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A new normal for family doctors

JMCFD

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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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A new normal for family doctors

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A new normal for family doctors

Dr Edward ZAMMIT

INTRODUCTION

We have now entered the second year of the COVID-19 Pandemic, and life is slowly returning to normal, or to the oft quoted 'new normal'.

Pandemic fatigue and a host of related health and social issues - including economic and psychological problems - are pushing society back towards some semblance of pre-pandemic normality.

There is no doubt that family doctors are going through a similar transition, yearning for a return to a life where a simple cough and sore throat do not trigger a chain of stress and anguish every time a patient steps into our clinics.

Having said that, there is no doubt that this pandemic has made us acutely aware how our workplace infection control and occupational health policies require a serious overhaul. There is also no doubt that 'standard infection' control practices during the years are obsolete at best, and family doctors have been taking their risk exposures for granted. In our waiting rooms, we get teenagers with meningitis mingling with elderly people with arthritis, and children with slapped cheek syndrome sitting beside pregnant women.

The new normal for family doctors would do well to include risk assessment for practices and clinics and the adoption of infection control measures.

COLLEGE ACTIVITIES

In the meantime, the Malta College of Family Doctors (MCFD) has been its usual busy self.

Major projects such as the latest update of the Specialist Training Programme in Family Medicine (STPFM) Curriculum have been completed, the Assessment Team has been strengthened thanks to the recruitment of a group of high-calibre professionals, a new Continuing Professional Development (CPD) Team has been set up and a structure is now in place to host Vasco da Gama exchanges.

All this in addition to the small incremental changes carried out over the past few months - changes which though seemingly insignificant on their own have contributed to significant improvements in the way MCFD operates and the processes and projects it administers and coordinates.

THE STPFM CURRICULUM

The updated Curriculum for the Specialist Training Programme in Family Medicine has been finalised. A companion handbook is being planned to facilitate its use. The Curriculum is available online on the MCFD and STPFM websites and also as a hardbound version. This has been a massive undertaking, made possible by the fruitful collaboration of a team of dedicated GPs and GP trainees, both local and international - the latter being the esteemed members of the EGPRN (European General Practice Research Network) who kindly peer reviewed the various curriculum modules.

STPFM

2020 had originally been earmarked for re-accreditation of our Specialist Training Programme in Family Medicine by the Royal College of General Practitioners (RCGP). COVID-19 disrupted this process as the RCGP could not send its representatives to Malta. Discussions between the MCFD and the RCGP led to a successful re-

accreditation and renewal of the MCFD-Health Division-RCGP tri-partite agreement in both 2020 and 2021. In 2022 new discussions will determine the date of the next re-accreditation.

ASSESSMENT TEAM

In 2021, a fresh call was sent to gauge MCFD members' interest in joining the team. Dr. David Sammut, Dr. Marilyn Harney and Dr. Simone Deguara rejoined the team together with veteran Dr. Marco Grech and a new member, Dr. Jurgen Abela. Dr. Marco Grech was chosen as the new Assessment Lead.

Preparations for the MCFD Summative Assessment 2021 were already underway in the first quarter of 2021.

MCFD SUMMATIVE ASSESSMENT

For the 2021 MCFD Summative Assessment, the Assessment Team recommended that the Recorded Consultation Assessment (RCA) should be the assessment format used to assess clinical skills and performance.

"This in view of the ongoing pandemic, thus limiting unnecessary exposure to both candidates and auxiliary staff needed to organise a CSA exam. Although the format is different, the standard expected of the candidates sitting for this exam are identical to those of the CSA" (Malta College of Family Doctors, 2021).

"It uses a format of pre-recorded consultations which provide a range of real-life patient's encounters in primary care as evidence of the level of competency in areas of patient care, along a broad base of the curriculum" (Malta College of Family Doctors, 2021).

CPD AND EDUCATIONAL ACTIVITIES

2021 made it clear that online CPD is here to stay. There is no doubt that offline CPDs are far more enjoyable, allowing MCFD members to socialise and mingle more freely (and buffets definitely trump eating croissants in front of a laptop). I am confident that we will soon be planning a few of these traditional CPDs. In the meantime, the MCFD's focus is on online CPDs and its members can benefit from a series of lectures and seminars organised/endorsed by the MCFD.

MCFD members, both Specialists in Family Medicine and GP trainees are encouraged to participate in these CPD activities not just as passive recipients but also as active participants and contributors. Members of other specialties and professions will always be welcome contributors and guests; but MCFD also believes in CPDs from GPs to GPs. While a secondary care perspective will often inform GP education to various extents, we must not forget the specific learning needs and unique primary care perspectives of a GP can only be accurately addressed by a fellow GP. We must not forget the ever-increasing number of GPs with special interests, be it Women's Health, Palliative Care, Migrant Services, etc., which are providing Family Medicine and Primary Health Care with an abundance of GPs with valuable in-depth knowledge and experience in various medical fields - knowledge and experience which they can share with their peers.

PATIENT EDUCATION

To honour its commitment to educate the public, the MCFD created and distributed patient education leaflets on Flu, Common Colds and COVID-19. These were distributed at University, the Homes for the Elderly and among teachers.

The plan is for the MCFD to engage in more patient education initiatives, whether of its own initiative or on invitation, and in collaboration with other entities.

Such initiatives will take many forms and will not be limited solely to the creation and distribution of leaflets but will make use of other media.

MCFD members are encouraged to submit ideas and offer their expertise and participation in such initiatives.

TEACHERS' COURSE

The last Teachers' Course took place in late 2019. The COVID-19 Pandemic threw the MCFD yet another curveball in this regard. A face-to-face course being out of the question, a possible online version was discussed. The unanimous conclusion was that an online version would lack the robustness and validity of a good face-to-face course.

Now that COVID-19 restrictions are being eased off, plans are underway to organise an MCFD Teachers' Course in the first quarter of 2022. The MCFD is also interested in hosting a EURACT Level 1 Teachers' Course in Malta in the last quarter of 2022. Both of these courses should contribute significantly to the current pool of certified GP Trainers.

VASCO DA GAMA MOVEMENT

The Vasco da Gama Movement (VdGM) is the WONCA Europe Network for New and Future General Practitioners / Family Physicians.

The VdGM works with doctors who are training in the speciality of family medicine and those in the first five years after qualifying as family medicine specialists and provides young doctors with opportunities in expanding their education, research skills, policy-making, leadership qualities and international collaboration.

Thanks to the efforts of a local team of young enterprising family doctors and former GP trainees, MCFD is actively participating in the VdGM's programmes. The objective of the current project is to host foreign GP Trainees for a 2-week study visit in Malta. This would require the kind involvement of host practices in private practice and attachments in health centres. This project is already well under way and calls will be sent in the coming months to identify host practices.

MCFD ELECTIONS

During the second quarter of 2021 a Call for President-Elect was issued and this was taken up by the current Honorary President, Dr Edward Zammit.

The term of this Council will expire towards the end of this year and calls for an election will be sent in December 2021 with the aim of having a new Council in place by mid-March 2022.

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RESEARCH ARTICLE

An analysis of mental health referrals from public health centres to the Emergency Department of Mater Dei Hospital, Malta

Dr Matthew PIZZUTO, Dr Matthew FORMOSA, Dr Marilyn HARNEY and Dr Gabriel ELLUL

ABSTRACT

Introduction:

Fifty per cent of the population experiences at least one mental disorder in their lifetime with 25% suffering one in the previous year. Recognition, diagnosis, treatment and referral depend on general practitioners (GPs). Prevalence of psychiatric problems in local primary care was 8% in 2017.

Aim:

To evaluate the number of patients with a psychiatric complaint referred to the Emergency Department at Mater Dei Hospital (MDH), Malta, the reason for referral and whether these referrals were associated with certain factors, including time of day.

Method:

Data of all patients with a psychiatric complaint referred to the Emergency Department from one of the primary health care centres in Malta was collected retrospectively using Excel. Referrals during the months of November and December 2019 were considered.

Results:

Sixty-nine patients inputted were equally distributed between November and December. Forty-two percent were females, the commonest age group was 19-30 years and most were triaged as Emergency Severity Index-2 upon arrival to the Emergency Department. Most patients were referred from the South region (Kirkop, Paola and Bormla). Most patients were referred between 09:01 and 17:00 hours. Twenty-seven point per cent were referred due to suicidal ideation closely followed by severe anxiety (21.7%).

Forty-three percent were discharged on the same day with an urgent psychiatric appointment being given, 20% were kept at MDH, 7.2% required care at Psychiatric Unit and 5% admitted to the psychiatric Mount Carmel Hospital (MCH).

Conclusion:

Suicidal ideation and severe anxiety are common complaints from government primary care to the Emergency Department. The majority of patients referred were given urgent psychiatric follow-up appointments in the community. The role of an onsite community psychiatrist would be twofold; immediate review for certain patients (such as

a walk-in system) and further follow up by the same person in the community to improve the continuity of care.

Keywords:
Community care, general practice, psychiatry, accident and emergency

INTRODUCTION

Fifty percent of the population experiences at least one mental disorder in their lifetime with 25% suffering one in the previous year (Wittchen et al., 2003). Recognition, diagnosis, treatment and referral depend on GPs. The prevalence of psychiatric comorbidities in a local study carried out in primary care was found to be 8% in 2017 (Baldacchino et al., 2017).

Primary health care aims to promote healthier lifestyles and prevent communicable and non-communicable diseases. During 2014, the cost of providing General Practitioner (GP) services through nine health centres, which is utilised by around 30 per cent of the Maltese population, was estimated at €10.3 million (Auditor General, 2016). The exact number of psychiatric patients reviewed is not known but considering that an average GP will review one patient suffering from psychiatric illness per five patients seen, this equals 6% of the whole population with around €2 million being invested (Witchen et al., 2003).

The three major local health centres are the ones found in Mosta, Floriana and Paola, which operate on a 24-hour basis in order to offer continuous medical care to patients (Government of Malta, 2021). Although only around 20% of patients (of all patients seen at primary care) are seen at night, Sundays and public holidays, this reduces the load being placed on the Emergency Department (ED) at Mater Dei Hospital (MDH), Malta's only government general hospital (Auditor General, 2016).

Despite the continued broadening and development of the GP function provided through health centres, during 2014 around 23% of all persons who utilised the services of Mater Dei Hospital's ED, could have been dealt with at health centre level (Auditor General, 2016). Additionally, most of these users were self-referred. This implies that patients are intentionally by-passing health centre services to the detriment of increasing pressures on MDH's resources (Auditor General, 2016).

Aim

The objectives of this study were threefold:

1. To approximate the number of patients referred from governmental health centres to the ED with suspected psychiatric disorders for specialist input.
2. To determine the most common reasons why patients are referred to the ED.
3. To determine whether there was a diurnal variation in patient presentation and referrals done comparing findings from both day and night shifts.

METHOD

This was a retrospective cross-sectional study carried out in January 2020. All the required permissions (from the Chief Executive Officer, the head of the ED and data protection at MDH) were requested and granted prior to the initiation of this study. This study did not require ethical approval since at no point did the authors make any contact whatsoever with any of the patients mentioned in this study.

Inclusion criteria were set to encompass all patients who were referred to the ED from primary care during the months of November and December 2019. November and December were specifically chosen as they were deemed to be two of the busier months in the health centres.

