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Journal of the Malta College of Family Doctors

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

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The need for policy and social involvement

Prof. Pierre MALLIA

Whilst president of the College I was often contacted by the media asking whether the MCFD had a policy on an issue. This happened on embryo freezing, the question of sea water near fish farms, and others. Of course some issues may be divisive and a college policy is not something on which a simple majority has to agree. They must be written in neutral and non-political form but having firm statements and proposals. The American Medical Association have a Policy Compendium, which starts from simple things like the use of seat belts, to other more controversial issues. The Royal Colleges issue regular statements both as guidelines for physicians and to express policy. For example, the Royal College of Physicians until recently held a policy against euthanasia.

I have often been an advocate for having a policy compendium. Unfortunately, the college has a lot of work to contend with often with not a full complement on council. The Summative Assessment is one such big activity. Yet people interested can be involved and given credit. The more written guidelines the college has other than simply a statute, the more one shows the integrity and stewardship of family doctors as a group. The fact that media call the President of the MCFD shows that the name is out there and that people are interested in what we have to say. I was frequently in a position to explain that the college does not yet have a compendium of policies and is concerned mostly with continuing professional development. However, I always presented to council the ill-feeling this induced in me. I also had a sense of disappointment on the opposite end of the phone. How was it that doctors do not have anything to say about contaminated waters near fish farms? This was a question that reporters emanate.

Indeed, such policies will need someone to do the background research. Family doctors have a social say and this gives us importance and advances family medicine as a speciality. Of course, one must simply state facts and policies without entering into political debate; although sometimes this is unavoidable. Conversely having a policy, say, on pollution caused by traffic congestion is naïve and probably this should not be a policy anyway. But acknowledging that it is a problem and giving suggestions on how things can be improved will certainly have beneficial effects. How long will governments ignore such a college before it realises the impact that it has? With this impact comes also pride of doctors forming part of the college and indeed better participation in membership.

So at the moment we have the issue of traffic congestion which triggers many ideas which can be evaluated. Amongst these are:

1. Decentralisation of government departments to local councils and local social services. Why should I have to go to a central department to hand in a form for social benefits? (Recently a patient of mine complained that he was asked to go in personally to hand in the form for renewal of a licence. The same holds for boat licences, etc.)
2. More use of internet for government applications, forms etc., avoiding people having to drive to departments.
3. Education:
   - Questioning whether schools really have to make parents' days on one particular day rather then spread them over a few months.

Indeed, one can even question the time of day and the necessity of some school meetings. (We attended the parents' day at sixth form and all parents and teachers were agreeing that this was not necessary).

- Scout and other social movements should be questioned and required to organise buses and meeting points for activities rather than have parents drive their children to camp sites and to the Gozo ferry. After all they should be the ones to set an example. Although many scout groups do this, others do not (and here I speak from experience with my children).

4. Questioning whether introducing a work-from-home day per week can improve work morale and reduce traffic.
5. Questioning whether it will be beneficial to limit large vehicles and deliveries to specific times of the day outside traffic hours.
6. Encouraging pooling of people going to work.
7. Obliging school transport to avoid parents taking children to school.

There are many other possible proposals. The college is in a position to collect proposals, form a small team to evaluate and issue a report.
Some areas in which the college ought to have a policy one are:

1. Substance abuse
2. Exercise
3. Sun block
4. Safe driving
5. Traffic
6. Pollution
7. End of life issues
8. Beginning of life issues
9. Women's health and rights
10. Men's health
11. Child rights
12. Vaccination
13. Disability
14. Community care
15. Home for elderly
16. Health promotion
17. Prevention of illness (e.g. suggestions on avoiding spread of influenza)
18. Illness and social services
19. CME/CPD and revalidation (so that when the time comes one is ready)
20. Current topics which affect health or medicine

Literature reviews and policies of the medical profession of other countries can be compared. But it is all well and good to speak out when one is not on council. On can easily ask, 'why did you not do it when you were president?' The present council can easily answer that – the amount of work involved. Once I have been relieved of the duties of council, I am taking the initiative to receive suggestions from college members which can be reproduced on this journal. If suggestions come forward to form a policy group which can present their suggestions to the AGM, this will be presented to council. Those interested please contact me on pierre.mallia@um.edu.mt.

Professor Pierre MALLIA
MD PhD CBiol MPhil MA(Law) DipICGP MMCFD FRCP(London) FRCGP(UK)
Editor, JMCFD
Former President, MCFD
Email: pierre.mallia@um.edu.mt

The Vasco da Gama Movement-reflections and experiences of an exchange programme

Dr Sacha BUTTIGIEG, Dr Stephanie SCERRI and Dr Yanica VELLA

INTRODUCTION

The Vasco da Gama Movement (VdGM) defines itself as the Network for Young and Future Family Doctors of the European Regional Branch of the World Organisation of Family Doctors (WONCA Europe). The early beginnings of this movement date back to 2002 during preparations for the Junior Doctor Programme initiated by Dr Alphonse Sips, a dedicated Dutch family doctor, as part of the 2003 WONCA Europe Amsterdam Conference. Together with a group of enthusiastic trainees from the Netherlands and support from the European Academy of Teachers in General Practice/Family Medicine (EURACT), Dr Sips went on to develop the first pre-conference meeting for six international groups, each involving trainees and EURACT teachers to serve as guides. This laid the foundations for the development of the VdGM (Vasco Da Gama Movement, 2012; Sloane, 2016)).

The ideals of the movement were set out in 2005 during a meeting that took place in Lisbon, the home of Vasco da Gama, from where he set out on a similar voyage of discovery and thus the name was born. Successful pre-conferences preceding the WONCA Europe Conference have been held annually since. Furthermore, VdGM has continued to grow and expand from then on to include a vast range of other events and activities, all with the aim of improving general practitioner (GP) empowerment, connection and support.

The VdGM seeks to work with doctors who are training in the speciality of family medicine and those in the first five years after qualifying as family medicine specialists. The movement strives to promote the profession of family medicine as innovative, influential and academically robust. This is done by giving young doctors opportunities in expanding their education, research skills, policy-making, leadership qualities and international collaboration. VdGM has a number of mechanisms in place to provide such opportunities. These include a number of exchange opportunities namely the Conference Exchange, the Hippokrates Exchange and the Family Medicine 360°.

The Conference Exchange generally lasts one to two days and takes place within a GP practice/office of a set country in the same period when a family medicine related conference would be taking place. The Hippokrates Exchange offers a lengthier experience within a GP practice/office in Europe which generally lasts a week or more, whilst the Family Medicine 360° programme further widens the horizons, allowing exchanges to happen all over the world and can last up to four weeks. These exchange visits are standardised in order to ensure fulfilment of certain learning objectives, giving doctors the opportunity to learn from one another in a different cultural and socio-economic context. The programme not only seeks to improve the individual's professional development but

also to entice doctors to be game-changers within their own working environment. A social programme is also organised in order to enhance the intercultural experience and help consolidate new friendships and collaborations. Travel and accommodation is generally financed by the chosen participants. Opportunities are in place for individuals from low income backgrounds to apply for bursaries and benefit from VdGM funds.

