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The MCFD at 35 years

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The MCFD at 35 years: looking to the future, supported by the past

Dr Maria Grazia GRECH

ABSTRACT

Background

The Malta College of Family Doctors (MCFD) was founded in April 1990 with Dr. Denis Soler as President. In tandem, the newsletter 'It-Tabib tal-Familja' was set up, which along the years became the Journal of the Malta College of Family Doctors (JMCFD). In April 2025, a new MCFD Council was elected, with a significant milestone being achieved: the election of the first female president in MCFD history.

Objective

To trace the contribution of women in MCFD Councils over the past 35 years.

Method

Historical review divided in a section on past female MCFD Council members and a section on equity and equality.

Results

It is clear that the election of a female president was not a fluke. It was the result of talented people who over time proved that talent and capability do not depend on gender. Apart from that, it also depends on having a culture that fosters recognition of talent above all. It depends on mutual support and on measures that promote participation with flexibility.

It is important to recognise that women in leadership roles in medicine and academia are disproportionately low compared to the ratio of women to men in medicine and healthcare professions. Thus, it is important to pay tribute to all the women who paved the way for this milestone to be reached.

Conclusion

Whilst auguring the MCFD and the JMCFD a happy 35th anniversary, the Council will keep looking forward to propelling the MCFD forward in excellence.

Keywords

Family medicine, gender equality, Malta College of Family Doctors, primary care.

INTRODUCTION

The Malta College of Family Doctors (MCFD) was formally announced in November 1989 with the first General meeting occurring in April 1990, and Dr. Denis Soler being approved as its first President. It was immediately supported on an international level by the Royal College of General Practitioners (RCGP) and the Canadian College of General Practitioners, with the former even giving a financial grant to kickstart the Continuous Medical Education (CME) programme locally.

Initial membership was also considerable, with 93 doctors gaining membership within the first year, coming from a mixture of both government and private practice. Apart from this, a journal was set up in tandem with the College foundation. Its initial incarnation was the newsletter 'It-Tabib tal-Familja', which through a number of changes evolved into the Journal of the Malta College of Family Doctors (JMCFD) in its current form.

A SIGNIFICANT MILESTONE: FIRST FEMALE MCFD PRESIDENT

This 35th anniversary is also a milestone for a second reason. In April of this year, a new Council was formed, and for the first time in the MCFD's history, a female president was elected. To mark this occasion, I would like to look at previous women who served on Council since its inception.

The first woman to serve on Council was Dr Jacqueline Padovani, who served as treasurer of the MCFD between 1994-1996. It is positive to note that this happened just three years after the MCFD was formed. Nevertheless, there were no female council members for ten whole years after this! The dry spell was broken in 2006 with Dr Louise Gatt serving as honorary treasurer between 2006-2008. In 2009, Dr Alexandra Gauci was elected research secretary and in 2010, she was joined by Dr Pamela Gauci as honorary secretary.

The Council elected in 2011 was one of the first balanced councils with Dr Myriam Farrugia elected as honorary secretary, Dr Doreen Cassar taking on the role of education secretary for training affairs, Dr Patricia De Gabriele becoming secretary of quality assurance, Dr Tania von Avendonk in charge of logistics and Dr Dorothy Zammit being part of the CPD team. Dr Von Avendonk served as honorary treasurer in subsequent councils, whilst Dr Cassar and Dr De Gabriele served as officers in vocational training, with Dr Cassar retaining this position until 2015. I would like to take this occasion to pay homage to Dr Tania von Avendonk, who passed away in 2018. Although my involvement with the Council began a few years later, it is very clear by all that was written about her and by those who knew her, that her hard work left a lasting impact on the MCFD.

In the 2014-2015 term, Dr Anne Marie Scerri and Dr Martina Falzon joined the council as assistant officers on behalf of GP trainees. Dr Scerri, eventually became an Assistant Officer in 2015-2016, with Dr Myriam Farrugia becoming a co-opted member, Dr Elanja Reiff becoming an assistant officer as a GP trainee representative and Dr Nathalie Psaila becoming education co-chairperson. Both Dr Farrugia and Dr. Psaila resigned in 2017, whilst Dr Scerri was co-opted as registrar in 2016-2017, retaining the role until 2018.

In 2017-2018, Dr Alexia Harney became assistant officer for educational activities, whilst Dr Reiff retained her role as GP trainee representative and she was joined by Dr Kristen Buhagiar as another GP trainee representative.

The 2019-2022 Council saw Dr Dorothy Zammit take on the role of treasurer, Dr Anne Marie Scerri being co-opted as registrar and Dr Nathalie Psaila take on the role of education secretary. My involvement with the Council also started in late 2019, when I became assistant officer as a GP trainee representative, a role I retained until 2023. I resigned at that point, since I did not remain GP trainee representative, and was co-opted as an officer in 2024, later on also joining the editorial board of the JMCFD. As can be noted, increased female participation was retained and kept growing. The penultimate Council prior to the present one included Dr Dorothy Zammit retaining her role as treasurer, Dr Anne Marie Scerri retaining her role as registrar, with Dr Marica Galea joining as vice-registrar and Dr Stefania Abdilla taking over CME.

The current Council has myself as President, Dr Esther Galea as assistant secretary, Dr Chanelle Gatt Azzopardi as registrar and Dr Melanie McElhatton as officer in the Education Committee, as well as Dr Yanica Vella who is the national exchange coordinator, a role she has held since 2022. There have been various other female GP trainee representatives across the past few years.

Female participation is not only limited to Council roles. Many women have given and still give important service as part of subcommittees, the assessment team, examiners, trainers and quality assurance officers amongst many other contributions which have allowed the MCFD to survive, thrive and continue to excel.

EQUITY AND EQUALITY

I went through college records and mentioned the name of every woman who served on council for a very specific reason. Women are now entering medicine at a higher rate than men: however, they remain strongly outnumbered in senior management and academic roles. Moreover, this trend, unfortunately, is not correcting itself at the same rate as the number of women entering the medical field. Reasons for this are many, complex and beyond the scope of this short editorial. My intention is not to use this as a pulpit, but as a tribute and acknowledgement of this issue.

Whilst being the first female president is an important and significant achievement, it is not only my own achievement: it is the achievement of every single woman who in their capacity of member of Council laid the groundwork and proved that strong leadership and a strong work ethic depend on individual talent, not gender. We should be proud to have a college which has women across many levels who give active and valuable contribution, and being a college which supports equity and equality in a way which is reflected by numbers rather than empty words and platitudes.

The MCFD has provided a supportive environment and allowed equal opportunities for many years. Initiatives to increase female participation in leadership roles are important, but ultimately it boils down to having a well-ingrained culture which sees abilities and talent first and foremost. It depends on embracing technological advances and other family friendly measures which eventually benefit both men and women. For that, I am immensely grateful to my predecessors as well as my current colleagues.

As president, I do not have any quotas or specific gender corrective plans in mind. The College retains the same vision that allowed me to be an active member of the MCFD: to keep looking for talent and capability, regardless of whether it is a man or a woman seeking to give contribution.

CONCLUSION

I would like to augur both the MCFD and the JMCFD a happy 35th anniversary. I would also like to thank the immediate past president Dr. Edward Zammit, who has been and still is a major source of guidance and support as vice-president and education secretary. The MCFD is still going strong, and I am very grateful to have the opportunity to help propel it forward in excellence.

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N.B. Information regarding Malta College of Family Doctors Councils from 2018 onwards was obtained from the minutes of meetings, some of which are still not publicly available.

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Evaluating GP trainees' feedback: a mixed-methods analysis of Family Medicine placements in Malta's 2023 Specialist Training Programme

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ABSTRACT

Background

The Specialist Training Programme in Family Medicine (STPFM) was established in Malta in 2007 to provide structured and rigorous training for General Practitioners (GPs). It focuses on clinical rotations in diverse settings, fostering skills in patient-centered care, diagnosis and preventive strategies. Trainee evaluations are critical for assessing and enhancing the programme's effectiveness.

Objectives

This study aimed to analyze GP trainees' evaluations of their Family Medicine placements in 2023. The objectives were to assess satisfaction levels, identify challenges, and propose enhancements to improve the training experience.

Method

A descriptive, cross-sectional, retrospective study was conducted using mandatory evaluation forms completed by GP trainees after their Family Medicine placements. Quantitative data were analyzed using satisfaction ratings, while qualitative data underwent item-content analysis to explore key themes and suggestions. Ethical considerations were met, with approval from relevant authorities.

Results

All 65 eligible GP trainees (100% response rate) participated, providing high satisfaction scores (76.1% - 92%). Teaching by trainers received the highest satisfaction (91.5%), while audit/performance review had the lowest (76.1%). Public sector trainers were rated higher in emergency care and minor surgery, while private sector trainers excelled in chronic disease management and practice management. Qualitative feedback highlighted the need for more hands-on training, structured interaction with trainers, and balanced scheduling.

Conclusion

The study revealed generally high trainee satisfaction with Family Medicine placements, underscoring strengths such as effective teaching and a supportive learning environment. Key recommendations include enhancing schedule flexibility, implementing constructive feedback mechanisms, increasing practical skills training, and fostering collaborative learning through peer discussions and home visit opportunities. These insights aim to refine and strengthen the STPFM, ensuring it continues to meet the evolving needs of trainees and healthcare systems.

Key words

Assessment, education, family practice, Malta, programme evaluation

INTRODUCTION

Background

The Specialist Training Programme in Family Medicine (STPFM) was launched in Malta in 2007 through a collaboration between the Primary Health Care Department and the Malta College of Family Doctors (MCFD). The development of this programme was a significant step towards improving the quality of healthcare in Malta, as it aimed to provide rigorous and structured training for General Practitioners (GPs) specializing in Family Medicine. This initiative followed the approval of the MCFD's training document by the Specialist Accreditation Committee within Malta's Ministry for Health in 2006 (Sammut, et al., 2006).

Since its inception, the STPFM has undergone continuous development, adapting its curriculum and training methodology to meet evolving healthcare challenges (Sammut and Abela, 2012; Sammut, et al., 2021). It is essential that GP trainees are equipped with the necessary skills, knowledge, and clinical experience to deliver high-quality patient care within the scope of Family Medicine. One of the key features of the programme is its emphasis on hands-on clinical experience, as it provides GP trainees with the opportunity to rotate through a variety of Family Medicine and hospital placements (Sammut and Abela, 2012). These placements, which occur in both primary care settings and hospital environments, expose trainees to a wide array of patient cases and treatment scenarios. This exposure is vital for developing the broad skill set required for family medicine, including patient-centered care, diagnosis, treatment, and preventive health strategies. In addition to clinical training, the programme also focuses on ongoing professional development, communication skills, and leadership, all of which are crucial for the role of a family doctor (Sammut and Abela, 2014).

The evaluation of training programmes is a crucial aspect of ensuring their effectiveness and relevance, and over the years, various feedback mechanisms have been implemented to assess both the trainees' progress and the quality of training provided. These evaluations provide valuable insights into the trainees' perceptions of the quality and effectiveness of the training, enabling the programme's coordinators to identify areas for improvement and enhance the overall educational experience (Liang et al., 2023).

Objective

The aim of this comprehensive review of GP trainees' evaluations of their Family Medicine placements during 2023 was to gain a deeper understanding of their experiences. The objectives of this review were to assess the level of satisfaction with the quality and effectiveness of the teaching they received, identify any significant challenges faced during the placements, and explore potential improvements to enhance the educational value of these posts.

