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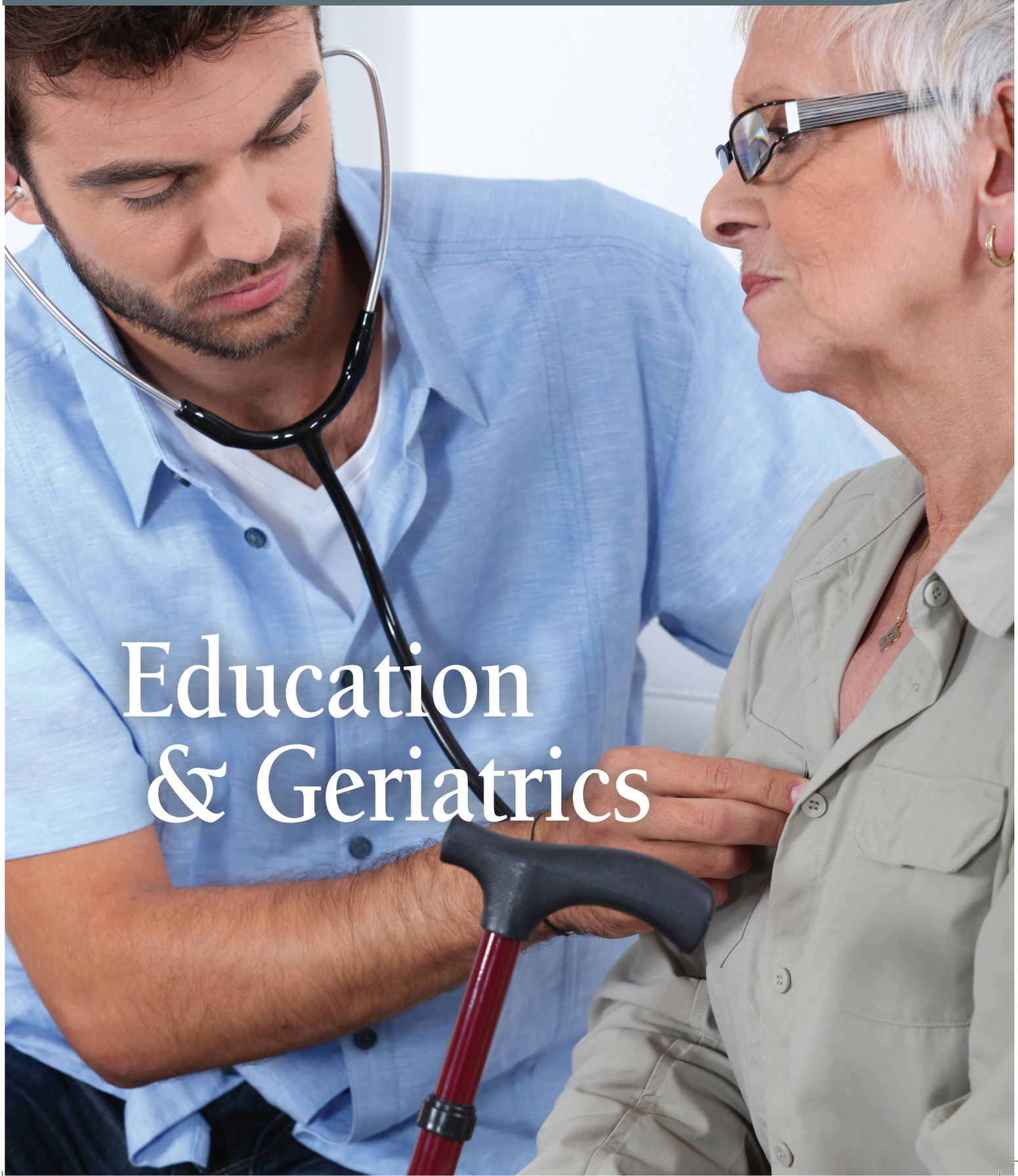

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JMCFD
JOURNAL OF THE **MALTA COLLEGE OF FAMILY DOCTORS**

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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CONTENTS

Guidelines for authors: mcfd.org.mt/resources/documents?did=8

Accreditation by the Royal College of General Practitioners

Prof. Pierre MALLIA

As members are aware the process for obtaining MRCGP(INT) had been started 10 years ago with an AGM vote. Over the past years the focus has been mainly on providing a final summative assessment for the Vocational Training Programme. Passing this programme involved a work-based assessment and an exam of two parts: a practical Clinical Skills Assessment and a written Acquired Knowledge Test. I am pleased to inform members that following this year's examination, in which we had External Development Advisors (EDAs) from the Royal College, the MCFD has been given full accreditation for three years. I immediately wish to thank the main coordinators and examiners: Drs Doreen Cassar, Dominic Agius and Marco Grech for their excellent and untiring work, especially under adverse situations in which a member of the team resigned just weeks before the exam and indeed during a period where the college was not sure whether it would get the question database in time from this person. All went well but this stressed the importance that the MCFD, which is now growing, to have an appropriate space of its own where property can be safely kept. I also would like to thank the Coordinators of the VT programme Drs. Mario Sammut and Gunther Abela, Dr. Tania von Avendonk for her excellent logistic planning, and indeed all those involved in the summative examination (see list below).

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CSA marking
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The MCFD is now the provider for MRCGP(INT) in Malta. Although there is a strong tripartite agreement between the MCFD, RCGP and the Department of Health, we are aware that this tripartite agreement depends on the strong relationship between our college and the RCGP. For this reason we are planning a separate memorandum of understanding which will empower the original one which I had the honour of signing with the then President of the RCGP Dr. Roger Neighbour, in London on 25th April 2006.

The EDA report acknowledges the excellent work done by the College in this year's examination and indeed acknowledges the difficulties we faced throughout this year. It encourages the MCFD to strive for premises of its own and indeed to direct more energy into benchmarking of trainers and continue to enhance our already good curriculum. The few people involved cannot do all the work and we are encouraging, through calls, people to involve themselves so that the process becomes independent of the functioning of Council. Indeed we have set up an education subcommittee chaired by Dr. Doreen Cassar but which has subcommittees which hopefully will be given limited freedom of action as long as decisions are taken in line with College policy. Approval always remains a council function but it would be useless having various tiers with themes being discussed extensively at each level. We should have faith in the doctors working in the first level.

The EDA report also encourages us to go for the MRCGP(INT) for members. Unfortunately the time when our own diploma in family practice (DFP) was to be recognized following a revision of assessment is gone and the RCGP itself has evolved in its extension of MRCGP(INT) to members of international organizations wishing to sit for the MRCGP(INT). We are suggesting recommendations for exemptions which I am sure will be accepted. But the AKT exam would be a requirement. This is not as difficult as one would suppose and there also is a process of privacy. Yet, whilst one appreciates that many may not feel the need, we should have the opportunity, being a Collegiate body striving for excellence in practice, to provide it for those who may wish.

We are very lucky, as quoted from a letter to me by the Medical Director of the MRCGP(INT) programme Dr. John Howard, that the current Chair of the Royal College, Dr. Claire Gerada, "is a passionate supporter for the strengthening of Family Medicine in Malta and the work of the MCFD". I thank Dr. Gerada for her support. I also wish to thank the Minister for Health, the Hon. Dr. Godfrey Farrugia who continues to support the Vocational Training programme and the agreement with the RCGP and, being a family doctor himself, understands very clearly (and dearly) our plight. He has not endeavored to divide health centres from private practice but seeks to help for the two to work in tandem. A heartfelt thanks as well.

The MCFD will continue to strive for excellence in practice. We have begun a programme of honoring past and present members with a fellowship in recognition of work done to promote family practice in Malta, especially through the College. Probity, an interest in life-long learning and showing that one is interested in family medicine beyond one's own practice is important in this regard. We will be offering the fellowship for active members who will show a minimum number of years of commitment to work in the college. This fellowship will then be a stepping stone, for those who wish, to obtain the Fellowship of the RCGP for which we are in continuous discussion.

There is a lot of work and I am confident that even many of the older members would feel that they will earn a better sense of satisfaction knowing that they leave behind a better situation for our patients and practices than they found when they started practice. The unity of purpose to better health systems of our specialty is what distinguishes us in medicine.

MCFD Education secretariat

Dr Doreen CASSAR

The Malta College of Family Doctors (MCFD) has grown from strength to strength thanks to the leadership it has had and moreover through the continued support of its members. What was a pioneering effort to unite and give credence to GPs in Malta and to the introduction of the idea of Family Medicine as a speciality, has given fruit.

Today we can look back and see Family Medicine registered as a speciality with its own register. This is not found in many EU countries despite the fact that all have a training programme for family medicine. The general membership has been the focus of the MCFD for many years. Continuing Professional Development (CPD) was one of the first goals of the College and today this has become an established, planned and well appreciated and attended event the College organises. Ever conscious of the need to provide up to date educational opportunities for its members, the College has a dedicated team that works hard to deliver.

The MCFD has also not only catered for established GPs but also for the training of new doctors into the speciality. Thanks to the efforts of a few, and the support of the general membership, today we have a training programme that is bearing fruit and that is recognised by the Royal College of General Practitioners (RCGP). This has not been an easy task but one which has seen much negotiation, work, commitment and development. We need to now have continuity and evolve further.

The College needs to focus on the educational outcomes of what has been achieved and plan for these to be strengthened along medical educational principles that are prevalent today. This is a task that the Council needs all members to be part of. It is every member's responsibility to be part of this. It is what makes us professionals.

The Education Secretariat wishes to introduce the plan for these developments, and highlight the needs these bring along. It wishes all members to understand these needs and offer their time and expertise so that we truly belong to our College.

The Education Secretary is the cog for educational subcommittees to have a common ethos and for coordination between different educational groups to occur. These groups have to cater for the different members of the College. Today the MCFD can categorise members as per international educational fora: trainees, new Specialists in Family Medicine (up to 5 years post specialisation) and established members.

The College has through the years also been the author and vehicle for Certificate, Diploma and Masters courses in different fields of Family Medicine. Membership has a rich and diverse post-graduate educational base. Some members have also continued their educational development to become trainers in Family Medicine while others also have an educational background in assessment and assessment writing.

EDUCATIONAL SUBCOMMITTEES

CPD for established Members

Dr Philip Sciortino, Dr Tania van Avendonk, Dr Daryl Xuereb and Dr Edward Zammit have been working together to cater for CPD for the last years. This group focuses on planning and organising relevant clinical topics for late evening educational updates and discussion. It bases these on needs assessment of members as well as the current updates of evidence, or local health system developments.

The College plans to evolve these meetings further. All members are welcome to participate either by joining the organising group or by forwarding their needs and ideas.

MRCGP (INT) for Established Members

Presently new graduates of the MCFD are awarded the membership of the MCFD, the MMCFD. This entitles one to apply for the MRCGP (INT). The Council of the MCFD aims to work on developing a similar pathway for gaining the MRCGP (INT) for established members, who through their ongoing active participation, have the MMCFD. The President, Prof Pierre Mallia, the Vice President, Dr Philip Sciortino and council members are working on achieving this.

Curriculum Board

The introduction of speciality training in Family Medicine required the writing of a curriculum. Thanks to Dr Daniel Sammut and Dr Sandra Falzon Camilleri the MCFD has its Curriculum for the training programme in

Family Medicine. A curriculum outlines the requirements of the teaching methods, assessment and identified learning outcomes. As new medical and educational evidence emerges this requires that the curriculum is updated.

The College needs interested members to commit to working in a team lead by Dr Marco Grech, so that the curriculum is updated and revised to meet the current standards in family medicine. The work will be identified and discussed in the group. Members will be entrusted to research individual chapters and identify the areas to be updated. The team is ultimately responsible for the final document update. Liaison with the relevant different educational subcommittees and Specialist Training Programme in Family Medicine (STPFM) coordinators, Dr Gunther Abela and Dr Mario Sammut will be essential.

MCFD Training Courses

The MCFD has striven to train members so that implementation of its vision for specialist achievement could take place. It offered the Diploma in Family Practice which had a large participation and also training and assessment courses so that the Specialist Training Programme could start. These courses need to continue and be revamped.