The VdGM also hosts a variety of special interest groups allowing for young doctors to develop themselves in issues that they feel passionate about such as research, quality and safety, teaching, health promotion, policy making and migration amongst many others. It also liaises with an extensive number of international organisations including the European General Practice Research Network (EGPRN), the European Rural and Isolated Practitioners Association (EURIPA), and the European Network for Prevention and Health Promotion in Family Medicine and General Practice (EUROPREV).

The pristine work carried out by the VdGM is only rendered possible through the work of its governing bodies. The VdGM council is composed of a number of delegates from countries all across Europe who hold regular meetings and make decisions about strategy, policy and direction. They are also responsible for electing the executive group which is responsible for the maintenance and development of the organisation and enables members to engage with different opportunities provided by the organisation. Each country participating in exchanges also appoints a national exchange co-ordinator who, together with his/her team of assistants, helps organise a host exchange programme and handles applications for exchange visits within his/her country. Currently in Malta a team is being set up to be able to host Malta's first exchange programme.

During 2019, three doctors were given the opportunity to participate in pre-conference exchange visits in Italy, Spain and England. Their experiences are being shared in the next segment of this article.

PRE-CONFERENCE EXCHANGE VISIT TO CHIERI, ITALY AND THE 6TH VASCO DE GAMA MOVEMENT CONFERENCE IN TORINO, ITALY, 24– 29 SEPTEMBER 2019, TORINO, ITALY BY DR SACHA BUTTIGIEG (GENERAL PRACTITIONER TRAINEE)

In September 2019 I had the excellent opportunity of participating in a conference exchange programme in Torino, Italy organized by the Vasco da Gama Movement (VdGM) under the auspice of Movimento Giotto which consists of a vibrant team of young doctors working in Italy. The experience consisted of a two day exchange programme followed by a 3 day forum entitled the 6th Vasco da Gama Movement Forum, with the latter also having significant organisational input from international members of the VDGM (see Images 1 and 2).

On the day of arrival all seventeen exchange participants from across Europe were invited for an introductory meeting at a local health centre, otherwise known as 'Casa della Salute', which is a privately owned clinic that is funded by the Italian government. A presentation was given by the organising committee which provided a detailed explanation of the Italian healthcare system and a review of the upcoming exchange visit itinerary. A tour of the premises was also given which allowed the participants to appreciate the logistics of the day-to-day running of such a clinic, find out more about the pros and cons of the government funding system as well as learning about working conditions and the out-of-hour service in the Italian primary healthcare system.

The next two days consisted of an experience in a similar health centre in Chieri, a town located 11km southeast of Turin. During this exchange visit I was attached to a senior general practitioner who I shadowed during consultations. I was also invited to see a small number of patients on my own, followed by discussion on a mutually agreed management plan with the senior doctor. This exchange visit was an important learning experience and an eye-opener on a number of levels, especially when observing the doctor-patient relationship overseas. Also, through observation and discussion on management of disease, the similarities and divergent approaches in treatment and access in care were

observed, together with the different subcultures and health belief models and prescribing/dispensing systems in Italy. An appreciation of the benefits of an electronic patient record system was sought.

The exchange programme was followed by a 3 day forum which saw the arrival of hundreds of young doctors (mostly in training or within 5 years of finishing specialisation) coming together for a number of lectures, workshops and tailor-made courses. The topics addressed were varied and invited participants to challenge their thoughts and their day-to-day practice as an opportunity for both individual and collective growth. Some highlights of the forum included discussions on patient empowerment, raising awareness on over-medicalisation, delivering bad news, international opinions on euthanasia, cross-cultural family medicine, shared decision making and improving collegiality and work ethic amongst colleagues.

GP trainees also had the opportunity of participating in an interactive pre-conference course on case-based scenarios using standardised simulated patients and receiving performance feedback from senior clinical teachers. Last but not least, the forum also provided workshops to learn about the special interest groups working within the VdGM such as those on mental health, domestic violence, international health medicine, migrant care, research and emergency medicine. Participants of the exchange programme were specifically given a platform to speak about their experience in the Italian practice they were in. This opportunity allowed for a comparative exercise of different practices across Europe and universal challenges faced in primary healthcare across this continent.

Another important facet to this experience was the social program organized by Movimento Giotto, who scheduled a number of interesting events such as a city walking tour, a visit to the Anatomy Museum of Torino as well as a number of get-togethers at local eateries. Such events helped create room for sharing of ideas in a less formal setting and enabled participants to establish connections in a broader medical community.

I believe that this experience has been highly beneficial for me and I would readily suggest similar opportunities to fellow trainee doctors. I find myself highly motivated and willing to help out in future exchange programmes in Malta. I believe it is worthwhile investing in trainees to attend such events as this not only helps them for personal growth but also serves as an energizing experience that can be helpful in bringing new ideas for improvement that can be implemented on a local level.

Image 1*: Dr Sacha Buttigieg (4th from right) during her exchange visit to Italy*

Image 2*: Dr Sacha Buttigieg (back row, 3rd from left) during her exchange visit to Italy*

PRE-CONFERENCE EXCHANGE VISIT AND THE 89TH EUROPEAN GENERAL PRACTICE RESEARCH NETWORK MEETING IN VIGO, SPAIN, 14 – 20 OCTOBER 2019 BY DR YANICA VELLA (GENERAL PRACTITIONER TRAINEE)

Vigo is a city on the northwest coast of Spain in the region of Galicia. This is where I had the opportunity to be a part of this exchange programme run by an excellent organisation offering a great experience in terms of clinical exposure, hands-on experience and team-work

(see Images 3 and 4). This experience was shared with another three exchange doctors from Belgium, UK and Portugal.

Upon arrival, we got a brief run-through on how the health care system functions in the region of Galicia. Each foreign delegate was introduced to their assigned GP trainer and trainee for the period of the exchange visit. This was followed by a briefing as to what our respective days were going to entail.

My exchange experience was held in Sardoma, twenty minutes away from Vigo. My mornings consisted of joint clinics with my mentor, where I got to see a mixture of acute and chronic presentations together with disease prevention assessments.

There was also exposure to telephone consultations, home visits and nurse-led clinics. The latter was especially of interest since it was run using an online system, making it very convenient and time efficient for the patient.

The GP I was with had a special interest in ultrasound imaging and held a special afternoon clinic, whereby abdominal ultrasounds were performed to aid in the differential diagnosis of the patient. This aided in the provision of better quality of care and referral to specialist services when warranted.

During one of the morning teaching sessions held, I had the opportunity to present how family medicine is practiced n Malta and comparisons were made with Galicia's system. This session highlighted the importance of recognising what is good and what is bad in each system and how sharing ideas might influence a change to the better of both healthcare systems.

This exchange programme sparked a huge interest amongst local journalists of the region, which led to several foreign delegates being interviewed and the story published in various papers and included in the news on local television.

During my period in Vigo, I attended the 89th European General Practice Research Network Meeting, which focused mainly on community care and how this could can improved. Topics tackled include research in community care and how different modalities of GP training can improve service provision. Also, different methods on how to reduce anxiety, depression and social isolation in older people were discussed. There were several workshops that touched on various aspects of community care. One workshop that I attended was on the social determinants of health and how these can have an impact on patients, and how we as GPs can support the patient in various ways to help address their medical complaints and overall wellbeing.