METHOD

The study takes the form of a descriptive, cross-sectional, retrospective study. This research design fits well within the purpose of the study, which aims to give an updated picture of the GP trainees' experiences at a defined time during their Family Medicine placements. Upon finishing their Family Medicine placements, GP trainees are obliged to fill in evaluation forms titled 'Trainee's Evaluation of Family Medicine Posts'. These are logged on the online Portfolio that had

been adapted from questionnaires developed by the Yorkshire Deanery's Department for NHS Postgraduate Medical and Dental Education (2003). The postgraduate training coordinators in family medicine then review and analyse this feedback to offer insights that address the gaps in GP training needs (Sammut and Abela, 2012).

Although anonymity was not feasible due to the identificable nature of the mandatory evaluations, several steps were taken to address this limitation and preserve data integrity. Pseudo-anonymity was applied by coding all responses and removing direct identifiers prior to analysis. Data was stored in a non-identifiable, password-protected Excel spreadsheet. Only one main researcher had access to identifiable data. Access was restricted to authorized personnel involved in the study. The dataset used for analysis was fully de-identified. A mixed-method approach was used by assessing the data in quantitative and qualitative methods. Item-content analysis was used to analyse the data qualitatively by refining items, identifying themes and ensuring alignment between the items and the construct they are designed to measure (Lawshe, 1975; Hsieh and Shannon, 2005).

Ethical considerations

Approval for this study was granted by both the Data Protection Officer and the Clinical Chairperson of Primary Health Care. The study addressed the evaluation and improvement of the training practices within the Family Medicine Specialist Training Programme. In accordance with the guidance outlined by Zeni (1998), the study is classified under the 'zone of accepted practice,' which allows for an exemption from formal ethical review when the focus is on routine educational improvements rather than experimental research. Additionally, since the data collected involved general feedback on training experiences and did not include sensitive personal information, such as health records or identifiable personal data, approval from a formal ethics committee was not required. This ensures that the study adheres to both data protection regulations and ethical standards while facilitating the enhancement of the training programme (Bristol and Weston NHS University Hospitals, 2022).

RESULTS

The response rate for this study is 100% among those eligible to participate, as completing it is a mandatory part of the Work-Based Assessment and Formative Assessment process. The eligible study population consists of trainees in their first year (n=23), second year (n=21), and third/final year (n=21), making a total of 65 participants.

Quantitative analysis

Satisfaction rates amongst GP trainees were notably high, ranging from 76.1% to 92% (Figure 1). Effective trainer teaching received the highest satisfaction score at 91.5%. Conversely, audit/performance review garnered the lowest satisfaction rate, with 76.1%.

When analysing the satisfaction ratings separately for training in government health centres and private general practice, notable differences emerged in various teaching domains. Trainees with public GP trainers reported higher satisfaction ratings in specific areas such as Emergency Care, Minor Surgery and Audit/Performance Review (Figure 2). The private sector achieved higher satisfaction scores in several other key teaching areas, including Teaching in the Clinical Situation, Practice Management, Use of Primary Care Team, Chronic Disease Management and Child Health Surveillance.

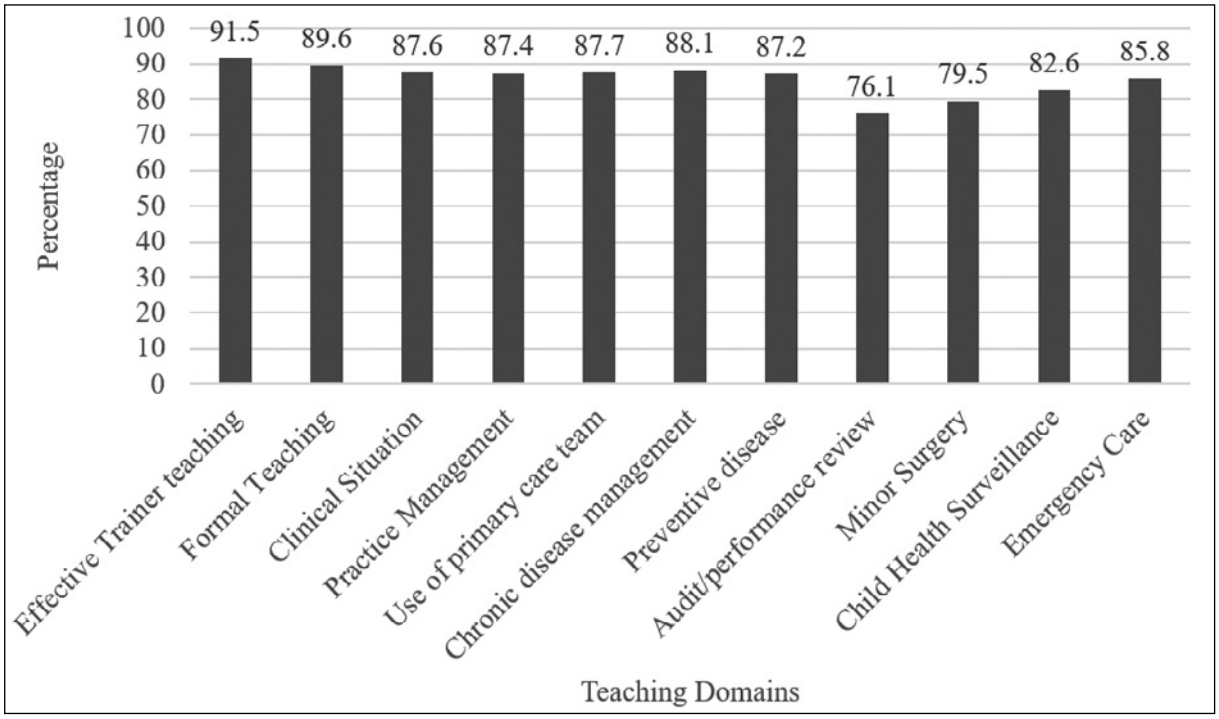

Figure 1: Trainee satisfaction ratings for teaching during the Family Medicine placement in 2023

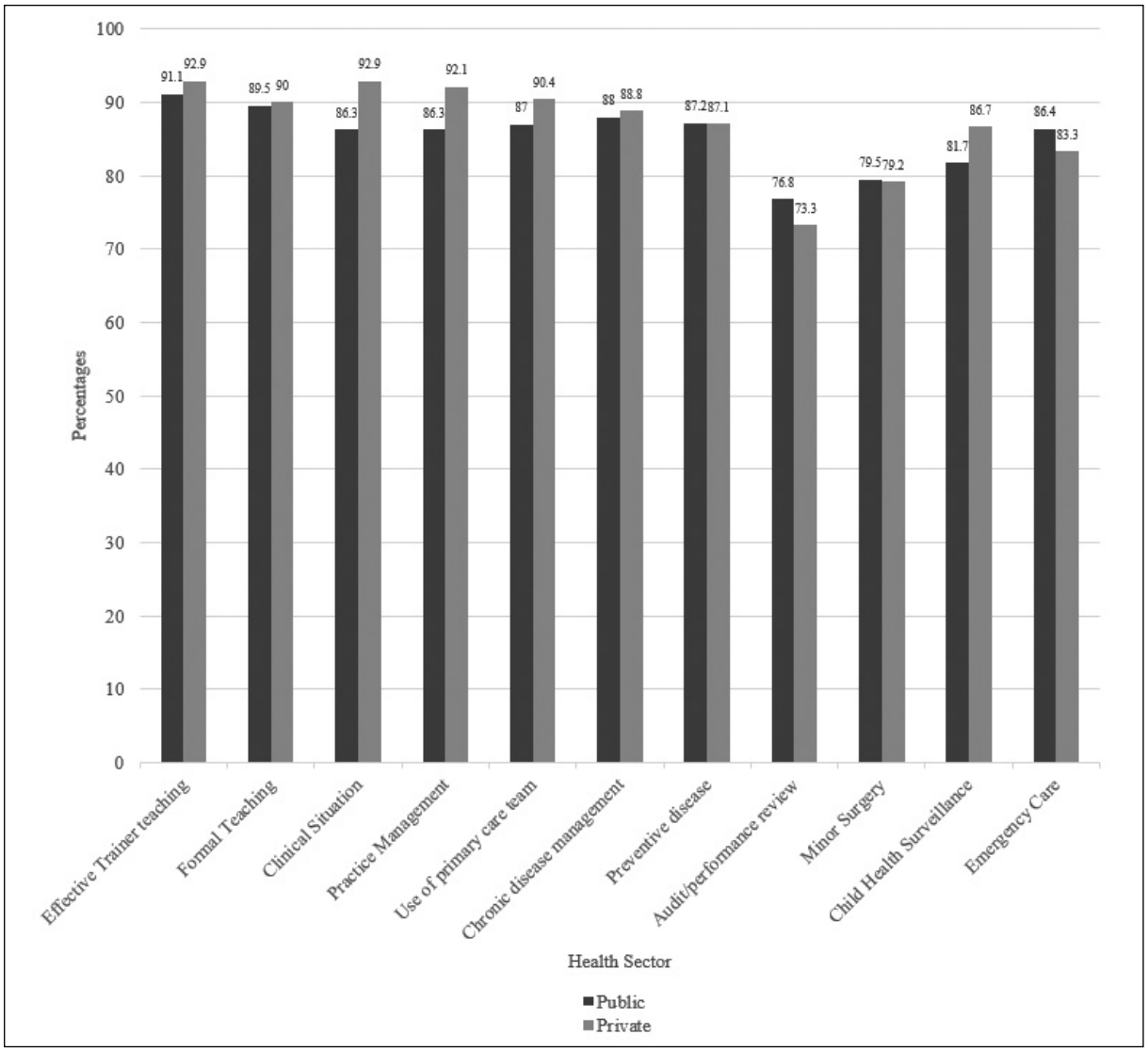

Figure 2: Private-public satisfaction ratings for teaching during the Family Medicine placement in 2023

Qualitative analysis

The GP trainees' written feedback was generally positive (Table 1) and included suggestions on how the practice could be improved as a teaching unit. Several key themes emerged from this study, highlighting critical aspects of the training experience (Table 2). The comprehensive analysis of the emerging themes and trainee feedback from the Family Medicine placements is presented in Table 3. This encapsulates the various insights gathered from trainees, highlighting their experiences, perceptions and suggestions for improvement. The analysis helps to identify areas of strength with the training programme as well as opportunities for enhancement, ultimately contributing to the continuous improvement of the educational experience.