Council members are involved in this area and their aim is to provide the framework needed so that educational areas are highlighted. Members who are trainers are encouraged to submit their names to help out in the planning, organisation and delivery of such courses.

Applied Knowledge Test (AKT) and Clinical Skills Assessment (CSA) writers

The MCFD has to date carried out training for eligible members to be versed with the principles for AKT item writing and CSA scenario writing. Training is carried out in a group with discussion of various points that members bring up. Teamwork is essential. These groups are lead by the AKT Lead, Dr Marco Grech and CSA Lead, Dr Doreen Cassar, respectively. There is continuing online and face to face support for new members. The mix of new and experienced writers is beneficial for all and the collegial experience has to date been positive.

Psychometrics Group

Psychometrics is an essential part of assessment analysis and feedback. This deals mainly with the statistical aspect of the membership examination. The Psychometrics lead, Dr Dominic Agius, is well experienced in this field and will be training and encouraging new members on joining the group.

Examiner Group Training

The MMCFD examination requires well trained examiners. To date many members have been trained in this role. External review by the RCGP has commented positively on the quality of examiners. Members who attended training found the session practical and asked for more sessions.

May I share with you some of the feedback we had:

- "It was the second experience as an examiner of the CSA session. I felt that the training sessions held before the exam did prepare me with a different, or rather, updated frame of mind and I was much more confident with marking during the session".
- "I do my best to keep Saturdays and Sundays sacred and usually do as little "medicine "as possible. I will next year look forward to spending a Saturday and Sunday, and possible a few more evenings, in doing this kind of "Medicine"."
- "Many thanks for giving me the opportunity to grow in my carrier as a seasoned family doctor. By working with you in this examination experience I became at once a student, an examiner, an examinee and a team player in a rewarding experience that will sustain my eagerness to continue working in the Family Medicine field. Thank you all."

We encourage members to become involved and be part of this experience.

Trainer in Family Medicine - CPD organisation group

Members are accepted as trainers once they have successfully undergone the Trainer in Family Medicine Course. Once they are entrusted with training a trainee they will face various positive experiences and challenges. Teaching adults is rewarding and continues to enable one to grow professionally. However this growth needs to be harnessed to reflect educational theory and research. Trainer CPD is thus a must. It is also a requisite of the employment contract for trainers.

Members in this group who have a special interest in medical education are encouraged to apply. Their role will be to:

a) Organise an annual training event for trainers
b) Organise 2 trainer meeting per year. During these meetings trainers will have the opportunity to share their experiences and challenges, and explore what the evidence is for dealing with these issues.

Trainer Accreditation Board

The MCFD aims at having trainers who are fit for this purpose. It has carried out many trainer courses. To date all trainers have been accepted as trainers. However the next step is to ensure that all trainers are suitable. Trainees and training need to be safeguarded. Eligible members are invited to apply to sit on this board. Their role will be to develop the parameters for trainer accreditation. These parameters have to be based on evidence based criteria.

MCFD Council members and the STPFM Coordinators will form part of this group.

Trainers Appeals Board

Quality assurance of the work place based assessment (WBA) has thrown light on issues that are causing concern on the quality of training. The MCFD needs to have an independent body that can be arbiter for such issues when they occur. A framework needs to be developed that stands up to scrutiny and protects trainee, trainers and the specialist training programme curriculum. Members are invited to apply to develop this group. It is imperative that members have no conflict of interest when joining this group.

MCFD Council members and the STPFM Coordinators will form part of this group.

Logistical support group

The MCFD subcommittees work hard and need logistical support. This group will help out in the outsourcing, event planning and on site organization of various functions and events. Members with a flair for the business aspect will find a rightful place in this group.

Secretarial and Administrative Support Group

The development of all the various groups within the education secretariat will need administrative support from time to time. This is especially so during examination time and event organization. Members are invited to join this group and give a hand that will be much appreciated. Confidentiality will be a requisite to join this group.

Specialist Training Committee in Family Medicine (STCFM)

The STCFM is the forum where the main stakeholders of the STP meet to discuss developments and decisions on the running of the STP. The representatives of the Department of Primary Health Care, MCFD, trainers and trainees meet on this committee chaired by the STPFM Coordinators. The MCFD encourages trainers and trainees to have their elected representatives active on this committee.

Conclusions

I have tried to give a bird's eye view of all that is being planned to give our College the right forum for growth. All this cannot happen if members do not live up to the challenge and get involved in the different areas they deem suits their own aptitude. One needs to remember that we all start with little experience, but being the professionals that we are, this encourages us to strive to deliver and put the knowledge and skills we have to the test. As a team we can achieve much.

The College leadership yearns to see more members participate and is committed to supporting anyone who is willing and can come forward. We promote professionalism and team working. The latter two are foundation stones one cannot ignore. They need to be respected at all times.

As the College Education Secretary I hope that the outline of the framework we have planned entices you and that this call for participation does not fall on deaf ears. I thank all of you for your continued support and truly hope that we all can see our College gain strength, grow and develop.

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INVITED ARTICLE

Geriatrics and gerontology in Malta

Dr Peter FERRY

ABSTRACT

Background

Malta has been in the forefront of both Geriatrics and Gerontology since 1988 with the establishment of the International Institute on Ageing.

Objectives and methods

Definitions of Geriatric medicine and gerontology are described, as well as under/postgraduate training opportunities in geriatrics and gerontology in Malta. Description of the two main associations of Geriatrics and Gerontology and the various geriatric services available in Malta are given, both in the public and private sector.

Conclusion

The way forward is proposed for both geriatric medicine and gerontology.

Key Words

Geriatrics, Malta, aging

INTRODUCTION

Malta has been in the forefront of Geriatric Medicine and Gerontology, both in the creation of the definition of Geriatric Medicine and the establishment of the International Institute of Ageing of the United Nations (INIA).

Definition of Geriatric Medicine: Geriatric Medicine is a specialty of medicine concerned with physical, mental, functional and social conditions in acute, chronic, rehabilitative, preventive, and end of life care in older patients. This group of patients is considered to have a high degree of frailty and active multiple pathologies, requiring a holistic approach. Diseases may present differently in old age, are often very difficult to diagnose, the response to treatment is often delayed and there is frequently a need for social support.

Geriatric Medicine therefore exceeds organ orientated medicine offering additional therapy in a multidisciplinary team setting, the main aim of which is to optimize the functional status of the older person and improve the quality of life and autonomy.

Geriatric Medicine is not specifically age defined but will deal with the typical morbidity found in older patients. Most patients will be over 65 years of age but the problems best dealt with by the specialty of Geriatric Medicine become much more common in the 80+ age group (European Union of Medical Specialists – Geriatric Section, 2008).

Definition of Gerontology: Gerontology is concerned primarily with the changes that occur between maturity and death and with the factors that influence these changes. It addresses the social and economic effects of an aging population and the physiological and psychological aspects of aging to learn about the aging process and possibly minimize disabilities.

In the last 50 years, the Maltese population has mirrored that in Europe and has increased in its longevity. In 2010, 16% of the total Maltese population consisted of persons aged 65 years of age and over (National Statistics Office, 2010). It is in this context that the specialty of Geriatric Medicine has been evolving since its birth in 1989. Since then it has endeavored to overcome the challenge of complex medical, social, psychological and economic conditions of older people. Together with the development of Gerontology, which is very well developed in Malta, it has continued to offer the highest quality of life possible for our older population.

TRAINING IN GERIATRIC MEDICINE

Undergraduate training in the Malta Medical School started in 1989; however specific assessment in the specialty has only been approved from this year (2013). Subjects taught at the undergraduate level include disease presentation, clinical assessment, the geriatric giants, stroke, and care in long stay institutions, rehabilitation and ethics. Medical students are also given small group teaching and bedside tutorials and attend ward rounds and clinics with consultant geriatricians at the Rehabilitation Hospital Karin Grech (RHKG).

Postgraduate training in Geriatric Medicine in Malta was officially set up in 2008 together with most of the other specialties. After completing their foundation programme and obtaining their Basic Specialist Training certificate,

doctors may apply for a Higher Specialist Training post in Geriatric Medicine. This is a 4 year training post which involves a rotation through acute, rehabilitation, chronic, respite and community care. Besides this, trainees have an opportunity to gain experience in psychiatry of the old age, orthogeriatrics, and palliative care and continence services.

TRAINING IN GERONTOLOGY

Training in Gerontology in Malta is the responsibility of the European Centre of Gerontology at the University of Malta. It delivers postgraduate courses at the level of Higher Diploma, Postgraduate Diploma and Masters in Gerontology and also supports students reading for a PhD in Gerontology. Courses are interdisciplinary in terms of the faculty and students.

International Institute of Ageing (INIA) – United Nations

INIA was inaugurated in 1988. It holds a number of training programmes on annual bases such as Social Gerontology, Economic and Financial aspects of Ageing, Health Promotion, Quality of Life and Well-being and demographic aspects of population ageing (INIA, 2001a). INIA also publishes its quarterly international journal, "Bold" which serves to disseminate research in Geriatrics and Gerontology on a global scale with specific reference to developing countries (INIA, 2001b).

MALTESE ASSOCIATIONS OF GERIATRICS AND GERONTOLOGY

The Geriatric Medicine Society of Malta (GMSM)

The GMSM was established in 2005 to improve the health and well-being of older persons and to further develop geriatric medicine and improve standards of care (Geriatric Medicine Society of Malta, 2005). The GMSM is officially recognized by the European Union Geriatric Medicine Society (EUGMS) and the European Union of Medical Specialists (UEMS – GMS) and representatives of the GMSM regularly participate in board meetings of these societies.

Malta Association of Gerontology and Geriatrics (MAGG)

MAGG was set up in 1998 in order to promote educational advancement of gerontologists and geriatricians (Malta Association of Gerontology and Geriatrics, 1998). Its main mission is to consider the holistic consideration of research in ageing, that is the physical, social, economic and psychological. MAGG is also a full member of the International Association of Gerontology and of the European Association of Gerontology.

UNIVERSITY OF THE THIRD AGE

This was set up in 1993 and its role is that of providing knowledge and promoting exchange of knowledge for registered senior citizens. The educational programmes span from health related topics to cultural and social activities.

NATIONAL HEALTH SERVICE CLINICAL GERIATRIC SERVICES IN MALTA

There are eleven consultant geriatricians in Malta. Although most of them practice in all aspects of geriatric medicine, most of them sub-specialize in dementia, falls, movement disorders, incontinence, ophthalmology and tuberculosis.

The service is consultant based with support by 4 Resident Specialists, 3 Higher Specialist trainees, 3 Basic Specialist trainees on rotation with general internal medicine, 8 Foundation doctors and 6 medical officers.

Clinical geriatric services are spread over acute, rehabilitation, complex continuing care and nursing home facilities namely: Mater Dei Hospital (MDH), RHKG, St Vincent De Paule Residence (SVPR), and 3 wards at Mount Carmel Hospital (MCH) and Zammit Clapp hospital nursing home (ZCH), Żejtun residential home, Cospicua Residential home and Mellieħa Nursing home.

Mater Dei Hospital (MDH)

Consultant geriatricians are present on a daily basis at MDH to assess older patients referred by physicians and surgeons and besides giving advice, assess suitability for continuing rehabilitation at RHKG or long term care (LTC). Another role at MDH is the Orthogeriatric service. This service was started in 2011, where older patients who present with a fractured neck of the femur are jointly managed between Orthopaedic specialists and Geriatricians from the day of admission to the day of discharge or transfer to rehabilitation.

Rehabilitation Hospital Karin Grech (RHKG)

There are eight wards specialized in rehabilitation of patients above 60 years of age. Pathologies vary from the whole spectrum of medical pathologies to that of general

and orthopaedic surgery. The majority of inpatient admissions to RHKG are from MDH; however, direct referrals from family doctors are accepted after discussion with the admitting consultant geriatrician.

Daily medical outpatient clinics and day hospital clinics are also run in this hospital. The latter deal with the most complex cases where input by the interdisciplinary team is necessary and patients have primary nursing. Referral to the outpatient and day hospital services by medical practitioners is through a ticket of referral.