I highly recommend this exchange programme as it helped me enrich both my medical and professional experience as a doctor. Having been exposed to a different health care system outside of Malta has given me insight as to what good is already being done in day-to-day practice and what can be improved in the future.

Image 3*: Dr Yanica Vella (centre) during her exchange visit to Spain*

Image 4*: Dr Yanica Vella (2nd from right) during her exchange visit to Spain*

PRE-CONFERENCE EXCHANGE VISIT TO MANCHESTER, UNITED KINGDOM AND THE ROYAL COLLEGE OF GENERAL PRACTITIONERS (RCGP) ANNUAL CONFERENCE AND EXHIBITION 2019 IN LIVERPOOL, UNITED KINGDOM, 20 - 26 OCTOBER 2019 BY DR STEPHANIE SCERRI (SPECIALIST IN FAMILY MEDICINE)

Towards the end of October 2019, I participated in a UK exchange programme together with other fellow GP trainees and 'First5' GPs. We were a cohort of 10 exchange trainees, 5 from Europe and another 5 from non-European countries. This exchange visit was organised in collaboration with the Young Doctors' Movements of WONCA, the World Organisation of Family Doctors. The exchange programme consisted of a two-day exchange visit to a UK GP practice, a day sightseeing, followed by the RCGP Annual Conference held in Liverpool (see Images 5 and 6).

For the first two days, I shadowed at 'The Doc's Surgery' set in Oak Street, in Central Manchester. Since this practice was located in central Manchester, it catered for a different cohort of patients from what a typical UK practice would care for, in that most of the patients were relatively young, with the exception of a community of Cantonese elderly who lived in the area. This practice in particular had a special interest in providing a service for LGBTIQ patients and providing sexual health screening to patients registered with this practice.

I started my first day of training by shadowing Dr Joslin, who is one of the main practice partners of the surgery. During this time, I had the opportunity to see how GPs in the UK work, especially how they deal with patients within the 10-minute appointment system and what type of patients they encounter in their day-to-day practice. I was particularly interested in how their electronic patient record system worked, and how record keeping in the national health system (NHS) is interlinked, making continuity of care much easier. A practice of great interest noted at this surgery was that telephone consultations and triaging are reserved solely for the 11am to 12pm period. This reduced the likelihood of interruptions during physical consultations to a minimum. Furthermore, to cater for cases where doctors were very concerned following telephone conversations with patients, specific appointment slots were kept free for such emergencies.

In the afternoon, I then divided my time with the two practice nurses of the surgery. Both of them have a licence to prescribe. I got to experience first-hand what they do, which ranges from sexual health check-ups to chronic disease management and performing spirometry on patients. The fact that nurses in the UK are able to prescribe means that the workload can be properly delegated between both nurses and doctors, which also helps to to deliver a better service to the patients that are registered at the surgery.

On the second day of my rotation, besides sitting with another GP partner of the practice, I had the opportunity to see the administrative side of things. I got to see the excellent work that receptionists and the clerical team do, in easing the doctor's workload, like for example, doing the referrals themselves, giving appointments for annual check-ups and handling complaints.

The remainder of the exchange visit consisted of attending the RCGP Annual Conference, which took place at the ACC Liverpool Conference Centre. The conference consisted of plenary lectures interspersed with parallel sessions. I tried to attend sessions that tackled different themes with the intent of increasing my clinical knowledge, helping to raise awareness of self-care within the work environment, gaining insights on the problems GPs are facing in this

Image 5: *Dr Stephanie Scerri (2nd from left) during her exchange visit to the UK*

day and age with the constant evolution of society in general, and discovering how technology can help/ hinder the doctor-patient relationship.

All in all, I consider this exchange visit to have been a very fruitful experience. It has broadened my mind-set as to how Maltese healthcare can improve considerably with more delegation of work amongst different healthcare professionals and with better use of a good electronic record keeping system that can facilitate the overall work of the general practitioner.

Image 6*: Dr Stephanie Scerri (2nd from left) during her exchange visit to the UK*

CONCLUSION

The recent rekindling of interest amongst local GPs in opportunities provided by the Vasco da Gama Movement is surely a welcome change. One hopes that more local GP trainees and young GPs will engage in such experiences in the hope of expanding links to an international GP community. A team of Maltese doctors is also undergoing discussions to create a local exchange programme for foreign GPs who wish to have an experience of the Maltese healthcare system. With such a venture one hopes that the place of the Maltese GP community will be further consolidated within the VdGM whilst young and future Maltese GPs will find a source of support and inspiration within this movement.

ACKNOWLEDGEMENTS

Dr Sacha Buttigieg, Dr Stephanie Scerri and Dr Yanica Vella would like to thank the relevant co-ordinators operating within the Malta College of Family Doctors who, through their liaison with Vasco da Gama Movement representatives, facilitated their participation in these exchange programmes.

Dr Sacha BUTTIGIEG
MD (Melit), MRCP (UK)
General Practitioner Trainee, Primary HealthCare Department, Malta
Email: sacha.buttigieg@gov.mt

Dr Stephanie SCERRI
MD (Melit), MRCGP (INT), MMCFD
Specialist in Family Medicine, Primary HealthCare Department, Malta
Email: stephanie.scerri@gov.mt

Dr Yanica VELLA
MD (Melit), MRCP (UK)
General Practitioner Trainee, Primary HealthCare Department, Malta
Email: janica.vella@gov.mt

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RESEARCH ARTICLE

A seven-year review (2011-17) of the work-based assessment component of Malta's Specialist Training Programme in Family Medicine

Dr Mario R SAMMUT and Dr Günther ABELA

ABSTRACT

Background

Work-based assessment (WBA) within Malta's Specialist Training Programme in Family Medicine is recorded using the 'One-to-One Appraisal' form in the General Practitioner (GP) Trainee Educational ePortfolio.

Objectives

The postgraduate training coordinators in family medicine review the above annually to see where the WBA is operating well and to identify where improvements are required.

Method

The 'One-to-One Appraisal' involves the completion of a scoring system (selecting one score from 'needs further development': 1-2-3; 'competent': 4-5-6; and 'excellent': 7-8-9) for twelve competency areas. The educational portfolio is reviewed using objective requirements listed in the form 'Review of the GP Trainee Educational Portfolio'.

Results

The review of educational portfolios revealed commendable practices including detailed educational plans and case-logs, a general trend of adherence to time frames, and high attendance rates for group-teaching sessions. While One-to-One Appraisal documents were filled in satisfactorily, the issue of remarkably high average scoring was encountered. Moreover disparities were seen between scores and comments in some of the 'GP trainee interim review by GP trainer' forms. Deficiencies were outlined in clinical supervision time, mainly during family medicine government placements, while incomplete adherence to placement requirements was noticed.

Conclusion

A significant amount of quality work was carried out by the GP trainees under their trainers' supervision. Two main areas of improvement were however outlined – the need for refining the GP trainers' score allocation and the importance of regular review of the portfolio by both trainees and trainers, with the prompt flagging of persisting unresolved issues to the training coordinators.

