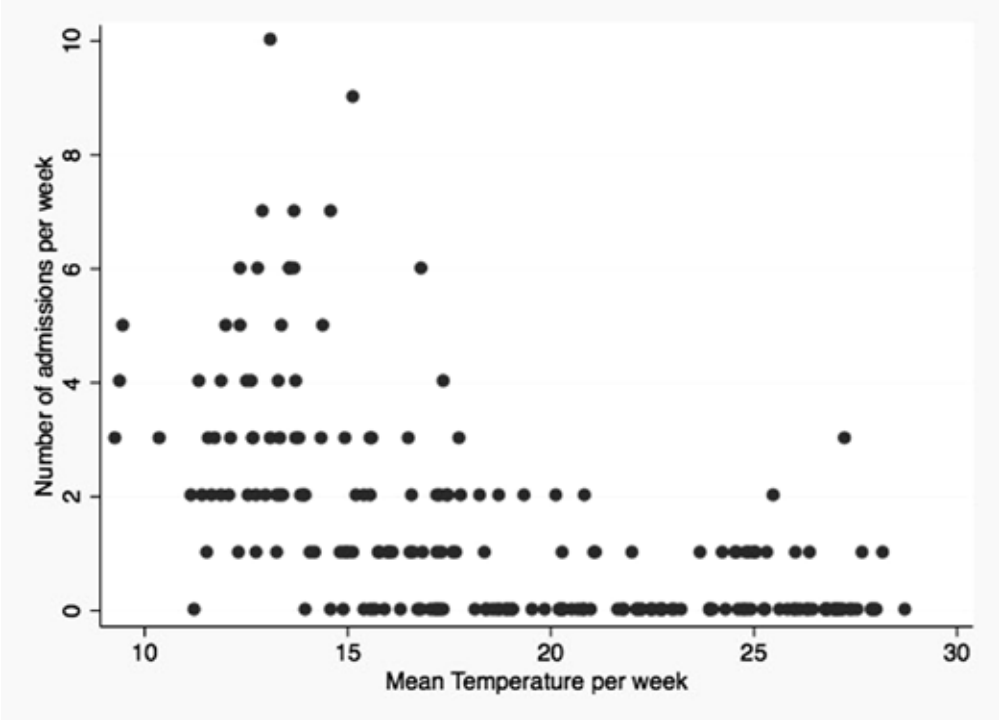


Figure 3: Kruskal-Wallis equality-of-populations rank test

Temperature Group	*Observations*	*Rank Sum*
Group 1: Below 10°C	*3*	*550.00*
Group 2: Between 10.1 and 15°C	*57*	*8941.50*
Group 3: Between 15.1 and 20°C	*58*	*5922.50*
Group 4: Between 20.1 and 25°C	*48*	*3153.00*
Group 5: Between 25.1 and 30°C	*39*	*2548.00*

chi-squared = 87.227 with 4 d.f.

probability = 0.0001

DISCUSSION

As the results show, 68% of the admissions occurred when the mean ambient temperature was between 10.91°C and 18.61°C (two standard deviations both directions from the mean of 14.76°C). This mirrors that of the countries studied in the northern hemisphere, where the number of hospital admissions is higher when the mean ambient temperature is low (Alonso et al., 2007; Deshpande and Northern, 2003; Johnson and Eccles, 2005; Panozzo et al., 2007; Reyes et al., 1997; Tang and Loh, 2014). This can be visually appreciated in the histogram of Figure 1 and the scatterplot of Figure 3, which illustrate a peak in the number of admissions in the temperature range mentioned above. The study also found that there is a significant difference in the number of admissions occurring in each mean ambient temperature category (groups defined above).

This information could be useful for a variety of purposes. Clinically, it could help general practitioners, paediatricians and emergency doctors to have a higher index of suspicion for bronchiolitis when the temperature is within the above mentioned range, and look more attentively for signs of respiratory distress needing referral to hospital or admission. From a service provision point of view, the study could help service managers to proactively prepare for higher admissions when the temperature drops, in turn avoiding bed shortages.

The study also provides information of academic interest about epidemiology of bronchiolitis in Malta. As already shown in a previous study done locally, bronchiolitis shows seasonal preference to the winter months (Casha et al., 2015). This study adds value by identifying the range of temperature in which most admissions occur and also proves that there is a significant difference in the number of admissions between the mean ambient temperature categories.

A drawback of the study is that it relied on data collected by the Department of Health Information and Research, in part gathered through the use of Electronic Case Summaries system. The system came into use in 2008 and had a usage rate of 60-70% in the first two years of use and 85% in the last two years. This raises questions about whether the undocumented cases were cases of bronchiolitis or not. The study also focussed only on the number of admissions to the main hospital, Mater Dei. Unfortunately, no data was available on the number of admissions to the Paediatric ward in the Gozo General Hospital due to bronchiolitis in the study period. It would have been interesting to determine whether a similar trends exists in Gozo. The study only included the number of cases discharged from hospital with a diagnosis of bronchiolitis; it did not take in account the number of patients presenting to the accident and emergency department and discharged with a diagnosis of bronchiolitis. It would have been interesting to know whether the rate of presentation to the accident and emergency department also varies with mean ambient temperature in a similar fashion. Further research in the area could include taking in account other environmental variables, like the level of humidity and wind direction. Also, the study did not include any reference to the viral aetiology of the cases admitted to hospital. It would have been ideal to determine whether a particular virus is causing the spike in admissions in the identified

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temperature range. This study could inspire others to try and seek answers for the points discussed above, and thereby improve the local epidemiological knowledge of bronchiolitis.

CONCLUSION

The study identified the temperature range where most of the hospital admissions due to bronchiolitis occurs (i.e. between 10.91°C and 18.61°C). The study also rejected the null hypothesis and accepted the alternate hypothesis, proving that there is a significant difference in the number of admissions between the various mean ambient temperature categories. The authors can conclude that in Malta, a higher number of hospital admissions for bronchiolitis among infants or children under two years occurs when mean ambient temperature is lower. This is in keeping with international literature.

It is hoped that the insight gained from these results will be considered in everyday GP practice, with GPs being more alert during colder temperatures to the possibility of bronchiolitis needing hospital admission, and in strategic health planning for availability of resources needed for hospitalised cases of bronchiolitis during colder temperatures.

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RESEARCH ARTICLE

Training in palliative medicine and Maltese doctors: a cross-sectional survey

Dr Jurgen ABELA, Prof. Pierre MALLIA

ABSTRACT

Introduction

Doctors struggle with end of life decisions. Few if any studies documented the level of training and need for further training in palliative care of local doctors.

Method

A national cross-sectional survey of all Maltase doctors registered with the Medical Council of Malta and having a local address.

Results

The response rate was 39.7%, totaling 396 responses. Thirty-one point one per cent of respondents did not have training in palliative care. Sixty-two point six per cent of respondents agreed that their training in palliative care should be extended. Female doctors and younger doctors were significantly more likely to agree to extend their training in palliative care. Past training in palliative care was significantly related to views on euthanasia.

Conclusions

The majority of Maltese doctors (68.9%) had some form of training in palliative care. Interestingly however, 62.6% of Maltese doctors agree to extend their training in palliative care. Not surprisingly, younger doctors were more eager to extend their training in this area, possibly due to lack of exposure and experience in palliative care. The (significant) relation between training in palliative care and views on euthanasia is an area for possible further study in the future.

Key Words

Palliative Care; Medical Education; Physicians

INTRODUCTION

Palliative Care (PC) aims to improve the quality of life of the patient with a limited prognosis through a combined approach addressing the physical, psychosocial and spiritual nature aspects of the patient, including bereavement support to the relatives of the patient (Charlton, 2002). Recent guidelines on the management of a variety of conditions specifically mention a palliative approach especially once the disease progression is rapid and associated with a significant symptom load (European Society of Cardiology, 2012; GOLD Strategy, 2015). Such palliative approach to managing disease and symptoms is also reflected in the training curricula of various medical disciplines and in the most recent guidelines for the management of certain non-malignant conditions in their end stage (Royal College of Physicians, 2015).

Consequently, doctors need to be trained and conversant with the basic issues involved in adopting a proper palliative approach, irrespective of the discipline in which they work. PC training in the medical field has received some attention over the last years. A recent study showed that putting PC as a non-compulsory aspect of the curriculum leads to poorer outcomes in medical students (Ostgathe et al., 2011). Interestingly, across the western world, various medical specialties have embarked on projects to identify which aspects of PC most suit their respective training curricula, thus acknowledging the fact that PC must be an essential aspect of medical training (Kirschen & Roff, 2011; Shoenberger et al., 2015). On the other hand, and possibly more controversially, there has been a recent proposal to actually shorten undergraduate medical training in general (Emanuel & Fuchs, 2012).

In Malta, medical students gain exposure to PC through their component of oncology. In addition, in the Specialist Training Programme in Family Medicine, GP

trainees are specifically assigned a rotation to palliative care, both at in-patient and at community level. Doctors specializing in Medicine may also have a rotation in palliative care. However, besides these specialties, as far as is known, few other local specialty training programmes require particular exposure of their doctors to palliative care.