St Vincent De Paul Residence (SVPR)

This complex of 1100 beds houses the frailest older people in our society. Besides having dedicated wards for dementia patients and psychogeriatric cases, care is provided by all the interdisciplinary team, including doctors, nurses, physiotherapists, occupational therapists, speech and language pathologists, podiatrists, dentists, chaplains and social workers. There is also an activity day centre which specializes in dementia care and dedicated units for short inpatient respite for patients with or without dementia. Recently a night shelter service has also been added to the services provided. The physiotherapy department offers a direct referral service to medical practitioners who have older patients requiring outpatient physiotherapy services.

Service in other nursing homes

Three long term care nursing home wards in MCH are covered by the services of a medical officer and are also visited regularly by consultant geriatricians. The government residential homes of Żejtun, Cospicua, ZCH and Mellieħa are visited regularly by consultant geriatricians on a consultation basis.

PRIVATE HEALTH SERVICE CLINICAL AND CARE GERIATRIC SERVICES IN MALTA

Acute Geriatric Medicine is practiced in one of the private hospitals in Malta with referrals being done directly with the geriatrician. Outpatient services are also offered in the same hospital and in other private clinics. A private rehabilitation unit which deals with inpatient interdisciplinary rehabilitation of older people was opened in 2012 and has also collaborated in partnership with the national health services during winter pressures. Domiciliary consultations by geriatricians are organised for frail older patients who are immobile.

GOVERNMENT, CHURCH AND PRIVATE RESIDENTIAL AND NURSING HOMES

There are 9 government residential homes, 13 church-run residential homes and 12 private-run residential homes. Admission to these homes is through a formal application which requires the patient's family doctor to fill in the required medical details and level of disability, cognitive status, mobility status, list of medications and other particular details specified by the home in question. For government home applications, the patient is assessed comprehensively by a geriatrician and a social worker and their level of disability classified on a severity and priority scale.

GOVERNMENT COMMUNITY SERVICES

Day centres

There are 20 day centres in Malta. Services in such centres include creative, social, physical, educational activities and dancing lessons. These activities are complemented by educational talks on topics of particular relevance to older adults. Guest speakers are invited to deliver lectures about health issues, home safety, welfare services, etc. In addition, outdoor activities are also organized once a month. Day centres also promote intergenerational activities by inviting students to share experiences with older adults (Ministry for Health, 2013a).

Home care help service

The home care help service offers non nursing, personal help and light domestic work to older adults or persons with special needs. The aim of such service is to allow the recipients of such service to continue living in their community as independently as possible. It also aims to provide respite and support for informal carers. Ultimately, the home care help service helps to avert or delay the demand for long-stay residential care by providing the required support in the client's own home (Ministry for Health, 2013b).

Meals on wheels service

The scope of the Meals on Wheels is to support older persons and others who are still living in their own home but who are unable to prepare a decent meal (Ministry for Health, 2013c).

Handyman service

The Handyman Service offers a range of around seventy repair jobs that vary from electricity repairs to

plumbing, carpentry and transport of items (Ministry for Health, 2013d).

Incontinence service

The aim of the Incontinence Service is to alleviate the psychological problem to which a person may, as a result of incontinence, be subjected. Moreover, through the supply of heavily subsidized diapers, this service helps to decrease the physical and financial strain exerted on those families who have members with incontinence problems (Ministry for Health, 2013e).

Telecare service

The Telecare service enables the subscriber to call for assistance when required. It aims to provide peace of mind to older adults, disabled persons and those with special needs, thus encouraging them to continue living in their own home. Telecare is also a source of reassurance for the subscriber's carers and relatives (Ministry for Health, 2013f).

Commcare unit

The aim of the CommCare team is to work in collaboration with clients and informal carers to promote health and maximise independence in everyday activities. Clients are assessed and referred to services, entities and other professionals as deemed necessarily. All referrals are individually assessed for eligibility and needs. Initial assessments are carried out over the phone and/or through a home visit. Referrals are received from hospitals, entities, general practitioners, and from carers and clients themselves (Ministry for Health, 2013g).

Private community services

There are various private companies which offer personal care, housekeeping, night care, respite services and meals on wheels to older people living at home.

CONCLUSION

Although Malta is at the forefront of both Geriatric Medicine and Gerontology, one must strive for continuing improvement. In terms of Geriatric Medicine, the creation of an Acute Geriatric Unit in MDH is long overdue. This will help to improve the quality of care for frail older people who are acutely ill, reduce the onset and progress of delirium, reduce length of stay and reduced unnecessary institutionalisation. With respect to Gerontology, research has to continue to try to answer the essential questions: how to increase life expectancy and slow down the ageing process and avoid age-related diseases.

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RESEARCH ARTICLE

General practice organisation and healthcare reform: what do Maltese general practitioners think?

Dr Daniel SAMMUT

ABSTRACT

Background

In Malta, two-thirds of primary healthcare is delivered by private general practitioners (GPs), mostly working single-handed without supporting staff. The combined lack of patient registration and transferable medical records lead to fragmentation of care, duplication of resources and suboptimal disease prevention and management. In 2009, the government proposed a reform to encourage partnerships which was shelved.

Aims

To explore the opinions of GPs about how practice organisation might influence them and their patients. To seek GPs' views about possible healthcare reform initiatives.

Methods

A postal cross-sectional survey of all specialists in family medicine resident in Malta. An instrument was designed, piloted and validated. SPSS® (v. 20) was used for analysis.

Results

One hundred and fifty (44%) questionnaires were returned. Respondents were representative of the sample as regards demographic and employment characteristics.

Only 26% of GPs are female, but most work in partnerships or the public service. Seventy-seven per cent of private GPs work single-handed. Group practitioners are more likely to utilise electronic medical records and appointments, and to employ secretaries.

Doctors acknowledge that although patients prefer one GP, partnerships can deliver better patient care. GPs believe that partnerships are beneficial for themselves, and would consider joining one. Females and young doctors favour partnerships.

Respondents, particularly young doctors, favour patient registration and reform. Public doctors who work part-time privately oppose reform.

Conclusions

Most GPs favour group practices and health reform, especially females and young doctors (whose proportions are increasing). Primary care should be urgently reformed and patient registration introduced. Public-private agreements would stimulate partnership formation. Public group practices could cater for means-tested citizens.

KEYWORDS

General practice, physician's practice patterns, delivery of healthcare, healthcare reform

INTRODUCTION

Private GPs cover two-thirds of primary healthcare consultations in Malta (Azzopardi Muscat and Dixon, 1999). The majority of them work completely alone, without the support of ancillary staff or other professionals (Sammut, 2000; Sciortino, 2002).

As there is no official patient registration system yet, patients often shop around for GPs and other specialists (sometimes inappropriately), frequently switching between public and private services. Such behaviour is not usually accompanied by concurrent transfer of patient records so it leads to fragmentation of care, duplication of resources and possible threats to patient safety. At the other extreme, some individuals may not seek healthcare and remain invisible to the system until they get complications.

The lack of continuous and multidisciplinary care in Malta undermines the role of primary healthcare as the provider of a comprehensive service, as central co-ordinator of healthcare and as gatekeeper to the use of

secondary care. Consequent to the inefficiency of primary care, secondary care services are being chronically inundated with health problems (The Times of Malta, 2010) that could have been prevented, minimised or managed entirely within primary care.

Reform of primary healthcare has been promised in electoral manifestos since 1991. In 2009, the Ministry for Social Policy launched a nation-wide consultation on a document entitled 'Strengthening Primary Care Services: implementation of a personal primary health care system in Malta' (Ministry for Social Policy, 2009). The main theme of this proposal was the introduction of patient registration, whereby citizens would register with a GP of their own choice. It also recommended financial incentives to encourage GPs to form group practices. Strong resistance from the medical profession was one of the reasons why this proposal was shelved (Massa, 2012).

In this study, a group practice is defined as two or more GPs working together in close collaboration, sharing work, resources and profits. Married GP couples fit this definition.

OBJECTIVES

- To obtain detailed data about the current organisation of general practice in the Maltese islands.
- To examine how GPs might view practice organisation affecting aspects related to patient care, including continuity of care, accessibility, comprehensiveness, multidisciplinary care, quality of clinical care and patient safety.
- To investigate how GPs might see practice organisation influencing them directly in their professional autonomy, hours of work, home visits, income, job satisfaction, burnout, professional isolation, continued professional development (CPD) and specialist training.
- To test the opinion of Maltese GPs about possible future reforms in local family medicine, namely patient registration, formation of group practices and multidisciplinary teams.

METHODS

A cross-sectional census was undertaken in March 2013 of all Specialists in Family Medicine registered with the Medical Council who were residing in Malta (Medical Council, 2012). Only non-residents were excluded from the sample.

The literature was searched for a pre-validated instrument. Unfortunately, identified questionnaires were country specific and locally inapplicable. Therefore, an original questionnaire was designed.

The core dimensions of primary healthcare identified by Kringos et al. (2010) were used to formulate questions about practice organisation vis-à-vis patient care. These include the process (accessibility, continuity, coordination, comprehensiveness) and outcomes dimensions (quality, efficiency). For questions regarding the effects of practice setup on doctors, themes were obtained from studies of perceptions, motivations and concerns of GPs (Farrugia, 2003; Feron et al., 2003; Kendall et al., 2009; Pederson et al., 2012). Questions regarding healthcare reform were generated from the main themes of the consultation document proposed by the previous government (Ministry for Social Policy, 2009).

The questionnaire consisted of 55 questions/statements. Seven dealt with demographic, employment and practice characteristics. Forty-five statements were flanked by a five-point Likert scale: 14 statements vis-à-vis patient care, 21 relating to doctors and 10 dealing with reform proposals. Two questions inquired about the ideal size of patient lists and partnerships. An open question solicited comments about practice organisation.

A pilot study was held with ten doctors to evaluate the relevance, comprehensibility and practicality of the questionnaire. Their feedback resulted in minor changes being made to the demographic section.

The Cronbach α coefficient was used to confirm the internal consistency of the questionnaire. Data was inputted into SPSS® (v.20). Statements were grouped according to themes. Those that lowered Cronbach α were excluded from analysis. Reliable values over 0.8 were obtained.

Ethical clearance was obtained from the Research Ethics Commitee of the University of Ulster. The questionnaire was mailed once, together with a covering letter to explain the rationale, methods, and ethical considerations. Respondents remained completely anonymous throughout the study.

In the analysis, ordinal five-point Likert-type responses were condensed into nominal variables with 'agree'/'disagree' categories - 'don't know' answers were labelled as user-missing. Pearson's Chi-square Test was used to identify associations between nominal variables. When cells had expected counts less than 5, Fisher's Exact Test was used preferentially because of its greater reliability in small numbers (McCrum-Gardner, 2008). For the main themes, responses to several Likert-type statements were combined into Likert scale variables

whose variance was tested for different subgroups using one-way ANOVA, after confirming normal distribution. Probability values less than 0.05 were considered statistically significant and less than 0.01 as highly significant.

RESULTS

Respondent characteristics, employment and practice setup

One hundred and fifty (44%) GPs returned the questionnaire. Twenty-six per cent were female - a percentage almost identical to the 24% in the parent GP population. The median age group of respondents (50 to 59 years) is very close to the mean age of the sample (49 years). Female GPs are highly significantly younger (p=0.000) (Figure 1).

Respondents work all over the archipelago. Figure 2 shows their employment distribution, and the considerable overlap between categories. Forty-nine per cent of males and 26% of females work privately full-time. This difference is significant (p=0.017). Contrastingly, 26% of males and 45% of females work in the public service (p=0.034). Sixty-five per cent of private GPs work completely single-handed, while 12% have locum arrangements. Twelve per cent work in close partnership with colleagues and 10% are married to other GPs (Figure 3).

Forty-eight per cent of respondents work in their own clinic and 41% work in premises owned by someone else. Thirty per cent work in a public health centre, while 6% work in another governmental department. Three per cent provide home visits only. Sixty-three per cent of full-time private GPs have their own clinic.

In March 2013, 20% (68/339) of all GPs held some form of employment with the public service (personal communication, Sammut, M.R., July 2013). In the present study, 31% (46/150) of respondents were employed by the public service. Although public doctors were slightly over-represented in the response, the percentage is quite close to that in the sample. Therefore, respondents are fairly representative of the sample in terms of employment status.