Table 1: Quotes representing the GP trainees' feedback on placements in Family Medicine in 2023

Trainer-related Positive Comments:

- "GP trainer was always available especially in the context of preparation for the exam, which needs regular feedback on performance in Consultation Observation Tools" *(Third-year doctor)*
- "I am always encouraged to enhance my thinking skills during the rotation and am given ample opportunity to ask questions and address any queries I have." *(Second-year doctor)*
- "Great exposure to various general practice issues and complaints. Always there to guide me when in doubt. Always willing to teach." *(Second-year doctor)*

Programme and Practice-related Comments:

- "All in all, a great and challenging teaching programme which motivated me to keep learning throughout my career as a doctor." *(Third-year doctor)*
- "Very well structured and useful!" *(Third-year doctor)*
- "The Practice provides a healthy learning environment where one can learn by observing, doing as well as teaching to other doctors. It provides a pool of resources from different sources - nurses, doctors, patients - which gives a holistic learning experience." *(Second-year doctor)*

Table 2, part 1: Key themes from GP trainees' evaluations in the 2023 Family Medicine placements

Themes	Quotes representing GP trainees' feedback
Relationship with trainers	• "Dr. (surname) allows time for discussion of cases, teaching points and also any queries that arise. Thank you." *(Second-year doctor)* • "Great teacher during this stressful period and always available to help." *(Third- year doctor)*
Training content and focus	• "More opportunities manning Orthopaedic, Diabetes, Gynae/OBS, Wellbaby." (Third-year doctor) • "more time allocated for practical skills" (First-year doctor)
Time management and scheduling	• "Having more shifts at HC co-inciding with those of trainer, would increase the opportunity for learning on the job and real-time case discussions." *(Second-year doctor)* • "More duties allocated with the trainer to be able to discuss cases or be assessed whilst practising" *(Second-year doctor)*

Table 1, part 2: Key themes from GP trainees' evaluations in the 2023 Family Medicine placements (continued)

Themes	Quotes representing GP trainees' feedback
Summative Assessment and feedback	• "Video recorded consults in the way they are currently assessed, especially without any clear guidance and without adequately specified feedback, should be relegated to a lesser important assessment weighting in the final summative mark than a designated eportfolio and logbook." (*Third-year doctor*). • "More time taking videos for the exam." (*Third-year doctor*). • "Being more considerate to individuals who require to take videos for examination purposes." (*Second-year doctor*)
Learning environment and facilities	• "Sometimes the workload at the health centres is quite taxing, leaving less time for active learning and taking of videos than one might need." *(Second-year doctor)* • "Work load and environment is very limiting when it comes to trying to take good videos to practice and for exam purposes." (*Third-year doctor*) • "The workload at the health centres sometimes makes it challenging to find opportunities to discuss and reflect on cases seen, given the pressures to meet the service demand." *(Third-year doctor)* • "Official shadowing period in first few weeks of rotation, being assigned to an SGP especially when it comes to exposure to home visits." *(First-year doctor)*
Suggestions for improvement	• "More emphasis on case based discussions on difficult or sensitive cases encountered during night duties." *(Third-year doctor)* • "There are a lot of good qualities in the current Practice; however, there could be more opportunity for first-hand practice, and for performing COTs (Consultation Observation Tools)." *(Second-year doctor)*

Table 3, part 1: Analysis of key themes and trainee feedback in Family Medicine placements

Themes	Analysis of Trainee Feedback
Relationship with trainers	• Positive feedback was often directed toward the availability and supportiveness of trainers. However, some trainees wished for more structured interaction, including more opportunities for shadowing and case discussions.
Training content and focus	• There was a recurring desire for more hands-on practice, particularly in areas such as acute GP skills, minor procedures, and specific case-based discussions. • Some trainees emphasized the need for a structured approach to teaching, with predefined topics and focus areas that align with exam requirements.
Time management and scheduling	• Several trainees highlighted the need for more dedicated time for revision, video consultations, and tutorials. Challenges in balancing clinical duties with educational needs were frequently mentioned. • Some trainees preferred more structured shifts with their trainers for real-time discussions and feedback.
Summative Assessment and feedback	• Concerns were raised about the current method of video summative assessment, with suggestions for more guidance and structured feedback • Some trainees requested more formal assessments and regular feedback to gauge their progress and areas needing improvement.

Table 3, part 2: Analysis of key themes and trainee feedback in Family Medicine placements (continued)

Learning environment and facilites	• The clinical workload was cited as a barrier to active learning and reflection, with some trainees finding it challenging to balance service demands with educational needs. • Proposals included dedicated spaces for video consultations and more integration of interdisciplinary learning opportunities.
Suggestions for improvement	• There was a suggestion for increasing direct supervision and involvement of trainers during clinical hours to enhance real-time learning opportunities. • More formal teaching sessions, regular CME events, and case-based discussions were commonly suggested. • Trainees proposed enhancing the curriculum with more practical skills sessions, as well as incorporating more structured learning plans.

DISCUSSION

A local comparison study evaluating GP trainees' feedback before and after a COVID-19 pandemic related break in training showed 89-91% ratings and 84-94% ratings respectively (Sammut, et al., 2021). Similarly, the current study showed high GP trainee satisfaction rates regarding effective GP training (91.5%).

This study included an internal comparison between private and public sectors, revealing that the private sector received slightly higher ratings than the public sector (92.9% vs. 91.1%). Conversely, a previous local comparison study showed a lower post-COVID rating of 84% for the private sector (Sammut, et al., 2021). During and after COVID, many sectors saw a reduction in resources and shifts in teaching modalities. The private sector might have faced delayed adjustments to these new standards, possibly explaining the lower ratings observed in the past study (Kaye, et al., 2020).

Trainees working with public GP trainers reported higher satisfaction in specific areas such as emergency care, minor surgery and audit/performance review. These results suggest that public health centres might provide more comprehensive or structured experiences in these domains, possibly due to a greater variety of cases or a stronger emphasis on procedural skills and critical care. Conversely, training with private sector GPs achieved higher satisfaction in several other key teaching areas, including teaching in the clinical situation, practice management, use of primary care team, chronic disease management and child health surveillance. The private sector might allow for more time and resources dedicated to long-term patient management, contributing to higher satisfaction. Such sector might also offer more flexible teaching methods and more direct involvement in managing a practice, thereby achieving higher satisfaction rates.

Trainees' qualitative feedback suggest the need for more structured interactions with trainers, particularly including increased opportunities for shadowing and case discussions. This is supported by various studies (Kelly and Hassett, 2021; Svendsen, et al., 2024). Structured interactions, akin to the methods used in Cognitive Behavioural Therapy, significantly enhances the effectiveness of the training process. Effective supervision is characterised by a supportive environment where feedback is structured and tailored to the individual trainee's needs. This approach fosters a stronger supervisory alliance, which is crucial for trainee development (Kelly and Hassett, 2021). A Danish prospective, explorative study emphasizes the role of peer feedback during clinical scenarios, suggesting that training in situ – where clinical teams practice and receive feedback in real-time – can promote better learning outcomes. This approach allows trainees to directly apply their learning in a clinical context, thereby enhancing

their skills and confidence during clinical hours (Svendsen, et al., 2024).

GP trainees frequently expressed the need for increased overlap in work shifts with their trainers. Studies on clinical training emphasize that overlap allows trainees to receive timely feedback, ask clarifying questions, and participate in real-time case discussions. This kind of immersive experience enhances both knowledge acquisition and confidence, as trainees can directly observe and interact with trainers during critical clinical decisions (Sinclair, et al., 2020). A Canadian-based observational study highlighted that real-time interactions, made possible through overlapping schedules, allowed trainees to make connections between theory and practice more effectively and receive feedback that directly applied to their immediate tasks (Piquette, et al., 2015). Similarly, a recent survey conducted by the Royal College of General Practitioners highlighted that structured mentorship, including shift overlaps, enhances the educational experience by fostering an environment where trainees can ask questions and discuss cases immediately (Royal College of General Practitioners, 2023).

Study method strengths, limitations and future implications

While the mandatory completion of evaluation forms by GP trainees was a strength of the review, there is a possibility that some trainees may have lacked the motivation to answer the open-ended questions, which could lead to potential non-response bias in the qualitative analysis. Those who chose not to respond might hold different perspectives and experiences from those who participated, potentially skewing the overall findings.

Additionally, social desirability bias could influence how trainees respond. In this context, trainees might provide answers they believe are more favourable or expected, rather than sharing their true opinions about their training experiences. This desire to conform to perceived expectations can obscure the authenticity of their feedback.

Selection bias could pose a significant challenge. Trainees who had positive experiences might be more inclined to complete the qualitative sections of the evaluation survey, while those who experienced challenges or dissatisfaction might choose not to answer these open-ended questions. This selective participation can result in an overly optimistic representation of the training programme.

The study's cross-sectional design limits the ability to establish causality, as it captures data at a single point in time rather than observing changes or developments throughout the duration of the training. Furthermore, the retrospective nature of the completion of the evaluations may introduce recall bias. Trainees may not accurately remember their experiences or may unintentionally misrepresent them when reflecting on past events.

Moreover, the halo effect could lead trainees to allow their overall impression of their trainers or the training programme to influence their optional evaluations of specific aspects when answering open-ended questions. For instance, if a trainee had a positive experience with one component of their training, they might rate other components more favourably than warranted. This bias can result in inflated ratings that do not accurately reflect the quality of individual elements of the programme.

Similarly, the Hawthorne effect may come into play, as trainees could alter their behavior or responses simply because they are aware that they are being observed or evaluated. This heightened awareness can lead to participants providing feedback that they believe aligns with what the evaluators want to hear, rather than their genuine thoughts and feelings.

The absence of demographic data, such as age, gender, and area of practice (North/Central/South) further limits the ability to conduct meaningful statistical analyses and assess how various factors may influence trainee feedback. Collecting such demographic data was deemed beyond the scope of this project. However, it is a crucial element that could enhance the understanding of the diverse experiences

among trainees. Future research can address this challenge.

This study evaluated the feedback of GP trainees regarding their placements in Family Medicine in 2023. It provided recommendations for future practice, education, and policy. Although the evaluation method used for assessing placements was appropriate, future research would benefit from incorporating similar feedback from GP trainers. This would not only help mitigate the identified biases but also provide a more comprehensive understanding of the training experience, enriching the feedback loop between GP trainees and trainers.

CONCLUSION

The evaluation of GP trainees' feedback on their 2023 Family Medicine placements underscores the effectiveness of the Specialist Training Programme in Family Medicine (STPFM) in providing a comprehensive and enriching learning experience. High satisfaction rates reflect the programme's strengths, including the quality of trainer support and the diverse training opportunities across public and private sectors. The findings indicate that the objectives of the study have been successfully met.

Recommendations

While the GP trainees expressed that they were generally satisfied with their placements in Family Medicine, four key actionable insights have been identified that could enhace the overall training experience.

These actionable insights include:

1. `Enhancing scheduling flexibility:
   Adjust schedules to ensure more overlap between trainees and trainers, facilitating real-time feedback and case discussions
2. Strengthening focus on practical skills:
   Increase opportunities for hands-on training by incorporating specific procedures, such as the administration of goserelin injection into the online portfolio as a direct observation procedural skill.
3. Improve summative assessment methodology**:**
   Revise the video consultation summative assessment process with clearer guidelines and constructive feedback mechanisms.
4. Foster collaborative learning:
   Support trainees in shadowing doctors during home visits and engaging in peer-to-peer learning through case discussions, regular group meetings, and shared learning resources

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A study of pneumococcal conjugate vaccine awareness and uptake among individuals aged 65 and over in the Gozo community attending Victoria Health Centre and Gozo community clinics

Dr Bryen GATT, Dr Samantha MERCIECA, Dr Martha CARUANA and Dr Ruth GRECH

ABSTRACT

Background

This study assessed awareness and uptake of the pneumococcal conjugate vaccine (PCV) among individuals aged 65 and over attending the Victoria Health Centre and Gozo community clinics.

Method

A total of 150 eligible participants, representing a diverse elderly population, were surveyed using a structured questionnaire between October and November 2024.