Lastly, ethical issues at the end of life (EoL) are challenging and commonly give rise to uneasiness for doctors (General Medical Council, 2010; Abela & Mallia, 2010).

In view of all the above, and also in view of the concerns which were raised in previous studies (Abela, 2015; Abela & Mallia, 2016), the authors felt that there is a need to study Maltese doctors' experiences and concerns on their training in PC. The aim of the study was to describe and quantify the thoughts amongst medical practitioners on EoL decision making. This study is being presented within the End Care project, an Erasmus + project aimed at supporting the harmonization of EoL practices (Mallia, Abela & Galea, 2016).

METHOD

A primarily quantitative methodology was adopted and accordingly, an anonymized questionnaire was used. The questionnaire was previously used in similar populations i.e. doctors and previously validated as part of the EURELD (European end-of-life consortium) initiative (Lofmark et al, 2008). The necessary permissions were sought from the authors of EURELD.

The questionnaire was sent by post to all medical practitioners who were listed on the Principal Register of the Medical Council of Malta as on November 2013. Only doctors who had a local address listed on the register were included (n =1007).

The questionnaire consisted of four sections, followed by a short comments section. The four sections related to demographic details; details on religion/philosophy of life; thoughts on PC and training; and lastly a section on past experiences and views in relation to end of life decisions.

Each questionnaire had a short note included where the aims of the study were explained and consent sought. The participants were asked to fill in the questionnaire and return it back within one month.

Every effort was done to ensure a good response rate (Kellerman & Herold, 2001; Seale, 2009). The introductory note was personalized, each participant had a prepaid envelope to return the questionnaire and the questionnaire was not long. However, contrary to existing recommendations, no reminder note was sent to the doctors. This was done since the authors felt that the area being studied was 'sensitive' and consequently felt that a reminder was inappropriate.

The University of Malta Research Ethics Committee approved the study. The data collected was analyzed using SPSS version 22.0 and Excel version 12.3.6. This paper is uniquely focused on the responses which concerned training in PC. The remaining contents of the questionnaire and issues arising from it have been published separately (Abela, 2015).

RESULTS

A total of 1007 doctors were included. Of these, a total of 396 doctors returned the questionnaire, giving a response rate of 39.3%.

Of those that answered, 40 were no longer actively practicing as doctors. As per questionnaire, they were asked to return the questionnaire unfilled. The subsequent analysis of results is thus limited to those doctors who were actively practicing at the time of the questionnaire (N= 356).

The results of the questionnaire pertaining to training are reported hereunder.

A. Demographic details

Of the respondents, 59.2% were males, whereas 40.8% were females. Overall, the respondents had been practicing for an average 19.72 years (95% CI: 18.3 – 21.0). A substantial number of respondents – 160 – registered family medicine as their specialty. The second most common specialty was medicine, which grouped people from internal medicine, respiratory medicine, cardiology and neurology. A detailed breakdown of the respondents per specialty is found in Table 1, followed by the age distribution in Figure 1.

B. Training in PC

The respondents were asked about two aspects of training in palliative medicine namely:

- whether they received training in PC. They were also asked what type and level of training they received.
- whether they agreed that their training in PC should be extended. They were also asked what options they preferred to extend training in PC.

Table 1: Distribution of respondents per specialty

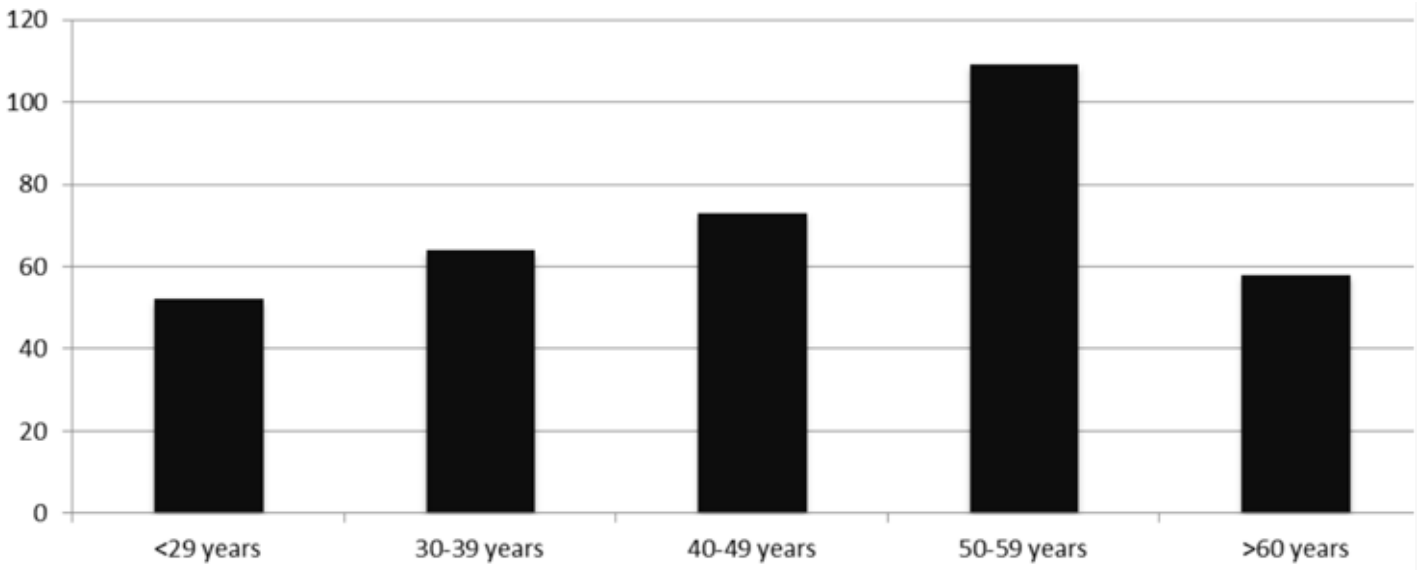
Specialty	Number	Percentage of total (N=356)
General Practice	160	44.9%
Medicine *	49	12.4%
Sugery**	45	11.4%
Anaesthesia	21	5.9%
Geriatrics	12	3.4%
Gynaecology	18	5.1%
Paediatrics	21	5.9%
Psychiatry	7	2.0%
Other***	23	5.8%

** Includes general medicine; neurology; cardiology; respiratory medicine; oncology, palliative medicine*

*** Includes general surgery, orthopaedics, ENT surgery, neurosurgery, ophthalmology*

**** Includes dermatology, radiology, public health*

Figure 1: Age distribution of respondents



With respect to their (past) training in PC, 31.1% of respondents stated that they did not have any training in PC. The remaining 68.9% had a variety of training opportunities/exposure in the past as summarized in Figure 2.

Moving on the second question, 37.4% did not agree that their training in palliative medicine be extended. Of the 62.6% who agreed, various options were put forward as to how the training should be extended and this is highlighted in Figure 3.

C. Further Analysis

On further analysis, female doctors and younger doctors were found to be statistically ($p<0.05$) more likely to agree to extend training in PC. The two responses are summarized together in Table 2. Further to this, past training in palliative medicine is significantly associated with views on euthanasia as summarized in Figure 4. No other significant associations were noted. However, a table listing the relation between specialty and training in palliative medicine has been included (Table 3).

DISCUSSION

A recent poll of 4,024 doctors in the British Medical Journal highlighted that the area which needs to be prioritized most to make the biggest clinical difference for people is end of life care (Murray & Aziz, 2008). The current study being presented formed part of a greater review on End of Life decision making amongst doctors. The focus of this particular paper is training in palliative medicine, especially with respect to past training and perceived need to extend the said training. As far as is known, this is the first study locally to analyze this area.

In this study it is significant that both age and gender showed a statistically significant relation with extending training in palliative training. It can be argued that older females are more likely to be sensitive to end of life care than older males and that younger doctors are also more cognizant of the importance of the area. Alternatively, it can be the case that these particular age groups feel somewhat 'inept' in palliative medicine and yearn to fill in a perceived void in knowledge or skills.