Forty-six per cent of group practitioners (including married to GPs) are female. This high representation is highly significant (p=0.001) (Figure 4). There is no significant association between age and group practice (p=0.305). Group practitioners are more numerous in the west and outer harbour regions and completely absent in Gozo (p=0.017).

Figure 1: Age distribution of GPs by gender

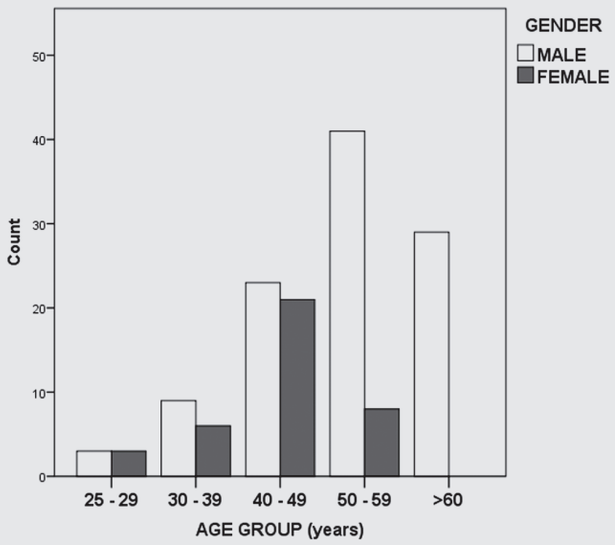


Figure 2: Employment status of GPs

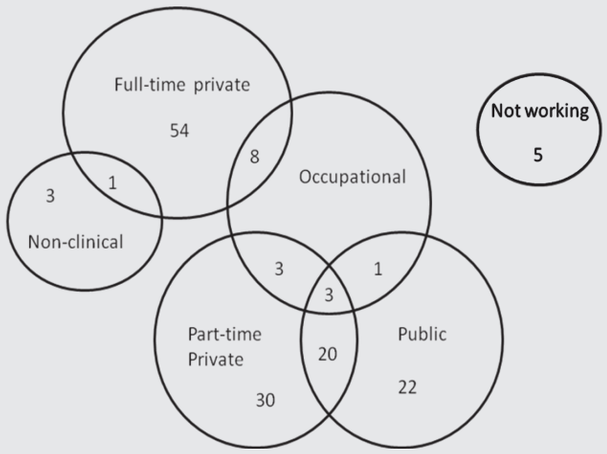


Figure 3: Practice setup of private GPs

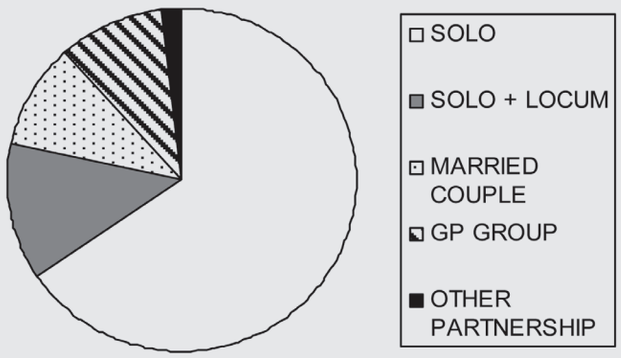
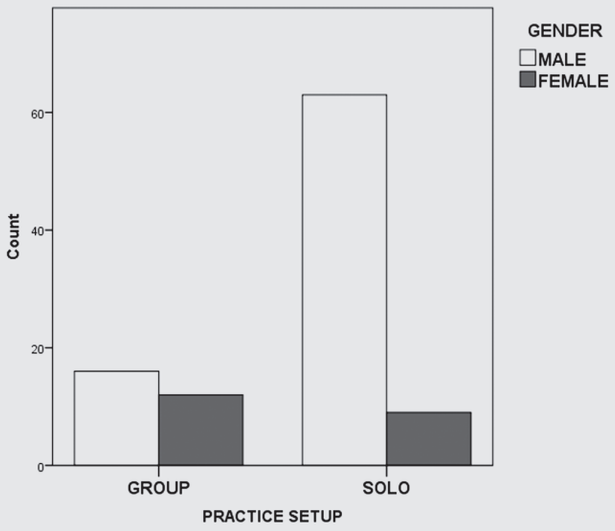


Figure 4: Practice setup of private GPs by gender



Of full-time private GPs, 43% keep electronic medical records, 25% use appointments and 19% use the services of a secretary. Group practitioners are significantly more likely to keep electronic records (p=0.000), use appointments (p=0.015) and employ a secretary (p=0.019). Only one solo GP employs a nurse.

GP Opinions

Table 1 summarises the responses to 45 Likert-type statements, condensed into 'agree'/'disagree'/'don't know' categories. Salient findings are further described below.

Practice Setup vis-à-vis the Patient

Fifty-three per cent of respondents think that solo practice excels in continuity of patient care and personalised care. Categories that show greater agreement are: males (p=0.005); doctors older than sixty (p=0.008); private GPs (p=0.001) and single-handed GPs (p=0.000).

Thirty per cent of GPs agree and 45% disagree that 'solo practice provides better patient care'. Males (p=0.000), doctors older than forty (p=0.003), private GPs (p=0.003) and solo practitioners (p=0.001) tend to agree more. Fifty-five per cent of respondents do not agree that 'solo practice is safer for patients', but males show greater agreement (p=0.011). Agreement with this statement correlates positively with age (p=0.002).

Over 80% of doctors believe that group practice improves accessibility, after-hours and emergency care, and comprehensiveness. Fifty-six per cent believe that coordination of care is better in groups, 69% think that partnerships can excel in multidisciplinary care and 84% believe that 'nurses have an important contribution to give to primary care'. Solo GPs (p=0.044), males (p=0.004) and public doctors who also work part-time privately (p=0.024) think that partnerships would lead to higher fees.

A Likert scale of combined median responses of six statements related to patient care shows that GPs think that group practices deliver better healthcare overall. Sixty-one per cent of respondents think that 'patients prefer solo GPs', with males (p=0.000) and solo GPs (p=0.000) being more likely to agree.

Practice Setup vis-à-vis the GP

Fifty-seven per cent of GPs, especially those older than fifty (p=0.028) and solo practitioners (p=0.000), think that 'solo practice gives more professional autonomy'. Thirty-three per cent agree and 20% disagree that 'solo GPs do more home visits', 47% agree while 19% disagree that 'group practice is more efficient' and 57% disagree that 'solo practice is more flexible'. Females (p=0.028) and GPs younger than fifty (p=0.036) tend to disagree. Sixty-nine per cent of respondents concur that 'group practitioners work less hours'.

Fourteen per cent of respondents agree and 21% disagree that group practitioners earn less income than solo GPs. Seventy-seven per cent concur that 'group practice enables paid leave while solo practice does not', 74% think that 'group practices can better afford renting or buying premises' and 79% believe 'it is easier for group practices to employ staff'.

Thirty-five per cent of respondents agree while 21% disagree that 'group practice gives better job satisfaction'. Doctors younger than forty (p=0.028) and group practitioners (p=0.045) show greater agreement. Seventy-one per cent of GPs, especially those younger than fifty (p=0.01), believe that single-handed GPs are more prone to suffer from emotional burnout. Twenty-nine per cent of GPs feel professionally isolated, with public doctors feeling less so (p=0.045).

Fifty-seven per cent of doctors think that solo practice is lonely. This is particularly true for females (p=0.011), doctors younger than forty (p=0.009) and group practitioners (p=0.016). Seventy-seven per cent believe that 'group practice enables healthy social interaction between partners', 87% think that group practitioners learn from each other, 73% think that 'group practitioners have more time for CPD' and 63% believe that 'group practices provide a better environment for specialist training'.

Twenty-eight per cent of respondents agree and 40% disagree that 'group practice is very hard because of conflict between GPs'. Males (p=0.001) and doctors older than

Table 1: Responses to Likert type statements (n=150)

STATEMENT	AGREE	DISAGREE	DON'T KNOW
Solo practice gives more professional autonomy	86	45	19
Group practice is not suitable for Malta	16	104	30
Patients prefer solo GPs	91	31	28
Group practice improves accessibility for patients	127	10	13
Patients want to see the same GP	126	7	17
Group practice doctors earn less income than solo GPs	21	31	98
Solo practice gives more personal care to patients	81	52	17
Group practice doctors work less hours per week	103	12	35
Continuity of care is better in solo practice	79	53	18
Group practice doctors have more time for CPD	109	9	32
Group practice is very hard because of conflict between GPs	42	60	48
Group practice enables healthy social interaction between GPs	115	9	26
Group practice doctors learn from each other	130	5	15
Solo practice gives better patient care	45	68	37
Group practice can offer a broader range of services	125	8	17
Group practice gives better job satisfaction	53	32	65
Group practice enables paid leave; solo practice does not	115	7	28
Solo practice is more flexible	44	86	20
I feel professionally isolated	44	80	26
Solo practice is lonely	86	50	14
Group practice improves after hours availability	126	9	15
Group practice caters for emergencies better	120	12	18
Solo practice is safer for patients	27	83	40
It is harder for a solo GP to keep up-to-date	65	63	22
It is easier for group practices to employ staff	118	3	29
Group practices can better afford renting/ buying premises	111	7	32
Group practices make family medicine impersonal	32	80	38
Group practice is more efficient	70	28	52
Group practice means higher fees	38	36	76
Solo GPs are more likely to suffer from professional burnout	106	20	24
Group practices provide better GP training environment	94	24	32
Group practices provide better coordinated care	84	25	41
Group practices enable better multidisciplinary care	104	19	27
Solo GPs do more home visits	50	30	70
I would consider working in a group practice	98	26	26
I would never trust a colleague enough to share all my work and income	21	98	31
Group practice is the way forward for the country	80	25	45
Government should encourage group practice formation with financial incentives and loans	115	14	21
Government should not favour any type of practice over another	92	36	22
Nurses give an important contribution to primary care	126	2	22
Any reform in primary care should be introduced gradually	127	8	15
Patient registration is sorely needed in Malta	92	31	27
Government should subsidise the employment of practice nurses by private GPs	95	16	39
Public group practices can be set up in Government Health Centres	78	23	49
Solo practice should remain the backbone of Malta's primary care	35	68	47

forty (p=0.04) show greater agreement, but solo and group practitioners do not differ in opinion. A Likert scale based on the medians of responses to 18 statements shows that GPs think that partnerships are the best setup for doctors. Sixty-five per cent of GPs would consider working in a partnership, except those older than sixty (p=0.017) and public doctors who also work part-time privately (p=0.028) (Figure 5).

Healthcare Reform and Group Practices

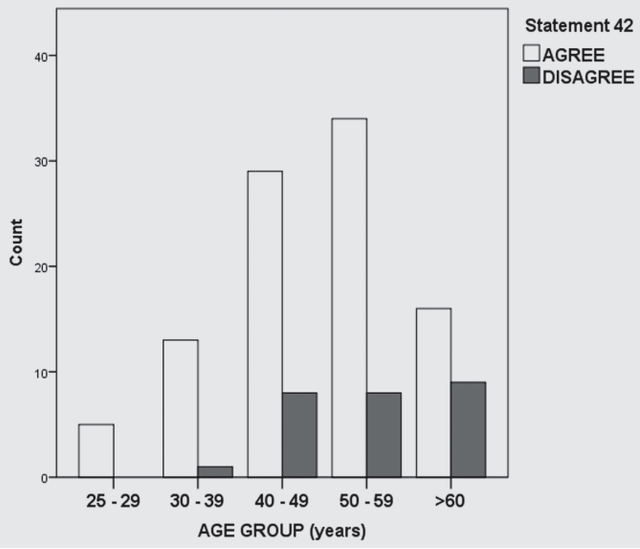
Sixty-one per cent of respondents believe that 'patient registration is sorely needed in Malta', although public doctors who also work part-time privately tend to disagree (p=0.015). On average, GPs think that each doctor should have a maximum list size of 2000.