These patients' demographics were noted, along with the reason for referral, the referring health centre and the follow-up plan provided after discharge from the ED. Information was gathered directly from ED review triaging sheets. Referrals from private general practice were excluded since this study's aim was to analyse governmental health centres' referrals.

All patients reviewed at the ED from the nine Health Centres around Malta (Mosta, Birkirkara and Rabat encompassing the north region; Gzira, Qormi and Floriana encompassing the Central region and Kirkop, Paola and Bormla encompassing the South region) were included in this study. Data was inputted and processed with Microsoft Excel 2010.

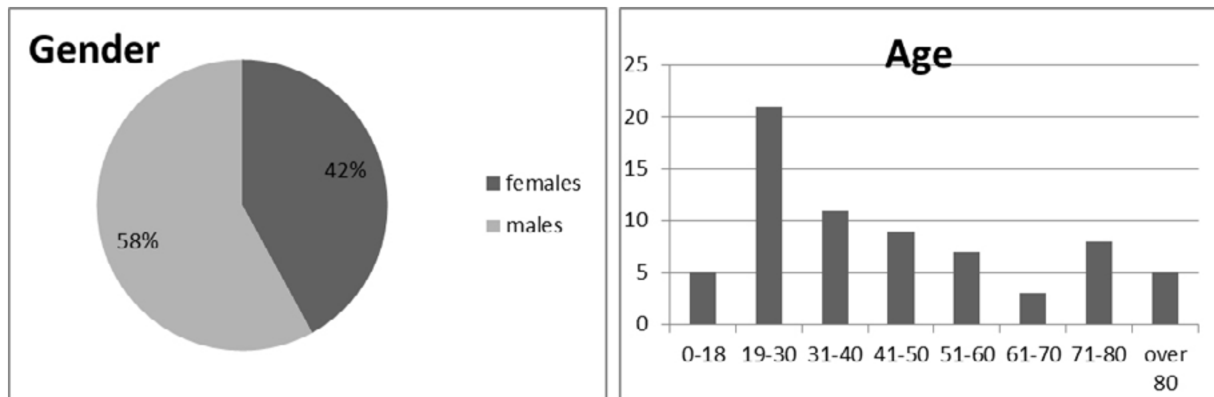

Figure 1 - Gender distribution (left) and the age of patients being referred to the ED

RESULTS

The number of patients being referred to the ED was similar in both November (52%) and December (48%). From the sample taken, there were more males (40 as opposed to 29 females) being referred to the ED for further investigation. The mean age of the patients overall was 42.6 years. The gender and age distribution of patients being referred can be seen in Figure 1.

The majority lived in the South catchment area (n = 27), followed by the north (n = 23) and then central (n =19). This can be seen in Figure 2 below. Marsa had the highest number of patients being referred to the ED.

Upon arrival to the ED, patients were triaged according to the severity of their presenting complaint using the Emergency Severity Index (ESI) scale. Patients assigned as ESI-1 are the most likely to be in danger of imminent death whilst those being assigned as ESI-5 being those who present with the least dangerous complaints. Eighty-three per cent of patients were immediately triaged as ESI-2. The mean ESI rating was 2.29 (CI 0.74; 0.91). The majority of patients (75%) were seen and referred between 08:00 - 19:59. The times chosen reflect the already existing shifts in place locally; the day shift is between 8:00-20:00 and night shift is between 20:00 to 08:00. ESI category of patients and time of referral can be seen in Figure 3.

The presenting complaints varied significantly from aggressive behaviour to severe side effects of treatments which required hospitalization (as can be seen in Figure 4). Twenty-seven point five percent were reviewed for suicidal ideation whilst severe anxiety came a close second with 21.7% of patients being referred with it. Other important causes included aggressive behaviour (10%), depression (10%) and deliberate self-harm (DSH) (8.7%). Moreover, Figure 4 also separates those referred in view of suicidal ideation alone and those with suicidal ideation (SI) and DSH combined.

Patients were seen at the ED by psychiatric trainees and then according to the findings, a plan was set up for each patient. From the cohort of 69 patients referred to the ED, 43% were reviewed by a psychiatric trainee and deemed fit for an urgent psychiatric outpatients appointment. Twenty per cent of patients were kept for further observation at MDH in a medical ward, some under constant watch whilst 7.2% had to be kept at the Psychiatric Unit at MDH. Six per cent of patients required hospitalization at MCH. Twenty three per cent of all referrals were either deemed not to warrant an outpatient psychiatric appointment or had their previously booked psychiatric appointment

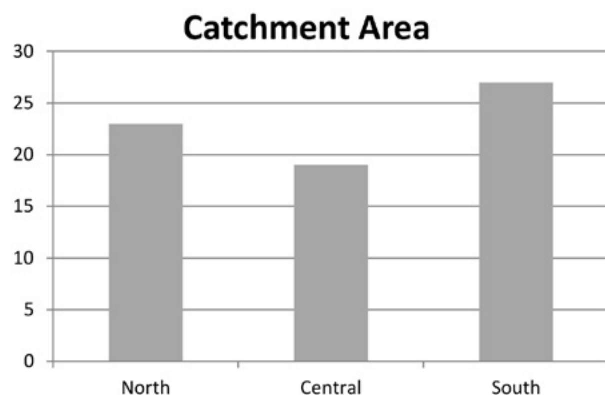

Figure 2 – Areas from which patients were referred

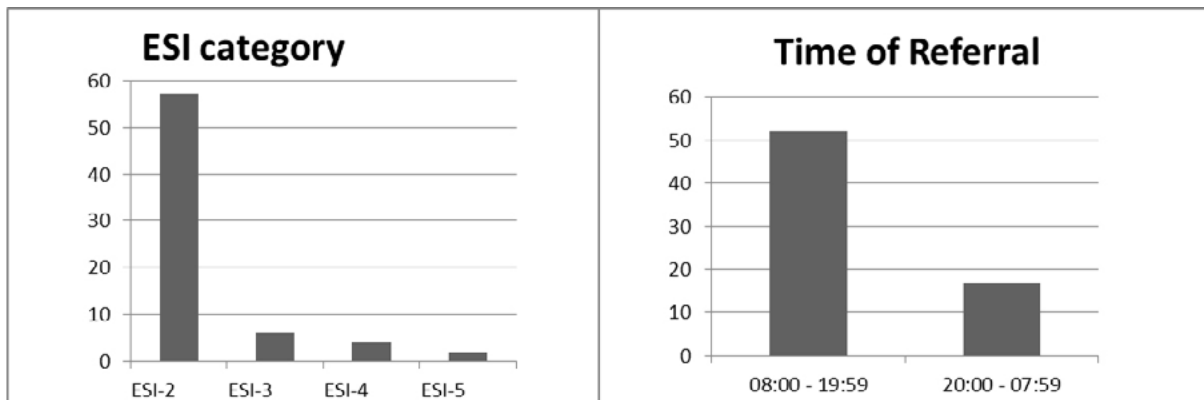

Figure 3 – ESI category once patients were reviewed at the ED (left) and time of arrival of patients (right)

date unchanged. All this information is illustrated in Figure 5.

The 4 admissions to MCH were balanced between males and females (50% for both).

DISCUSSION

Males were more likely to present with a psychiatric condition requiring referral to the ED. This is an interesting point since usually females are more willing to seek help for their mental health issues (Doherty et al., 2010). However, males are more likely to have serious issues when they present which can result in more referrals as was seen in the current study (Biddle et al., 2004).

The most common age group requiring referral was that of people aged between 19 and 30 years. This might have been due to alcohol and drug-related problems manifesting in DSH attempts, suicidal ideation and severe anxiety symptoms (Goodyear-Smith et al., 2017). Seven percent were patients aged above 80 and most were referred due to an inability to cope with depression following the death of a loved one. This was justified since a drastic change had occurred with severe implications on one's mental health and not all people can cope with such a swift unexpected change (Margrett et al., 2010).

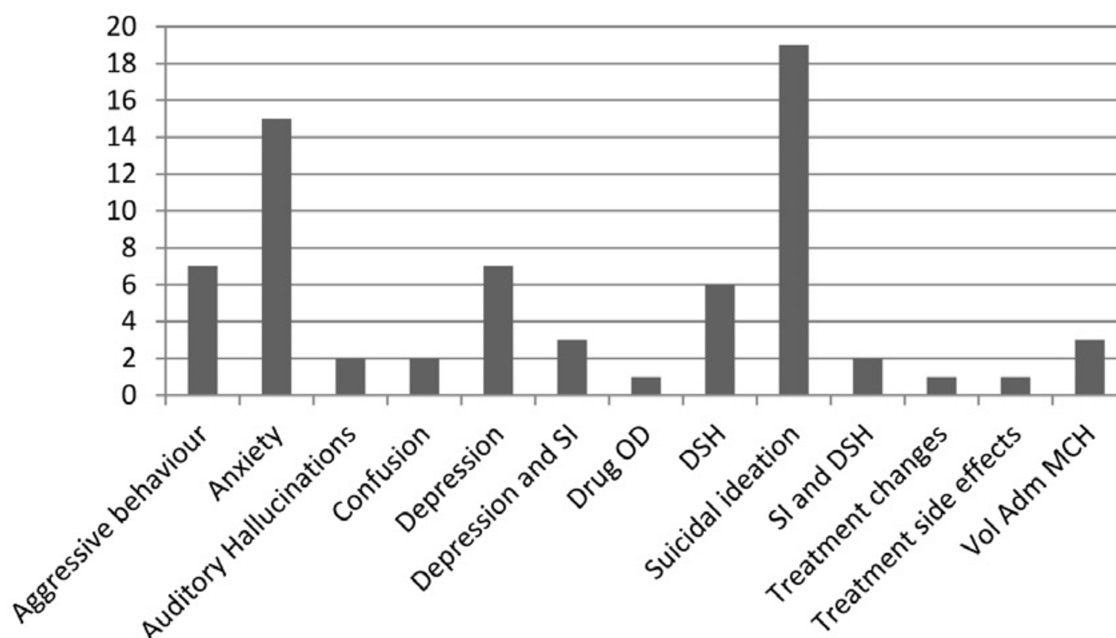

Figure 4 – presenting complaint of patients (NB: SI – suicidal ideation; OD – overdose; DSH – deliberate self-harm; Vol Adm MCH – voluntary admission Mount Carmel Hospital)

The referrals were well distributed amongst the three main regions locally, with the southern region having a slightly higher referral rate than the north, and the latter having a slightly higher referral rate than the central region. Considering that the inhabitants of Marsa had the highest referral rate of any town, this might be due to the immigrants living there. It has been well established in literature that migrants suffer from more mental health problems (von Werthern et al., 2018).

Figure 4 above only denotes the initial and main complaint and reasons for referral. However, there were often a number of secondary issues which had also arisen and had to be dealt with at the ED with the help of further testing and psychiatric review.

The local ESI triaging system has been mentioned above and indeed the low mean ESI number in this study consolidates the fact that the vast majority of referrals were not only warranted but also of an urgent nature. This meant that the patients referred required immediate review and management by a psychiatrist.

The difference in referral rate between day shifts and night shifts is probably due to the total amount of patients being seen by GPs. It is well known that health centres are busier during the day and indeed, during the night, only Mosta, Paola and Floriana Health centres remain open to offer a 24 hour service. This study did not review the percentage referral rates during the day and night to determine whether there is a difference in the rates of referrals between patients being seen during the day or during the night.