In addition to demographic details of respondents, the authors also analyzed difference in responses between specialties. The largest represented specialty was general practice. Although there were differences in attitudes and responses between specialties, these did not reach significance levels. There might be various explanations for the observed differences between specialties. PC is likely to interest different specialties in a different way. Dermatologists, for example, may meet with EoL cases less often than those doctors doing internal medicine. Conversely the way PC is done in hospital may differ significantly than how it is done at a community level. The primary intention of this paper however is an across-the-board analysis of perceptions of doctors and the majority are in agreement with the need to have more training in PC. The fact that there was a statistical significant

Figure 2: Training received in palliative medicine

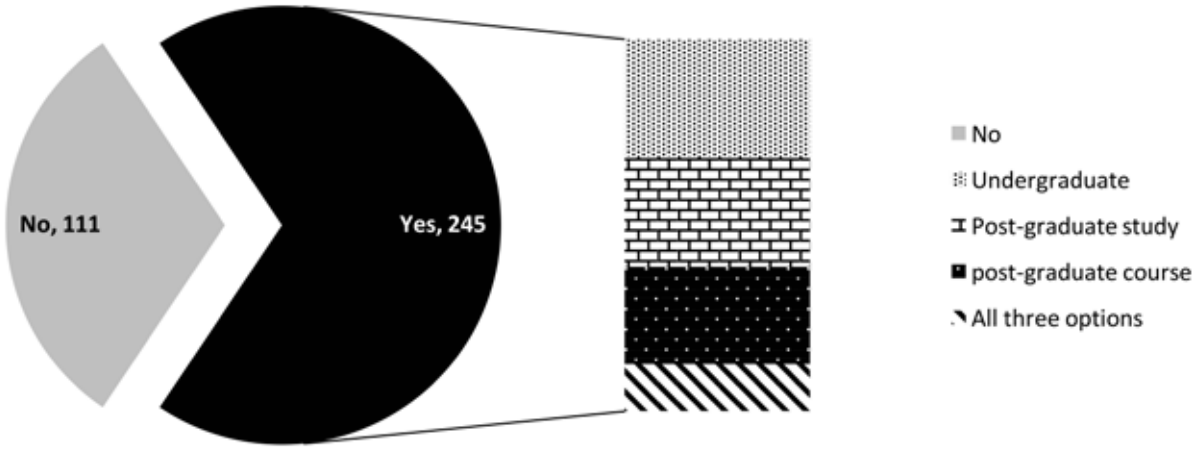


Table 2: Association between extending training and age/gender of doctors

	AGE (p=0.021)					GENDER (p=0.019)	
Extend Training in PM	<29 years (N=52)	30-39 years (N=64)	40-49 years (N=73)	50-59 years (N=108)	>60 years (N=58)	Male (N=233)	Female (N=122)
YES	78.8%	78.1%	61.6%	49%	56.8%	57.1%	72.9%
NO	21.2%	21.9%	38.4%	51%	43.2%	42.9%	27.1%

Figure 3: Doctors who agreed to extend training in palliative medicine and options chosen
(KEY - Undergrad. Ed: Undergraduate Education; PG Educ: Postgraduate education; PG Course: Postgraduate course)

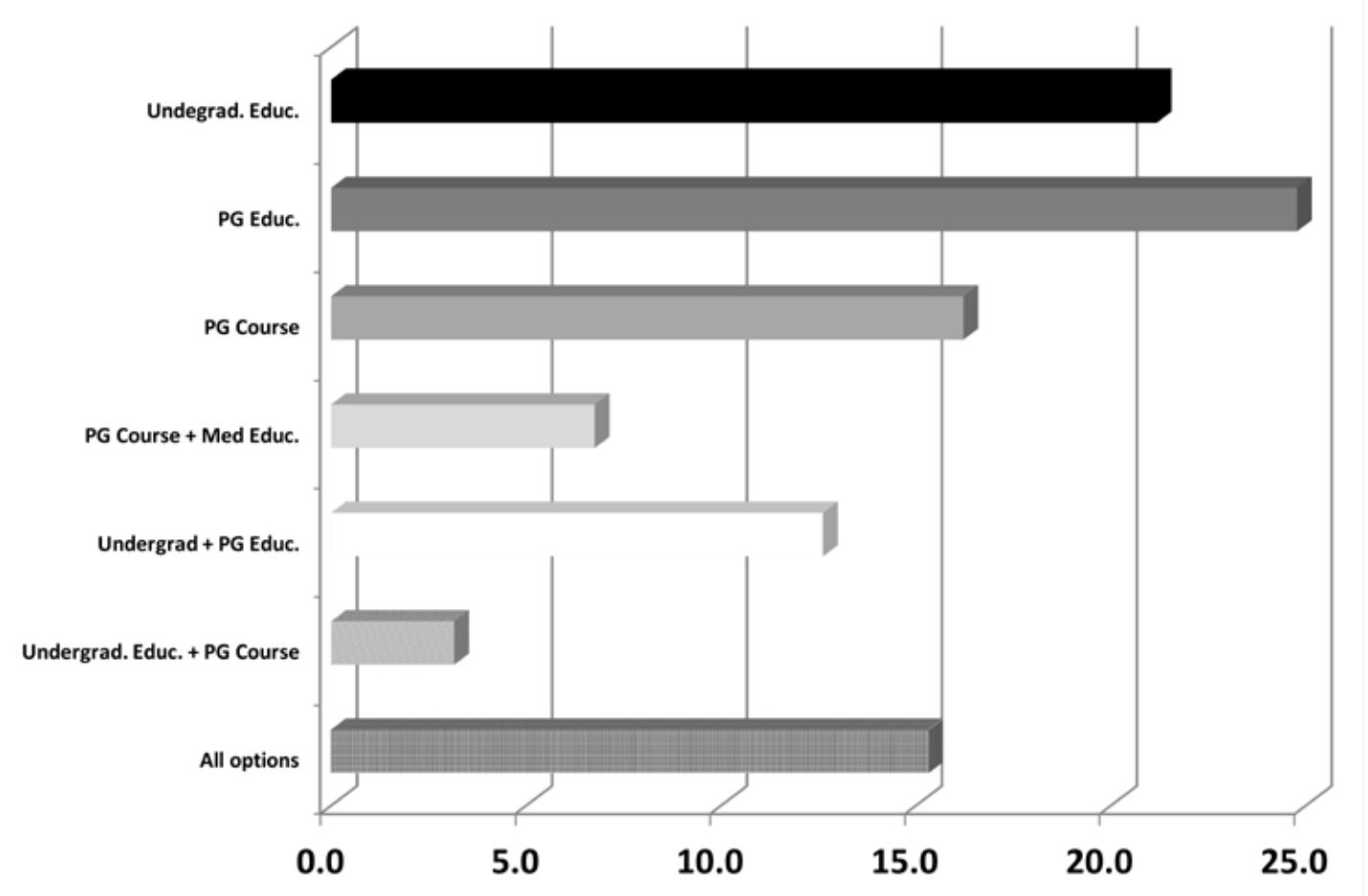
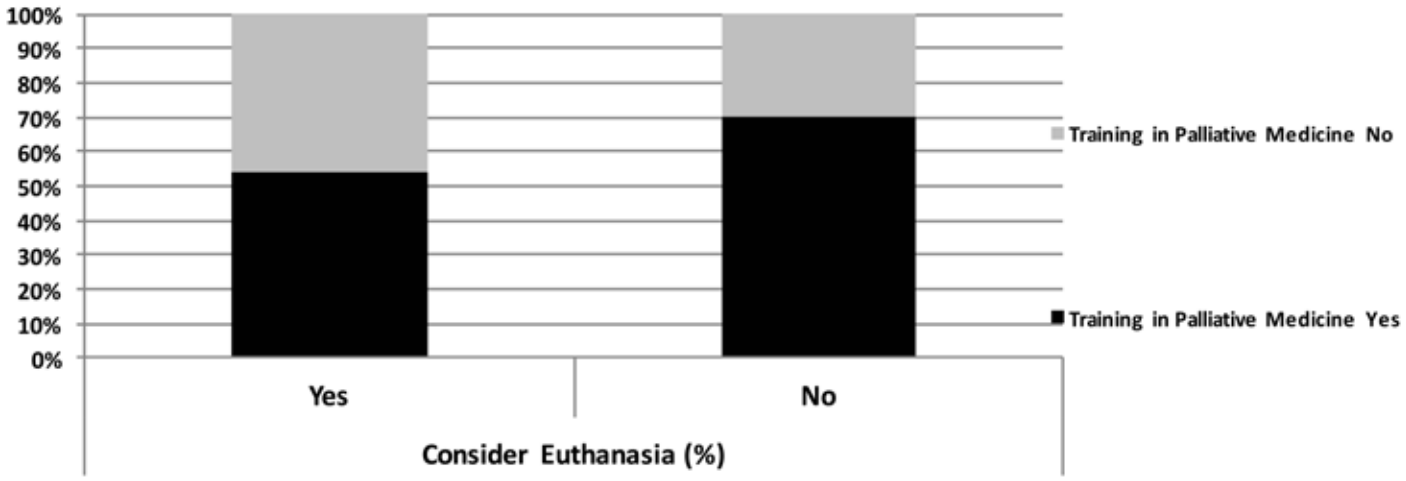


Table 3: Specialty of Doctors and Training in Palliative Medicine

	Past Training in Palliative Medicine (p=0.74)			Extend Training in Palliative Medicine? (p=0.43)		
	YES	NO	Total	YES	NO	Total
Anaesthesia	76.19% (16)	23.18% (5)	100% (21)	66.67% (14)	33.33% (7)	100% (21)
General Practice	71.25% (114)	28.750% (46)	100% (160)	60.38% (96)	39.62% (63)	100% (159)
Geriatrics	66.67% (8)	33.33% (4)	100% 1(2)	66.67% (8)	33.33% (4)	100% (12)
Gynaecology	50.00% (9)	50.00% (9)	100% 1(8)	77.78% (14)	22.22% (4)	100% (18)
Paediatrics	76.19% (16)	23.81% (5)	100% 2(1)	52.38% (11)	47.62% (10)	100% (21)
Psychiatry	42.86% (3)	57.14% (4)	100% (7)	57.14% (4)	42.86% (3)	100% (7)
Other	52.17% (12)	47.83% (11)	100% (23)	73.91% (17)	26.09% (6)	100% (23)
Medicine	71.25% (39)	28.75% (10)	100% (49)	63.27% (31)	36.73% (18)	100% (49)
Surgery	66.67% (28)	33.33% (17)	100% (45)	60.00% (27)	40.00% (18)	100% (45)

Figure 4: Association between past training and views on euthanasia (p=0.05)



difference in age, with younger doctors perceiving the need more than older ones, also shows the increasing importance and relevance of this emerging field. PC was not a specialty a few decades ago and was previously conceived in a purely physical sense rather than a broader biopsychosocial approach.