Key Words

Education, family practice, workplace, educational assessment, Malta

INTRODUCTION

Background

A Specialist Training Programme in Family Medicine (STPFM) was drawn up by the Malta College of Family Doctors (MCFD) and approved in 2006 by the Ministry for Health's Specialist Training Committee (Sammut, 2017). Such training was launched a year later within the Department of Primary HealthCare (PHC) and by 2017 produced 70 graduate specialists in family medicine (Sammut, 2017). The three-year training programme consists of placements that are 50% in family medicine and 50% in other relevant specialities (Sammut and Abela, 2012). Each trainee practices and trains under the supervision of a GP trainer and other appropriate specialists, while also participating in weekly group teaching sessions within a half-day release course (HDRC) (Sammut and Abela, 2012).

Successful completion of the STPFM requires a GP trainee to pass the work-based assessment (WBA), the applied knowledge test (AKT), and the clinical skills assessment (CSA). Besides being one of the three components of the summative assessment, WBA also provides formative assessment for the trainee through annual appraisal of an electronic educational portfolio, which includes reports from the GP trainer and supervisors of other speciality placements, from healthcare professionals (multi-source feedback) and from patients through consultation satisfaction questionnaires (Sammut and Abela, 2014).

The educational portfolio also allows the GP trainee to record learning experiences (through the trainee self-rating scale, educational plans, tutorial programmes, video-consultation analyses and case-based discussions), clinical experiences (including logs of cases seen during various attachments) and educational activities (such as teaching and learning within the HDRC, basic and advanced life support certificates) (Specialist Training Programme in Family Medicine – Malta, 2012).

In the annual appraisal, the GP trainer and trainee review the progress of the trainee, plan future training using the educational portfolio and complete the 'One-to-One Appraisal'. The latter and the educational portfolio are then reviewed by the postgraduate training coordinators in family medicine using the form 'Review of the GP Trainee Educational Portfolio' which comprises a list of objective requirements. If such requirements are met, the trainee is recommended for progression to the next year of training or, if in the final year, is certified as having completed the final-year appraisal and educational portfolio and, consequently, passed the WBA. In cases of unsatisfactory review, the procedures that are followed comprise remedial actions and, if needed, progress review and appeals boards (Specialist Training Programme in Family Medicine – Malta, 2014).

Objectives

As recommended in the report by the External Development Advisers of the UK's Royal College of General Practitioners following their visit to Malta in July 2010, a yearly Quality Management Report has been drawn up since 2011 by the postgraduate training coordinators to:

- analyse the annual appraisal processes,
- verify the areas in which the WBA is functioning properly and
- outline other areas which need further development.

This study reviews the reports issued from the years 2011 until 2017.

METHOD

The educational portfolio is reviewed using objective requirements listed in the form 'Review of the GP Trainee Educational Portfolio' (Specialist Training Programme in Family Medicine – Malta, 2014).

The 'One-to-One Appraisal' (Specialist Training Programme in Family Medicine – Malta, 2014) involves the completion of a scoring system for twelve competency areas (NHS & RCGP, 2005), selecting one score from:

- 'needs further development': 1, 2 or 3;
- 'competent': 4, 5 or 6; and
- 'excellent': 7, 8 or 9.

The twelve competency areas (NHS & RCGP, 2005) are the following:

1. Communication and consultation skills
2. Practising holistically
3. Data gathering and interpretation
4. Making a diagnosis / making decisions
5. Clinical management
6. Managing medical complexity
7. Primary care administration and information management technology
8. Working with colleagues and in teams
9. Community orientation
10. Maintaining performance, learning and teaching
11. Maintaining an ethical approach to practice
12. Fitness to practise

The scores gathered from these surveys were transcribed into a Microsoft Excel spreadsheet to enable quantitative analysis.

The postgraduate training coordinators reviewed the GP trainee educational portfolio for a number of requirements (listed below), using the criteria of completion as necessary, with the obligatory details, in the required numbers, on time and with the mandatory signatures. Reports were also vetted for consistency, both internal (between different sections within the same report) and external (between different reports), and note was taken of deficiencies pointed out in post evaluations.

The requirements of the educational portfolio are:

- Learning record: educational agreement, trainee self-rating scales, educational plans, tutorials with GP trainers and hospital supervisors, video analyses of patient consultations and case-based discussions;
- Formative assessment: trainee interim reviews by GP trainer, reports on GP trainee by hospital clinical supervisors, multi-source feedback questionnaires (completed by members of the GP trainee's team) and consultation satisfaction questionnaires (completed by adult patients);
- Educational activities: record of HDRC group teaching sessions attended, participation in the delivery of one HDRC session per academic year discussing guidelines/journal articles, basic/advanced life support certificates;
- Clinical Experience: child health surveillance in well baby clinics, direct observation of procedural skills;
- Evaluation of Posts: in hospital and family medicine.

Ethical considerations

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

RESULTS

The review of the educational portfolios revealed commendable practices including:

- detailed educational plans with specific targets and outcome reviews;
- the performance of extra tutorials, case based discussions and video analyses of patient consultations;
- detailed logs of cases seen, including problem cases;
- high attendance rates by trainees for group teaching HDRC sessions; and
- a general trend of adherence to the time frames necessary for submission of portfolio requirements.

While One-to-One Appraisal documents were filled in satisfactorily, the issue of remarkably high average scoring was encountered, with trainees already being scored 5 or 6 (medium to high competency scores) after the first year of training (see Figure 1). Moreover, disparities were seen between scores and comments in some of the 'GP trainee interim review by GP trainer' forms. On the other hand it was noted that, over the years, cross-referencing (between scores and comments) by the GP trainers in general was more evident with less disparities in the reports completed.

In their training post evaluations, some trainees outlined deficiencies in their clinical supervision training time, mainly during family medicine placements in government service. While a very small minority of trainers keeps failing to fill in important sections in various reviews performed (despite repeated reminders from the training coordinators), a proportion