Suicidal ideation (SI) is classified as R45.8 under International Classification of Diseases-10 (ICD-10) and is the idea or thought which one has to end their lives (World Health Organization, 1992). SI can arise due to a multitude of reasons, even manifesting itself as a reaction to an acute stress event, severe depression, acute rejection and organic causes. The latter requires careful investigations and hence the reason why patients were referred to the ED. Suicidal ideation can result in deliberate self-harm and/or suicidal intent, with both being serious indicators that the patient needs urgent help. Suicidal ideation can be either noted by the patient who seeks help or else noticed by their relatives. It was the commonest problem faced by GPs during this period with a total of 27.5% of all cases. These should all be taken seriously and in fact all cases were referred to the ED for further evaluation.

Anxiety is described in the ICD-10 as a sub-section in F41 (World Health Organization, 1992). Anxiety can range from phobias to palpitations to tachycardia. Depressive and obsessional symptoms, and even some elements of phobic anxiety, may also be present, provided that they are clearly secondary or less severe. Anxiety on its own was never the cause of referral but

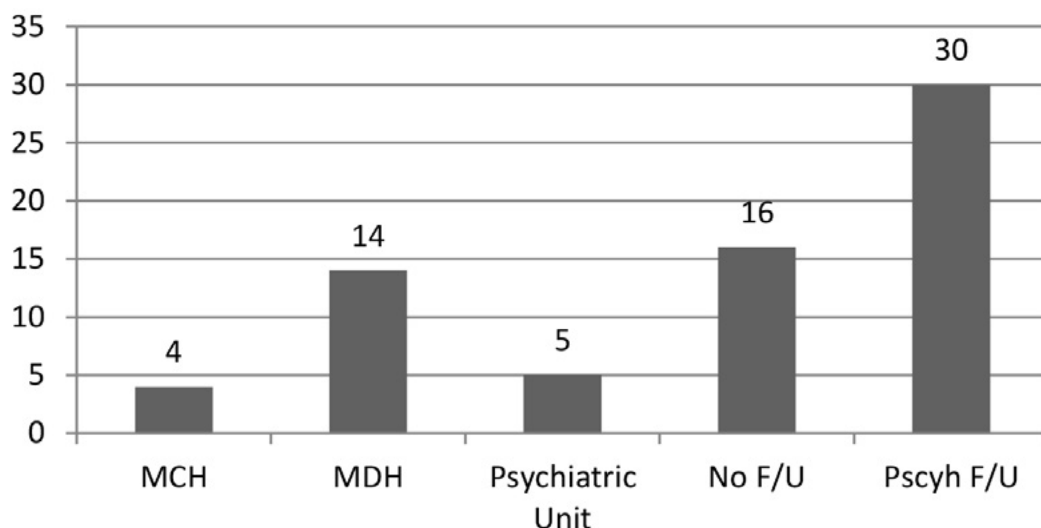

Figure 5 – follow up of patients after initial encounter at the ED

often times (66%) was associated with other serious issues such as depression, insomnia and suicidal ideations which warranted further evaluation. Nearly half (46.7%) of patients reviewed in view of anxiety presented with chest pain and palpitations, further complicating the presenting complaint and challenging the general practitioner. Patients with psychiatric diseases are known to suffer from medical conditions around 2-3 times more frequently than their counter part general population (Harris et al., 1998); hence cardiac disease should have been rightly ruled out. Moreover, these patients often resort to smoking and alcohol, the former being a strong independent risk factor of cardiac disease further complicating the case.

Another important group of disorders is affective/mood disorders (listed under F30-39 in ICD10). In depressive episodes (F32), there are mild, moderate or severe episodes, in which the patient suffers from lowering of mood, reduction of energy, and anhedonia. Capacity for enjoyment, interest and concentration is reduced, with marked tiredness after minimum effort also noted (World Health Organization, 1992). Other commonly associated symptoms include insomnia, decreased appetite, and reduced self-esteem with frequent feelings of worthlessness. The lowered mood does not depend on external daily activities, with depression being present even in the morning. Depending upon the number and severity of symptoms, a depressive episode may be specified as mild, moderate or severe.

Recurrent depressive disorder is characterized by repeated episodes of depression (F32), without any history of independent episodes of mood elevation and increased energy. There may be brief episodes of mild mood elevation and over activity (hypomania) immediately after a depressive episode, sometimes precipitated by antidepressant treatment. The more severe forms of recurrent depressive disorder (F33.2 and F33.3) have much in common with earlier concepts such as manic-depressive depression, melancholia, vital depression and endogenous depression (World Health Organization, 1992). Around 10% of patients were seen due to both depressive episodes and recurrent depressive episodes requiring referral to the ED. Thirty per cent of patients who were referred due to depression had associated suicidal ideation and hence two separate categories were put in Figure 4.

Ten per cent of patients were referred in view of aggressive behaviour towards their family members. These patients required urgent investigations and psychiatric review in view of uncovering the underlying cause of their behaviour. Unfortunately aggressive behaviour commonly leads to domestic violence (Hsieh et al., 2017). This can also stem from personality disorders such as bipolar disorder and narcissism. Common factors leading to aggressive behaviour include both alcohol and drug intoxication along with organic causes which need to be ruled out by the appropriate investigations (Hsieh et al., 2017).

Deliberate self-harm (DSH) was also a common problem facing GPs. This ranged from intentional overdose with a particular common drug (such as paracetamol) to self-inflicted injury with sharp objects (such as knives). The reasons behind these acts were not fully understood at GP health centres, but they usually include wanting more attention diverted to oneself to an actual attempt and suicidal intent (ICD 10).

Other issues facing GPs included acute confusion (3%), auditory hallucinations (3%), drug overdose (OD) (1.4%) and treatment side effects (1.4%). Patients who were reviewed at a health centre, following initial assessment were referred to the ED, where they received the proper treatment. The patient who was referred to the ED was referred in view of paracetamol OD and required further assessment. The patients seen and diagnosed with acute confusional state and auditory hallucinations all needed to be investigated further about the cause since organic causes need to be excluded as they are important differential diagnoses of both. Another patient had to be referred in view of unstable depression. The patient had recently been started on sertraline and ever since had been complaining of lethargy, weakness and insomnia (Joint Formulary Committee, 2020). In view of the above, the patient was referred for further assessment and to determine whether these

symptoms were due to sertraline or another underlying pathology.

A note should also be made about a number of patients who recognized their problems and requested a voluntary admission to Mount Carmel Hospital. They recognized that they had an issue, sought help and were referred in view of a toxicological screening prior to voluntary admission to MCH.

This shows that the decision to refer these patients was completely justified since it was backed up by the ESI number at the ED.

Strengths

This study enlisted all patients referred to the ED from the governmental primary health sector for the total duration of two months. Follow up of all patients was accounted for after being managed at the ED.

Limitations

This study relied on documented evidence and hence has an inherent and unavoidable bias related to the quality and legibility of documentation. Furthermore, certain inferences on diagnoses made at the ED were not necessarily backed up by psychiatric specialists and may thus be open to further diagnostic scrutiny. This study only reviewed referrals done by the main governmental health centres and did not include referrals done by private general practice.

CONCLUSION

The aims set for this study were all achieved. Suicidal ideation and severe anxiety were common complaints referred from the government primary care setting to the Emergency Department. Locally, there are community mental health services but only with scheduled appointments. Considering that nearly half of the patients only required psychiatric follow up and another quarter did not require any kind of follow up, a psychiatrist on site at the main health centres would have been able to do this (as a walk-in service). Alternatively a psychiatrist on call specifically for health centres would be beneficial for advice or possible review in the community. Moreover, the follow-up can be done with the same psychiatrist in the community to ensure continuity of care is maintained. Psychiatry dilemmas remain due to patient's vague symptoms which can easily arise from multiple systems, some of which should be considered as life threatening.

Recommendations

A psychiatrist on site in the community might be a great addition since, as can be seen in this study, most patients reviewed at the ED were discharged with a psychiatric outpatient appointment. Moreover, a psychiatrist in health centres can arrange psychiatric follow ups in the community which would ease the burden on patients and ensure a smooth follow up. Even if patients are sent to the ED, the local centre psychiatrist can follow those patients up during both day and night.

A number of patients were sent to MCH, most of them being on a voluntary basis and this could have been facilitated in the community with direct transportation keeping in mind that the patients were not under the influence of drugs and/or alcohol which would have required admission to MDH first.

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RESEARCH ARTICLE

Comparing GP trainees' evaluations of placements within Malta's Specialist Training Programme in Family Medicine before and after a COVID-19 pandemic related break in training

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ABSTRACT

Background:
Malta's Specialist Training Programme in Family Medicine lasts for three years, made up of three six-month training posts in family medicine interspersed with other-speciality placements lasting eighteen months in all. As a result of the COVID-19 pandemic, all training was suspended from 23 March to 5 July 2020.

Objective:
A comparison of GP trainees' evaluations of their training placements during the six-month periods before and after the training break was carried out to identify if and how training was affected by the pandemic and what corrective measures or improvements were needed.

Method:
Training placements are evaluated by GP trainees through online forms on their ePortfolio. The information from these forms was transcribed into Microsoft Excel to enable quantitative and qualitative analysis. Feedback given for posts during October 2019 to March 2020 (i.e. prior to the COVID-19 enforced break in training) was compared with that given during July-December 2020.

Results:
GP trainees were satisfied overall with the teaching provided during the family practice and other-speciality posts. Post-break satisfaction ratings in government health centres rose while those for private general practice declined, both as a consequence of the pandemic. While a post-break drop in satisfaction ratings for Paediatrics was attributed to the pandemic, similar declines for Taster and Orthopaedics posts were unrelated.

Conclusion:
The COVID-19 pandemic affected teaching in government practice positively through reducing patient numbers, which allowed a better training environment. Private practice was affected negatively by the pandemic, namely through limited clinical scenarios for teaching. The

post-break drop in ratings for Paediatrics also was attributed to the pandemic which reduced outpatient attendance, doctor-patient interaction and consultation dynamics.

Recommendation:
Training during placements within the STPFM can be improved and safeguarded from negative factors such as a pandemic if administrators endeavour to enhance the educational environment.

Key Words
Education, family practice, program evaluation, COVID-19, Malta

INTRODUCTION

Background

The Specialist Training Programme in Family Medicine (STPFM) was inaugurated in Malta in 2007 by the Primary HealthCare Department and the Malta College of Family Doctors (MCFD). This followed approval in 2006 of the MCFD's training document by the Specialist Accreditation Committee within Malta's Ministry for Health (Sammut, et al., 2006).

The STPFM lasts for three years, made up of three six-month training posts in Family Medicine (supervised by a General Practitioner [GP] trainer) which are interspersed with training placements in other specialities (supervised by specialist consultants) lasting eighteen months in all. The mandatory specialties are classified as major (Emergency, Medicine, Paediatrics, Obstetrics & Gynaecology and Orthopaedics) and minor (Dermatology, Ear Nose & Throat, Geriatrics, Palliative Care/Hospice, Ophthalmology and Psychiatry). There are also two short Taster posts in specialities chosen by the GP trainees according to their educational needs (Zammit, Sammut and Abela, 2017).