There was a very significant association between past training in palliative medicine and views on euthanasia (Figure 4). This trend resonates with other similar studies on professionals abroad (Zenz, Tryba & Zenz, 2015). It can be argued that the increased awareness (through training) on symptom control and also the complex interplay of physical-psychosocial-spiritual at EoL counters the support for euthanasia.

Overall, this study should also entice the Malta Medical School to train undergraduates in PC with perhaps an approach which takes into consideration both hospital care and home care. In addition, local specialist training programmers possibly need to address any lacunae in the training programmes with respect to palliative medicine. In particular, besides challenges of symptom control, doctors will need to be comfortable with the moral and medico-legal aspects of medical care, which might differ between hospital and home care, and which include the issues of futility and artificial nutrition/hydration. In this regard, an Erasmus + project currently being run by the Bioethics Research Programme at the University of Malta EndCare project intends to study further this area of practice. In particular, it will focus on the fears and moral dilemmas, and provide an appropriate curriculum for EoL decisions for professionals.

STRENGTHS AND LIMITATIONS

As far as is known, this study was the first cross sectional survey of all Maltese doctors with respect to their experiences and views on training in PC. The authors used a previously validated questionnaire. On the other hand, the response rate to the questionnaire, though comparable to other local studies (Inguanez & Savona Ventura, 2005), was low. This was a primarily quantitative study, aimed at describing the current local situation. Its findings could be augmented/confirmed with a qualitative study which could be more focused on the actual needs of doctors.

CONCLUSION

The majority of Maltese doctors are in favour of extending their training in PC and a greater majority had some form of training in the past. Younger doctors and female were (significantly) more resonant to training in palliative medicine. Previous training/exposure to PC was found to significantly influence the views of doctors on euthanasia, i.e. the more a doctor is trained in PC, the lesser is the chance they would consider it for their patients. The findings of this study should influence educators at undergraduate and postgraduate levels to consider amending their curricula in this regard.

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MCFD annual general meeting 2016 - president's report

Prof. Pierre MALLIA

The conclusion of the 25th anniversary of the MCFD with the graduation of the first fellows of the college was a tribute to the hard work that the college has done over the years. It is important to stress that Fellows are those who have spent at least five years of service to the College. With this dinner we have launched the cooperation with patient groups.

In this regard we should view patients as partners, as sister colleges do abroad. If there is an advocate for patients it is the family doctor and therefore it is only natural that a College representing the Family Doctors collaborate with patient groups and their mother organisation (the Malta Health Network) which represents patients. How this will come more to life depends on a lot of factors but certainly we can use the opinions of patient groups to plan research, the part of the website in which we can give information to patients, and indeed collaboration in organising joint meetings, especially to disseminate information. Fostering mutual understanding of issues, including political, will diffuse any 'us' and 'them' ideas which may go around.

For this reason I have proposed to council that the College, which is now a Voluntary Organisation, be able to support its members to apply for EU research funds. To apply for such funds one needs a mother organisation which is financially stable, can audit the research and even provide logistic and secretarial support (the funds to pay for which coming from the same funds that one is awarded). The College will be the legal body responsible for the research, which is why it has to appoint its own auditor to monitor the projects. In the same way when academics apply for EU funds and become the main coordinators and principal investigators of the research, it is the Rector of the university who is legally responsible. Conditions and terms will apply including that the authors of papers have to acknowledge the Malta College of Family Doctors, under whose aegis the research falls.

The potential researcher will have to find a project manager ready to work and draw up the application. An agreement will be reached with such an individual such that, should the project be awarded to the researcher, the former will be employed as the project manager. Together with this project manager the funds will pay for monitoring, auditing and any secretarial assistance necessary to be legally responsible for the project. The College for example will issue any calls for application and help the researcher transparently choose research and administrative assistants, etc. At this stage this proposal is being studied by Council and if approved will be passed through the AGM.

One such project we will surely apply for funds is to disseminate education for patients, working collaboratively with patient groups – as it is they who know 'what they need to know'. Creating a platform for education and research will be beneficial not only to patients and doctors wishing to do research but to health care in general. It will help understand the problems and bring an evidence base to what is usually opinion and speculation.

I am working very hard to make the education subcommittee as independent from council as possible. Council members are not experts in the field which is developing quickly, and neither are they expected to be so. Of course there will be many education subcommittee members on council. But the committee's work has grown to the extent that it needs continuous decisions and meetings and it is practically impossible to have this committee wait for another council meeting to make its daily decisions. Moreover it is not conducive either that most of the time of council meetings is dedicated only to the Vocational Training summative assessment. Decentralising the work of council shows that the College has grown in maturity. Of course council will remain responsible for everything, including decisions. But discussions, which take a long time, can be done at subcommittee level and then council deals with the final report with one person giving an explanation. As long as decisions

at subcommittee are taken in the spirit of the objectives of the MCFD there should be no problem.

What concerns me as President is that the interface between the MCFD and its collaborators (at the moment the Royal College of General Practitioners [RCGP] and the Health Division [DH]) are politically motivated (in the sense of medical politics). One needs to identify people who are diplomatic and understand that the DH is in many ways our client. Whilst we are responsible for the needs of the vocational trainees and what they have to learn, we have to be sensitive to the needs of our major client. The President, Vice President and Education Secretary form the political interface with the RCGP. The political interface with the DH is principally the Education Secretary and the Vice President. Their job is to see that discussions are fair and run smoothly.

The College is also collaborating with the Association of Private Family Doctors [APFD] to develop media educational programmes. This has been discussed by the secretary. I see this as part of a larger vision of working with patients. Indeed ideas for such programmes can come both from the experience of doctors and from that of patients. Discussions analysing consultations are the way being proposed. There are various models on how this can work: these are being analysed and I thank Drs Jason Bonnici and Philip Sciortino for working on this issue.

The Journal of the MCFD [JMCFD] continues to be a success. I am happy that many young doctors are producing papers of quality and this reflects the motivation doctors feel when they are given incentives to publish. It is also a mark of increasing standards. The journal continues to evolve and we are adamant on issuing three copies every year (for the sixth consecutive year now). As editor I continue with the condition that we obtain adverts solely to cover costs of printing and distribution and not to make a profit. This way we can reach our members regularly.

Recently on council the proposal to offer the Diploma in Family Health was again mentioned. Personally I have steered away from this due to issues which arose the first time it was offered. But if council continues to think this is feasible I am happy to do it.

The Royal College of General Practitioners has re-opened the possibility of APEL – the Acquired Process of Educational Learning. The RCGP is responsible for this UK programme for General Practitioners. In our case it was opened for those who contributed directly to making the Summative Assessment for Vocational Training and who continued to give their services in this regard. Of course everyone can apply and as President I will support all applications. However I should make it clear that the award is not ours to give and the final say (which will probably be very strict) will be in the hands of the RCGP.

The MCFD will be exploring ways in which we can collaborate with the University of Malta [UoM]. Any post-graduate qualifications can be done through the university and indeed we can collaborate with the Department of Family Medicine. Of course we would have to relinquish all ownership and the fees which the UoM will take may not make it feasible for us. So everything still has to be evaluated. Conversely there is always the possibility of offering diplomas if we register ourselves as an educational body. There is now a national equivalence body for educational certificates. One would have to fulfil criteria for post-graduate certificates and diplomas which will be valid across Europe.

Finally this year marks another one in which the RCGP sends its External Development Advisors in order to accredit our educational process for Vocational Training which gives new members the right to apply for the MRCGP(INT). I am sure that our educational team will score highly. I take this opportunity to thank all the people involved in this summative assessment both from the past council and the present. It would not be fair not to include also the coordinators and others involved in the process who are employed by the Health Division.

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MCFD AGM 2016: secretary's report April 2015 – May 2016

Dr Jason J BONNICI

The experience for us as part of the council of the Malta College of Family Doctors and as Honorary Secretary has continued its learning curve during the past year. In this we have the assistance of Ms. Lorraine Gauci at the MCFD Secretariat. A copy of material that passes through MCFD Council is retained at the MCFD Secretariat as a "soft copy" and as a "hard copy".