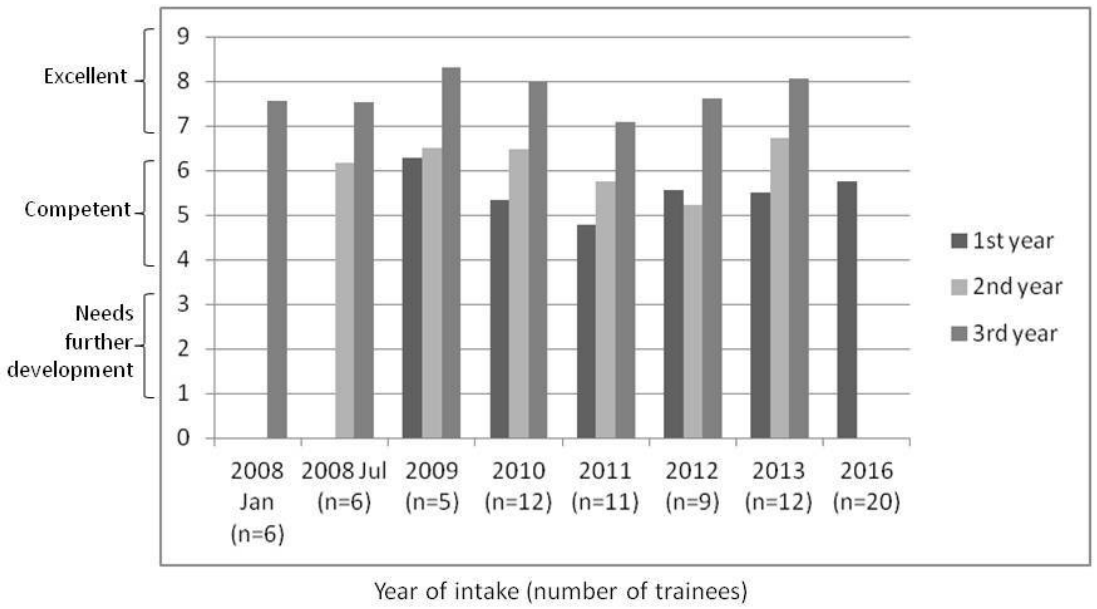

Figure 1: Comparison of average annual appraisal scores

Year of appraisal	Percentage Unsatisfactory Appraisal
2012	45%
2013	25%
2014	56%
2015	60%
2016	70%
2017	65%

Table 1: Comparison of the percentage unsuccessful appraisals from 2012 to 2017

of trainees were noted to have inputted forms late, relevant to their placement dates (in some cases by over 6 months). Some of these forms were then not signed by the relevant clinical supervisors or GP trainers, with these issues having to be addressed in subsequent remedial actions that the trainees had to perform.

Such issues with forms and other problems resulted in trainees being unsuccessful in the review of their annual appraisal. The percentage unsuccessful appraisals varied between a low of 25% to a high of 70% during the period 2012 – 2017 (see Table 1). In the majority of cases the issues were minor in nature (such as incomplete or missing documents). As such, these were tackled by remedial actions issued by the postgraduate training coordinators. More serious issues (such as failure by the trainer or supervisor to sign off as satisfactory an end-of-placement report) required review by a progress review board.

DISCUSSION

Discrepancy between scores and comments

While the revealed commendable practices showed that the trainers and trainees involved were working well together, a worrying discrepancy was noted between the remarkably high average competency scores after the first year of training and the critical comments in some of the 'GP trainee interim review by GP trainer' forms. A typical example is of a trainee being given an excellent score for a particular competency by the trainer, who then lists

improvements that are needed for that area in the comments section. The high scores might be a result of the popularity of the specialist training programme in family medicine, with the ensuing competitive selection process resulting in the appointment GP trainees of high quality.

Such high scoring might also result from reluctance amongst some trainers to grade trainees as 'needing further development' when so required. In this regard, GP trainees in the UK were found to "place a low value on rating scale scores and they perceive a lack of honesty in assessments … that undermines the credibility of workplace-based assessment" during hospital training (Sabey and Harris, 2011). This concurs with a 2011 report entitled 'Evaluation of the RCGP GP Training Curriculum' that identified reluctance in recording concerns by some hospital-based clinical supervisors in their reports on GP trainees (Bedward, et al., 2011). In fact 'failure to fail' students has been identified as an issue for medical educators, including general practitioners (Cleland, et al., 2008).

A contrast was evident between high scores awarded in the competency areas and the critical comments made in end-of-placement reports by some trainers. This highlights the need for the theme of assessment and score allocation to be given its due importance. Periodic discussion of this theme is warranted in trainer continuing professional development (CPD) sessions.

Although regular trainer CPD meetings had been envisaged for the STPFM since 2006 (Sammut, et al., 2006), such sessions were only introduced ten years later (Abela and Sammut, 2015). This launch followed a recommendation in 2015 that GP trainers undergo further training in formative / work-based assessment during regular CPD meetings that are organised specifically for them (Abela and Sammut, 2015). Subsequently, an educational needs assessment provided useful information that enabled the set up of regular CPD meetings for GP trainers within Malta's STPFM (Sammut and Abela, 2017).

During 2019 the GP trainer CPD meetings tackled the assessment of video consultations and case-based discussions (Sammut and Abela, 2019). Following positive feedback from the participants, it is planned that the same topic will be tackled further during 2020, with members of the MCFD Assessment Team providing training in assessment (Sammut and Abela, 2019). Continuing training in assessment for trainers and assessors of GP trainees has been recommended in the UK (Bedward, et al., 2011), with international evidence showing that training in assessment, among other teaching skills, is of benefit to the GP teacher (Guldal, et al., 2012).

Deficiencies in clinical supervision

The deficiencies outlined by some GP trainees in their clinical supervision training time within family medicine placements in government service have persisted despite having been identified previously. In their post evaluation forms, trainees repeatedly commented that, despite working in the same roster as their trainers, they are then assigned on the weekly roster to work in different venues. In fact, in a comparison by Sammut and Abela of evaluation forms collected during the first (2007-08) and fifth years (2011-12) of the STPFM, GP trainees had suggested that they be assigned to work in the same health centre as their trainers, and that more clinical teaching be provided despite the heavy workload and lack of staff (Sammut & Abela, 2013).

GP trainees need face-to-face supervision provided by experienced GP trainers working beside them (Wearne, 2011), with such direct supervision being known to have a positive effect on patient outcome and trainee development (Kilminster, et al., 2007). Unfortunately, despite regular reminders from the postgraduate training coordinators in family medicine to the Primary HealthCare administration, GP trainers and their trainees continue to be assigned daily duties in different venues.

Issues with reviews and forms

Issues with reviews and forms are the reason for unsuccessful appraisals, which varied between 25% and 70% during 2012 – 2017 (see Table 1). The identified issues of incompletely filled reviews, late submission of forms and missing signatures of trainers/supervisors may be avoided or identified and tackled if trainees update their educational portfolio regularly

(preferably on a weekly basis). Trainers are also advised to regularly review the portfolio with their trainees and make sure that they properly follow instructions related to the completion of required forms. The efficacy of WBA is enhanced by the provision by the trainer of accurate feedback based on the needs and focused on the performance of the trainee (Norcini and Burch, 2007).

Regular reviews of the educational portfolio are especially important in preparation for the 'Trainee Interim Review by GP Trainer' and for the 'One-to-One Appraisal', not only to inform the completion of these documents, but also to ensure that the portfolio presented for review reaches the required standard. There is good evidence that regular feedback from mentors enhances the success of well-implemented portfolios in effectively supporting professional development in post-graduate healthcare education (Webb, et al., 2006; Driessen, et al., 2007; Tochel, et al., 2009).

GP trainers and/or GP trainees are advised to involve the training coordinators as soon as possible in any persisting unresolved issues in order to hopefully facilitate an early resolution. It is to be noted that a procedure for the review of trainers and trainees who have recurrent problems during the STPFM was recommended by the postgraduate training coordinators in the Quality Management Report for 2015 (Abela & Sammut, 2016a). The procedure was subsequently compiled by the coordinators and was approved in 2016 by the Specialist Training Committee in Family Medicine for subsequent implementation (Abela & Sammut, 2016b).