To ensure the quality and success of teaching programmes, evaluation is an important tool, not only for teaching in general (Morrison, 2003) but also for family doctor training in particular (Karim, et al., 2013). While studies have been carried out over the years to evaluate the STPFM (Sammut, 2009; Sammut and Abela, 2013; Sammut and Abela, 2019), training posts are reviewed regularly by GP trainees who are mandated to fill in evaluation forms on the educational ePortfolio. Such feedback is monitored systematically by the postgraduate training coordinators in family medicine who then tackle any resulting issues to improve the quality of training provided (Sammut and Abela, 2012).

As a result of the COVID-19 pandemic, the Specialist Training Committee in Family Medicine (STCFM) decided that all training within the STPFM be suspended from 23 March 2020 because the quality of training had been compromised by the suspension of normal services within other specialities and by additional demands being posed by the situation in family medicine (Sammut and Abela, 2020). Three months later the STCFM agreed that training placements in family practice and in other specialities be restarted on 6 July 2020 as government health centre and private practice services were returning to pre-COVID-19 levels and as hospital outpatient and other routine clinical services had either resumed or were in the process of starting again (Sammut and Abela, 2020).

Objective

Following the resumption of training after the 3-month break enforced by the COVID-19 pandemic, the postgraduate training coordinators felt that a comparison of the trainees' evaluations of their training placements in the six-month periods before and after 23 March – 5 July 2020 was warranted to identify if and how training was affected by the pandemic and what corrective measures or improvements were needed.

METHOD

Placements in family medicine (in government health centres and private general practice) and in other specialities are evaluated by GP trainees through online forms on their ePortfolio. These were adapted from questionnaires developed by the Yorkshire Deanery Department for NHS Postgraduate Medical and Dental Education (2003). The information from these forms was transferred to Microsoft Excel spreadsheets so that anonymous analysis could take place, both quantitatively and also qualitatively using item-content analysis (Krippendorff, 1989). Feedback

given for posts during the six-month period of October 2019 to March 2020 (i.e. prior to the COVID-19 enforced break in training in April-June 2020) was compared with that given during the subsequent six-month period of July-December 2020.

Ethical considerations

Permission for this study was provided by the Data Protection Officer and the Clinical Chairman of Primary HealthCare. Ethical approval was not required since no sensitive personal data were gathered. This study also falls within the 'zone of accepted practice' (Zeni, 1998), as regular reviews of GP trainee evaluations form part of the training coordinators' own internal quality assurance and practitioner research, with the ultimate aim of improving the training programme.

RESULTS

As the completion of post-placement evaluation forms is mandatory in the training programme, all GP trainees in training gave their feedback. The participating trainees consisted of those in their first (n=18), second (n=16) and third/final (n=18) years of training, totalling fifty-two.

Quantitative analysis

The percentage satisfaction ratings for teaching during the 6-month period of October 2019 - March 2020 (prior to the break in training during April-June 2020 due to the COVID-19 pandemic) were compared with those for the post-break 6 months (July- December 2020).

GP trainees were very satisfied overall with the teaching provided during the family practice posts, with pre-break ratings of 81-91% and post-break ratings slightly higher at 84-94% (Figure 1). When looking separately at the satisfaction ratings for teaching in government health centres and those in private general practice, it was noted that in the former the ratings increased by 5 to 11 percentage points from the pre-break to the post-break period, while for the latter the ratings decreased by 3 to 7 percentage points.

The GP trainees' satisfaction with the effectiveness of training in the other specialities during the 6-month periods before and after the 3-month COVID-19 break may be viewed in Figure 2 (major specialities lasting 6 weeks to 3 months) and in Figure 3 (minor specialities lasting 2 weeks to 1 month). The trainees were very satisfied overall with training provided during the major speciality posts (86-94% ratings) and

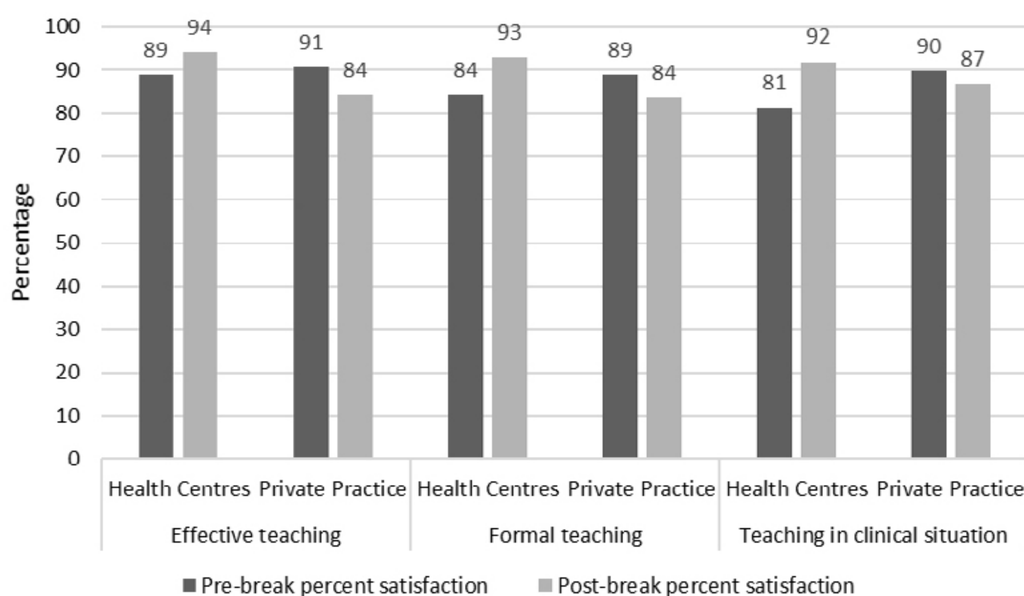

Figure 1 - Trainee satisfaction ratings for teaching during the Family Medicine placement for October 2019-March 2020 (prior to the April-June 2020 break intraining due to the COVID-19 pandemic) and for July-December 2020

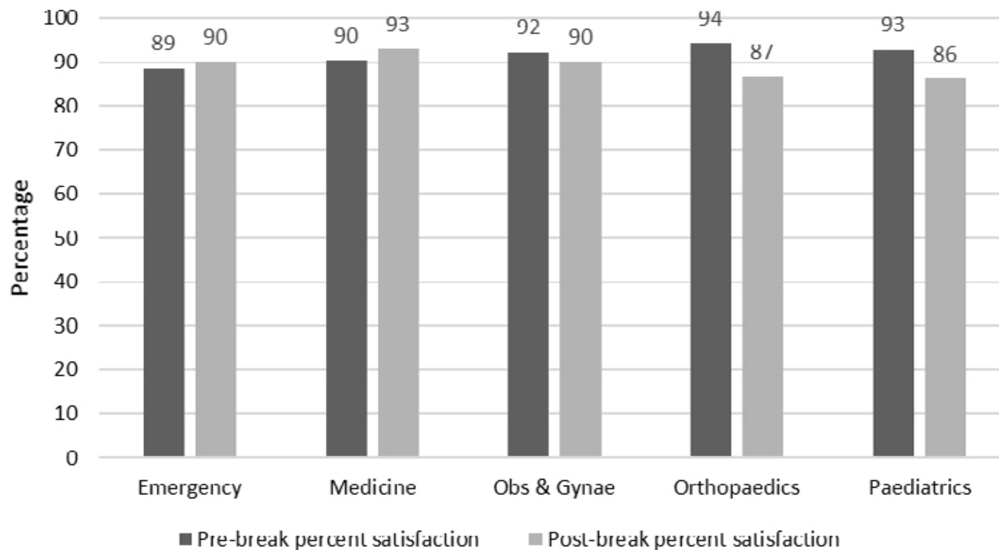

Figure 2 - Trainee satisfaction ratings for effectiveness of training during Major Speciality Placements for October 2019-March 2020 (prior to the April-June 2020break in training due to the COVID-19 pandemic) and for July-December 2020

quite satisfied with minor-speciality post training (78-97% ratings).

The specialities that had a notable drop in satisfaction rating from the 6-month pre- break period to the 6-month post-break period were the Taster posts in various optional specialities (94 to 86%) by 8 percentage points and the posts in Orthopaedics (94 to 87%) and Paediatrics (93 to 86%) by 7 percentage points. On the other hand, there were two minor specialities which were awarded a higher rating by 9 percentage points after the COVID-19 break: these were the posts in Ear, Nose & Throat (ENT) from 79 to 88% and Ophthalmology from 78 to 87%.

Qualitative analysis

The GP trainees made suggestions how the practice could be improved as a teaching unit within the family medicine placements (Table 1), with the top two concerning training in the government health centres. The trainees in fact emphasised the importance of working in the same shift and health centre as their trainers (18 suggestions in all) and requested more or

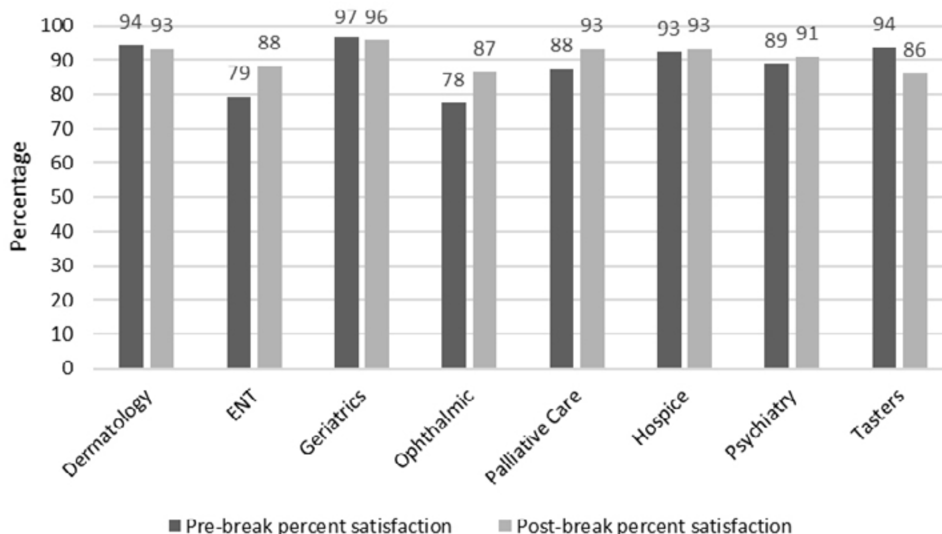

Figure 3 - Trainee satisfaction ratings for effectiveness of training during Minor Speciality Placements for October 2019-March 2020 (prior to the April-June 2020 break in training due to the COVID-19 pandemic) and for July-December 2020. [NB:ENT – Ear, Nose & Throat]

Table 1: 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 [Pre-break: October 2019 – March 2020; post-break: July-December 2020]

Suggestions for improvement	Number	
	Pre- break	**Post- break**
Working in same shift / health centre as trainer	12	6
More / protected clinical teaching despite workload / lack of staff in health centres	9	2
Continuity of care of patients (seeing same patients in follow up clinics) to improve learning	6	0
Being assigned for more exposure to specialty clinics in health centres	5	3
Case-based teaching using clinical scenarios and challenges in health centres	4	4
More tutorials on Clinical Skills Assessment	4	2
Private practice exposure should be longer to improve experience (more hours if full-time, longer post if part-time)	1	6

protected clinical teaching in view of the heavy workload and lack of staff (11 total requests).