Results

Findings revealed a low pneumococcal vaccine uptake rate of 6.76%, with lack of awareness (72.6%) identified as the primary barrier. Although healthcare professionals play a vital role in influencing vaccine decisions, mass media emerged as the leading source of vaccine information, surpassing direct physician recommendations. This study found no significant association between vaccine uptake and chronic disease status, gender, or education level, although higher education was linked to greater awareness ($p = <0.05$).

Conclusions

The results highlighted the need for a multifaceted public health strategy, including enhanced physician engagement, targeted awareness campaigns, improved accessibility, and educational outreach to address misconceptions. Limitations of this study included the small sample size, convenience sampling, and potential biases in self-reported responses. Strengthening public health education and physician-led interventions is critical to improving pneumococcal vaccine coverage among Gozo's aging population.

Key words
Health education, pneumococcal vaccine, preventive health, primary healthcare, vaccine uptake.

INTRODUCTION

In 2024, the Maltese government started providing the pneumococcal conjugate vaccine (PCV) for free to patients who are 65 years and over. This study was conducted to assess whether those eligible have enough information about the vaccine and their willingness to take it.

PCVs target the bacteria *Streptococcus pneumoniae* which is known to cause pneumonia and may also lead to invasive pneumococcal disease with complications such as meningitis and septicaemia. One of the vaccines available is the PCV 20 (20-valent pneumococcal conjugate vaccine) which provides immunisation against the following serotypes of *S.pneumoniae* (1, 3, 4, 5, 6A, and 6B, 7F, 8, 9V, 11A, 10A, 12F, 14, 15B, 18C, 19A and 19F, 22F, 23F, and 33F) (Tereziu & Minter, 2023).

S.pneumoniae is the most common pathogen which causes community acquired pneumonia worldwide. It accounts for up to 15% of pneumonia cases in the United States and 27% worldwide. Seasonality of infection is mainly winter and spring. *S.pneumoniae* tends to be more common in patients over 65 years, children less than 2 years old, smokers, alcoholics, those who have asplenia, chronic obstructive pulmonary disease and asthma. The World Health Organization (WHO) estimated that 1.6 million deaths in 2005, including 1 million children less than 5 years of age, occurred due to *S.pneumoniae*. It is a common co-infection in influenza patients and affects the morbidity and mortality in such patients (Dion & Ashurst, 2023).

Aim

This study aimed to assess the general awareness of the patients who are eligible for free PCV and who attend Victoria Health Centre (VHC) and Gozo Community Clinics (GCC). It also aimed to assess factors influencing individuals' decisions to get vaccinated and barriers to vaccine uptake and assesses attitudes towards future pneumococcal vaccination administration.

Objectives

This study evaluated the general knowledge and awareness of pneumococcal disease and the availability of the PCV vaccine among individuals aged 65 and over. It also aimed to identify key barriers to the vaccine uptake. Additionally, the study examined the role of healthcare professionals in promoting pneumococcal vaccination and assessed the effectiveness of public health initiatives in raising awareness among older adults. Furthermore, it explored potential disparities in vaccine awareness and uptake based on various demographic factors, including (but not limited) to age, geographical location and socioeconomic status. Based on the findings, this study intended to propose targeted interventions to enhance PCV awareness and uptake, including tailored public health strategies and improvements in healthcare provider practices.

METHOD

Study population

The study population consisted of individuals aged 65 and over who attended VHC and GCC between October and November 2024 and who met the eligibility criteria for the PCV. A total of 150 participants who met the inclusion criteria were included in this study. This sample represented a diverse group of elderly individuals with varying levels of awareness, experiences and potential barriers related to pneumococcal vaccination.

Data source

Data for this study were collected through a structured questionnaire administered to eligible patients. The questionnaire, available in both English and Maltese based on the participant's preference, included multiple-choice questions, Likert scale items, and demographic questions. The key areas of inquiry covered by the questionnaire included:

- **Awareness of the PCV:** Participants were asked about their knowledge of the vaccine and its benefits.
- **Vaccination status:** Participants were queried about whether they had received the PCV.

- **Healthcare provider recommendations:** The questionnaire explored whether healthcare providers had recommended the PCV to participants.
- **Presence of chronic conditions:** Participants were asked about any underlying chronic conditions, as these may influence vaccination decisions.
- **Attitudes and barriers to vaccination:** The questionnaire assessed participants' attitudes toward vaccination and identified potential barriers preventing uptake, such as misconceptions, fear or access issues.

Data collection and analysis:

This study employed a cross-sectional study design, collecting data at a single point in time. Participants who gave free informed consent completed a structured paper-based questionnaire. Before data collection, they were informed about the study's purpose and assured of the confidentiality and anonymity of their responses, with no personally identifiable information recorded.

Ethical clearance

Prior to the study, approval was obtained from the institution's Chief Executive Officer and Data Protection Officer. As the data used were fully anonymized, the study did not meet the criteria for human subjects research under the Declaration of Helsinki and GDPR Recital 26 pertaining to Ethics Committee approval.

Sampling method

Participants were recruited using a convenience sampling method, whereby the first 150 patients visiting the VHC and GCC who met the eligibility criteria were invited to participate. Doctors at these facilities distributed the questionnaires to patients during their visits. This sampling method ensured that the target population was represented within the study.

Data analysis

The collected data was analysed using statistical software. The analysis included both descriptive and inferential statistics:

- **Descriptive statistics:** Frequencies and percentages were calculated to summarize the responses to the questionnaire, offering an overview of participant awareness, vaccination status and other variables.
- **Inferential statistics:** Chi-square tests were applied to assess any associations between variables, such as the relationship between chronic conditions and vaccination uptake, or the correlation between healthcare provider recommendations and vaccine acceptance.

The analysis provided a comprehensive overview of the PCV uptake and the factors influencing it among the elderly population in the Gozo region. This methodology aimed to identify gaps in awareness, barriers to vaccination, and areas where interventions could be implemented to improve vaccination rates.

RESULTS

Participant demographics

A total of 150 participants were included in the study. The gender distribution was almost equal, with 49.3% males and 50.7% females. A chi-squared test revealed no significant association between gender and vaccine uptake (Cramer's V = 0.0528), suggesting that gender does not influence vaccine acceptance.

In terms of age distribution, 30% of participants were between 65 and 70 years old, 33.4% fell within the 71-75 age range, 25.3% were aged 76-80, and the remaining 11.3% were over 80 years old (Figure 1).

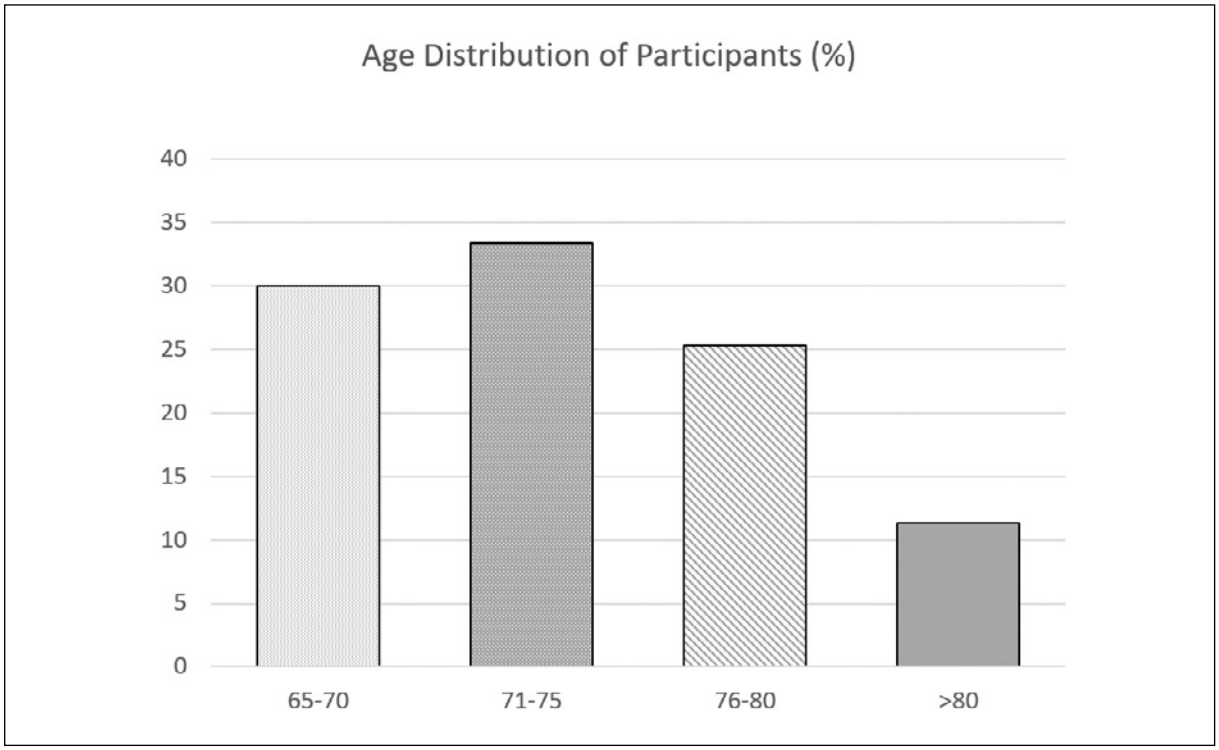

Figure 1: Age distribution of participants (percentage)

Health status and chronic disease

A substantial proportion of participants (82.3%) reported having a chronic disease (Figure 2), with hypertension (32%) and diabetes mellitus (22%) being the most prevalent conditions. Regarding vaccine uptake among those with chronic illnesses, 28.7% were unwilling to receive the PCV vaccine, whereas a combined total of 42.6% (15.6% very willing and 27.0% extremely willing) expressed a strong willingness to take it (Figure 3). A chi-squared test analyzing the relationship between chronic disease status and vaccine uptake found no statistically significant association (Cramer's V = 0.0199), suggesting that having a chronic disease does not notably influence the decision to get vaccinated.