Forty-five per cent of respondents disagree while 23% agree that 'solo practice should remain the backbone of Malta's primary care'. Males (p=0.034), GPs older than forty (p=0.045), private doctors (p=0.035) and solo GPs (p=0.013) show more agreement. Sixty-nine per cent of GPs, but 92% of females (p=0.003), disagree that 'group practice is unsuitable for Malta'. Fifty-three per cent of GPs think that 'group practice is the way forward for the country'. Public doctors who work part-time privately tend to disagree (p=0.035).

Seventy-seven per cent of GPs think that the state should encourage the formation of group practices with financial incentives. Public doctors who also work part-time privately tend to disagree (p=0.038). Sixty-three per cent of respondents agree that 'the government should subsidise the employment of practice nurses by private GPs' and 52% favour the setting up of public group practices. On average, GPs believe that the best number of partners for a practice would be four.

A Likert scale based on the medians of responses to three statements shows that GPs are in favour of primary healthcare reform in the direction of group practices. This opinion does not vary significantly by age, gender, geographical area of work, employment status or practice organisation. Eighty-five per cent of GPs think that reform should be introduced gradually.

Figure 5: Level of agreement by age group with statement 42: 'I would consider working in a group practice'



DISCUSSION

The vast majority of private GPs work single-handed, most without the aid of professional or secretarial staff. Paradoxically, this survey has revealed that most GPs believe that group practices are superior to solo practice both in the provision of patient care and in permitting doctors a better quality of life. Solo practice was deemed better only in allowing better relationship continuity of care and professional autonomy. A large majority of GPs answered that they would actually consider working in a group practice. Despite these opinions, there are evidently practical factors that impede private GPs from joining partnerships.

When asked whether income is lower in a group practice, 14% of respondents agreed, 21% disagreed and the majority did not know. This response indicates uncertainty about this topic. In a group practice, partners can benefit financially from economies of scale in pooling and sharing of resources. However, international studies have shown that many solo GPs resist joining partnerships because they fear a reduction in income (Josephs, 1982; Feron et al., 2003; Kendall et al., 2009). This fear can materialise particularly in the local situation, where private GPs derive their income solely from fees they charge their patients in a competitive free market, without the assurances of patient registration, fixed fees, or state financial aid.

Another factor that may hinder the formation of group practices is lack of trust in colleagues. All partnerships presuppose a sharing of power and absolute trust between the partners (World Health Organisation, 2009). Lack of trust has been observed locally by a male in his fifties:

'Practice organisation in Malta depends much on the concept of trust and support, which I feel is lacking and is the reason why group practices have not flourished.'

Females and GPs younger than forty are more critical of single-handed practice than their colleagues. Only one-fourth of Maltese GPs are female, but most work in partnerships or the public service. Indeed, international

data shows that females are more likely to work in a salaried post or a partnership (Boerma, Groenewegen and Spreeuwenberg, 2003; Britt et al., 1996; Cooke and Ronalds, 1985; Maheux et al., 1988). These choices may reflect a preference of females for a non-competitive and supportive environment, for fixed hours of work and income, and a need to balance work with family responsibilities. The proportion of local female GPs is small but is increasing progressively, following the global trend of feminisation of the profession (Boerma and van den Brink Muinen, 2000). Indeed, 58% of GPs who graduated in Malta between 2010 and 2013 were female (Sammut, M.R., personal communication, 2013).

This survey did not find any association between age and group practice. This goes against the trend in Europe, where young GPs tend to participate more in partnerships (Feron et al., 2003, Baudier et al., 2010; Grytten et al., 2005; Mayorova et al., 2005; Pederson et al., 2012). The average age of Maltese GPs is 49 years, but is expected to fall due to the considerable influx of young doctors occurring since the introduction of specialist training. In fact, 26 GPs have graduated over the last three years (Sammut, M.R., personal communication, 2013).

The majority of respondents favour primary healthcare reform and patient registration. The advantages were beautifully expressed by a male in his fifties:

'Patient registration... would not only underline the role of the GP as the real gatekeeper to our health system but would discourage doctor shopping, which is rampant... we are sometimes trodden upon roughly by our colleagues the consultants...'

Most respondents think that the future of primary care lies in partnerships, and that the state should invest in private group practices. Public doctors who also work part-time privately tend to oppose patient registration and partnerships, probably because these developments would threaten their income from private work. Contrastingly, GPs younger than forty are more in favour of reform in the direction of group practices, auguring well for the future of partnerships in Malta.

LIMITATIONS

This study was a cross-sectional observational survey. Such a study can identify associations between factors, but can never prove causation, unlike interventional studies.

The survey was mailed because of practical difficulties encountered in obtaining up-to-date e-mail addresses of all GPs. When e-mail reminders were sent on available addresses, many of these proved invalid.

The response was poor at 44%. Non-response bias can invalidate survey data, because non-respondents might have different opinions from respondents (Parker and Dewey, 2000). Still, non-response bias is generally of less concern in physician surveys than in surveys of the general public (Kellerman, 2001). Although most GPs did not return the questionnaire, respondents are fairly representative of the sample in demographic and employment characteristics.

CONCLUSIONS

This study has achieved its aims by accurately describing the current practice setup of Maltese GPs and their opinions about how practice organisation might influence them and their patients. In addition, it has tested their views about primary healthcare reform.

The results clearly show that GPs strongly favour partnerships. They acknowledge that, though patients prefer one doctor, a group practice is able to deliver better healthcare. Most doctors think that partnerships would also benefit professionals. A large majority of GPs favours healthcare reform and patient registration. Furthermore, most believe that the state should stimulate the development of group practices with financial incentives.

RECOMMENDATIONS

- Primary healthcare in Malta should be urgently reformed, adopting an integrated model so as to reduce healthcare inequalities.
- There should be extensive discussion with the associations and the Malta College of Family Doctors (MCFD) throughout all stages of planning and implementation.
- Reform should be implemented in an incremental fashion perhaps over a decade.
- Patient registration should be introduced to reinforce the GP functions of disease prevention, first point of care, management of chronic disease and gatekeeper to secondary care.
- Public-private partnerships should be established, thus utilising the patient-friendliness, management skills, efficiency and cost-containing strengths of the private sector.
- Group practice formation should be encouraged by providing financial aid to private GPs in the form of interest-free loans for acquiring/restructuring premises, and for buying equipment.
- The state should promote multidisciplinary care by subsidising the employment of secretarial and nursing staff by private GPs, who should retain the right to choose their employees.

- Public group practices could be established in government health centres, utilising current premises and staff. These practices would be equivalent to the private service in all respects, except that they would remain free of charge to cater for means-tested citizens.
- Public GPs who do not wish to join a partnership could continue to run a 24hr walk-in emergency service.
- The following measures would help preserve relationship continuity of care:
  - list size not exceeding 2000 patients
  - practices not exceeding four partners
  - use of personal lists and appointments
- Management continuity of care could be ensured through a nation-wide IT system to unite primary and secondary care in both public and private sectors. This would allow monitoring and audit of healthcare processes and outcomes.
- Private practices should receive financial incentives linked to:
  - preventive interventions
  - quality chronic disease management
  - patient satisfaction
  - approved learning/teaching activities.
- The MCFD should organise courses in partnership management, harnessing the expertise of group practitioners.

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RESEARCH ARTICLE

Specialist training in Family Medicine in Malta during 2007-2012

A comparative evaluation of the first and fifth years of the programme

Dr Mario R SAMMUT, Dr Gunther ABELA

ABSTRACT

Background: As a result of Malta's entry to the European Union in 2004, Family Medicine was recognised as a speciality and subsequently a three-year programme of Specialist Training was launched in 2007 by the Primary Health Care Department and the Malta College of Family Doctors. By 2012, three cohorts of GP trainees had completed the training programme.

Objective: Evaluation is important in ensuring quality and success in provision of teaching programmes in general, and family-doctor training in particular. While evaluation and improvement of the programme is performed on an ongoing basis, a comparison of the trainees' evaluations of the first (2007-8) and fifth (2011-2) years of the training programme was carried out in order to identify areas where consolidation or further improvement was needed.

Method: Evaluation forms are completed by trainees after each post in family or hospital practice and after each group-teaching session. The information from these forms is transcribed into MS Excel to enable quantitative and qualitative analysis. The feedback given during the period 2007 – 2008 was compared with that given during 2011 – 2012.

Results: During the first and fifth years of the training programme, GP trainees were 80-90% satisfied with the effectiveness of the training provided during the family practice posts, and over 90% satisfied with the presentation, content and relevance of the teaching provided during the group teaching sessions. Their overall satisfaction with the effectiveness of training in the other specialities improved from 53-92% to 65-95%.

Conclusion: While GP trainees' satisfaction with their training generally remained high or improved, specific areas were identified in family medicine and hospital placements where changes for improvement are merited.

Recommendations: The continuing enhancement of the working environment within family medicine and hospital training is essential to ensure clinical and formal teaching tailored to the needs of the GP trainee. Hospital placements would benefit from the availability of a named clinical supervisor for each trainee in all specialities, the ability to see patients independently and then discussing them with the supervisor, and the provision of daily placements being more GP-relevant and community-oriented.

KEY WORDS

Education, specialization, family practice, program evaluation, Malta

INTRODUCTION

Family Medicine was recognised as a speciality in Malta as a result of the country's entry to the European Union in 2004. A Specialist Training Programme in Family Medicine (STPFM) – Malta was drawn up by the Malta College of Family Doctors in 2006 (Sammut et al., 2006) and subsequently approved by Malta's Specialist Accreditation Committee that same year. After Dr Mario R Sammut was appointed as National Coordinator of the programme in 2005, Specialist Training in Family Medicine was launched in Malta on the 9th July 2007 by the Primary Health Care Department and the Malta College of Family Doctors.

While training takes place under the auspices of the Department within the Ministry for Health, the College ensures the quality of the academic programme and curriculum, of the trainees' training and the continuing professional development of their trainers, and of the summative assessment at the end of specialist training (Sammut et al., 2011). Quality assurance of the work-based assessment is carried out by the Postgraduate Training Coordinators in Family Medicine, Dr Mario R Sammut and Dr Gunther Abela, who were appointed to the post in 2008 and confirmed in 2012. Since the

programme's launch, three cohorts of GP trainees have successfully completed the STPFM: eleven trainees in 2010, another ten in 2011 and, following a limited intake in 2009, five more trainees in 2012 (Sammut and Abela, 2012).

The three-year programme comprises designated training posts, based 50% in family practice (with a GP trainer supervising each trainee) and 50% under the supervision of a specialist in appropriate hospital specialities: Medicine, Paediatrics, Obstetrics & Gynaecology, Accident & Emergency, Dermatology, Ear Nose and Throat, Geriatrics, Palliative Care/Hospice, Ophthalmology and Psychiatry. The GP trainees also participate in a Half-Day Release Course (HDRC) consisting of weekly 4-hour academic group activities (Sammut and Abela, 2012).

Evaluation is important in ensuring quality and success in provision of teaching programmes in general (Morrison, 2003), and family-doctor training in particular (Kelly & Murray, 1991). In order to facilitate the launch of Malta's STPFM, a pre-implementation evaluation of the programme was carried out in 2006 by means of a survey of the potential GP trainers and trainees. The participants considered assessment not only as a strength (through the various methods being used), but also as a barrier (due to the difficulties anticipated in coordinating the assessment methods). Moreover, the assessment of competences was also viewed as an improvement that was needed by the programme. (Sammut, 2009).

Subsequent to the pre-implementation evaluation of the first edition of the training programme, an Educational Portfolio was developed for the trainees to maintain and present for Annual Appraisal as part of their continuous Formative Assessment. At the end of the 3-year programme, a Summative Assessment is held, consisting of a Work-Based Assessment (based on the Annual Appraisal of the Educational Portfolio), an Applied Knowledge Test and a Clinical Skills Assessment. (Sammut et al., 2011; Sammut and Abela, 2012)

The Formative Assessment component of the STPFM undergoes quality assurance by the postgraduate training coordinators through the systematic monitoring of regular feedback received from the trainees and trainers/supervisors after each placement and HDRC session, with any action deemed necessary being taken (Sammut and Abela, 2012). The coordinators also publish a yearly quality assurance report based on their review of the educational portfolios of the GP trainees (as part of the annual appraisal process). Although evaluation and improvement of the programme are performed on an ongoing basis, it was felt that a comparison of the trainees' evaluations of the first (2007-8) and fifth (2011-2) years of the training programme was also warranted in order to identify areas where consolidation or further improvement was needed.