The GP trainees proposed a number of ways how their other-speciality assignments could be improved. Tables 2 and 3 list the proposed improvements for the major and minor other-speciality posts respectively. The top suggestion was for more outpatient sessions in all other-speciality posts (31 requests), followed by 28 requests for a longer placement in minor other-speciality posts, 21 proposals for more formal teaching/tutorials across all other-speciality placements and 16 appeals to see patients alone / hands-on during all other-speciality posts.

DISCUSSION

Family medicine placements

While GP trainee satisfaction ratings for the overall family medicine placement and for government health centres during July-December 2020 were slightly higher compared to October 2019 - March 2020 (by 3 and 5-11 percentage points respectively), the drop of 3-7 percentage points for private general practice was intriguing (Figure 1).

The probable reasons for this drop in satisfaction with teaching during private GP posts were given by the trainees themselves in comments they wrote in the evaluation forms. In

Table 2: 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 the major other-speciality posts [Pre-break: October 2019 – March 2020; post-break: July-December 2020]

	Emergency		Medicine, Mater Dei Hospital		Medical Consultant Clinic, Health Centres		Obs & Gynae		Orthopaedics		Paediatrics	
Suggested improvements	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**
More outpatients, less wards/theatre/duties			4	3					3	3	4	2
More formal teaching/tutorials		1	1				1	1		2	2	4
Seeing patients alone & discussing with consultant			1		2							3
More time/exposure to these clinics					3							1
Formal introduction / adequate training before working in admission room							3	1				
More exposure to admission room								2				
Gaining experience and learning from outpatients of different specialities				2								
Being assigned to care also for Emergency Severity Index 3-4 cases	2											

Table 3: 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?'* regardingthe minor other-speciality posts [Pre-break: October 2019 – March 2020; post-break: July-December 2020]

	Dermatology		Ear, Nose & Throat		Geriatrics		Ophthalmology		Palliative Care		Hospice		Psychiatry		Tasters	
Suggested improvements	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**	**Pre-break**	**Post-break**
Longer placement	1	2	1	1	1	1					5	4	3	4	4	1
More outpatients, less ward rounds			3	2		1				2			3			1
Seeing patients alone / hands-on	3	2	2					1					1		1	
More formal/ protected teaching/ tutorials				2				1		1			2		1	2
More exposure to casualty / emergency clinic				1			3	1								
An induction session at the start of the placement				2					1							1

reference to the July-September 2020 period, one trainee in fact stated that "due to the COVID19 pandemic the number of patients attending the practice decreased greatly from previous periods - I would say we saw only 30-40% of what we would usually see. This situation also resulted in a smaller variety of presentations, and as such teaching through clinical scenarios was in some ways limited." Another trainee added that "the current situation prevented us from implementing much research/auditing as previously planned." In Europe, while distance-learning solutions are being sought due to the COVID-19 pandemic, face-to- face skills training in clinical settings remains an integral part of medical training (Michels, et al., 2020).

However the situation in private practice then improved during October-December 2020, as

reported by a GP trainee who wrote that "the greater workload throughout these three months allowed for a greater variety of GP trainer and trainee discussions to take place on the different cases encountered." In fact, there were no less than 6 recommendations made by trainees after the COVID-19 suspension of training that private practice exposure should be longer (more hours if full-time, longer post if part-time) to improve their experience in this placement, as compared to just one such recommendation made before the break in training (Table 1).

Regarding government health centres, one possible reason for the post-break improvement in satisfaction ratings for teaching was provided by a trainee who commented that "due to the COVID situation patient numbers in the health centre have reduced, which allowed a better training environment; ideally this should be the norm." Another GP trainee agreed, revealing that "given (that) the overall influx of patients decreased in view of (the) COVID 19 pandemic, more time could be allowed for discussion with (the) trainer." The relationship between the trainee and the trainer is central to learning, with the former's engagement in clinical challenges needing to be balanced by the latter's provision of clinical, educational and professional support (Wearne, et al., 2012).

Moreover, the state teleconsultation service introduced by Primary HealthCare as a consequence of the pandemic was welcomed by a trainee who stated that the service is "very helpful, telecommunication is ever-developing and a vital part of family medicine. This post helped me improve these skills, which would not have been possible at the health centre". Another trainee also "found telemedicine to be very useful and would strongly suggest a part time rotation for all trainees." Training in the utilisation of telemedicine has become more pertinent in these pandemic times and its integration into specialist training curricula improves both trainee education in care provision and patients' access to specialty care (Lee and Nambudiri, 2019).

Currently GP trainees are assigned morning duties at Primary HealthCare's telemedicine centre on an ad hoc basis by health centre principal GPs, meaning that they would not be in the same health centre as their official GP trainer during that time. There are a number of certified and experienced GP teachers working in telemedicine who had to renounce participation in GP training because the telemedicine centre is not a 'hands-on' health centre. If trainees were assigned an official rotation to telemedicine, each could be paired for that period with one of the 'inactive' GP teachers, who would provide the trainees with experienced supervision in terms of tele and video-consultations.

Two perennial problems regarding training in the government health centres were again highlighted in the results of this study (Table 1): that of GP trainees not being assigned to work in the same shift and health centre as their GP trainers and of the curtailment of clinical teaching by the heavy workload and lack of staff. Despite repeated recommendations made over the years for trainees and trainers to be assigned to work together in the same venue and for the facilitation of 'on the job' training (Sammut and Abela, 2013; Sammut and Abela, 2019), these have not materialised despite evidence in the literature that such arrangements facilitate clinical teaching and work-based assessment (Spencer, 2003; Norcini, 2003).

Other speciality placements

Three other-speciality placements experienced notable drops in satisfaction ratings for teaching from October 2019 – March 2020 to the post-COVID 19 break period of July-December 2020.

The reason for the post-break decrease in rating of 8 percentage points for the two- week Taster posts in various optional specialities was not related to the COVID-19 pandemic, as revealed in the comments made by the GP trainees on their evaluation forms. One trainee reported that the problem was that the "taster placement took place during Christmas and New Year's (and) hence (s/he) missed two days of placement since they fell on (a) public holiday. Clinics and lists were quieter than usual", while another made a suggestion to "avoid having the taster weeks during festive seasons" for the same reason. In fact one GP trainee had the placement curtailed by a week as all the consultants were

on leave. Consequently the MCFD agreed with a proposal made by the postgraduate training coordinators in family medicine that, as from spring 2021, these posts take place during January, April, July and October instead of during March, June, September and December (Psaila, 2020).

The 7 percentage point drop in satisfaction rating for the Orthopaedic post following the training suspension also was unrelated to the COVID-19 pandemic. Three trainees gave medium (50-60%) scores for formal and ward teaching, with one of them recommending "more exposure to out-patient cases, where GP training is most relevant, less emphasis on ward work - more opportunity for formal teaching". On the other hand, a similar drop for the Paediatrics placement was squarely attributed to the pandemic by 8 out of the 9 GP trainees, many of whom were relatively dissatisfied (giving scores of 60-70%) with the teaching provided. One of them specified that "COVID-19 had quite a (negative) impact on outpatient attendance, as well as (on) doctor-patient interaction and consultation dynamics". This situation has been mirrored in the United States of America, where there were reports of outpatient volume being considerably reduced during the pandemic with adverse consequences on trainees' exposure to different diseases and their ability to develop skills in managing them (Edigin, et al., 2020).

While most of the minor other-speciality placements and all the major ones were scored in the high eighties or nineties in the percentage satisfaction ratings for teaching by the GP trainees, the only two minor specialities which were given lower scores were ENT (79%) and Ophthalmology (78%) for the pre-break period of October 2019 – March 2020. The reasons for this were given by the trainees in the evaluation forms.

Regarding the ENT post, the pre-break overall satisfaction ratings were reduced by the low scores (20-40%) given for teaching by one GP trainee who stated that "unfortunately the consultant made very little effort to teach during the placement and (I) was not involved in clinical decision making and rationale". Three trainees asked for more outpatient sessions and less ward rounds ("a greater focus on the outpatient setting, as ward rounds generally involved reviewing patients post-op"), while there were two requests to see patients alone / hands-on ("ideally having a room in which to see patients would be helpful, whether this is logistically possible is another thing").

Similarly, the pre-break satisfaction ratings for the Ophthalmology post were negatively affected by the 50-60% scores given by two GP trainees. While one did not provide any reason for the low score, the other wrote that, as s/he was assigned to a consultant working in a specialised area of ophthalmology, "unfortunately given this factor educationally I did not get to see much of the more common conditions". Three trainees asked for more exposure to emergency cases at the casualty clinic, with one explaining that "on the days where I joined in the emergency room, I feel that I improved my knowledge in the treatment of acute conditions".

The GP trainees' suggestions for improvements to the other-speciality posts focused mainly on the location (outpatient rather than ward-based), the duration (longer placements in minor other specialities) and the method (a balance of formal teaching and hands-on training). GP trainees can benefit from productive and fulfilling teaching experiences in outpatients when provided with quality teaching and supervision (Logan, Rao and Evans, 2021). However, if the trainee is restricted to the passive role of observer, clinical teaching remains limited because hands-on learning on the job is essential for professional development (Spencer, 2003). Moreover other- speciality placements need to be of adequate duration to permit an improved or increased exposure to each speciality during postgraduate training (Lennon, et al., 2013).

Study method limitations, strengths and implications for the future

While the completion of feedback forms on placements in family medicine and other specialties is mandatory for GP trainees, a bias may have been introduced in the qualitative analysis by disinterested trainees not replying to open questions. The information gathered did not include demographic data of the repondents

such as age and gender as this was considered to be beyond the aim of the study. Statistical analysis to highlight any significant differences between the pre and post-training break periods was not performed, this not being within the scope of the project, which was to detect areas for improvement in training posts.

This study investigated how an external issue such as a pandemic affected specialist training in family medicine in Malta; it also provided suitable recommendations for future practice, education and policy. Although the project comprised a suitable evaluation of placements by GP trainees, research involving similar feedback from GP trainers and other-speciality supervisors would be of benefit.

CONCLUSION

While GP trainees were very satisfied overall with the teaching provided during the family practice posts, the satisfaction ratings for teaching increased in government health centres and decreased in private general practice after the training suspension. The COVID-19 pandemic affected teaching in government practice positively through reducing patient numbers, which allowed a better training environment for the trainee and more time for discussion with the trainer. Private practice was affected negatively by the pandemic, namely through a drop in attending patients, a smaller variety of presentations and limited clinical scenarios for teaching.

All the major other-speciality posts and most of the minor ones were scored in the high eighties or nineties by the GP trainees in the percentage satisfaction ratings for teaching. Of three placements that experienced notable drops in ratings during July- December 2020 after the COVID-19 training break, only that in Paediatrics was attributed to the pandemic which was held responsible for decreases in outpatient attendance, doctor-patient interaction and consultation dynamics.

Recommendations

Training during placements within the STPFM can be improved and safeguarded from negative factors such as a pandemic if Primary HealthCare and administrators of other specialities endeavour to ameliorate the educational environment for GP trainees.