The contents of this report are as follows

A) **Internal Structure**
1. Voluntary Organisation
2. MCFD Council 2013-2015
3. MCFD Council 2016-2019
4. Changes in statute
5. Membership
6. Honorary Fellowship of the Malta College of Family Doctors
7. Premises

B) **Educational Activities**
1. The GP Licensing Examination
2. The Graduation Day for GPs
3. Training for GPs to become GP Trainers
4. Continued Medical Education/Continuous Professional Development Activities
5. CPD for GP Trainers
6. Training with the RCGP
7. APEL-RCGP

C) **Communication**
1. Journal of the Malta College of Family Doctors
2. Media Project
3. Webpage

D) **International Fora**
1. EUROPREV
2. WONCA
3. Vasco da Gama Movement

A) INTERNAL STRUCTURE

1. VO/0973

MCFD is **a Non-Governmental Organisation** with the Commissioner of Voluntary Organisations with VO Number VO/0973. All this places the rights and responsibilities of MCFD within a regulated framework. Members can refer to the Office of the Commissioner for Voluntary Organisations or check on website www.voluntaryorganisations.gov.mt. Funds exist for Voluntary Organisations working alone or in partnership with other VOs, but MCFD has not to date taken up the opportunity.

2. MCFD Council 2013-15

Four Council Meetings took place during this time: 23.04.15; 13.07.15; 06.10.15; and 18.11.15. The **members of the council** were: Prof. Pierre Mallia (President), Dr. Philip Sciortino (Vice-President), Dr. Tanya van Avendonk (Treasurer and Events Co-ordinator), Dr. Adrian Micallef (Registrar), Dr. Doreen Cassar (Education Secretary), Dr. Jason Bonnici (Secretary), Dr. Marco Grech (Assessment Lead and Assistant Secretary), Dr. Jean-Pierre Cauchi (officer co-ordinating revision of statutes), Dr Edward Zammit (officer involved in Continued Medical Education activities), Dr. Daryl Xuereb (officer involved in Continued Medical Education activities) and Dr Jan Chircop. Dr Jan Chircop resigned in October 2015. Through the provisions of the statutes approved during AGM 2013, one of Dr. Anne-Marie Scerri and Dr. Martina Falzon was **assistant officer on behalf of the GP Trainees** for a number of council meetings.

3. MCFD Council 2016-19

Elections took place in January 2016. New Council and their roles

a. Prof Pierre Mallia – President (moved on from the role of President-Elect) and Editor of JMCFD
b. Dr Philip Sciortino – Vice-President; officer in charge of CME activities
c. Dr Edward Zammit – SAC Representative; CSA Lead; co-chair of the Education Secretary; assisting webmaster Jan van Avendonk in the IT changes
d. Dr Daryl Xuereb – Honorary Treasurer
e. Dr Natalie Psaila – co-chair of the Education Secretariat
f. Dr Jason Bonnici – Hon. Secretary
g. Dr Ann-Marie Scerri – GP Trainee representative; will be trained in the role of Registrar by outgoing registrar Dr Adrian Micallef.
h. Dr Elanja Grech – GP Trainee representative.
i. Dr Myriam Farrugia – co-opted with full voting rights.

Three Council Meetings took place during this time: 23.02.16; 29.03.16 and 24.05.16.

4. Changes to Statutes

The statutes as changed in the previous AGM have been implemented. Fellowship of the Malta College of Family Doctor has been conferred. The obligations of contractual agreements in case of a caretaker council have meant that the education subcommittee continued with its preparation for the GP Licensing Exam 2016.

5. Membership

The **membership database is being updated.** Office secretary Lorraine Gauci, Jan van Avendonk, previous registrar Dr Adrian Micallef and previous treasurer Dr Tania van Avendonk are compiling a spreadsheet that can be updated for membership according to attendance to CME and in respect to membership fees paid.

At the end of 2015, MCFD had 232 full members and 19 associate members who were fully paid. Continued MCFD membership linked to attaining CPD points may seem not worth enforcing as there is no utility for members but members need to keep in mind that accreditation in some form may come in at some point.

6. Honorary Fellowship of the Malta College of Family Doctors

The conferring of the Hon. FMCFD was done during an activity combined with the Graduation of the new FDs and the 25th Anniversary of MCFD in October 2015.

7. Premises

The realities of yearly GP Licensing examinations, possible future courses including MRCGP(Int) for GPs with grandfather clause and the CME activities mean a lot of time and energy is spent in finding suitable sites and shuffling dates to accommodate other bookings. The present council has aired the suggestion to search for premises dedicated to MCFD to cater for these and other future needs. **A suggestion was forwarded to the Ministry for Health for common premises for all medical colleges**; with a couple of exceptions there is consensus among colleges for this call. No definite proposal of site has been officially mentioned.

The previous council had aired the proposal to **submit interest with estate agents within the parameters of the required specifications and the current finances at disposal**. The present council is interested to continue along this path. Proposals brought forward would be discussed without commitment.

B) EDUCATIONAL ACTIVITIES

1. The GP Licensing Examination

The house keeping done in respect to the GP Licensing Examination shows that a minute number of GPs are involved. More recruits are needed to free stretched volunteers to other efforts. A number of issues arose that meant that change in personnel occurred: the Assistant Leads took over the roles vacated by the previous Leads, but the latter continued to contribute as part of the team.

- **The tri-partite contract between MCFD-DH-RCGP is due for renewal.** The MCRGP(Int) gives respectability to our specialty. The contract needs to be renewed and for this MCFD needs the support of all GPs/FDs. MCFD has political direction to renew as per previous conditions.
- The **board responsible for seeing out the execution of the examination** is the remit of Dr Edward Zammit as Assessment Lead and CSA Lead, Dr Marco Grech as AKT Lead and Dr David Sammut as Examination Lead. Dr Edward Zammit and Dr Natalie Psaila as education co-chairs are responsible for seeing out the logistics of the examination.

- The **AKT Writers group** is made up of AKT Lead Dr. Marco Grech, AKT Assistant Lead Dr Myriam Farrugia and the following GPs: Dr. Alexia Harney, Dr. Edward Zammit, Dr Doreen Cassar, Dr Tania van Avendonk and Dr. Francis Borg. Producing good quality AKT questions in quantity annually is a challenge.
- The **CSA Writers group** is made up of CSA Lead Dr Edward Zammit and the following GPs: Dr. Doreen Cassar, Dr. Marco Grech, Dr. David Sammut, Dr. Myriam Farrugia, Dr. Alexia Harney, Dr. Tracy Lee Vidal, Dr. Fabrizia Azzopardi, Dr. Lynn Pace, Dr. Glen Micallef and Dr. Simone Deguara.
- There is currently no **Curriculum Group**.
- The **Psychometrics** in 2015 was done by statistician Dr Victor Martinelli. He will have the same role in 2016.
- Dr Tania van Avendonk, Dr Lynn Pace and Dr Miriam Farrugia are finishing the QA Report for 2015. A new team is needed for 2016. MCFD has contacted the University of Malta to see if this can be farmed out.

The preparations for the examination itself (set-up, personnel and logistics) took and to date still take a lot of time, effort and energy:

- meetings with training co-ordinators;
- on-site meetings with the officers responsible for the facilities where the separate parts of the examination take place (the written AKT part at the Medical School and the clinical CSA part at Qormi Health Centre);
- issuing calls for candidates, examiners, marshalls, AKT writers, CSA writers, and members of the Angoff team; and
- training sessions for the colleagues involved in all these processes.

We encourage colleagues who have received training on any of these processes to come forward and be part of the team. A particular appeal is to the graduands of the previous years, they who have been examinees a short while ago, to come forward and make the contributions they yearned for.

2. The Graduation Day for GPs

The graduation day of the new FDs was combined with the conferring of the Hon. FMCFD during an activity marking the 25th Anniversary of MCFD in October 2015.

3. Teachers' Course Nov-Dec 2015

First session took place at MCAST with 13 participants and 3 tutors. Second session is due at Tal-Virtu Seminary. Assignment was due on 6th January 2016. Another Teachers' Course is planned to take place in September and October 2016.

4. Continuous Professional Development (CPD) and Continued Medical Education (CME) Activities

The program of CPD for the paid up members of the MCFD remains its **main educational service for the members of the College**. It is the major point of contact with the general membership. Average attendance is of approximately 50 members.

The CME team is made up of Dr. Philip Sciortino, Dr. Tania van Avendonk, Dr Edward Zammit and Dr. Daryl Xuereb. The core team takes care of the academic, logistic and promotional aspects of the events. However, there is a wider number of people who provide secretarial, IT and administrative support.

The content is designed by balancing the **perceived needs** by the CPD team with the sponsorship opportunities. Sometimes the activity is co-organised with another professional body.