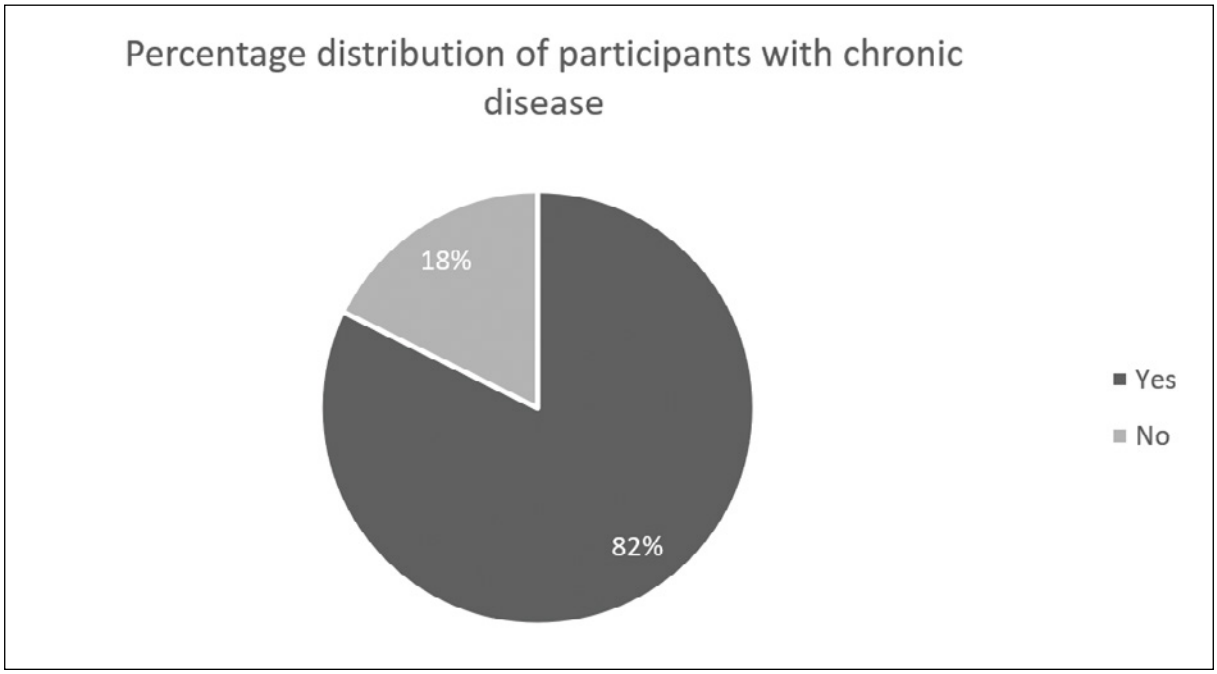

Figure 2: Percentage distribution of participants with chronic disease

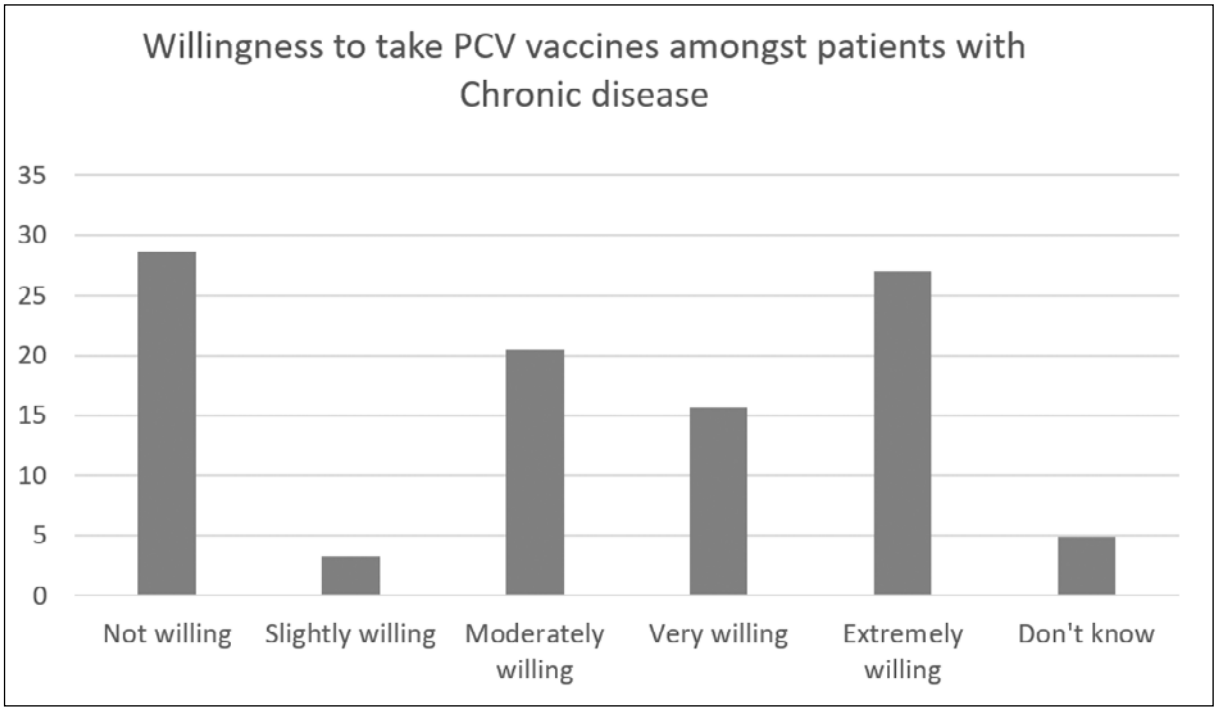

Figure 3: Vaccination willingness among individuals with chronic illnesses (percentage)

Education level

The majority of participants had attained primary education. A chi-squared test examining the correlation between education level and vaccine uptake showed no statistically significant relationship (Cramer's V = 0.1528), indicating that education level does not have a notable impact on vaccine acceptance.

Information sources and promotion

A total of 56.08% of participants reported having heard of the PCV vaccine, while the remaining participants were unfamiliar with it. Among those who were already aware of the vaccine, the most common source of information about the vaccine was media outlets (including TV, radio, and newspapers), as shown in Table 1. Thus, media outlets were the main reason for the participants' awareness of the vaccine. Doctors were the second most frequently cited source of such information, but at a considerably lower percentage compared to media sources. The data suggested that mass media plays a crucial role in disseminating information about the PCV vaccine, while healthcare professionals contribute to a lesser extent.

Table 1: Percentage distribution of PCV vaccine awareness sources. (The first column includes the various sources of information that led to participants knowing about the vaccine. The second column shows the percentage of participants who chose the relevant source. Data is in descending order.)

Source of information that made the participants aware of PCV	Percentage
Media Outlets - TV, Radio, Newspaper	44.44%
Doctor	19.75%
Other	11.11%
Friends/family	8.64%
Internet/social media	8.64%
Combined sources from the above	7.38%

When considering strategies for promoting the PCV vaccine, the most preferred approach was a combination of doctors and mass media, with 40 participants indicating this as the most effective method. Another 37 participants suggested that including community programmes alongside doctors and media could further enhance outreach. The data suggested that while media plays a crucial role in disseminating vaccine information, integrating healthcare providers and community outreach programs could enhance vaccination awareness and uptake.

Vaccine uptake and barriers

The majority of participants (91.89%) reported that they had not received the PCV vaccine, while only 6.76% had taken it, and 1.35% were unsure about their vaccination status. These findings indicated low uptake rates, highlighting the need for increased awareness and encouragement from healthcare providers.

Among those who had received the vaccine, the most common reasons for doing so included a doctor's recommendation and the presence of a chronic illness. This suggested that healthcare professionals play a crucial role in influencing vaccination decisions, particularly for individuals with underlying health conditions. However, given that only 6.76% of participants had taken the PCV vaccine, the small sample size of vaccinated individuals presented a limitation in fully understanding the broader motivations and potential influencing factors.

Among participants who had not taken the PCV vaccine, the most frequently reported reason was lack of awareness, with 72.6% stating that they did not know about the vaccine. Additionally, 6.7% cited concerns about side effects, while 4.4% felt they did not have enough information to make an informed decision.

DISCUSSION

This study was an insightful analysis of the current uptake and awareness of the pneumococcal vaccine among patients at Victoria Health Centre, which is the main public health centre on the island of Gozo. It explored vaccine acceptance with regards to PCV20 – an uncharted territory for research in the Maltese islands.

In 2018, a study focusing more on influenza vaccination in Malta showed that pneumococcal vaccination in Malta was low and that the main limiting factors for vaccination were physician recommendation and lack of physician awareness on the vaccine (Camilleri et al., 2018). A plausible limiting factor mentioned then was the fact that the PCV vaccine was not available for free to the public.

Our study indicated that whilst significant improvements have been made since then, more can be done to improve vaccination rates in the local population. The following is a discussion about the various factors associated with PCV uptake, taking into account the present study and various studies published internationally.

As seen from the results, chronic disease and gender differences did not show any statistically significant association with vaccine uptake. In a detailed scoping review, being male was identified as a barrier in two studies carried out in the United States (U.S.). On the other hand, health status was identified both as an enabler and as a barrier in different studies (Nasreen et al., 2022). The small population could account for the lack of association in these results. When taking into account the education level, whilst statistical testing found no significant association with vaccine uptake, the higher the education level, the higher the percentage of patients who had heard about the vaccine ($p=<0.05$). In addition, awareness of the vaccine was significantly associated with vaccine uptake ($p=0.01$) and this has also been reported in multiple previous studies (Nasreen et al., 2022; Wan et al., 2024). Awareness of the vaccine is a significant predictor of uptake, highlighting the importance of educational campaigns.

A physician's recommendation of taking the PCV vaccine has been positively correlated with vaccination intention and uptake in various studies (Ekin et al., 2023). Recommendation or prescription of the pneumococcal vaccine from a healthcare provider were identified as enablers of vaccination in various countries including Japan, France, Poland, Canada and the U.S. (Nasreen et al., 2022). A local study in 2020 concluded that there is a need for geriatricians and family doctors in Malta to be reminded of

the guidelines surrounding the pneumococcal vaccine (Zerafa et al., 2020). Interestingly, from our study, a significantly higher percentage of males (p=<0.001) were recommended to take the vaccine than females and a higher percentage of smokers and ex-smokers were recommended to take the vaccine by their doctor than non-smokers (p=0.069). Patients in our study who knew of the vaccine were mostly aware of it through the media and from a doctor's recommendation/ information. A doctor's recommendation was also the number one reason for taking the vaccine prior to the date of the study.

In the present study, the commonest reasons for not taking the PCV vaccine until the date of study were lack of awareness (74.1%), concerns about side effects (12.2%) and not having enough information about the vaccine (8.16%). This emphasizes the importance of good public campaign as well as healthcare education in general. Other articles reflect the same reasons for low vaccine uptake internationally. In a recent study carried out nationally, examining the percentage of elderly aged >65 years who resided in a particular elderly home, only 12.3% had heard about the vaccine and only 7.7% took it (Farrugia et al., 2024). In our study the percentage of people who had heard of the vaccine is much higher, amounting to 56.1%. This could be attributed to the fact that the study was carried out at a time where the vaccine was being advertised for the first time on media. Differences in the population studied (including social status and health status) could also contribute to the difference in results attained. Out of those who had heard about the vaccine, 14% were still not willing to take the vaccine whilst only 12% had taken the vaccine. The primary reason for this could be that up till the date of the study the PCV vaccine was not available for free to the public, but other reasons such as concerns about side effects, not having enough information about the vaccine and past negative experiences with vaccination cannot be taken for granted. In fact, cost of PCV and subsidy eligibility or applicability has been found to be a determining factor of vaccination in other studies (Wan et al., 2024).

Strengths and weaknesses

This study represented one of the first comprehensive analyses of PCV vaccine awareness and uptake in Malta. It incorporated a detailed questionnaire, included a diverse set of demographic and health-related variables, and utilized statistical tests to assess associations between key factors.

However, there were several limitations to consider:

1. Small sample size: With only 150 participants, statistical power was limited, and findings may not be generalizable to the entire population.
2. Convenience sampling bias: Participants were selected from a single health centre, which may not be fully representative of the broader community.
3. Response bias: Self-reported data may be subject to recall bias or social desirability bias.
4. Question order bias: The way questions were structured may have influenced participant responses.
5. Given these limitations, future studies should aim for a larger, randomized sample across multiple healthcare facilities to improve generalizability and statistical reliability.