Family medicine training posts can be enhanced as follows:

- the allocation of GP trainees to work in the same shift and health centre as their GP trainers in government practice;
- the balancing of trainees' clinical duties with the provision of clinical teaching and support by their trainers to safeguard their educational collaboration;
- the prolongation of the private practice placement (more hours if training full-time and a longer post if part-time), in the context of an increase in the duration of the whole training programme, to improve GP trainees' experience in this post; and
- the introduction of formal training in telemedicine for trainees, perhaps through a part-time rotation, with possible assignment to GP trainers located at the telemedicine centre (instead of the current system where trainees are assigned ad hoc and without their trainers' supervision).

Recommendations for improving training in other-speciality placements include:

- the provision of regular placements in outpatient and casualty clinics where cases seen are more community-oriented and GP-relevant;
- an increase in duration of minor other-speciality posts to improve exposure and experience;
- an improvement in formal teaching according to the GP trainee's educational needs; and
- the ability of trainees to see patients independently and then discuss their hands-on management with supervising consultants.

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Trends in public perception towards euthanasia and physician- assisted suicide in the Maltese Islands

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ABSTRACT

Aim:

To gather information about the perceptions of the residents of Malta on the subject of euthanasia and physician-assisted suicide and subsequently compare and contrast such perceptions with those of other countries.

Method:

An online questionnaire aimed at getting demographic information of the respondents and to gauge their perception towards euthanasia and physician-assisted suicide was distributed electronically via the internet between 29th September and 18th November 2018.

Findings:

The vast majority of the population sample studied found euthanasia and physician-assisted suicide acceptable in cases where the patient is either incurably sick, terminally ill, or in great pain. It is still unclear whether this is due to lack of education about what is and what is not euthanasia, such as pain relief, removal of extraordinary treatment and palliative sedation.

Conclusion:

In Malta, public support for the end-of-care decisions discussed in this paper has seen an increase throughout the years, similar to what has been experienced in other Western countries. More public education concentrated in particular on various possibilities ought to be considered.

Keywords:

Euthanasia, physician-assisted suicide, Malta, end-of-life decisions, bioethics

INTRODUCTION

Background

Euthanasia, as well as Physician-Assisted Suicide (PAS), have been considered in a number of jurisdictions as being legitimate options for the terminally-ill patient requesting to die in dignity (Radbruch et al., 2015). Notwithstanding, the moral acceptance of both remains acrimoniously disputed (Boer, 2007). Irrespective of their personal views on such matters, policy makers have to gauge the feeling of the general public towards euthanasia and PAS in the sphere of 'End of Life' alternatives (hereinafter referred to as EOLs, an EOL when referred to in the singular) when formulating new policies.

Recent public surveys on media show lack of proper justifications for euthanasia. For example, many said that people should not die in pain or have their life prolonged. Even amongst health care professionals there are differences in understanding proper management of end

of life, with legitimate procedures sometimes being thought of as an act of killing (Abela and Mallia, 2016a). Doctors in general would wish for more training in Palliative Care (Abela and Mallia, 2016b).

The survey carried out in this study hinges on specific and well defined concepts. For this purpose the definitions used in this study are examined in the subsequent sub-section.

Definitions

Euthanasia is the act that causes the death of the patient through administering life-shortening treatment at the expressed will of the patient (Pridgeon, 2006). This implies that for euthanasia to subsist there must be the killing of a live creature or the act of letting a creature die, the clear intention for an individual A to kill another individual B; the intention to kill must be specific, and at least partially, explains the cause of the death of B. The causal journey must not be accidental, or partially accidental, but it must be more or less the deliberate act which follows the conceived plan of A. The act of killing B must therefore be voluntary. The motive for the defined action must be the good of the person killed (Wreen, 1988).

Euthanasia excludes death by *force majeure* (implying that out of dire necessity, only one patient can be attended to, and that therefore another patient dies because of the omission of the physician to treat the patient), refusal of medical treatment, lack of treatment given to a person who is brain dead, "indirect euthanasia" (when the use of pain-killing measures administered by a doctor result in the shortening of the patient's life), termination of a medically pointless treatment, and brain death (Trankle, 2014).

Euthanasia is considered to be a deliberate life-shortening act – including an omission to act – by a person other than the person concerned, at the request of the latter. Strictly speaking, euthanasia "occurs when a person usually a physician actively, and intentionally ends a patient's life by some medical means..." (Cohen et al., 2014).

Involuntary euthanasia occurs when euthanasia is administered on a mentally competent patient who did not request it. Non-voluntary euthanasia happens when the patient is not mentally competent and therefore, legally, is unable to request euthanasia. Passive euthanasia occurs when an omission - for example switching off a mechanical ventilator - leads to the death of the patient (Chao, Chan and Chan, 2002; Garrard and Wilkinson, 2005; Emanuel et al., 2016b).

PAS occurs when a physician supplies information or the means of committing suicide; however, the patient actually terminates his or her own life without the physician's direct involvement (Materstvedt et al., 2003).

It should be noted that removal of extraordinary or disproportionate treatment is not passive euthanasia and neither is increasing pain relief even if this hastens death considered as active euthanasia both within moral (including religious) reasoning and within the Maltese law (Bioethics Research Programme, 2017).

The arguments justifying the use of euthanasia and/or PAS pivot around the phenomenon of autonomy (Yuill, 2013; Pesut et al., 2019). Autonomy is the ethical principle of respecting an individual's capacity and freedom to make his or her own choices. The prerequisites for autonomy are:

a. Rationality;
b. A plurality of options; and
c. Deliberation free from coercion and manipulation

The debate on euthanasia and PAS spans a period of circa three thousand years and resides within two spheres of ethical debate: the right of choice of death and the pursuit of happiness. These spheres of debate resulted from the creation of two sets of dichotomies: autonomy versus paternalism, pleasure versus pain.

How the dichotomy autonomy versus paternalism featured in the euthanasia and PAS debate

Exponents of the traditional ethical principle are opposed to the argument of the legalisation of euthanasia based on the existence of the right to autonomy of the individual. Most often these exponents hail from the theological field

wherein they contend that life is sacred and no man has the power to decide when to terminate his own life or the life of others (Arrigo, 2016). These critics opine that advocates of euthanasia utilising the principle of personal autonomy as the cornerstone of their argumentation are shearing off the argument of euthanasia and its implications from moral judgment (Safranek, 1998). They also argue that personal autonomy is unattainable given that it is very difficult for an individual to decide without external pressure. Moreover, they state that these advocates of euthanasia and/or PAS using the personal autonomy argument are victims of internal inconsistency, and this is due to the fact that the same advocates for the legalisation of euthanasia and/or PAS create safeguards to hedge the use of euthanasia and/or PAS from abuse. Such 'safeguards' are normative and binding and are constructed on one particular view of what is "the good" limiting the availability of other options, therefore constructing a contradictory position to their argument, and the personal choice of the individual is being taken over by some form of external authority, moral or legal.

On the other hand, exponents of the personal autonomy principle build their argument on the element of "harm", which is employed by utilitarians such as John Stuart Mill, as the yardstick against which an action is considered to be justified or not. If one's deeds or choice of action does not cause harm to others than it is a legitimate action. John Stuart Mill is quoted as saying that "over himself, over his own body and mind, the individual is sovereign." Moreover, he continues stating that "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others" (Mill, 1859). In modern times a contender of this line of argument is Peter Singer. The latter argues that "incurably ill people who ask their doctors to help them die at a time of their choosing are not harming others" (Singer, 2000). It is clear therefore that advocates of the legalisation of euthanasia or PAS on the principle of personal autonomy, contend that no harm ensues to any third-party from any decision of requesting euthanasia and having this decision being upheld and/or by being assisted in the administration of suicide. These advocates of euthanasia and/or PAS argue that there is no position from which any moral authority could deny the individual the right to terminate one's bodily existence.

How the dichotomy happiness versus pain featured in the euthanasia and PAS debate

The concept of happiness features also in the argumentation for euthanasia and/or PAS. This is because it is presumed that man aspires to the attainment of happiness. The problem, however, relates to the precise choice of terminology denoting the desired state and distinguishing it from the undesired state, sadness, distress, discomfort and pain. Philosophical literature features the term eudaimonia, meaning the state of living-well – being well, well-being – which implies that it is composed of all goods. Aristotle furthermore describes this as the ability which suffices for living well; perfection in respect of virtue (Aristotle, Irwin and Irwin, 1999). So, if one had to assume that the description of eudaimonia does not only include excellence through virtues but comprises "well-being", or "living well/flourishing", the decrease in health and happiness, and increase in sickness, sadness, pain and decline, equals the opposite - lack of health and unhappiness.

In ancient Greek and Roman culture, the virtue of a *good death* was achieved when natural death occurred quickly (Mystakidou et al., 2005). Marcus Aurelius is celebrated for his quote where he expressly stated that a dignified death must be accepted as an event of natural incidence. He glorifies dignified death to the extent that he equates dignified death to death of the moribund's choice (Aurelius, 2017).

In contemporary ethics discourse, the central ethical issues for or against euthanasia and PAS when drawing from the dichotomy happiness versus pain are the following (Joint Committee on Justice and Equality, 2018):

a. The ethical principle for the request for autonomy
b. The principle of beneficence
c. The principle of non-malificence

Table 1 – The questions asked in the first section of the survey.

Question 1	“Please choose your gender”
Question 2	“Please choose your age range”
Question 3	“Please choose your level of education”
Question 4	“Is Malta your country of residence?”

Table 2 – The questions asked in the second section of the survey.

Question 1	“I know the difference between passive and active euthanasia, voluntary, involuntary and non-voluntary euthanasia”
Question 2	“Should euthanasia or physician-assisted suicide be available to people who are incurably sick, terminally ill, or in great pain?”
Question 3	“Do you think an individual has the right to commit suicide?”
Question 4	“Do you think a person suffering from unbearable emotional and mental pain should be allowed to request euthanasia?”
Question 5	“Should there be a possible alternative therapy that is still in research or still not legally approved, would you try it?”
Question 6	“Should euthanasia be legalised so that it would be practiced under careful guidelines and doctors have to report these activities?”
Question 7	“Do you think patients will still be able to request euthanasia if there is a proper palliative and terminal care system?”
Question 8	“Do you think that (doctors) administering euthanasia is a criminal act?”
Question 9	“What do you think is the appropriate age for one to request euthanasia?”
Question 10	“Will you trust doctors who accept and considered physician assisted suicide as an alternative?”
Question 11	“Do you think that the main duty of a doctor is to preserve life?”
Question 12	“In case the law prohibits euthanasia for nationals of your country and residents in your country, do you think this restriction should be applicable also for foreign citizens not resident in your country?”

Objective

In Malta, the broad recognition of the right to 'individual autonomy', irrespective of the guise it takes, recently kindled the debate on the need for the availability of EOLs. This objective of the study is to gather information about the perceptions of the residents of Malta on the subject of euthanasia and PAS as EOLs and subsequently compare and contrast such perceptions with those of other countries.

METHOD

An online questionnaire, produced with Google Forms, was distributed electronically between 29th September and 18th November 2018 through mailing lists and social media. The questionnaire was open to all residents in Malta aged 16 years and over.