CONCLUSION

A significant amount of quality work was carried out by the GP trainees under their trainers' supervision. This review also outlined two main areas of improvement: the need for refining the GP trainers' score allocation; and the importance of regular review of the portfolio by both trainees and trainers, with the prompt flagging of persisting unresolved issues to the training coordinators.

RECOMMENDATIONS

Arising from the review of the One-to-One Appraisal, it is recommended that the theme of assessment and score allocation be given its due importance and periodically discussed in the trainer CPD sessions, which were launched in 2016 after repeated reminders by the coordinators.

Arising from the review of the educational portfolio, the following recommendations are made:

- The trainees should review and update the work logged in their educational portfolio at least once a week in order to keep on track.
- The trainee and trainer should also ensure they follow instructions related to completion of forms and regularly review the portfolio to ensure it reaches the required standard.
- A procedure for managing training concerns and issues that was proposed in 2014, compiled by the coordinators and approved in 2016, should be implemented when necessary.

Dr Mario R SAMMUT
MD, DipHSc, MScH, MScPC&GP(Ulster), FMCFD, MRCGP[INT]
Senior General Practitioner & Postgraduate Training Coordinator in Family Medicine, Specialist Training Programme in Family Medicine, Primary HealthCare, Mtarfa, Malta
Email: mrsammut@rocketmail.com

Dr Günther ABELA
MD, MMCFD, MRCEM, FIMC.RCS(Ed), PG Cert Clin Lds (Open), LLCM
Senior General Practitioner & Postgraduate Training Coordinator in Family Medicine, Specialist Training Programme in Family Medicine, Primary HealthCare, Mtarfa, Malta
Email: gunther-p.abela@gov.mt

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A qualitative study – the experience of general practitioners with older adult patients with osteoarthritis

Dr Doriella GALEA

ABSTRACT

Background

Osteoarthritis is a degenerative condition commonly effecting older adult patients in the community. There is a "demographic transition" leading to an ageing population.

Objectives

To perform a qualitative study about how general practitioners (GPs) look at osteoarthritis, and its effects on patients' lives as regards the biopsychosocial model. The aim is to analyse the GPs' perspectives about the local available sources and any possible improvements.

Method

Interpretative phenomenological analysis (IPA) was used as it allows the discovery of the details of each individual GP. Two GPs who have been practising for more than 5 years within the community volunteered through the Malta College of Family Doctors. Snowball sampling was used to recruit another two. Semi-structured interviews were then conducted, transcribed and analysed.

Results

There was a common feeling that dealing with such a widespread disease is challenging within the community and there is a need for a specialised osteoarthritis clinic in the community to cater for all these patients' needs via an interdisciplinary team. The need for a holistic approach was agreed amongst all the participants. There were four major themes: (i) osteoarthritis as a major health concern, (ii) the GP – a key role in the management of osteoarthritis in the community, (iii) challenges in community care and (iv) the future of primary care in the management of osteoarthritis.

Conclusion

Osteoarthritis is a common, challenging condition which is treated by GPs; but being multi-faceted, input from other professionals is required.

Keywords

Osteoarthritis, older adults, general practitioners, interdisciplinary team

INTRODUCTION

Stating the Problem

Osteoarthritis, also known as osteoarthrosis is a degenerative condition affecting any joint in the body (Kumar, et al., 2004). It can be described as simple "wear and tear" by the treating physician, but it can seriously hamper one's activities of daily living. Being so common, it is mostly treated in the community by family doctors or general practitioners. Within the community there are various degrees of osteoarthritis, and it may affect one or more joints (Kumar, et al., 2004). There are also individuals who have to undergo major operations that involve joint replacements which necessitate more intensive rehabilitation (Malta National Statistics Office, n.d.; Malta Directorate for Health Information and Research, 2012).

Worldwide there is a "demographics transition" whereby the rates of mortality and fertility are decreasing, leading to a shift towards an ageing population (United Nations, 2017). Internationally the average male life expectancy is 79 years and that of females is 83. Since 2001 this has increased by 3 years for males and 2.12 years for females. There was an estimated increase in the Maltese population from 411,579 in 2011 to 429,000 by 2025; however this has already been exceeded with a current population of 432,761 in 2019 (Malta National Statistics Office, n.d.; Worldometers, n.d.).

According to the European Health Interview Survey carried out between 2014 and 2015, and published in February 2018, 12.5% of the Maltese population who are over 15 years of age had self-reported osteoarthritis. There was an unexpected decline in self-reported osteoarthritis from 15% in the survey carried out in 2008 to 12.5% in 2015. This might possibly be explained as these figures are based on self-reports rather than data being gathered by healthcare professionals. This condition is mostly found in persons above the age of 65. In the latest survey of 2015, 30.7% of people in the 65-75 age group reported osteoarthritis, with an increase to 44.3% in the 75 years and over age group. There was no difference between the male and female groups. As a result of the growing ageing population, these numbers are expected to increase in future years. (Malta Directorate for Health Information and Research, 2008 and 2018)

Having an ageing population implies that there will be a rising number of patients with osteoarthritis (Malta National Statistics Office, n.d.). However, as yet there are no guidelines locally about the management of osteoarthritis, neither for general practitioners nor for specialists working within the hospital setting. General practitioners (GPs) often form a random or convenient interdisciplinary team – that is they contact the necessary team member depending on the case (Malta Directorate for Health Information and Research, 2012).

Research Aims

The aim of the study is to explore how general practitioners (GPs) look at osteoarthritis, its effects on patients' lives and the currently available resources within the community. It will seek to understand the GPs' daily experiences and challenges when dealing with patients with osteoarthritis and referral to secondary care.

These are the three research questions:

a. How are general practitioners contributing to the management of osteoarthritis in the community?
b. What are their daily challenges when working with patients with osteoarthritis?
c. What is lacking locally? Do general practitioners feel the need for local guidelines?

METHOD

Ethical approval was granted from the Ethics Committee within the Faculty of Medicine and Surgery of the University of Malta. GPs were invited to participate via the Malta College of Family Doctors. GPs who had been working in the local community for at least 5 years were eligible. Two candidates were eligible and they referred to two other GPs who were interested (snowball sampling). Informed consent was taken.

Interpretative Phenomenological Analysis

Data was collected by means of semi-structured interviews, then transcribed and analysed using Interpretative Phenomenological Analysis (IPA) to come up with different superordinate themes and sub-themes. IPA was chosen as the most suitable qualitative methodology since the interest is to understand the individual lived experiences of GPs working with older adults with arthritis in the community. This resonates the phenomenological philosophy of IPA. At the same time, IPA is idiographic because it is interested in the detail of an individual case (Smith, 2008).

Data was collected by means of semi-structured interviews, then transcribed and analysed using IPA to come up with different superordinate themes and subthemes.