CONCLUSION

This study highlighted the low awareness and uptake of the pneumococcal vaccine among individuals aged 65 and over in Gozo. Only 6.76% of participants had received it, with lack of awareness (72.6%) being the predominant barrier.

Healthcare professionals play a critical role in vaccine uptake, as seen in previous studies and reinforced by this study. However, the results showed that mass media (TV, radio, newspapers) remains the leading source of vaccine information, surpassing direct recommendations from doctors. This suggests that while healthcare providers are trusted, they may not be actively discussing or promoting the vaccine as effectively as media outlets.

The findings also indicated that chronic disease status, gender, and education level

did not significantly influence vaccine uptake. Nonetheless, higher education levels were associated with greater awareness, reinforcing the importance of education in vaccination campaigns.

To address these gaps, a multifaceted approach is proposed to increase vaccine awareness and uptake, focusing on leveraging healthcare providers, expanding public awareness campaigns, improving accessibility and addressing misconceptions. A stronger emphasis on public health education and structured physician recommendations is essential to achieving higher vaccination rates and ultimately reducing pneumococcal disease burden in the aging population.

Recommendations

Based on the findings, the most effective recommendations should focus on increasing awareness through trusted sources like doctors and media, addressing concerns about side effects, and providing clear, accessible information about the vaccine's benefits and availability.

Table 2 outlines recommendations and specific strategies to achieve these goals. These recommendations are designed to address the key findings from the analysis and ensure that patients are well-informed and motivated to make decisions about the vaccine.

Table 2: Recommendations and key actions

Recommendation	Key Actions
Leverage healthcare providers as trusted sources	Encourage doctors and nurses to proactively recommend the vaccine, especially for patients with chronic illnesses or those over 65. Provide healthcare professionals with training and resources to address concerns about side effects and vaccine efficacy.
Enhance public awareness campaigns	Utilize mass media (TV, radio, newspapers, and social media) to promote vaccine benefits, safety, and availability. Develop targeted campaigns for older adults and individuals with chronic conditions.
Address barriers to uptake	Create educational materials to address misconceptions and fears, such as concerns about side effects. Ensure that information is available in clear, simple language and multiple formats (brochures, videos, online content).
Improve accessibility and convenience	Increase vaccine availability at local clinics, pharmacies, and community health centres. Offer mobile vaccination units or home visits for individuals with mobility issues.
Community engagement	Partner with community organizations and leaders to promote vaccine awareness and address cultural or social barriers. Host informational sessions or Q&A events in community centres to address concerns and provide accurate information.
Monitor and evaluate	Regularly assess the effectiveness of awareness campaigns and vaccination programs through surveys and feedback. Use data to refine strategies and address emerging barriers.

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Deprescribing tendencies within primary health care – a literature review

Dr Justin BONNICI and Dr Marco GRECH

ABSTRACT

Background

Polypharmacy increases in older persons and in multimorbid patients thus becoming prevalent in primary health care. While deprescribing offers a patient-centered, systematic approach to reducing potentially inappropriate medicines, implementation remains inconsistent based on clinical, systemic, and patient-level factors.

Aim

The purpose of this literature review is to outline the enablers and barriers of deprescribing in primary care and, on the basis of current evidence, identify successful solutions for implementation.

Method

A review of the literature was performed utilising PubMed, Medline, Cochrane Library and Embase, as institutional databases. English publications between 2020 and mid-2025 were screened utilising predefined inclusion and exclusion criteria. The Critical Appraisal Skills Programme (CASP) framework was used to critically appraise the peer-reviewed articles. Data were synthesised thematically with arising patterns grouped into their own main themes and sub-themes.

Results

Dominant themes that occurred were prescriber confidence, patient refusal, time constraints, and lack of overt guidelines as key barriers. Enablers such as multidisciplinary collaboration, use of evidence-based deprescribing tools (e.g. STOPP/START, Beers Criteria), and patient engagement were reported across all settings. Implementation strategies varied between settings but the majority contained important pharmacist interventions, education programmes, and formal implementation protocols.

Conclusion

Deprescribing within primary care can be done and is necessary but requires multi-faceted interventions targeting individual prescribers, systems, and patients. To enhance uptake and sustainment, deprescribing has to be incorporated into routine care in combination with training, decision aids, and policy-level promotion.

Keywords

Barriers, deprescribing, facilitators, polypharmacy, primary care.

INTRODUCTION

The increased prevalence of polypharmacy among the older person poses a huge challenge to primary healthcare systems globally. Polypharmacy, or the concurrent consumption of several drugs, five or more, is quite frequently the outcome of treating multimorbidity, especially in the older person. Although such prescribing is clinically warranted, particularly when evidence-based practice is the impetus, it also heightens the risk of hospitalization, adverse drug events (ADEs), drug interactions, and reduced quality of life (QOL) Thus, deprescribing has become a vital methodology for streamlining drug therapy regimens and enhancing patient outcomes (Hung, Kim and Pavon, 2024).

Deprescribing is defined as the intentional and supervised process of reducing, tapering or discontinuing medications that no longer provide benefit or are likely to harm. Deprescribing is not a failure of treatment but rather a dynamic and active approach to medication management that is concordant with patient-centered principles of care. It enables regular re-assessment of treatment goals, clinical necessity and patient preference (Thompson and McDonald, 2023).

General practitioners (GPs) and other primary care providers are well-positioned to initiate and coordinate deprescribing. Their role as ongoing and integrated carers of patients provides a bird's eye view of long-term medication regimens and evolving clinical needs. GPs often must manage several simultaneous chronic conditions and are charged with reconciling clinical guidelines and patient reality. In spite of this fundamental role, the process of deprescribing is replete with challenges. The factors are time constraints, sporadic access to specialists, fear of withdrawal reactions, lack of training in deprescribing skills and concern about damaging the therapeutic relationship with patients (Alrawiai, 2023). In the United Kingdom, initiatives such as Structured Medication Reviews and clinical guidelines, viz. STOPP/START criteria have been initiated in order to facilitate adequate deprescribing (Alrawiai, 2023).

Above all, deprescribing cannot be envisioned as just a set of interventions or tools but as a clinical tendency; a tendency influenced by culture, experience, attitude, and support systems. A GP's likelihood of pursuing deprescribing can be equated to their awareness of medication harms, their comfort with clinical uncertainty, and how supportive the healthcare system is seen to be. These incorporate elements like access to multidisciplinary teams, the presence of deprescribing prompts in electronic health records, and the provision of structured clinical education (Liacos, Page and Etherton-Beer, 2020).

Although GPs are at the centre of deprescribing, attention is being given to the role of other health-care professionals (HCPs), notably the pharmacist. Pharmacists, particularly when they are members of primary care teams, can conduct helpful medication reviews, identify potentially inappropriate medication (PIM), and assist in the implementation of deprescribing plans. Rea et al. (2023) demonstrated the effectiveness of pharmacist-driven deprescribing interventions at 16 primary care sites in the United States (U.S.), resulting in the discontinuation of over 350 medications, prescriber acceptance rates over 90%, and substantial cost savings. This highlights the benefits of collaborative care models in supporting rational prescribing.

Despite growing awareness, deprescribing is underappreciated. Barriers confront deprescribing at multiple levels; patient (e.g., reluctance to disturb known treatments), provider (e.g., uncertainty), and system (e.g., absence of standardised procedures). Clinical guidelines also generally prioritize medication addition over deprescribing, thereby leaving clinicians with limited guidance when considering cessation. Accordingly, deprescribing is most often reactive, prompted by adverse events or hospitalisation, and not proactive, which works to limit its more general preventive potential (Thompson and McDonald 2023).

Aim

The purpose of this literature review is to outline both the facilitators and barriers of deprescribing in primary care from the prescriber's point of view, to address patient and system level issues on the basis of current evidence, and

to identify potential successful solutions for implementation.

METHOD

The method is guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to enable a transparent assessment and process of the literature. Although not expressly systematic, this review integrates similar elements, comprising systematic database searching with predefined inclusion and exclusion criteria, alongside a critical appraisal of included studies.

Databases and search strategy

A search plan was employed in identifying studies that were relevant to the topic. Searches were conducted on various electronic sources, including PubMed, MEDLINE, the Cochrane Library and Embase. Search terms were carefully selected and developed from relevant Medical Subject Headings (MeSH) and keywords. Boolean operators, such as AND and OR, were also utilized to combine terms and enhance the specificity of the search. The search terms used were "deprescribing," "primary care," "general practice," "attitudes," "polypharmacy," and "barriers AND facilitators." Boolean operators have been applied with various combinations of the terms above.

Inclusion and exclusion criteria

To enable a high-quality review, strict inclusion and exclusion criteria were established. The inclusion criteria are outlined as below:

- Original research and peer-reviewed articles.
- Only systematic reviews, literature reviews, randomised controlled trials, observational studies and meta-analysis studies were included in the search.
- Scientific research published between the years 2020-2025.
- The research was conducted primarily in primary care settings.
- Investigation of attitudes, barriers, facilitators and practices towards this role.
- Research that investigates drugs commonly deprescribed, as well as the effects of such a role.
- Existing English research.
- Studies addressing adults.

The exclusion criteria were as follows:

- Only research in tertiary and secondary care.
- Articles unavailable in full text.
- Research not related to human health.
- Studies lacking qualitative methodology.

These research standards ensure that the narrative literature review is not only adequate and pertinent but also up to date and of high quality, hence adding to a proper review of significant worth regarding polypharmacy and deprescribing among the population.

Screening and selection process

All records identified and retrieved were screened. This was initially achieved by optimizing the title and abstract to exclude non-relevant studies. Second, systematic review and overview of the entire text were done to find potentially eligible articles. To have an orderly and unambiguous approach to the selection process, a PRISMA-inspired method was employed, which entailed identification, screening, eligibility, and inclusion/exclusion criteria. Several records were manually located by searching reference lists of relevant, high-quality studies.

Quality evaluation

The methodological quality of studies in the analysis was evaluated by the Critical Appraisal Skills Programme (CASP) tools and respective checklist. The evaluation was conducted for each study depending on its specific design. All studies were analyzed regarding methodological quality, applicability to research questions and clarity of reporting. Quality appraisal was necessary because it enabled the detection and judgment of evidence from literature but did not form the sole exclusion criterion unless there were severe negative findings.

Key areas checked were: research objectives clarity, appropriateness of methodology, the recruitment process, data analysis and collection, and the overall contribution of findings. Research studies not meeting a minimum criterion of methodological quality or not pertinent to the

purpose of the review were excluded. This appraisal process helped with a more targeted high-quality synthesis of evidence to shape the review's conclusions.

Data synthesis

Findings were thematically synthesized to permit recurring themes, shared patterns and variability by setting. These were observed and classified accordingly, as follows:

- System level factors:
  - Healthcare system barriers.
  - Organizational facilitators.
  - Resource considerations.

- Provider level factors:
  - Barriers to clinical decision-making.
  - Professional relationships.
  - Implementation strategies.

- Patient level factors:
  - Attitudes and preferences regarding polypharmacy/deprescribing.
  - Communication issues.
  - Engagement strategies.

Limitations of methodology

Given the nature of a narrative literature review, the following limitations may be faced by the project:

- Selection bias is most frequently occurring in study screening and thematic synthesis contexts.
- Publications can be biased, as results of negative value may be underreported.
- Language bias, because of exclusion of non-English language studies.

Nevertheless, the approach employed during search strategy and data extraction through critical appraisal guarantees transparency and reliability of the results.