5. CPD for GP Trainers

An original offer by PHCD for a CPD for GP Trainers did not materialize into an activity. An alternative activity for GP Trainers was organized in November 2015 by the co-ordinators of the Specialist Training Programme for family doctors. PHCD has in 2016 submitted an improved offer for a CPD for GP Trainers. Three Tutors have submitted interest to MCFD to organize it. The ball has been set rolling to make this happen.

6. Training with the RCGP

Members of MCFD involved in running the GP Licensing Exam attended a run of the RCGP Licensing Exam in March 2016. The representatives were Dr Marco Grech, Dr Edward Zammit and Dr David Sammut.

7. APEL-RCGP

The RCGP has set into motion its mechanism to render the MRCGP(Int) by acquired experiential learning to those members of MCFD who cannot sit for the exam because of their previous commitments and who have contributed to family medicine in Malta. The necessary calls have been issued in May 2016.

C) COMMUNICATION

1. Journal of the Malta College of Family Doctors

The Journal continued its work thanks to the efforts of its Editorial Board: Prof. Pierre Mallia as Editor, Dr. Anton Bugeja and Dr. Mario Sammut as Assistant Editors and Dr. Glorianne Pullicino as member. Three issues per year are being printed and distributed to the membership. The latest issues of the JMCFD have been uploaded on OAR@UoM and are accessible via this link: https://www.um.edu.mt/library/oar/handle/123456789/5332

2. Media Project

MCFD has taken up a suggestion by APFD to submit a TV project depicting the work and role of the family doctor. All is in its premature stages and members interested to be involved are welcome. The College of Pharmacists may be involved too.

3. Webpage

MCFD webmaster Jan van Avendonk is responsible for updating the webpage and for sending the **email alerts**. The members who are not receiving the email alerts are invited to update the webmaster on contact@mcfd.org.mt with the details of the email address. Assisted by Dr Edward Zammit a Dropbox address and the use of iCloud to store MCFD material is being undertaken.

D) INTERNATIONAL FORA

1. EUROPREV

MCFD participation in EUROPREV has been lacking since 2013. Any member who is interested to participate in this international forum is welcome to contact any council member to move things forward.

2. WONCA EUROPE (World Organisation of Family Doctors – Europe branch)

The MCFD Hon. Secretary attended the WONCA Europe meeting in July 2014 and October 2015, and has registered to attend the WONCA Europe meeting in June 2016. No attempts are being made to send a MCFD representative to the WONCA Europe meeting prior to the WONCA World meeting (where the new WONCA President will take the seat) in September 2016.

3. Vasco da Gama Movement

MCFD has put things in order with WONCA Europe so that if the GP Trainees want official participation in the Vasco da Gama Movement they can do so. Dr. Anne-Marie Scerri, one of the GP Trainee representatives, has presented to her colleagues what the movement is about. An open invitation is in place for the GP Trainees and the GPs who have graduated in the past 5 years to take this opportunity. None has been forthcoming to date.

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Hon. Secretary, Malta College of Family Doctors
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Dr Denis Soler MD MSc FRCGP FMCFD 1948 - 2016

Dr Mario R SAMMUT

Dr Denis Soler, the first recipient of the Hon. FMCFD, May 10, 2013

The demise of Denis Soler on July 29, 2016 at the age of 68 years was mourned not just by his beloved family, friends and patients, but also by the family medicine community in Malta by whom he was regarded as a pioneer.

In 1988, Denis together with fellow family doctors Wilfred Galea and Ray Busuttil, were asked by the University of Malta's Faculty of Medicine and Surgery to devise a development plan for family medicine in Malta. Their report recommended the development of a University department of family medicine, the establishment of a programme of continuing medical education for family doctors, the development of a vocational training programme in family medicine and the setting up of a college of family doctors.

The Malta College of Family Doctors (MCFD) in fact was founded just two years later on April 4, 1990, with Denis as its first president. This was closely followed by the launch of a continuing professional development programme in September 1990, with such educational events for family doctors being regularly organised by the college to this day.

Following lobbying by the MCFD, a Department of Family Medicine was formally set up in April 2001 at the University of Malta's Medical School, with Denis as head of department. After initially focusing on the provision of an undergraduate teaching programme of lectures, tutorials and community placements, this was followed in 2007 by the launch of a postgraduate MSc in family medicine.

In 2000, the MCFD, under the continuing presidency of Denis, together with the Medical Association of Malta and the Director General (Health), approved a memo regarding the introduction of a course in vocational training in family medicine. This was the first step in the process leading to the launch of specialist training in family medicine in Malta during 2007, which training programme was afterwards accredited by the UK's Royal College of General Practitioners.

Meanwhile, during 2002, Denis led the college in discussions with the Ministry of Health regarding the elevation of Family Medicine to the status of a speciality. The Health Care Professions' Act, that that subsequently was passed through the Maltese Parliament in 2003, ensured such specialist status for Maltese family doctors.

Thus, within 20 years of the preparation, in 1988, of a plan for family medicine in Malta by Denis Soler, Wilfred Galea and Ray Busuttil, all four objectives of such plan were achieved, together with specialist status for family medicine.

For his contributions to the development of family medicine in Malta, Denis was made a fellow of the Royal College of General Practitioners (FRCGP) and was awarded the first honorary fellowship of the Malta College of Family Doctors (FMCFD) on May 10, 2013 (see accompanying photo).

As stated in his obituary, Denis Soler's life was short but lived well.

May the Lord grant him eternal rest.

Dr Mario R SAMMUT
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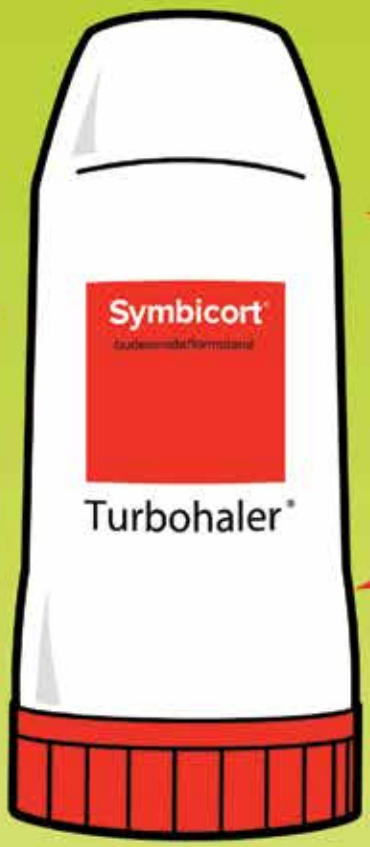
ACKNOWLEDGMENT
This appreciation was first published in the Times of Malta, August 4, 2016.

Reference

Sammut M.R., 2015. Silver service - 25 years of activities by the Malta College of Family Doctors (1990-2015). Journal of the Malta College of Family Doctors, 4(2), pp 6-17.

Symbicort® Turbohaler®

(budesonide/formoterol)