METHOD

All GP trainees participate in the programme's evaluation process, irrespective of whether they are assigned to a GP trainer in government or private practice. After each post in family or hospital practice and after each group-teaching session, trainees are requested to complete evaluation forms. The placement evaluation forms were developed by the Yorkshire

Figure 1: Trainee Satisfaction Ratings for the Half Day Release Course

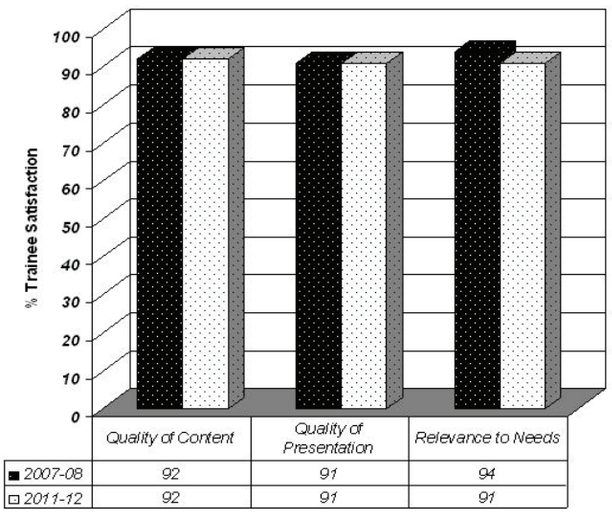


Figure 2: Trainee Satisfaction Ratings for the Family Medicine placement

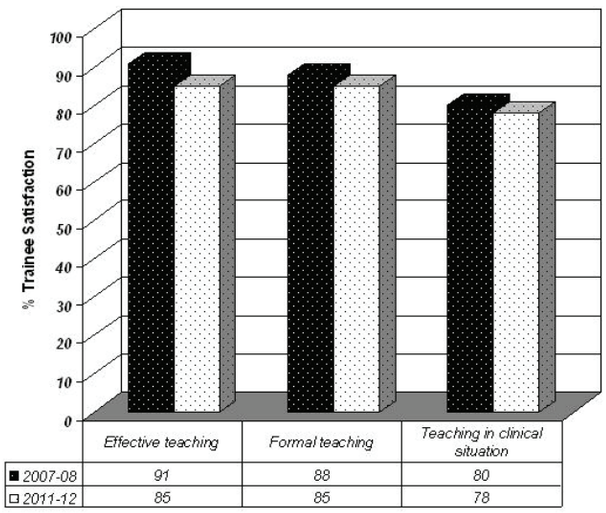


Table 1: Comments representing the GP trainees' feedback on group teaching sessions

CONTENT & RELEVANCE: • Concise, interesting, important topics that are relevant, useful, practical, clinically-based • Good, informative, thorough overview that is clear, understandable, detailed • Up to date, review of latest guidelines with important points / clinical tips given
PRESENTATION: • Good presentation, structured, interactive, time for questions, provokes reflection • Different modalities used: visual aids, group exercises, case discussions, video consultation analysis, experiences and examples from daily practice, Multiple Choice Questions, Clinical Skills Assessments • Different lecturers (friendly, approachable), GP trainee involved, guest intervention, inclusion of real patient

Deanery Department for NHS Postgraduate Medical and Dental Education (2003), while the teaching session evaluation form was devised by Sammut et al. (2007). The information from these forms was transcribed into MS Excel to enable quantitative and qualitative analysis, the latter by item content analysis. The feedback given during the period 2007 – 2008 was compared with that given during 2011 – 2012.

Ethical considerations

No ethical approval was needed since sensitive personal data were not gathered.

RESULTS

One hundred per cent of the GP trainees submitted post-placement evaluation forms, this being a mandatory requirement of the training programme. On the other hand, the response rate for the evaluation forms completed on an optional basis after the group teaching sessions was 87.4% for the 2007-8 group of trainees (initially numbering 11 for the autumn 2007 semester, then rising to 17 in January 2008) and 72.4% for the 2011-2 cohort of 29 trainees.

Quantitative analysis

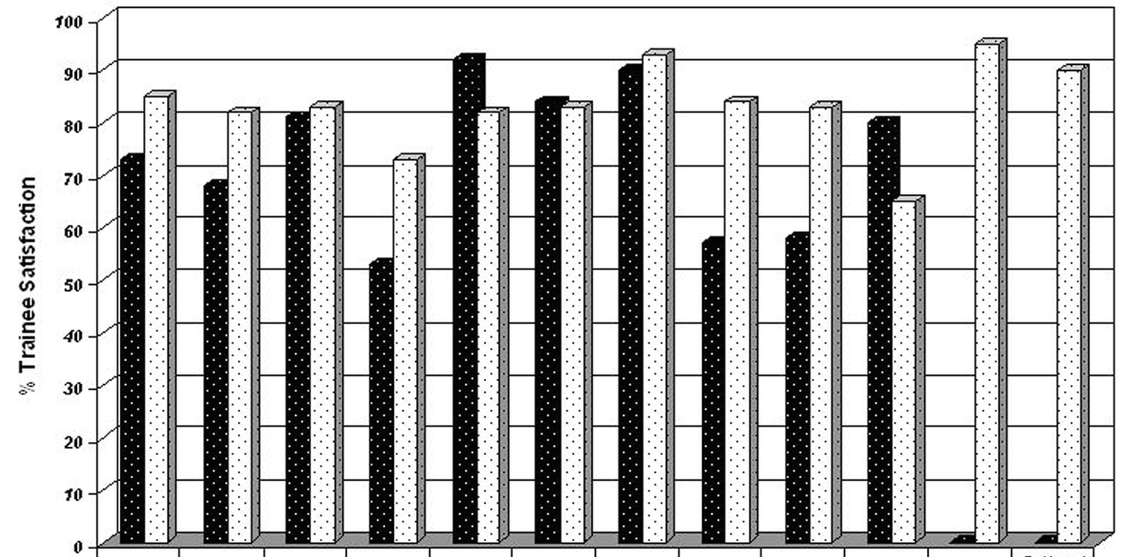
When one compares the ratings for the years 2007-2008 and 2011-2012, GP trainees were over 90% satisfied with the presentation, content and relevance of the teaching provided during the group teaching sessions (Figure 1), and 78-91% satisfied with the teaching provided during the family practice posts (Figure 2).

Their satisfaction with the effectiveness of training in the other specialities improved or was maintained except for Psychiatry and Dermatology where there

Table 2: Quotes representing the GP trainees' feedback on placements in family medicine

POSITIVE COMMENTS: • "This post has prepared me to understand better the role of GP w/in the primary care setting. I have also understood better the difference between the primary care setting and that of secondary care, and know how I must work and adapt to fully serve the patient in this primary care setting." (First year trainee) • "Throughout these 3 years, I have gained so much experience in Family Medicine, in all aspects i.e. communication skills, making a diagnosis, management & holistic approach. Dr (surname) has helped me grow as a person & and as a doctor & I will continue to value his advice & practice throughout my years to come working as a GP." (Final year trainee)
SUGGESTIONS FOR IMPROVEMENT: • "To have as much time as possible when the trainer and trainee are working in the same place and time for the trainee to consult the trainer in real-time about patients." • "We should be allowed to join other community based clinics such as Podology, Physiotherapy, MMDNA etc so as to work better with other specialities and make better use of resources."

Figure 3: Trainee Satisfaction Ratings for Other Speciality Placements



	Medicine	Obs & Gynae	Paed-iatrics	A&E	Derma-tology	ENT	Geriatrics	Ophthal-mology	Palliative Care	Psych-iatry	Hospice	Optional (OOP & Pain Cl)
■ 2007-08	73	68	81	53	92	84	90	57	58	80	0	0
□ 2011-12	85	82	83	73	82	83	93	84	83	65	95	90

was a decline from 80% to 65% and from 92% to 82% respectively (Figure 3). Two specialities (Orthopaedics [OOP] and Pain Clinic) were introduced subsequently, as was a separate evaluation of visits to Hospice Malta; thus comparisons could not be made between 2007-08 and 2011-12 for these three placements.

Figures 4 and 5 show that there was an increase in the lowest percentage satisfaction rating from 53% in 2007-8 to 65% in 2011-2, and that certain specialities were awarded a lower rating by about 10% or more than others during both years. The trainees' overall satisfaction with the effectiveness of training in the other specialities improved from 53-92% to 65-95%.

Qualitative analysis

The GP trainees' written feedback regarding their HDRC group teaching sessions was quite positive and is summarised in Table 1. The trainees found the family medicine placements beneficial to their preparation for a career in general practice (Table 2), but also made suggestions how the practice could be improved as a teaching unit (Tables 2 and 3).

Although the trainees felt that their other speciality assignments did provide them with the necessary confidence to handle community cases related to the relevant specialities (Table 4), they proposed a number of ways how these posts could be improved. Tables 5 and 6 list the top overall difficulties and proposed improvements respectively, with Table 4 showing quotes specific to the Accident & Emergency (A&E), Dermatology and Psychiatry posts.

DISCUSSION

Half-Day Release Course

With satisfaction ratings at just over 90%, the GP trainees were happy with the quality of the content and presentation of the teaching sessions within the Half-Day Release Course, as well as the relevance to their needs (Figure 1). Table 1 shows that they preferred interactive and thought-provoking presentations where diverse speakers made use of various teaching modalities and provided clear updated information about topics relevant to clinical family practice, as recommended by Hutchinson (2003).

Family Medicine Placements

While GP trainee satisfaction ratings for the Family Medicine placement during 2011-2 remained high at 78-85%, one must admit that there was a slight drop (of about 4 percentage points) from the 80-91% satisfaction rates awarded during 2007-8 (Figure 2). The probable reasons for this are found in Tables 2 and 3, where the recurrent suggestion that the GP trainee and trainer are posted to work together in the same venue within the government GP service has not been heeded by the management, despite the obvious educational advantages of this arrangement in facilitating clinical

Table 3: Top results from item content analysis of replies by GP trainees to the question *'Can you suggest any way in which you think the Practice could be improved as a teaching unit?'* regarding family medicine posts

SUGGESTIONS FOR IMPROVEMENT	NUMBER	
	2007-8	2011-2
More clinical teaching despite workload / lack of staff in health centres	6	11
Working in same health centre as trainer	7	7
Being assigned to special / paramedical clinics in health centres	1	4
Teaching in minor surgery in health centres	2	2

teaching (Spencer, 2003) and work-based assessment (Norcini, 2003). However, despite this shortcoming, GP trainees still greatly appreciate the invaluable role of the Family Medicine post in preparing them to practice as future specialists in family medicine within the primary health care system, preferably in close collaboration with community healthcare professionals.

Other Speciality Placements

The majority of the other (mainly hospital) speciality placements were awarded higher satisfaction ratings by the GP trainees during 2011-2 than in 2007-8, with the overall satisfaction of the effectiveness of training improving to 65-95% from 53-92% (Figure 3). There was also an improvement in the lowest percentage satisfaction rating from 53% in 2007-8 to 65% in 2011-2 (Figures 4 and 5). These quantitative results are consistent with favourable comments from the GP trainees regarding how they learnt to handle frequent problems in primary care that are related to the various specialities (Table 4).

However it must be noted that there were a few placements whose satisfaction ratings were approximately 10% less than the other specialities: these were A&E, Ophthalmology and Palliative Care in 2007-8 (Figure 4) and A&E and Psychiatry in 2011-2 (Figure 5). Moreover, there were two hospital placements which experienced a drop of ten percentage points or more (Figure 3): these were Psychiatry (from 80% in 2007-8 to 65% in 2011-2) and Dermatology (from 92% in 2007-8 to 82% in 2011-2).