RESULTS

The search presented a total of 854 initial records via Pubmed, Embase, Medline and Cochrane Library. The search terms and Boolean operators were employed as specified in the previous section together with the relevant inclusion and exclusion criteria. A total number of 43 scientific articles were included in the production of this literature review. A PRISMA flow diagram was utilised to showcase the search undertaken and the findings are depicted hereunder in Figure 1. A PRISMA flowchart template was retrieved from primsa-statement.org. The original article had a total of 43 studies; however, for the purpose of this article a total number of 25 studies were utilised. These were reduced from the original study as it was modified for the purpose of the article subject.

Themes and sub-themes were extracted according to the aim of the article. The main focus of the theme was the health care professionals' attitudes and beliefs regarding the deprescribing process within their community clinics and how this affects their consultation and management options with their patients. These were based, as described in the data synthesis, via system, provide and patient level factors. Thereafter, articles were reviewed by utilising the CASP assessment tool to filter out the sub-themes chosen for the production of this article. This is shown in tabulated form within Table 1.

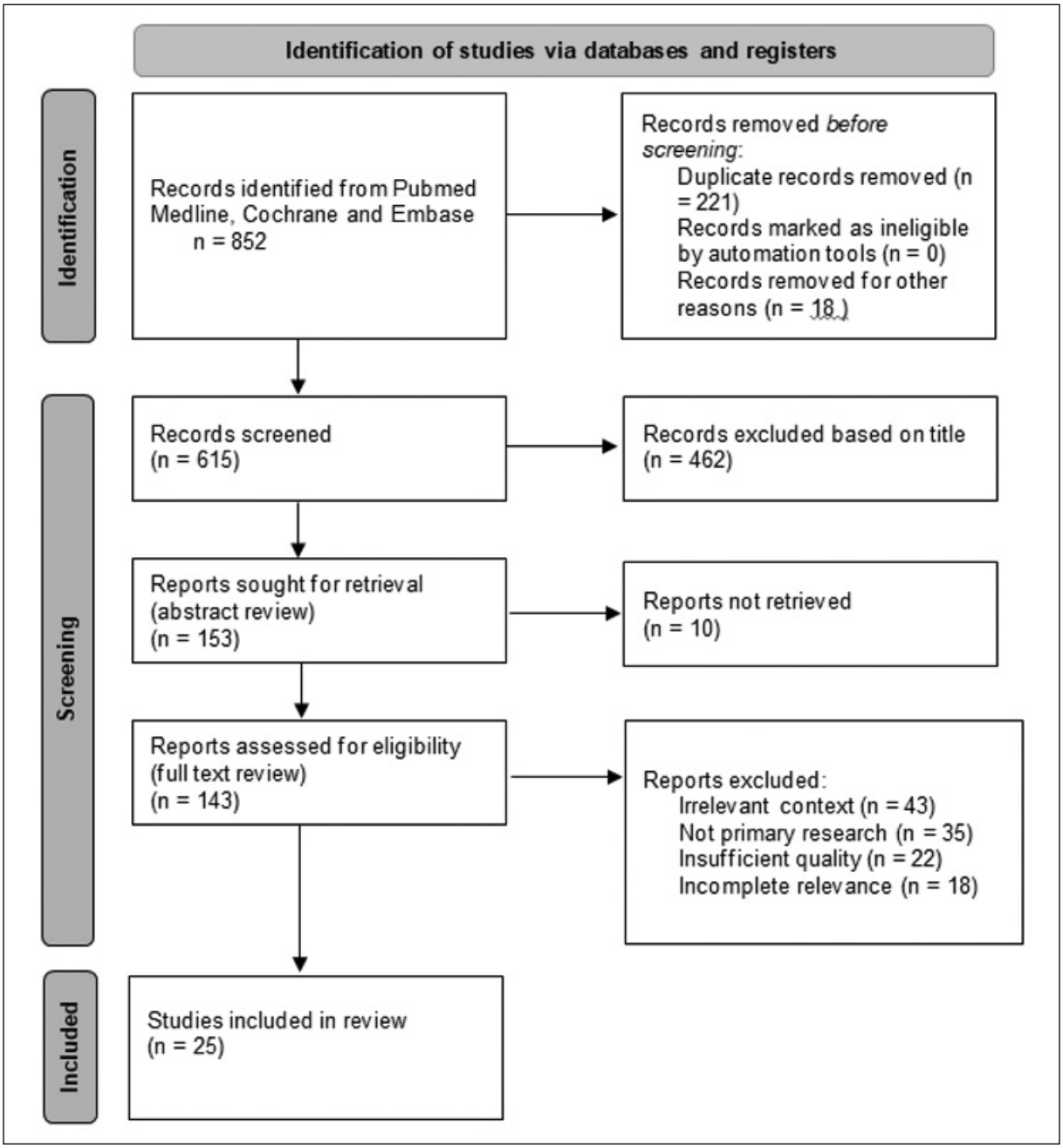

Figure 1: PRISMA flowchart showing the selection of the articles in this literature review

Table 1: Main themes and sub-themes of the individual selected articles

Author and year	Main themes and sub-themes
Alrawiai (2023)	Implementation Barriers; Stakeholder Perspectives
American Geriatrics Society 2023 updated AGS Beers Criteria®	Deprescribing Tools; Enablers; Guidelines
Bloomfield et al. (2020)	Clinical Outcomes; Stakeholder Perspectives
Bužančić and Hadžiabdić (2023)	Stakeholder Perspectives; Patient-Centred Factors
Carollo et al. (2024)	Implementation Barriers; Deprescribing Tools; Patient-Centred Factors
Chang et al. (2024)	Deprescribing Tools; Behavioural Theory
Goh et al. (2023)	Implementation Barriers; Stakeholder Perspectives; Patient-Centred Factors; Enablers; GP Trainees
Hung, Kim and Pavon (2024)	Implementation Barriers; Deprescribing Tools; High-Risk Drug Classes; Stakeholder Perspectives; Patient-Centred Factors
Ibrahim et al. (2021)	Clinical Outcomes
Lee et al. (2021)	High-Risk Drug Classes; Falls
Liacos et al. (2022)	Deprescribing Tools; High-Risk Drug Classes; Stakeholder Perspectives; Patient-Centred Factors; Enablers
Maher et al. (2020)	Deprescribing Tools
Niznik et al. (2022)	Implementation Barriers; Patient-Centred Factors
O'Mahony et al. (2023)	Deprescribing Tools
L'Mahony et al. (2021)	Clinical Outcomes
Rea et al. (2023)	High-Risk Drug Classes; Enablers; Barriers
Reeve (2020)	Deprescribing Tools; Stakeholder Perspectives; Patient-Centred Factors; Enablers; Barriers
Reeve et al. (2024)	High-Risk Drug Classes; Stakeholder Perspectives
Robinson et al. (2024)	Implementation Barriers; Patient-Centred Factors
Scott et al. (2024)	Stakeholder Perspectives; Enablers
Seppälä et al. (2022)	Stakeholder Perspectives
Thompson and McDonald (2023)	Implementation Barriers; High-Risk Drug Classes; Enablers
Trenaman et al. (2022)	Enablers; Implementation Barriers
Veronese et al. (2024)	Clinical Outcomes; Stakeholder Perspectives
Wang et al. (2023)	Implementation Barriers; Deprescribing Tools; Stakeholder Perspectives; Transitions of Care; Enablers

Deprescribing

Deprescribing is conceptualized as the intentional process of discontinuing medications that are no longer beneficial or are potentially harmful to the patient, particularly in the context of polypharmacy (Hung, Kim and Pavon, 2024). In an era of aging population and increasing prevalence of multimorbidity, deprescribing has emerged as a high-priority research field as a component of quality prescribing.

Why deprescribe?

The goals of deprescribing should be patient-centered and proactively done in a manner so as to minimize harm and enhance QOL. A number of strategies may be employed during deprescribing. Withdrawal of non-essential medications has been found to reduce the incidence of potentially inappropriate medication (PIMs) by 30–60%, thereby enhancing compliance with required treatments (Bloomfield et al., 2020). Bužančić and Hadžiabdić (2023) also documented similar findings where up to 40% of older persons are prescribed at least one PIM.

One of the key targets in older patients is the reduction of fall risk. Medications such as benzodiazepines, opioids, antidepressants, antipsychotics, and anticholinergic agents are known contributors (Lee et al., 2021; Niznik et al., 2022). However, studies suggest that deprescribing alone may not have a significant effect on fall risk reduction if not combined with other multifaceted interventions due to the multifactorial complexity of falls (Seppälä et al., 2022).

Other benefits of deprescribing, which are not necessarily linked with the patient's health, include saving costs to policymakers and patients, promotion of safer prescribing, accepting that all medications have potential side effects, and reducing the social burden to patients and carers, particularly regarding compliance with drugs (Veronese et al., 2024).

Which populations are targeted?

Older adults are disproportionately affected by polypharmacy and therefore are more vulnerable to drug-related problems. Older age itself is not an independent risk factor but is often associated with multimorbidity, complex treatment regimens, transitions of care, and physiological changes that all contribute to a higher risk of drug adverse events (Maher et al., 2020).

Renal impairment patients are particularly vulnerable since lowered kidney function heightens the risk of harm with unadjusted medications (O'Mahony et al., 2021). For instance, inappropriate NSAID prescribing remains common, even among older people. Evidence supports that pharmacist-led intervention can enhance deprescribing; highlighting the importance of collaboration between doctors and pharmacists to optimise prescribing practices and improve patient outcomes (O'Mahony et al., 2021). Similarly, having more than one prescriber and increased transfers between care settings - between community and hospital or between hospital and residential care - can lead to medication miscommunication and errors. Lack of proper clear documentation and lack of regular review often result in the continuation of unjustified treatments (Wang et al., 2023).

Frailty and dementia, two geriatric giants, are further grounds for deprescribing. Dementia has an association with increased likelihoods of PIMs, while frailty has been argued to increase the risk of ADEs, which could further exacerbate already existing vulnerabilities (Reeve et al., 2024). Additionally, care givers often have the complex task of keeping track of medication regimens, something that is time-consuming and results in further issues of safety and adherence (Ibrahim et al., 2021).

Supporting tools and guides

There are numerous tools and guidelines to aid practitioners, with the most current guidance on initiating, continuing or stopping medications. All of these tools whether explicit, implicit, or hybrid ought to support, not replace clinical judgment. Explicit tools are based on robust evidence and consensus, while implicit tools rely more on professional decision-making and nuanced clinical reasoning. Although potentially valuable, to what extent these tools are used in day-to-day general practice is unknown (O'Mahony et al., 2023).

Well-known explicit tools include the Beers Criteria, widely adopted in the United States (American Geriatrics Society, 2023), and the STOPP/START criteria, commonly used in European and UK settings (O'Mahony et al., 2023). There exists no tool that can capture all clinical scenarios. The best deprescribing strategies are those that form part of comprehensive, multimodal programmes that combine prescriber training, evidence-based support and active patient involvement (Reeve, 2020).

Approaches to deprescribing

Effective deprescribing follows a structured, evidence-informed process that is both practical and sustainable within the primary care setting. Given that GPs manage the majority of patients with multimorbidity and polypharmacy, they are central to initiating and sustaining deprescribing interventions. There has been growing interest in establishing models and national guidelines that standardise deprescribing practices, enhance interdisciplinary collaboration, and promote patient-centred decision-making. Among several contributions in this area, two stand out for their application of theory into clinical practice: the Italian national position statement by Carollo et al. (2024) and the internationally validated framework proposed by Scott et al. (2024).