The Sample Size (hereinafter referred to as SS) was calculated taking into account the population statistics spanning from 2012-2016 including the relevant benchmark revisions in 2017. The relevant statistics were drawn from the figures and calculations as reproduced in News Release dated 12 February 2018 by the National Statistics Office of Malta (hereinafter referred to as the NSO). In this case the sample size SS was of 549 with a confidence interval of 4.18 and confidence level of 95%. The sample size was kept at 549 through a threshold setting in the appropriate software limiting the number of interviews.

The questionnaire was divided into two separate sections, the first one containing four questions (shown in Table 1) with the intention of gathering socio-demographic data while the second section contained 12 questions (shown in Table 2), whose objective was to gauge the respondents' views on euthanasia and PAS to determine whether these tally with those of residents of other Western countries. All responses were fully anonymous.

The survey has been modelled as a public perception survey. This means that the survey captures and targets the views of the residents in Malta who can be sophisticated respondents, but not health practitioners.

For the merits of the analysis of this survey, "residents in Malta" implies that their residence is usual residence is in Malta. In this case, this means the place where a person normally spends

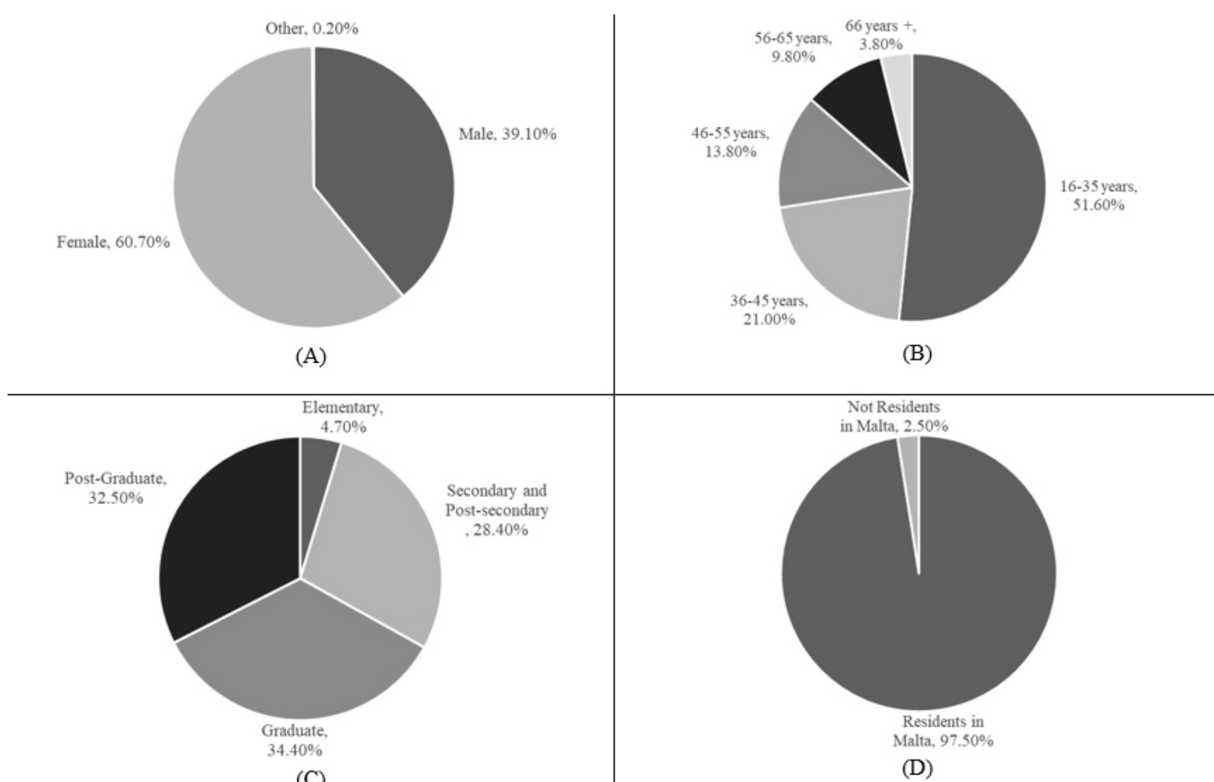

Figure 1: *Demographic data of the survey respondents' showing their (A) gender, (B) age bracket, (C) level of education attained and (D) the percentage of whom are residents of Malta or not.*

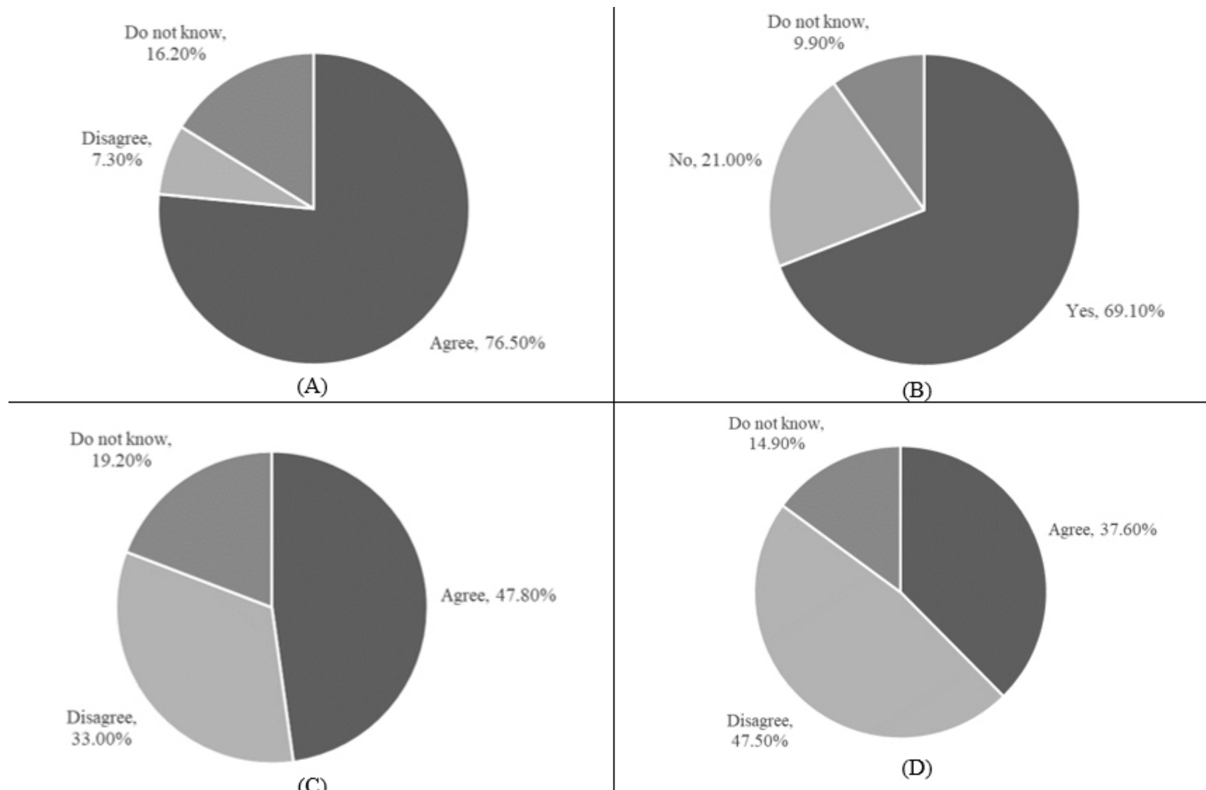

Figure 2*: Answers to the following questions: (A) Question 1 - "I know the difference between passive and active euthanasia, voluntary, involuntary and non-voluntary euthanasia"; (B) Question 2 - "Should euthanasia or physician-assisted suicide be available to people who are incurably sick, terminally ill, or in great pain?"; Question 3 - "Do you think an individual has the right to commit suicide?"; Question 4 - "Do you think a person suffering from unbearable emotional and mental pain should be allowed to request euthanasia?*

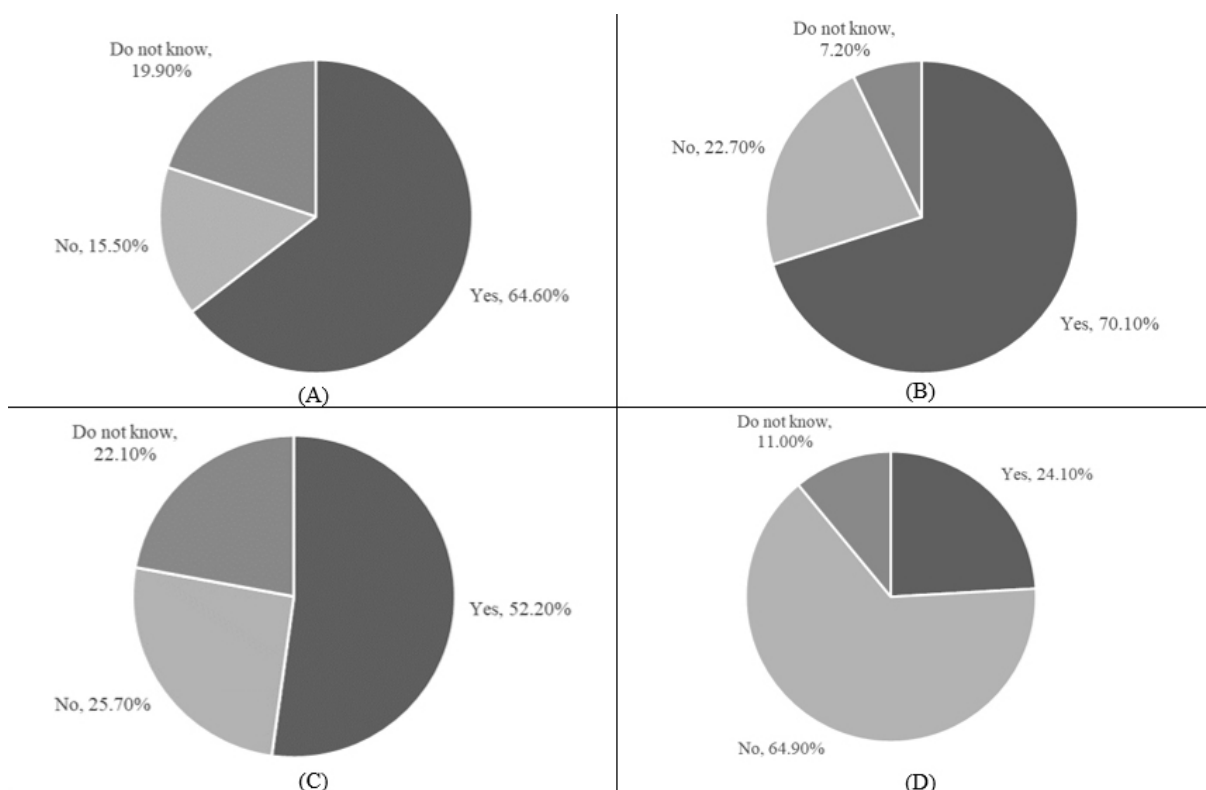

Figure 3*: Answers to the following questions: (A) Question 5 - "Should there be a possible alternative therapy that is still in research or still not legally approved, would you try it?"; (B) Question 6 - "Should euthanasia be legalised so that it would be practiced under careful guidelines and doctors have to report these activities?"; (C) Question 7 - "Do you think patients will still be able to request euthanasia if there is a proper palliative and terminal care system?"; (D) Question 8 - "Do you think that (doctors) administering euthanasia is a criminal act?"*