RESULTS

The four superordinate themes are:

1. Osteoarthritis as a major health concern,
2. The GP – A key role in the management of osteoarthritis in the community
3. Challenges in community care
4. The future of primary care in the management of osteoarthritis

From the results it is clear that osteoarthritis is a common disease which affects the individual in a biopsychosocial way. Being so common, GPs tend to see more patients with this condition making this study more relevant. All participants realised their vital role in managing the condition, and act as a co-ordinator to meet the patients' needs. The main challenges in the community may be divided into the macrosystem and microsystem. The major challenges in the healthcare system are the lack of time and lack of readily available interdisciplinary team. The challenges in the microsystem system vary from financial issues to inadequate home support. All participants stressed the importance of more services in the community and a more readily available community interdisciplinary team. More awareness should be raised amongst family practitioners. There were mixed feelings amongst the participants about the need for a specific policy.

The following four tables show the different superordinate themes, themes and subthemes which were identified after transcription of data from the four interviews.

Table 1: Superordinate theme 1 - Osteoarthritis as a major health concern

SUPERORDINATE THEME 1: Osteoarthritis as a major health concern

Theme 1: Common and increasing prevalence		
Theme 2: The debilitating nature of arthritis	**Subtheme 1:**	The biopsychosocial aspect - physical - pain, mobility, number of co-morbid diseases - social - psychological - hopelessness and helplessness
	Subtheme 2:	The invisible side, being dismissed, unmet needs
	Subtheme 3:	Vicious cycle (self-aggravating)
Theme 3: Different degrees and types of osteoarthritis		
Theme 4: Osteoarthritis and the Maltese	**Subtheme 1:**	Maltese lifestyle contributing to disease - lack of exercise - obesity
	Subtheme 2:	Likely population attitude - osteoarthritis seen as "handicap" - resistance for treatment

Table 2: Superordinate Theme 2 - The GP - A key role in the management of osteoarthritis in the community

SUPERORDINATE THEME 2: The GP - A key role in the management of osteoarthritis in the community	
Theme 1: Patient centred approach - Establishing a collaborative relationship with the patient	**Subtheme 1**: Validation of patient's problem rather than dismissing it
	Subtheme 2: Negotiating a plan
	Subtheme 3: Coordinating and roping in support for the patient - liaising with other professionals - services - support from neighbours and family
Theme 2: Patient education	
Theme 3: GP as a motivator	

Table 3: Superordinate 3 – Challenges in the community

SUPERORDINATE THEME 3: Challenges in community care	
Theme 1: Challenges in the macrosystem (health care system)	**Subtheme 1:** Lack of time
	Subtheme 2: Fragmentation of the interdisciplinary team
	Subtheme 3: Lack of specialised professionals within the community
	Subtheme 4: Patients lost in the waiting lists
	Subtheme 5: GPs not aware of the available community services
	Subtheme 6: Private GPs unable to refer to physiotherapy (public sector)
	Subtheme 7: Rehabilitation facilities
Theme 2: Challenges in the microsystem (patient related and social environment)	**Subtheme 1:** Living arrangements and social support - inadequate housing - support from family and neighbours - the difference between rural and urban areas
	Subtheme 2: Patients' attitudes towards life - Maltese seeing osteoarthritis as a "handicap"
	Subtheme 3: Patients' reluctance and non-adherence
	Subtheme 4: Financial challenges
	Subtheme 5: Patients' co-morbid diseases

Table 4: Superordinate theme 4 - The future of primary care in the management of osteoarthritis

SUPERORDINATE THEME 4: The future of primary care in the management of osteoarthritis	
Theme 1: Specialised osteoarthritis clinic	**Subtheme 1:** Interdisciplinary team
	Subtheme 2: Effective inter-professional communication
	Subtheme 3: Better doctor-patient relationship
Theme 2: Enhancing awareness amongst GPs	
Theme 3: Increase community services and rehabilitation facilities	
Theme 4: Guidelines about osteoarthritis as an attempt to use them within the local practices	

DISCUSSION

Osteoarthritis as a major health concern,

Osteoarthritis has a big impact on patients' lives, especially the geriatric population, that is those above the age of 65 (Bowker, et al., 2012). It is of major health concern as it is common and increasing in prevalence with an ageing population. Its impact is great as it is a debilitating and progressive condition which affects the individual in the whole biopsychosocial aspects.

Firstly, from a biological point of view, osteoarthritis links to two of the geriatric giants as described by Professor Bernard Isaacs (1924-1995) who was a leading professor of geriatric medicine. Osteoarthritis is associated with immobility and instability (falls). The other geriatric giants are incontinence and cognitive impairment (Bowker, et al., 2012). These are called "geriatric giants" because they are very common health challenges among older adult patients and have a major impact on their lives.

Immobility may be caused by various factors including osteoarthritis and stroke. This in turn may lead to loss of independence and self-space. The loss of independence is associated with social isolation as the individual might not be able to go out as previously. This "social detachment" is linked to psychological distress and hopelessness.

Osteoarthritis may lead to immobility which exacerbates the risk of other serious complications, mainly deep vein thrombosis, pressure ulcers with poor healing secondary to malnutrition and muscle wasting. All these are components which make a person "frail" (Bowker, et al., 2012).

Frailty is an important concept when dealing with older adult patients with reduced physiological reserve who hence are more prone to severe complications (Kumar, et al., 2004; Bowker, et al., 2012). An extreme example, yet unfortunately common, is that of osteoarthritic patients who have limited mobility and severe difficulties in instrumental activities of daily living. Such patients may suffer from malnutrition and are mostly bed or chair bound leading to pressure ulcers. Having poor physiological reserve; they would heal poorly, may get infected and may result in severe sepsis and possibly death.

Osteoarthritis may also lead to pain which can ultimately result in falls. This may in turn lead to fractures, urgent hospitalisation and surgery with post-operative complications.

The participants claimed that they notice a difference in the attitude of Maltese as opposed to foreigners. Whereas the former tend to see the condition as a "handicap", the latter do their best in order to continue with their usual activities and also manage to go abroad. Unfortunately, the predominance of a sedentary lifestyle amongst many of the Maltese leads to obesity and increased risk for osteoarthritis.

The GP – A key role in the management of osteoarthritis in the community

All the participants emphasised the important role GPs play in the management of osteoarthritis in the community. The GP is usually the first healthcare professional who manages the patient with osteoarthritis and refers to other professionals accordingly. A patient-centred approach is important in the management plan. The GP co-ordinates the patient's care and helps in patient education, including the reduction of major risk factors such as obesity, sedentary lifestyle, tobacco and alcohol. Despite this. genetic factors have also been linked (Kumar, et al., 2004). According to the 2002 Health Interview Survey, 40.2% of patients with osteoarthritis confirmed some limitations in their day-to-day activities in the previous six months. This was significant when compared to the 18% in the non-osteoarthritic group. To this end, the aim of the 2010 report for the prevention and control of non-communicable diseases in Malta is in fact to reduce the percentage of arthritic patients with self-reported activity limitations (during the previous 6 months) from 40.2% to 30% by 2020 (Malta Department of Health Promotion and Disease Prevention, 2010).

Various strategies are being undertaken in order to reduce the rate of this non-communicable disease including training and support for healthy living, weight management and healthy eating classes, and promoting physical activities (Malta Department of Health Promotion and Disease Prevention, 2010).