Figure 4: Trainee Satisfaction Ratings for Other Speciality Placements 2007-2008
(Light columns: rating > ~10% lower than other specialities; broken line: lowest percentage satisfaction rating)

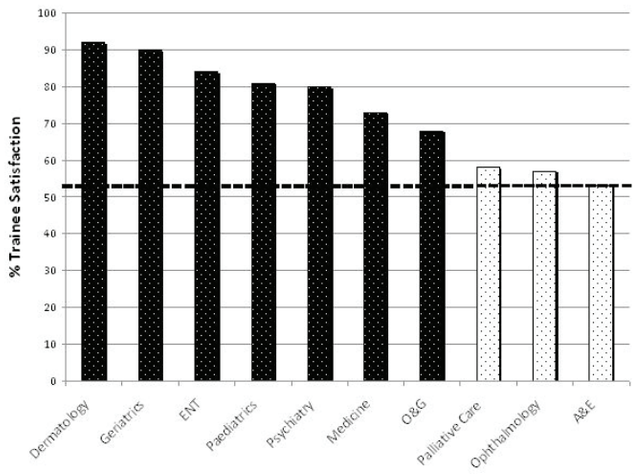


Figure 5: Trainee Satisfaction Ratings for Other Speciality Placements 2011-2012
(Light columns: rating > ~10% lower than other specialities; broken line: lowest percentage satisfaction rating)

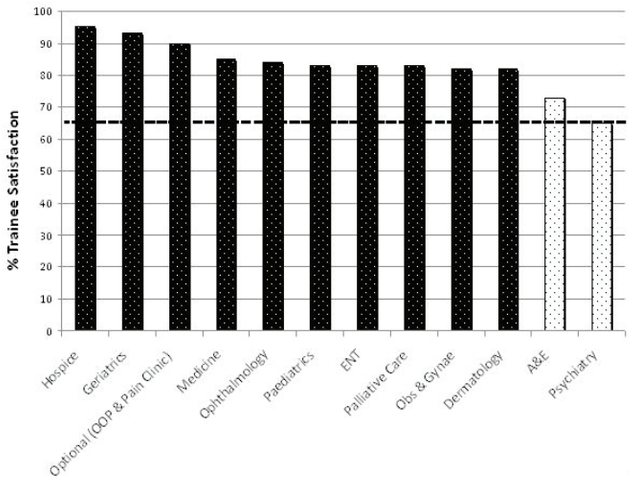


Table 4: Quotes representing the GP trainees' feedback re placements in other specialities

POSITIVE COMMENT: "I learnt a lot about the presentation, investigation and management of the common (name of speciality) pathologies that present in General Practice."
NEGATIVE COMMENT: "Mostly not being able to get a lot of formal teaching due to the intense workload of the department." (Accident & Emergency)
SUGGESTIONS FOR IMPROVEMENT: "Being able to see dermatology patients independently and then discussing each pt with the consultant. Exposure to patients at GU clinic … perhaps if the patient is asked beforehand if it is OK for the GP trainee to sit in." (Dermatology) "Choose to join a particular consultant/s … more available for teaching and tutorials. Being allowed to see patients independently at POP … with supervision. More exposure to mental health services available to GPs out of hospital i.e. community-based psychiatry services." (Psychiatry)

Table 5: Top results from item content analysis of replies by GP trainees to the question *'What major difficulties did you experience in this post?'* regarding other speciality posts

	A&E		MEDICINE		OBS & GYNAE		PAEDIATRICS		DERMATOLOGY		ENT		GERIATRICS		OPHTHALMOLOGY		PALLIATIVE CARE		PSYCHIATRY		TOTAL	
DIFFICULTIES EXPERIENCED	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2
Lack of formal teaching			5	1	4	2					1				2		3			1	15	4
High workload / lack of staff	4	4								1					2		3			1	9	6
Lack of backup at A&E								10													0	10
Problem attending GU Clinic									1	7											1	7
Lack of space/opportunity to see patients alone				1	1			1		2	1									1	2	5
Limited to house-officer ward duties																	3	3			3	3
Full-time duties, in shift	2	3																			2	3
Hostility to general practice	2	2																			2	2
Not enough time with consultant							2	1												1	2	2
Lack of outpatient exposure			3											1							3	1
Lack of curriculum			2						1										1		4	0

Qualitative feedback from GP trainees (Tables 4 and 5) revealed that the main reason why their satisfaction rating with the A&E remained among the lowest was the high workload that the staff had to handle which, as a result, limited to a minimum the time available for clinical teaching that should be the heart of medical education (Spencer, 2003). On the other hand, there still was an appreciable increase in the satisfaction rating from 53% in 2007-8 to 73% in 2011-2 (Figure 3). This may be attributed to the conversion of the A&E post from the original three-month full-time roster to a six-month part-time morning roster in order to address the regular absence of night-time supervision of GP trainees under the previous roster (Sammut et al., 2011).

Although the hospital speciality of Dermatology was given a very good satisfaction rating of 82% in 2011-2, this still meant a decrease of 10 percentage points from the excellent rating obtained in 2007-8. The GP trainees' qualitative feedback revealed two possible reasons for this slight drop (Table 5). One was their inability to see cases alone before discussing their management with the supervising consultant, mainly due to lack of clinic space – this problem in the Dermatology placement has been rectified since then, although it is still encountered in other hospital placements. As clearly stated by Spencer (2003), clinical teaching is limited if the learner remains a passive observer. Secondly GP trainees felt frustrated at being unable to attend the Genitourinary (GU) Clinic (reportedly for reasons of confidentiality) when "on the job clinical teaching is the core of their professional development" (Spencer, 2003).

Another hospital speciality which saw a drop in its satisfaction rating from 80% in 2007-8 to 65% in 2011-2 was that of Psychiatry. The probable reason for this was that GP trainees were assigned to the firm of one consultant who was very busy with administrative duties. The trainees' desire to be allowed to choose their supervisors from consultants who are more available for teaching (Tables 4 and 6) was in fact implemented in January 2013, bringing it in line with other specialities.

Table 6: Top results from item content analysis of replies by GP trainees to the question 'In what ways can the educational value of the post be improved?' regarding other speciality posts

	A&E		MEDICINE		OBS & GYNAE		PAEDIATRICS		DERMATOLOGY		ENT		GERIATRICS		OPHTHALMOLOGY		PALLIATIVE CARE		PSYCHIATRY		TOTAL	
SUGGESTED IMPROVEMENTS	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2	2007-8	2011-2
More formal teaching			6	1	5			5	2		1				1		3		1	1	19	7
More outpatient exposure			3	3	3	2								1			2	6	2	2	10	14
Seeing patients alone / hands-on				2					1	3		2				2				2	1	11
Less operating theatre sessions					9	2															9	2
Exposure to GU Clinic										7											0	7
Named supervisor		4																		1	0	5
Attendance to specific clinics				5																	0	5
Protected teaching time	1	4																			1	4
Curriculum			3						1										1		5	0
Structured timetable											1				1	1				1	2	2
Part-time duties, no shift	3	1																			3	1
More time with consultant							3	1													3	1

Hopefully this change will result in an improved satisfaction rating for Psychiatry in the future.

Limitations of study method and suggestion for further research

While the provision of feedback on the family medicine and hospital placements is mandatory for GP trainees, a bias may have been introduced from non-response by disinterested trainees regarding the HDRC group teaching sessions. The information gathered did not include the gender or whether the trainee was assigned to government or private practice as this was deemed beyond the objectives of the project. Although statistical analysis could have been performed to highlight any significant differences between the 2007-8 and 2011-2 groups, the authors felt that this was not within the scope of the study since the main aim was to identify areas where consolidation or further improvement was needed.

While the study provides an extensive evaluation of the training programme by GP trainees, future research would benefit from obtaining similar feedback from GP trainers and hospital clinical supervisors.

CONCLUSION

While group teaching sessions and placements in family practice were generally deemed very satisfactory, and the overall satisfaction with the hospital placements improved, there were specific areas identified that merited changes for improvement. These were the fact that the GP trainee and trainer were often not placed to work together in the same venue within the government GP service, the lack of teaching due to the heavy workload at the A&E Department, the inability of trainees to see patients alone before discussing them with their supervisors in certain hospital specialities, and the absence of choice of a preferred supervisor within a specific hospital speciality.

RECOMMENDATIONS

While group teaching sessions and placements in family practice were generally deemed satisfactory by the GP trainees, the educational value of the latter would be improved further if the Primary Health Care Department administration endeavoured to arrange for the GP trainer and trainee to work together in the same clinic.

Recommendations for improving hospital training include:

- the availability of a named clinical supervisor for each trainee in all specialities;
- the ability to see patients independently and then discussing them with the supervisor;
- the provision of daily placements that are more GP-relevant and community-oriented; and
- the continuing enhancement of clinical and formal teaching tailored to the needs of the GP trainee.

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A case of Diogenes Syndrome

Dr Peter FERRY

ABSTRACT

Diogenes Syndrome is a syndrome of extreme self-neglect, domestic squalor, excessive hoarding, social withdrawal and refusal of all help and lack of concern regarding one's personal residential situation. A case report of an 83 year old lady with mild dementia and Diogenes Syndrome is described.

KEY WORDS

Diogenes, syndrome, senile, dementia

INTRODUCTION

Diogenes Syndrome (DS), also known as Senile Squalor Syndrome, is a complex spectrum of behaviours found in persons who are living reclusively. It is characterized by an extreme self-neglect of environment, health and hygiene, combined with compulsive hoarding of refuse and the patient's complete denial of his or her surroundings or symptoms (Iqbal et al., 2010).

DS was named after Diogenes the Cynic (412 - 323 BC), the Greek philosopher who was best known for wandering the streets of Athens in the daylight with a lamp in search of an honest man. Diogenes slept in a barrel, was often found begging and engaged in forbidden public habits. DS was first described as a geriatric syndrome in 1966 because of its multifactorial aetiology and association with functional decline. Most patients are single or widowed and live alone, and their decline tends to be lengthy in duration. There is an association with falls, incontinence and increased mortality. These reclusive patients present with some form of physical illness such as cutaneous ulcers or neuropathy or malnutrition. The incidence is 5 per 10,000 in patients 60 years and over. Some patients with DS have a prior psychiatric history; most of them have above average intelligence, work histories, stable family backgrounds and adequate social resources (Reyes-Ortiz, 2001).

Diogenes Syndrome is often identified by chance (e.g. a person collapses, trapped in rubbish, etc.), by having recurrent visits to hospital for self neglect, or through a trigger by public health after complaints from neighbours. One should suspect Diogenes Syndrome in a filthy patient who is unkempt and malodorous with neglected feet and poor dentition. The patient's family may raise issues of hoarding behaviour and self neglect. The differential diagnosis is elder abuse, mental illness, delirium, dementia, poverty or alcohol abuse.

Clinical features of Diogenes Syndrome may include self neglect, lack of self-consciousness about their personal habits, hoarding of rubbish, aloofness, suspiciousness, emotional lability, aggressiveness, distortion of reality and nutritional deficiencies.

Multiple deficiency states have been associated with DS including deficiencies of iron, folate, vitamin B12, vitamin C, calcium and vitamin D, serum proteins and albumin, water and potassium (Clarke, Mankikar and Gray, 1975).

The purpose of this case report is to demonstrate how such a well described syndrome may be neglected by both doctors and social workers unless it is recognized as a clinical entity and diagnosed.

CASE REPORT

A consultant geriatrician was contacted by the nephew of an 83 year old spinster to visit her at home as he noted that she was becoming a bit forgetful, may not have been taking her chronic medication and has had a couple of falls recently. She is an independent lady who lives in a large house in the village core, surrounded by neighbours.

Before the geriatrician stepped into the house, the nephew warned him that her house, which was actually a mansion, was "in a bit of a mess" as she would not accept anyone to help keep it clean and that she has "a habit of collecting all sorts of rubbish". As soon as he entered the house, the stench of rotting garbage hit him, and it was unbelievable that this poor lady could live in such unhygienic conditions. There was household waste all over the place, including on the floor, on furniture and in every room including the kitchen (see Photo 1), bedroom and living room (see Photo 2). The garden was overgrown and also contained mounds of rubbish.

The lady was lacking insight about her social situation. When confronted with the problem, she could not understand what the fuss was about, saying she "collected stuff which she would find handy in time of need."

During the visit, the lady sustained a near fall on an empty plastic bottle which was lying on the floor. It became obvious that this lady's condition was a medical health

emergency, although this would not have been so obvious had she been seen in a clinic or hospital situation.