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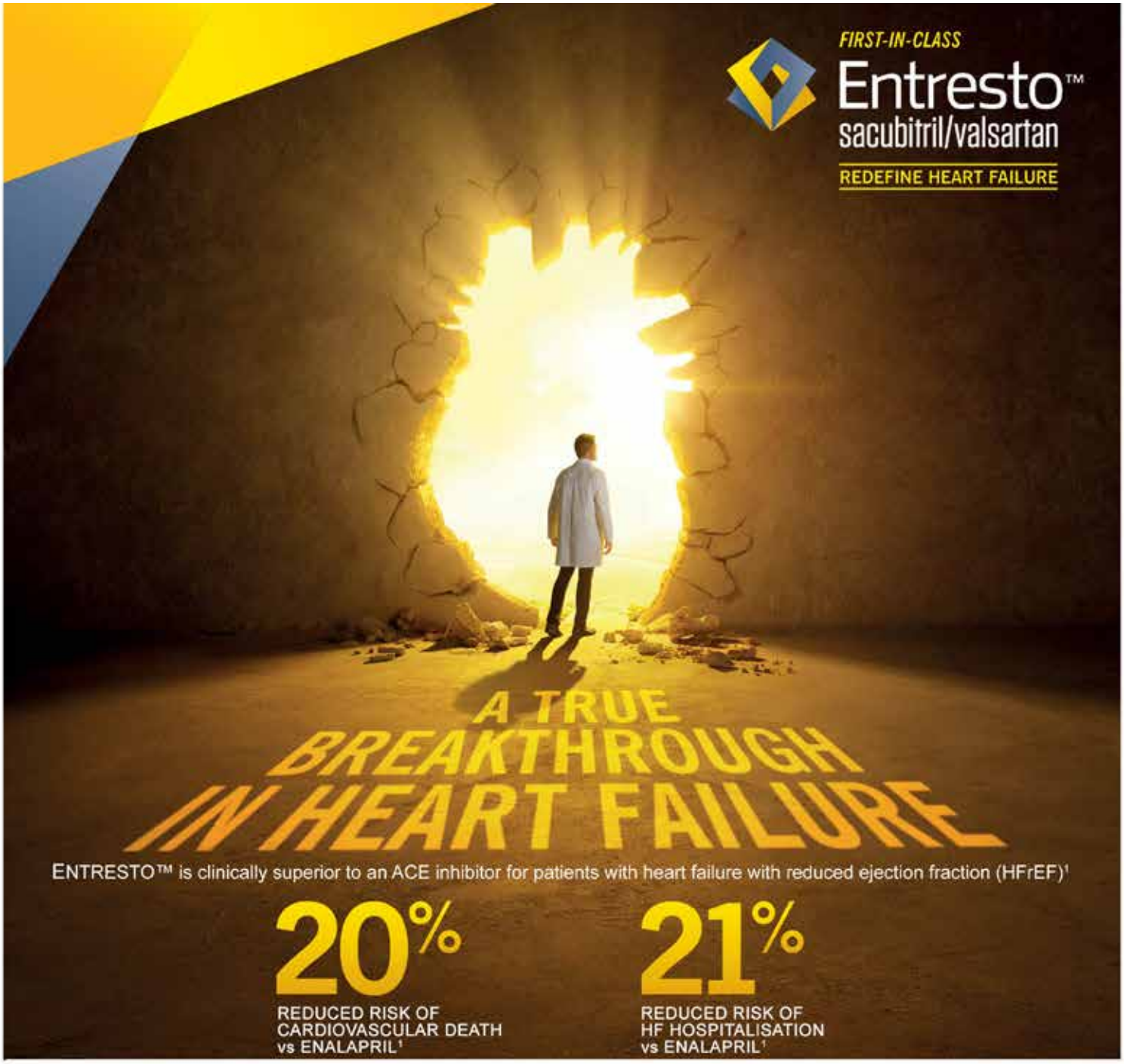
ABRIDGED PRESCRIBING INFORMATION. Refer to Summary of Product Characteristics (SmPC) before prescribing. Symbicort®Turbohaler®100 micrograms/6 micrograms/inhalation, inhalation powder Symbicort®Turbohaler® 200 micrograms/6 micrograms/inhalation, inhalation powder (budesonide/formoterol fumarate dihydrate) Indication Asthma: Treatment of asthma where the use of a combination (inhaled corticosteroid and long acting β2 adrenoceptor agonist) is appropriate. Symbicort Turbohaler 100/6 is not appropriate for patients with severe asthma. COPD *(Symbicort 200/6 only)*: Symptomatic treatment of patients with COPD with FEV1 <70% predicted normal (post-bronchodilator) and an exacerbation history despite regular bronchodilator therapy. Presentation Inhalation powder. *Symbicort Turbohaler 100/6*: Each metered dose contains 100 mcg budesonide/inhalation and 6 mcg formoterol fumarate dihydrate/inhalation. *Symbicort Turbohaler 200/6*: Each metered dose contains 200 mcg budesonide/inhalation and 6 mcg formoterol fumarate dihydrate/inhalation. Refer to the SmPC for information on the method of administration. Dosage and Administration Asthma Not intended for the initial management of asthma. Dose should be individualised. If a patient requires dosages outside recommended regimen, appropriate doses using individual inhalers should be prescribed. When long-term symptoms are controlled, titrate to the lowest effective dose, which could include a once daily dosage. Symbicort **maintenance therapy – regular maintenance treatment with a separate rescue medication**: *Adults (≥18 years, including elderly)*: 1-2 inhalations twice daily (maximum 4 inhalations twice daily). *Adolescents (12-17 years)*: 1-2 inhalations twice daily. *Children 6-11 years (Symbicort 100/6 only)*: 2 inhalations twice daily. *Children under 6 years*: Not recommended. **Symbicort maintenance and reliever therapy – regular maintenance treatment and as needed in response to symptoms**: consider for patients with (i) inadequate asthma control and in frequent need of reliever medication (ii) previous asthma exacerbations requiring medical intervention. *Adults (including elderly)*: 1 inhalation twice daily or as 2 inhalations once daily. 2 inhalations twice daily may be appropriate for some patients (200/6 strength only). Patients should take 1 additional inhalation as needed in response to symptoms. If symptoms persist after a few minutes, an additional inhalation should be taken. Not more than 6 inhalations should be taken on any single occasion. A total daily dose of more than 8 inhalations is not normally needed; however, up to 12 inhalations a day could be used for a limited period. Patients using more than 8 inhalations daily should be strongly recommended to seek medical advice and should be reassessed; their maintenance therapy should be reconsidered. Patients should be advised to always have Symbicort for reliever use. *Children and adolescents under 18 years of age*: not recommended. *COPD (Symbicort 200/6 only): Adults (≥ 18 years)*: 2 inhalations twice daily. Contraindications Hypersensitivity to active substances or excipient. Warnings and Precautions If treatment is ineffective, or exceeds the highest recommended dose therapy should be reassessed. Sudden and progressive deterioration in control requires urgent medical assessment. Treatment should not be stopped abruptly. Patients should have their appropriate rescue medication available at all times i.e. either Symbicort or a separate reliever. If needed before exercise a separate reliever should be used. Therapy should not be initiated during an exacerbation. Serious asthma-related adverse events and exacerbations may occur. If asthma symptoms remain uncontrolled or worsen patients should continue treatment but seek medical advice. If paradoxical bronchospasm occurs Symbicort should be discontinued. It responds to a rapid-acting inhaled bronchodilator and should be treated straightaway. Systemic effects may occur, particularly at high doses prescribed for long periods e.g. Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, cataract, glaucoma and more rarely a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). Height of children should be monitored. Potential effects on bone should be considered especially in patients on high doses for prolonged periods that have co-existing risk factors for osteoporosis. Prolonged treatment with high doses of inhaled corticosteroids, particularly higher than recommended doses, may also result in clinically significant adrenal suppression. Additional systemic corticosteroid cover should be considered during periods of stress e.g. severe infections or elective surgery. Transfer from oral steroid therapy to Symbicort may result in the appearance of allergic or arthritic symptoms which will need treatment. In rare cases, tiredness, headache, nausea and vomiting can occur due to insufficient glucocorticosteroid effect and temporary increase in the dose of oral glucocorticosteroids may be necessary. To minimise risk of oropharyngeal candida infection patients should rinse mouth with water. Observe caution in patients with thyrotoxicosis, phaeochromocytoma, diabetes mellitus, untreated hypokalaemia, or severe cardiovascular disorders. Re-evaluate need for Symbicort in patients with active or quiescent pulmonary tuberculosis, fungal and viral infections in the airways. Hypokalaemia may occur at high doses. Particular caution recommended in unstable or acute severe asthma. Monitor serum potassium levels. In diabetic patients consider additional blood glucose monitoring. The small amounts of milk proteins present may cause allergic reactions. Drug Interactions Concomitant treatment with potent CYP3A4 inhibitors should be avoided. If this is not possible the time interval between administration should be as long as possible. Symbicort maintenance and reliever therapy is not recommended in these patients. Not recommended with beta adrenergic blockers (including eye drops) unless compelling reasons. Concomitant administration with quinidine, disopyramide, procainamide, phenothiazines, antihistamines (terfenadine) and TCAs can prolong the QTc-interval and increase the risk of ventricular arrhythmias. L-Dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with MAOIs, including agents with similar properties such as furazolidone and procarbazine, may precipitate hypertension. Elevated risk of arrhythmias in patients receiving anaesthesia with halogenated hydrocarbons. Hypokalaemia may increase the disposition towards arrhythmias in patients taking digitalis glycosides Fertility, Pregnancy and Lactation No data available on the potential effect on fertility. During pregnancy, use only when the benefits outweigh the potential risks. Budesonide is excreted in breast milk, however at therapeutic doses no effects on the child are anticipated.

Undesirable effects *Common*: headache, palpitations, tremor, Candida infections in the oropharynx, coughing, mild irritation in the throat, hoarseness. *Uncommon*: tachycardia, muscle cramps, nausea, dizziness, bruises, aggression, psychomotor hyperactivity, anxiety, sleep disorders. *Rare*: hypokalaemia, cardiac arrhythmias including atrial fibrillation, supraventricular tachycardia and extrasystoles, bronchospasm and immediate and delayed hypersensitivity reactions including exanthema, urticaria, pruritus, dermatitis, angioedema and anaphylactic reaction. *Very Rare*: depression, behavioural changes (predominantly in children), angina pectoris, prolongation of QTc-interval, hyperglycaemia, taste disturbance, Cushing's syndrome, adrenal suppression, growth retardation, decrease in bone mineral density, cataract, glaucoma and variations in blood pressure. As with other inhalation therapy, paradoxical bronchospasm may occur in very rare cases. Package Quantities Each Symbicort Turbohaler contains 120 inhalations. Legal Status POM. Marketing Authorisation Numbers MA 046/00901-2. Marketing Authorisation Holder (MAH) AstraZeneca AB, Gartunavagen, S-151 85 Sodertalje, Sweden. Further product information available on request from Associated Drug Company Limited, Triq l-Esportaturi, Mriehel, Birkirkara BKR 3000, Malta. Tel: (+356) 2277 9115. Abridged Prescribing Information prepared 12/15. Symbicort and Turbohaler are trademarks of the AstraZeneca group of companies. URN No: 13/0125 Date of Preparation: August 2016

AstraZeneca Respiratory

Reference: 1. Adelphi Respiratory Disease Specific Programme 2009. **2.** Olaf Selroos *et al. Treat Respir Med* 2006; 5 (5): 305-315. **3.** Engel *et al. Br J Clin Pharmacol* 1992; 33(4): 439-44.