A number of studies have been conducted abroad that evaluate the experience of general practitioners working with patients suffering from osteoarthritis and which assess patients' satisfaction. A complex rapport may exist between patients and their caring general practitioner as patients may feel that their pain is taken for granted and not appropriately managed. Many patients feel disappointed with late diagnosis and management. On the other hand, GPs may avoid using the term "osteoarthritis" to avoid encouraging patients to take the "sick" role as many general practitioners feel that osteoarthritis is an inevitable part of ageing and adopt a fatalistic approach (Paskins, et al., 2014; Torio, et al., 1997).

Challenges in community care

The challenges met in community care may be divided in those of the macrosystem and the microsystem. The macrosystem refers to the health care system in Malta while the microsystem is the patient's social support network.

Taking the macrosystem first, the participants mentioned the lack of time during the consultation in family practice. Apart from this there is fragmentation of the interdisciplinary team with further difficulties for private GPs as they are unable to refer to services (such as physiotherapy services) in the public sector. It was emphasised that there is lack of some specialised professionals in the community such as the service of occupational therapy. Some patients are lost in the waiting lists and at times it is very frustrating for the patient and the caring GP to know what has happened to their appointment. Some GPs may be unaware of all the services currently being offered and this would need to be addressed. There is also a lack of rehabilitation facilities in the community and referral to these services can only be done through a hospital referral.

Secondly, when it comes to the microsystem some patients have inadequate housing and lack of social support from family and neighbours, especially in the urban areas. The participants mentioned the reluctance of some patients to adhere to the given advice, mostly because of

issues of stigma. This occurs when patients are reluctant to use a stick. Older adults might also have financial challenges which impede them from accessing some medications or private services. Also, having medical co-morbidities makes it more challenging for an individual with osteoarthritis to adapt.

The future of primary care in the management of osteoarthritis

The future might see a specialised osteoarthritis clinic with an inter-disciplinary team involvement. Having better inter-professional communication and more effective doctor-patient relationship will benefit all parties. Increasing disease awareness amongst GPs and extending community services will be ideal in the management of the condition. There was uncertainty about the need of a specific guideline for the management of osteoarthritis.

Strengths of the study

This study is the first such local study which tried to address a common problem. The appropriate tool – IPA – was used. With the author being a medical doctor, this may have helped in leading the semi-structured interviews. These interviews were carried out at the GPs' clinics hence making the GPs feel more at ease in their familiar environment. There was inter-rater reliability as the author's supervisor went through the interviews and made sure that the themes reflected the GPs' experiences. Also the main themes were cross-checked with the participants themselves so as to increase the validity of the results.

Limitations of the study

Ideally a pilot study would have been conducted prior the study itself, but this was not possible because of time constraints. Another limitation of the study is the small number of participants that was recruited. Ideally more participants would have been recruited so as to be able to have a wider range of experiences. Despite this IPA is mostly focused on the intense experience of the participant.

For a more complete study about the impacts of osteoarthritis, other members of the multidisciplinary team as well as patients and their relatives should have been included. The selection process may have resulted in the participation of more interested and up-to-date GPs, hence possibly not representing the average GP. The participants may have felt a bit uneasy in expressing themselves in front of another medical professional.

Although all participants agreed to conduct the interviews in English, some may have felt more confident expressing themselves in Maltese. Bias in the transcription process was reduced by cross-checking by the author's supervisor. At the end, the themes were shown to the respective participants so as to make sure that these really reflect their thoughts. This was the time for any clarification or amendment of different themes.

Relevance of the Study

Being the first local study of its kind, it was challenging to conduct; however, it contributed to the local community by highlighting areas for possible improvements.

To date there are no local guidelines for the management of osteoarthritis. However, there are a number of international guidelines such as the National Institute for Health and Care Excellence (NICE) guidelines published in February 2014 in the UK and those published by the American Society of Rheumatology in 2012 (National Institute for Health and Care Excellence, 2008; Hochberg, et al., 2012). There are some discrepancies in these guidelines, but both underline the impact such disease may have on the quality of life. Unusually so for the scientific and medical field, the NICE guidelines emphasise the biopsychosocial model. The NICE guidelines allow healthcare professionals not only to treat the patients' pain, but also appreciate the great impact it may have on their psychosocial wellbeing – 'Can he/she do the shopping?'; 'Does it affect his/her hobbies?'; 'What about his/her self-esteem as he/she is becoming more dependent?'

The Elderly Needs Assessment Survey of 2012 highlights a number of facts about the older adult in the Maltese community. It sheds light on the negative impact immobility has on older people's

lives. It not only interferes with the basic activities of daily living but also affects instrumental activities of daily living, such as going shopping to the grocer. Osteoarthritis is the commonest disease of the older adults leading to immobility (Malta: Department of Health Promotion and Disease Prevention, 2010). Being so common it is an important disease that deserves a sound holistic approach when it comes to managing it. Unfortunately, the community services being offered - including transport, handyman services, cleaning services amongst others – are being underutilised (National Institute for Health and Care Excellence, 2008).

CONCLUSION

The three main research questions were answered in the study, with a number of important points and recommendations being highlighted.

How are general practitioners contributing to the management of osteoarthritis in the community?

The main finding of the study is that osteoarthritis is a common disease which affects the individual in a multimodal way which is best managed in an interdisciplinary team. They all emphasised the key role being played by the GP in the management of the condition.

What are their daily challenges when working with patients with osteoarthritis?

As illustrated in the results section and discussion a number of challenges were acknowledged by the participants. These were subdivided into the challenges in the healthcare system and the problems some patients have because of poor support network.

What are we lacking locally? Do general practitioners feel the need for local guidelines?

A number of proposals were mentioned but the strongest recommendation of all is that for the establishment of a specialised osteoarthritis clinic at the health centres. This would allow for a holistic approach to the patients' needs through an interdisciplinary approach. It would be ideal as different professionals would share the same clinic and address the patients' different needs. This would ultimately be cost-effective and would reduce a lot of the current red tape and decrase the waiting times. To man such clinics, there surely needs to be a bigger number of professionals who are motivated in making these patients' lives better. Such clinics would be similar to the already-functioning fibromyalgia clinics at the local health centres.

Major emphasis on the importance of healthy lifestyle is to be done locally. The Health Promotion Department is already working hard in promoting a healthy lifestyle; but possibly more should be done. There should be more education amongst the general public, in schools and amongst GPs. Also, GPs should be updated regularly as to the available local services so as to make better use of the already existing services. Meetings between GPs (working locally) and public service officials would allow for better discussion about local needs and would allow improved local services.

A self-help group for patients with osteoarthritis and other rheumatological conditions is already established in Malta. Its aim is to enhance the well-being of patients by empowering them in their daily lives. However, the lack of awareness amongst the interviewed GPs may reflect a general lack of awareness of its existence. Promoting its function amongst GPs would surely allow it to help an even greater number of affected patients.

In conclusion the research questions were adequately tackled in this study. Further research including different team members might add more useful ideas for better person-centred management of osteoarthritis in the community.

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Dr Doriella GALEA

MD, MRCP (UK), MRCP Geriatrics, MSc Family Medicine, MA Ageing and Dementia Studies

Higher Specialist Trainee in Geriatric Medicine, Karin Grech Rehabilitation Hospital, Malta

Email: galeadoriella@gmail.com

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