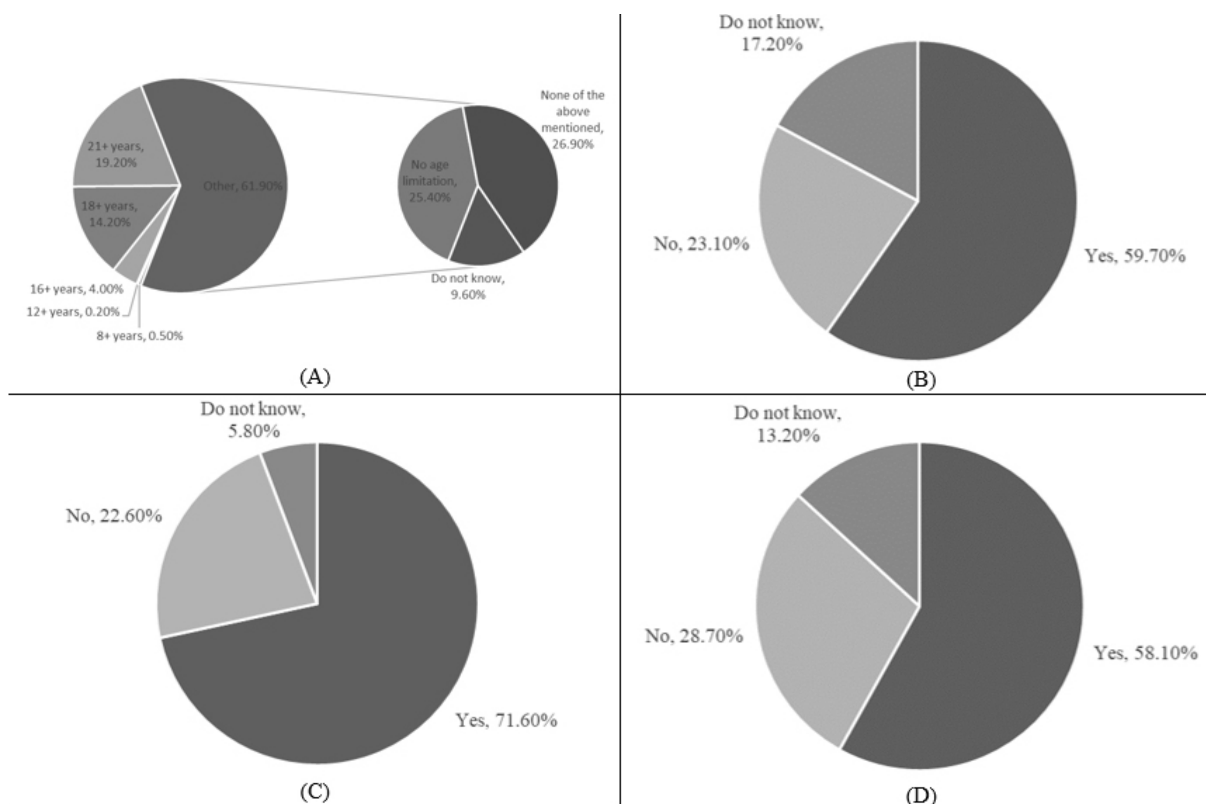

Figure 4: *Answers to the following questions: (A) Question 9 - "What do you think is the appropriate age for one to request euthanasia?"; (B) Question 10 - "Will you trust doctors who accept and considered physician assisted suicide as an alternative?"; (C) Question 11 - "Do you think that the main duty of a doctor is to preserve life?"; (D) Question 12 - "In case the law prohibits euthanasia for nationals of your country and residents in your country, do you think this restriction should be applicable also for foreign citizens not resident in your country?"*

the daily period of rest, regardless of temporary absences for purposes of recreation, holidays, visits to friends and relatives, business, medical treatment or religious pilgrimage, is in any abode or dwelling within the territory of Malta, including but not only Gozo.

"Usual residents in Malta" are those who have lived in their place of usual residence for a continuous period of at least 12 months before the reference time; or those who arrived in their place of usual residence during the 12 months before the reference time with the intention of staying for at least one year.

As research on human subjects was not involved, approval from a research ethics committee was not needed for this study.

RESULTS

The SS was of 549 persons, the majority of whom were females (60.7%) aged between 16 and 35 years (51.6%) as shown in Figures 1(A) and 1(B), respectively. Regarding the level of education attained by the responders, the majority had achieved a graduate or post-graduate and postgraduate level at 34.4 and 32.5%, respectively, as shown in Figure 1(C). Only the responses from those who answered that they are residents in Malta were analysed, which amount to 97.5% of the responses, as illustrated in Figure 1(D).

The replies to the questions asked in the second section of the survey are shown in Figures 2-4.

DISCUSSION

The subject matter of this work inherently draws from public policy, philosophy and legal theory. Notwithstanding, the focal perception analyzed is that of public policy. Public policy addresses the issue of the legalization of euthanasia and/or PAS, and its implementation strategy. The essential objective of public policy is to define the policy problem and seek alternative viable solutions. Philosophy determines what is ethically acceptable and what is not ethically acceptable. It also delves in the definition of

major concepts around which the legalization debate of euthanasia and PAS revolves. On the other hand, legal theory deals with the issue of the 'right to die', and if it exists at all, its management. Legal theory attempts to answer the basic question to which extent is one to divorce morality from law, and eventually from public policy.

When asked whether the respondents knew the difference between the various forms of euthanasia or not, the vast majority (76.9%) replied in the affirmative. Such a result could be because most respondents have a graduate- or postgraduate- level of educational attainment and therefore are more likely to know such differences.

Whilst the rate of respondents agreeing to the statements that an individual has the right to commit suicide and that a person suffering from unbearable emotional and mental pain should be allowed to request euthanasia was relatively low, the absolute majority agreed that euthanasia or PAS should be available to those patients who are terminally ill or in great pain. Of interest is to note that the acceptance of euthanasia and PAS by the residents of Malta participating in this study has increased substantially when compared to 2008, which in turn, had seen a more modest increase when compared to a similar study done in 1981. In Malta the increase of support towards euthanasia was noted over a span of years from 1981 – 2008, where in 2008 the mean score of acceptance was of 2.64 from 1.44 in 1981. Malta in 2008 was midway between the more conservative European Countries which were the CEE countries and the more liberal Western European Countries (Cohen et al., 2014).

This clearly shows that the mentality of the surveyed residents of Malta has started to move away from that of Central and Eastern European countries and more towards that of more liberal Western European countries in which support towards euthanasia and PAS is increasing (Emanuel et al., 2016a). On the other hand, public support for euthanasia and PAS has seen a plateau in the United States of America, and a decrease in Central and Eastern European countries (Emanuel et al., 2016a). The increase in public support towards these end-of-life options in Malta could result from the fact that most of the respondents were of a newer generation and therefore possess a different mindset compared to that of older generations. The recent increase in migration of people from Western countries to Malta due to economic reasons could also have influenced the results.

Another factor is the lack of education about end of life management and therefore education in these areas is vital before a survey can properly assess attitudes to euthanasia in the future.

However, the percentage indicated in the survey tallies well with survey results recorded in the US. In 2018 (Brenan, 2018), when asked the question "When a person has a disease that cannot be cured and is living in severe pain, do you think that doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?", 72% of respondents replied that they were in favour of permitting doctors to end the patient's life by painless means.

In the case of PAS when considering the US, in 2015 68% of respondents replied that PAS should be permitted when a person has a disease that cannot be cured and is living in severe pain, if the patient requests it (Dugan, 2015).

Additionally, most respondents do believe that the main duty of a physician is to preserve life and that they would still trust a physician who has accepted and considered PAS as an alternative; meaning that most respondents believe that physicians who practice such end-of-life decisions would still be maintaining their professional duty.

Respondents could not reach a consensus as to which is the minimum age where one can request euthanasia, with most of the replies being divided between the "no age limitation" and "none of the above mentioned" options; only 0.5% and 0.2% agreed with the minimum age being set at 8 and 12 years respectively. This question is one of the most hotly debated issues in ethical debates on end-of-life and the replies gathered from this study further confirm its complexity (Brouwer et al., 2018). Out of the three European countries where euthanasia is

legalised, only Luxembourg prohibits minors from requesting it (Watson, 2014; Cuman and Gastmans, 2017).

Particularly interesting was the fact that, 64.6% of residents in Malta are ready to experiment with alternative therapies that are still in research or still not legally approved, and that 52.2% of the residents in Malta believe that the availability of palliative care will not hinder the entertainment of the request for euthanasia by the requesting patient. Again, this of course is influenced by knowledge of the public of what palliative care consists of - including practices which prima facie may be considered euthanasia but which in fact are not.

Finally, alongside euthanasia and/or PAS there should be proper psychiatric help for the requesting patient, and psychological support to the persons accompanying the requesting patient in the final journey. However, it is of maximum importance that proper funding and adequate provision of the service of palliative care is budgeted for; and guaranteed as an essential process for being an alternative to euthanasia and/or PAS. It is also imperative that one encourages in-depth reflection, discussion and education between all the relevant entities, including social and religious institutions, healthcare professionals, patient representatives and relevant voluntary organisations which can further provide information on the subject to the general public.

While implicitly acknowledging the power given to the doctors in general (as van den Berg has done in his oeuvre "*Medische macht en medische ethiek"* where it was assumed that this is derived from the advancements in medical technology), respondents were mostly concerned in controlling that power rather than the involuntary killing of the vulnerable individuals (van den Berg, 1969).

It is to be borne in mind that the argument in favour of euthanasia and or PAS hinges on the concept of compassion rather than on financial constraints or utilitarian concerns. This means that palliative care must be readily available as an option to the requesting patient, so that if upon due reflection, the request for euthanasia or PAS will be recanted, the terminally ill patient will be left with a viable option which may help in making the dying process less painful, without hastening unduly the passage to death.

Strengths, limitations and suggestions

Malta is a small country with no large cities but many villages, with a total population of 500,000 over an area of 316 km^2 (National Statistics Office, 2020). Therefore, people who live in the country are by no means excluded as they are close to main villages. It is acknowledged that older people may have been excluded from this study as they do not use electronic media. However previous surveys questioned the same cohort structure and therefore its use may be considered appropriate here. Moreover, the age range reflected a good proportion from each category.

As this study was carried out exclusively in English and online, the population represented in this study may not be representative of the whole population, and therefore further in-depth studies are advised to facilitate the way forward regarding public education on euthanasia.

CONCLUSION

As of 2018, the acceptance of euthanasia and PAS as end-of-life options for those who are terminally ill and in unbearable pain has increased in the Maltese islands among those surveyed, mirroring similar trends occurring in other Western countries. The reasons behind this trend have been theorized as being, at least partially, due to a change in generation and migration. Lack of education about palliative care and what is actually allowed, for example that pain relief which hastens death with the intention only of relieving pain following a standard of practice is not active euthanasia, and that removal of treatment which is considered extraordinary or disproportionate is not passive euthanasia (this includes life-prolonging treatment) could have affected the outcome. Social institutions ought to engage in public education about what is and what is not allowed for an act to be considered direct killing.

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