Her nephew stated that the Public Health Department was already informed about the case as the patient's next door neighbours had complained about the smells and pests coming from this lady's house. When she was confronted as to whether she was experiencing any problems with the neighbours, she expressed surprise as to why recently her neighbours were slightly aloof as she did not feel that she had offended anyone!

A quick elective admission to the Rehabilitation Hospital Karin Grech (RHKG) with the patient's consent was organized, the purpose of which was to perform a comprehensive geriatric assessment on her and also to give enough time for her nephew to clean her house and make it habitable once again. Her nephew recounted that this was not the first time that he had to clean the house and that a few years previously he had spent 4000 Euros in skip hire to get rid of all the rubbish she had accumulated.

The lady was admitted to RHKG a couple of days later as the nephew preferred to postpone admission after a family occasion. In the meantime, the patient scalded her foot with hot water and this resulted in a grade 2 burn on the dorsal aspect of her left foot.

Her burn was attended to with local therapy and systemic antibiotics for associated cellulitis. Her cognition was assessed and, as this showed mild cognitive impairment with a Mini Mental State Examination (MMSE) of 21/30, she was started on Donepezil 20mg daily. She was also assessed by a psychogeriatrician, who confirmed the diagnosis of Diogenes Syndrome and confirmed that her Donepezil and Paroxetine 20mg daily should be continued. A blood workup was done including a haematinic screen and vitamin C and D levels. As the latter were found to be deficient, she was started on Vitamin C and D supplements as well as on calcium.

On the ward, her foot wound infection and burn recovered; however she continued to manifest compulsive hoarding behaviour by collecting objects of no value from the ward environment and storing them in her bedside locker.

Discussions with the patient and her nephew resulted in a decision to re-home her in a smaller house, also belonging to her, in the hope that once she returns home it would be more manageable in the future to have it re-cleaned rather than her original mansion. The discharging interdisciplinary team recommended regular visits by community nurses, the psychiatric outreach team and community liaison nurses to try to prevent the situation recurring quickly. The Telecare system was also installed in her house.

DISCUSSION

Diogenes Syndrome is often characterized by a tendency to hoard excessively. This syndrome may be due to a reaction to stress in older people with certain personality characteristics or as the end stage of a personality disorder. However in the case described above the patient manifested dementia, which may also have triggered the disorder.

Studies on Diogenes Syndrome describe the following common clinical features: poor personal hygiene, hoarding of litter, very poor surroundings with filth in or around the house, resistance to offers of help, social withdrawal and a shameless attitude (Reyes-Ortiz, 2001).

The patient described in this case report satisfies all the clinical features described above. She also had an associated dementia. It must be noted that half to two-thirds of patients with Diogenes Syndrome have an underlying psychiatric disease, mostly dementia (Wrigley and Cooney, 1992).

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Although it may be argued that this lady's problem with compulsive hoarding has not been reversed and that she may be at risk at home, it was agreed by both the geriatric and psychogeriatric teams that she carried enough mental capacity to return home, once she accepted regular community care visits. She definitely did not want to be admitted to a 24 hour residential institution and thus her autonomy had to be respected.

References

Clark, A.N., Mankikar, G.D. and Gray, I., 1975. Diogenes syndrome: a clinical study of gross neglect in old age. *Lancet*; 1: 366-368.

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NOTICE

Joint call for applications

In its quest to ***balance the ever growing educational needs with the sustainability of active human resources****, and* ***to increasingly involve the membership in active participation****, the Council of the Malta College of Family Doctors is currently seeking to gauge the interest of the College's members to participate in a number of subcommittees which are planned to be set up to oversee the various educational needs of our Specialty.*

For these reasons, the Council has decided to open applications as follows:

1. From ***trainers*** for the following sub-committees:
   - Trainer CPD
   - Curriculum Review Board
   - Specialist Training Programme Committee
   - Trainers Accreditation Board
   - Trainer Appeals Board
   - AKT Group
   - CSA Group
   - Psychometric Group
   - Examiner Training
   - CME for members
   - Logistical support group
   - Secretarial and Administrative Support Group

2. From ***trainees*** for the following sub-committees:
   - Curriculum Review Board
   - Specialist Training Programme Committee

3. From ***graduates of the MMCFD/MRCGP[Int] programme*** for the following sub-committees:
   - Curriculum Review Board
   - AKT Group
   - CSA Group
   - Psychometric Group
   - Trainers Accreditation Board
   - Trainers Appeals Board
   - Examiners Training
   - CME for members
   - Logistical support group
   - Secretarial and Administrative Support Group

4. From the ***general membership*** for the following sub-committees:
   - AKT Group
   - CSA Group
   - Psychometric Group
   - Examiner Training
   - CME for members
   - Logistical support group
   - Secretarial and Administrative Support Group

Applications should include a clear indication of the area/s of interest. Applicants will need to satisfy the following criteria:

- Possess good team working skills,
- Be professional and meticulous in their work,
- Have a sound IT knowledge,
- Be able to attend to any necessary meetings,
- Be able to work against deadlines,
- Have academia at heart,
- Be fully paid up members of the Malta College of Family Doctors

The Council reserves the right to conduct interviews. The choice of applicants by the Council is final. Applications, accompanied by a Curriculum Vitae, should be sent by **Friday 27th December 2013** to:

The Honorary Secretary of the MCFD Council
Malta Federation of Professional Bodies
127, Sliema Road, Gzira GZR 1633

Prof. P. Mallia President MCFD
Dr. J. Bonnici Honorary Secretary MCFD

MALTA COLLEGE OF FAMILY DOCTORS
127, Professional Centre, Sliema Road, Gzira, GZR 1633 MALTA (Europe) | Email: contact@mcfd.org.mt
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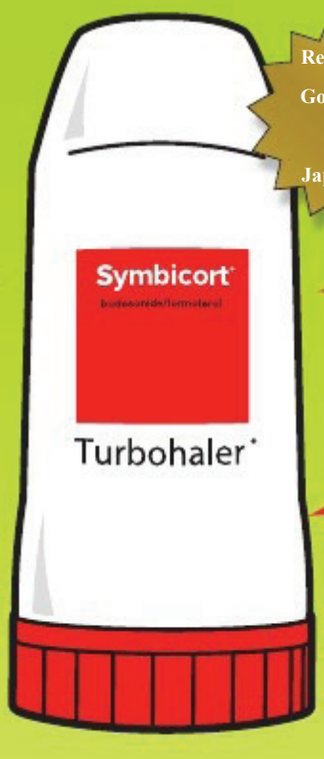

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Symbicort 100/6 is not appropriate for patients with severe asthma. **COPD *(Symbicort 200/6; 400/12):*** Symptomatic treatment of patients with severe COPD (FEV1 <50% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular therapy with long-acting bronchodilators. **Dosage and Administration: Asthma (Symbicort maintenance therapy – regular maintenance treatment with a separate rescue medication):** ***Adults (including elderly)*** **100/6 and 200/6:** 1-2 inhalations twice daily. Some patients may require up to a maximum of 4 inhalations twice daily; **400/12**: 1 inhalation twice daily. Some patients may require up to a maximum of 2 inhalations twice daily ***Adolescents (12-17 years)*** **100/6 and 200/6:** 1-2 inhalations twice daily; **400/12:** 1 inhalation twice daily. ***Children 6 years and older*** **100/6 only:** 2 inhalations twice daily. ***Symbicort is not recommended for children under 6 years. Symbicort 400/12 is not recommended for children under 12 years.*** Not intended for the initial management of asthma. Dose should be individualised. If an individual patient requires dosages outside recommended regimen, appropriate doses of β_2 adrenoceptor agonist and/or corticosteroid should be prescribed. When long-term symptoms are controlled, titrate to the lowest effective dose, which could include a once daily dosage. **Asthma (Symbicort maintenance and reliever therapy – regular maintenance treatment and as needed in response to symptoms)** ***for Symbicort 100/6 and 200/6 only (NOT recommended with 400/12 strength);*** especially consider for (i) patients with inadequate asthma control and in frequent need of reliever medication (ii) patients with asthma exacerbations in the past requiring medical intervention. Close monitoring for dose-related adverse effects is needed in patients who frequently take high numbers of Symbicort as-needed inhalations. ***Adults (including elderly)*** **100/6 & 200/6:** 1 inhalation twice daily or as 2 inhalations once daily. For some patients a dose of 2 inhalations twice daily may be appropriate (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 (200/6*):*** ***Adults:*** 2 inhalations twice daily. **(400/12*):*** 1 inhalation twice daily. **Contraindications, Warnings and Precautions etc.:** ***Contraindications:*** Hypersensitivity (allergy) to budesonide, formoterol or lactose (which contains small amounts of milk proteins). ***Warnings and Precautions:*** If treatment is ineffective, or there is a worsening of the underlying condition, therapy should be reassessed. Sudden and progressive deterioration in control requires urgent medical assessment. Patients should have their appropriate rescue medication available at all times, i.e. either Symbicort or a separate reliever. If needed for prophylactic use (e.g. 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 and patients should continue treatment but seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation of Symbicort. Paradoxical bronchospasm may occur, with an immediate increase in wheezing and shortness of breath after dosing. This responds to a rapid-acting inhaled bronchodilator and should be treated straightaway. As with any inhaled corticosteroid, systemic effects may occur, particularly at high doses prescribed for long periods. These may include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, cataract and glaucoma and more rarely a range of psychological or behavioral effects. 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. Therefore additional systemic corticosteroid cover should be considered during periods of stress such as severe infections or elective surgery. Treatment with supplementary systemic steroids or inhaled budesonide should not be stopped abruptly. During transfer from oral steroid therapy to Symbicort, a generally lower systemic steroid action will be experienced which may result in the appearance of allergic or arthritic symptoms which will need treatment. In rare cases, symptoms such as tiredness, headache, nausea and vomiting can occur due to insufficient glucocorticosteroid effect and temporary increase in the dose of oral glucocorticosteroids is sometimes necessary. Observe caution in patients with thyrotoxicosis, phaeochromocytoma, diabetes mellitus, untreated hypokalaemia, or severe cardiovascular disorders. As with other β_2 adrenoceptor agonists, hypokalaemia may occur at high doses. Particular caution recommended in unstable or acute severe asthma as this effect may be potentiated by xanthine-derivatives, steroids, diuretics and hypoxia. Monitor serum potassium levels. Hypokalaemia may increase the disposition towards arrhythmias in patients taking digitalis glycosides. In diabetic patients, consider additional blood glucose monitoring. Symbicort contains lactose monohydrate, as with other lactose containing products the small amounts of milk proteins present may cause allergic reactions. ***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 patients using potent CYP3A4 inhibitors. Not to be given with beta adrenergic blockers (including eye drops) unless there are compelling reasons. Concomitant administration with quinidine, disopyramide, procainamide, phenothiazines, antihistamines (terfenadine), MAOIs 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. Risk of arrhythmias in patients receiving anaesthesia with halogenated hydrocarbons. Concomitant use of other beta adrenergic drugs or anticholinergic drugs can have a potentially additive bronchodilating effect. **Pregnancy and Lactation:** Should only be used 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, 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:*** psychiatric disorders including 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 and glaucoma and variations in blood pressure. As with other inhalation therapy, paradoxical bronchospasm may occur in very rare cases. **Package Quantities:** Each Symbicort Turbohaler 100/6 or 200/6 contains 120 inhalations. Each Symbicort Turbohaler 400/12 contains 60 inhalations. **Legal Category:** Prescription Only Medicine (POM). **Marketing Authorisation Number(s):** MA046/00901-3. **Marketing Authorisation Holder (MAH):** AstraZeneca AB, Gartunavagen, S-151 85 Sodertalje, Sweden. **Further product information available on request from:** Associated Drug Co. Ltd., Triq L-Esportaturi, Mriehel, Birkirkara, BKR 3000, Malta. Telephone: (+356) 22778000. Fax (+356) 22778120. **Abridged Prescribing Information prepared:** 04/12. Symbicort and Turbohaler are Trade Marks of the AstraZeneca group of companies.URN: 12/0447 **Date of Preparation:** October 2012.

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

*JIDPO (Japan Industrial Design Promotion Organisation) Good Design Award Japan 2010: http://www.g-mark.org/award/detail.html?id=36687&sheet=outline&lang=en

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