Suspected adverse reactions and medication errors should be reported. Report forms can be downloaded from **www.medicinesauthority.gov.mt/adrportal** and send by post or email to: **ADR reporting/Sir Temi Zammit Buildings, Malta Life Sciences Park, San Gwann SGN 3000, Malta.**
Suspected adverse reactions and medication errors should also be reported to Associated Drug Company Limited on +356 2277 8115.



ENTRESTO™ ▼(sacubitril/valsartan)
Presentation: Each film-coated tablet of Entresto 24 mg/26 mg, 49 mg/51 mg and 97 mg/103 mg contains sacubitril and valsartan respectively (as sacubitril valsartan sodium salt complex). **Indications:** In adult patients for treatment of symptomatic chronic heart failure with reduced ejection fraction. **Dosage & administration:** The recommended starting dose of Entresto is one tablet of 49 mg/51 mg twice daily, doubled at 2-4 weeks to the target dose of one tablet of 97 mg/103 mg twice daily, as tolerated by the patient. In patients not currently taking an ACE inhibitor or an ARB, or taking low doses of these medicinal products, a starting dose of 24 mg/26 mg twice daily and slow dose titration (doubling every 3 - 4 weeks) are recommended. A starting dose of 24 mg/26 mg twice daily should be considered for patients with SBP ≥100 to 110 mmHg, moderate or severe renal impairment (use with caution in severe renal impairment) and moderate hepatic impairment. Do not co-administer with an ACE inhibitor or an ARB. Do not start treatment for at least 36 hours after discontinuing ACE inhibitor therapy. Entresto may be administered with or without food. The tablets must be swallowed with a glass of water. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. Concomitant use with ACE inhibitors. Do not administer until 36 hours after discontinuing ACE inhibitor therapy. Known history of angioedema related to previous ACE inhibitor or ARB therapy. Hereditary or idiopathic angioedema. Concomitant use with aliskiren-containing medicinal products in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 m2). Severe hepatic impairment, biliary cirrhosis and cholestasis. Second and third trimester of pregnancy. **Warnings/Precautions:** Dual blockade of the renin angiotensin-aldosterone system (RAAS): Combination with an ACE inhibitor is contraindicated due to the increased risk of angioedema. Entresto must not be initiated until 36 hours after taking the last dose of ACE inhibitor therapy. If treatment with Entresto is stopped, ACE inhibitor therapy must not be initiated until 36 hours after the last dose of Entresto. Combination of Entresto with direct renin inhibitors such as aliskiren is not recommended. Entresto should not be co administered with another ARB containing product. Hypotension: Treatment should not be initiated unless SBP is ≥100 mmHg. Patients with SBP <100 mmHg were not studied. Cases of symptomatic hypotension have been reported in patients treated with Entresto during clinical studies, especially in patients ≥65 years old, patients with renal disease and patients with low SBP (<112 mmHg). Blood pressure should be monitored routinely when initiating or during dose titration with Entresto. If hypotension occurs, temporary down-titration or discontinuation of Entresto is recommended. Impaired or worsening renal function: Limited clinical experience in patients with severe renal impairment (estimated GFR <30 ml/min/1.73m2). There is no experience in patients with end-stage renal disease and use of Entresto is not recommended. Use of Entresto may be associated with decreased renal function, and down-titration should be considered in these patients. Impaired renal function: Patients with mild-moderate renal function are more at risk of developing hypotension while patients with severe renal impairment may be at a greater risk of hypotension. Entresto is not recommended din patients with end-stage renal disease. Hyperkalaemia: Entresto should not be initiated if the serum potassium level is >5.4 mmol/l. Monitoring of serum potassium is recommended, especially in patients who have risk factors such as renal impairment, diabetes mellitus or hypoaldosteronism or who are on a high potassium diet or on mineralocorticoid antagonists. If clinically significant hyperkalaemia occurs, consider adjustment of concomitant medicinal products or temporary down-titration or discontinuation of Entresto. If serum potassium level is >5.4 mmol/l discontinuation should be considered. Angioedema: Angioedema has been reported with Entresto. If angioedema occurs, discontinue Entresto immediately and provide appropriate therapy and monitoring until complete and sustained resolution of signs and symptoms has occurred. Entresto must not be re administered. Patients with a prior history of angioedema were not studied. As they may be at higher risk for angioedema, caution is recommended if Entresto is used in these patients. Black patients have an increased susceptibility to develop angioedema. Patients with renal artery stenosis: Caution is required and monitoring of renal function is recommended. Patients with NYHA functional classification IV: Caution should be exercised due to limited clinical experience in this population. Patients with hepatic impairment: There is limited clinical experience in patients with moderate hepatic impairment (Child Pugh B classification) or with AST/ALT values more than twice the upper limit of the normal range. Caution is therefore recommended in these patients. **B-type natriuretic peptide (BNP):** BNP is not a suitable biomarker of heart failure in patients treated with Entresto because it is a neprilysin substrate. **Interactions:** Contraindicated with ACE inhibitors, 36 hours washout is required. Use with aliskiren contraindicated in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 m2). Should not be co-administered with another ARB. Use with caution when co-administering Entresto with statins or PDE5 inhibitors. No clinically relevant drug-drug interaction was observed when simvastatin and Entresto were co-administered. Monitoring serum potassium is recommended if Entresto is co-administered with potassium-sparing diuretics or substances containing potassium (such as heparin). Monitoring renal function is recommended when initiating or modifying treatment in patients on Entresto who are taking NSAIDs concomitantly. Interactions between Entresto and lithium have not been investigated. Therefore, this combination is not recommended. If the combination proves necessary, careful monitoring of serum lithium levels is recommended. Co-administration of Entresto and furosemide reduced Cmax and AUC of furosemide by 50% and 28%, respectively, with reduced urinary excretion of sodium. Co-administration of nitroglycerin and Entresto was associated with a treatment difference of 5 bpm in heart rate compared to the administration of nitroglycerine alone, no dose adjustment is required. Co administration of Entresto with inhibitors of OATP1B1, OATP1B3, OAT3 (e.g. rifampicin, ciclosporin), OAT1 (e.g. tenofovir, cidofovir) or MRP2 (e.g. ritonavir) may increase the systemic exposure of LBQ657 or valsartan. Appropriate care should be exercised. Co-administration of Entresto with metformin reduced both Cmax and AUC of metformin by 23%. When initiating therapy with Entresto in patients receiving metformin, the clinical status of the patient should be evaluated. **Fertility, pregnancy and lactation:** The use of Entresto is not recommended during the first trimester of pregnancy and is contraindicated during the second and third trimesters of pregnancy. It is not known whether Entresto is excreted in human milk, but components were excreted in the milk of rats. Entresto is not recommended during breastfeeding. A decision should be made whether to abstain from breast feeding or to discontinue Entresto while breast feeding, taking into account the importance of Entresto to the mother. **Undesirable effects:** Very common (≥1/10): Hyperkalaemia, hypotension, renal impairment. Common (≥1/100 to <1/10): Anaemia, hypokalaemia, hypoglycaemia, dizziness, headache, syncope, vertigo, orthostatic hypotension, cough, diarrhoea, nausea, gastritis, renal failure, acute renal failure, fatigue, asthenia. Uncommon (≥1/1,000 to <1/100): Hypersensitivity, postural dizziness, pruritis, rash, angioedema. **Packs sizes:** Entresto 24 mg/26 mg – x28 tablets; Entresto 49 mg/51 mg – x28 tablets; Entresto 97 mg/103 mg - x28 & x56 tablets. **Legal classification:** POM. **Marketing Authorisation Holder:** Novartis Europharm Ltd, Frimley Business Park, Camberley, GU167SR, United Kingdom. **Marketing Authorisation Numbers:** Entresto 24 mg/26 mg film coated tablets EU/1/15/1058/001; Entresto 49 mg/51 mg film coated tablets EU/1/15/1058/002-004; Entresto 97 mg/103 mg film coated tablets EU/1/15/1058/005-007. **Please refer to the Summary of Product Characteristics (SmPC) before prescribing.** Full Prescribing Information is available on request from Novartis Pharma Services Inc., Representative Office Malta, P.O. Box 4, Marsa, MRS 1000, Malta. Tel: +356 21222872. 2016-MT-ENT-16-JUN-2016

NOVARTIS

ACE = angiotensin-converting enzyme

Reference: 1. McMurray JJV, Packer M, Desai AS, et al; for PARADIGM-HF Investigators and Committees. Angiotensin-neprilysin inhibition versus enalapril in heart failure. N Engl J Med. 2014;371(11):993-1004.

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