Carollo et al. (2024) propose a five-step framework applicable across various care settings, with a particular emphasis on the role of general practice. The process begins with identifying patients at risk from inappropriate medications; typically older individuals with multiple chronic conditions or those recently discharged from hospital. This is followed by a comprehensive medication review, evaluating each drug's necessity, risk–benefit ratio and relevance to the patient's current health status. Ideally, this step is supported by interprofessional collaboration between GPs, pharmacists, and nurses. A deprescribing plan is then created through shared-decision making focusing on aligning treatment with patient preferences and health goals. The fourth step involves executing the plan via gradual dose reduction or abrupt cessation, depending on the medication and clinical context. Finally, a structured follow-up is essential to monitor withdrawal symptoms, recurrence of conditions, or new clinical concerns. In general practice, this model encourages continuity of care, clear documentation, inter-provider communication, and integration of deprescribing protocols into routine workflows.

In a complementary approach, Scott et al. (2024) developed a clinician-informed framework grounded in international consensus. Their model simplifies deprescribing into four stages: identify, evaluate, stop, and monitor. It was piloted via a cross-sectional survey involving 263 HCPs including doctors, pharmacists and nurses from 25 countries. The study highlighted 17 discrete activities across the four stages, including risk–benefit assessment, medication reconciliation, patient engagement in decision-making, and planning for follow-up. Although most participants acknowledged the importance of all these steps, those involving active patient participation, such as exploring beliefs and personal goals, were less frequently integrated into routine care. This disconnection between theoretical ideals and clinical reality underscores a persistent barrier in embedding truly patient-centred deprescribing into everyday practice.

Collectively, these two frameworks underscore the fundamental components required for safe and effective deprescribing in primary care: structured clinical processes, multidisciplinary teamwork, patient engagement, and behaviourally informed implementation strategies. Carollo et al., (2024) highlight the value of system-level policies to support change, while Scott et al. (2024) focus on the practical demands faced by frontline clinicians. Together, they emphasise the need for both policy-level (top-down) and practice-level (bottom-up) initiatives to embed deprescribing as a standard aspect of care.

Attitudes, behaviours and beliefs of the HCP

Deprescribing is increasingly recognised as an essential aspect of rational prescribing and medication optimisation in primary care. Yet, the implementation of deprescribing practices is influenced by the attitudes, beliefs, and behaviours of HCPs practicing in these settings. GPs, pharmacists and nurses display variability in their attitudes, ranging from active

engagement to passive resistance, based on clinical, interpersonal, and organisational considerations (Chang et al., 2024).

Attitudinal variability across professions

Primary care HCPs acknowledge the value and the necessity of deprescribing, particularly in older adults with multimorbidity. Chang et al. (2024) used the Theoretical Domains Framework in a cross-sectional study of the behavioural determinants of deprescribing by physicians, pharmacists, and nurses. The findings demonstrated significant interprofessional differences: pharmacists most frequently viewed deprescribing as an essential professional role, while nurses were less likely to view deprescribing as part of their role. Physicians, although generally supportive of deprescribing, were torn due to concerns about patient outcomes, litigation, and perceived specialist expectations.

Robinson et al. (2024) also indicated that while the majority of primary care clinicians accept the clinical and ethical foundations of deprescribing, their willingness to deprescribe depends on contextual circumstances like the complexity of the case, the source of the original prescription and time pressures. Clinicians are more likely to deprescribe if the drug was initially prescribed by them and less likely if it was from secondary care. This concept points to a real psychological barrier; one founded on professional boundaries and clinical hierarchy.

A landmark study by Bužančić and Hadžiabdić (2023) provided more insight into interprofessional differences in deprescribing attitudes among European primary care. This cross-sectional study found that all three groups of HCPs recognized deprescribing as important but had vastly different feelings of ownership and perceived roles in deprescribing. Pharmacists were more likely to report that they felt competent and accountable for conducting deprescribing conversations, as found in the results of Rea et al. (2023). Nurses were less confident and had doubts about their involvement, consistent with similar apprehensions reported by Chang et al. (2024).

Of note, this same study also found that institutional guidelines, professional culture, and hierarchical level impacted on the perceived autonomy of each profession. GPs, while theoretically supportive of deprescribing, regularly cited external reasons e.g., specialist referral or pressures from the system, to refrain from doing so. These findings reinforce the belief that deprescribing is part of a broad professional culture and cannot be addressed solely by education; organisational and structural change is equally required.

Role of experience and training

Level of clinical experience appears to impact both attitude and willingness to deprescribe. Goh et al. (2023) conducted a study where it found that primary care trainees were particularly reticent to make decisions to deprescribe, with a preference to preserve therapeutic inertia rather than risk destabilising care. Their diffidence was also compounded by the lack of formal training in the principles of deprescribing, highlighting undergraduate and postgraduate medical education as an area for reform.

In fact, training and exposure to deprescribing guidelines were consistent predictors of confident behavior. Robinson et al. (2024) and Chang et al. (2024) both recognized that early-career doctors and trainees were less confident when initiating deprescribing conversations, particularly in the absence of formal training or mentorship. Conversely, more seasoned clinicians who had participated in multidisciplinary reviews or who had used validated tools such as STOPP/START were far more likely to actively deprescribe (Scott et al., 2024). The latter addressed this learning requirement by proposing a ten-step proactive deprescribing protocol, with the objective of rendering deprescribing a standard component of clinical practice and not a last resort. Their proposals welcome clinicians to conduct regular medication reviews, to document therapeutic goals and to utilize validated deprescribing algorithms - principles that would facilitate increased assurance in structured clinical practice.

Patient-centred beliefs and communication styles

Another significant predictor of HCPs' actions is their presumptions about patient expectations.

Bloomfield et al. (2020) found that GPs tend to anticipate patient resistance to deprescribing, and therefore, avoided mentioning the potential for medication withdrawal at all. However, patient-centered studies such as Goh et al. (2023) revealed that older adults are, in fact, open to deprescribing, if it is clearly explained, done together, and with attention to their individual goals and anxieties. This disconnect between assumed versus actual patient attitudes highlights a communications gap that should be bridged to improve deprescribing acceptance.

The Necessity-Concerns Framework, employed in various studies, provides a conceptual framework in which these interactions can be understood. It proposes that the likelihood of medication adherence is determined by the patient's belief in its necessity compared to concerns about potential harms. GPs have a tendency to internalise this framework when describing their deprescribing approach, but variability in its application can lead to heterogeneity in patient outcomes (Goh et al., 2023).

Pharmacist and nurse-led deprescribing initiatives

Pharmacists have been pioneers in active deprescribing efforts. Rea et al. (2023) evaluated pharmacist-led deprescribing interventions within the Veterans Affairs system, demonstrating high rates of successful medication discontinuation, interprofessional collaboration, and significant cost savings. Regular reviews by pharmacists, good patient communication, and coordination with physicians to synchronize deprescribing plans were all highlighted; demonstrating a care model that can be applied to larger primary care practices.

Trenaman et al. (2022) provide insightful perspectives on the ways in which pharmacists reason about and implement deprescribing in inter-professional practice environments. The study revealed that pharmacists were highly invested in the process of deprescribing, based on their understanding of pharmacotherapy and patient-centered care. They made conscious identification of medication hazards and started discussions on deprescribing. Interestingly, the study reported that pharmacists viewed deprescribing as not just a technical process but part of general medication safety and therapeutic optimization. This is contrary to a more cautious view by some GPs, who occasionally would refrain from decision-making due to perceived complexity or deference to specialists' advice. The findings underscore the necessity for formally recognizing and integrating the role of pharmacists in deprescribing, as their actions were characterized by proactive interaction, team spirit, and priority for patient outcome improvement.

While nurses play a central role in chronic disease management and patient monitoring, their involvement in deprescribing is often hindered by role boundary uncertainty, lack of training, and hierarchical primary care team dynamics (Chang et al., 2024). This calls for greater work to enable nurses' empowerment through targeted education and policy efforts that well define their role in deprescribing conversations.

CONCLUSION

This review of the literature set out to map the ground of deprescribing in primary care through examination of HCPs' attitudes, beliefs, and practices. The review puts deprescribing in a central role as a complex yet essential component of medication optimisation, particularly in the context of an ageing population with polypharmacy and multimorbidity. The evidence consistently demonstrates that healthcare clinicians value the clinical and ethical importance of deprescribing but are limited by a range of individual, interpersonal, and system facilitators to its practical application.

In conclusion, deprescribing is an evidence-based, viable strategy for increasing the quality and safety of care in patients with very complicated medicine regimens. There is a need for future studies to center on developing scalable care models that incorporate deprescribing into regular clinical workflows, multidisciplinary communication, and patient activation. By overcoming existing barriers and leveraging facilitators, primary care systems have the potential to shift toward a more sustainable patient-centered model of pharmacotherapy.

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The impact of telemedicine on primary care accessibility, barriers and patient outcomes

Ms Ella HASLETT

ABSTRACT

Background

Telemedicine has emerged as a promising solution to alleviate pressure on clinical services and improve efficiency in overstretched primary care systems. Telemedicine offers highly accessible and convenient care with the potential to improve clinical outcomes for patients with chronic conditions. Despite these benefits, socioeconomic, technological, operational, and patient safety barriers may limit equitable implementation.

Objectives

The aim of this narrative literature review is to critically examine the impact of telephone and video consultations on primary care delivery. It assesses how telemedicine influences access to care, identifies key barriers to its equitable use, and evaluates associated clinical outcomes, particularly in the context of chronic disease management.

Method

A narrative literature review was conducted, and 39 studies were selected to evaluate how telemedicine impacts healthcare access, identify significant barriers to widespread implementation and assess health outcomes within primary care.

Results

Telemedicine was found to improve patient satisfaction and enhance patient empowerment with self-management. Rapid scaling of telemedicine services during the COVID-19 pandemic, however, raises critical concerns about patient safety and the quality of care provided.

Conclusion

A hybrid model combining traditional face-to-face consultations with innovative digital appointments, holds the potential to transform person-centred healthcare as we know it today. Future research should prioritise evaluating the clinical effectiveness of telemedicine and assess specific clinical outcomes to validate its long-term role in primary care transformation.

Keywords

Barriers to care; chronic disease; health service accessibility; primary health care; telemedicine.

INTRODUCTION

Telemedicine is the delivery of remote health services through telecommunications. This includes use of telephone calls, video conferencing, online messaging and email to conduct digital care which does not require face-to-face contact (Turner et al., 2022). While in use since the 1990s, adoption of telemedicine surged during the COVID-19 pandemic to reduce disease transmission (Chang et al., 2021). As health systems, including Malta's, continue to implement digital solutions post-pandemic, it is essential to evaluate the impact of telemedicine on access to care, patient outcomes and review barriers to implementation.

The Maltese National Health Systems 2023-2030 Strategy commits to expanding telemedicine services across Malta to enhance service efficiency and improve access to healthcare by reducing wait times for appointments (Ministry for Health, Malta, 2022). International strategies also provide useful context for understanding how health systems are positioning telemedicine within primary care. The National Health Service (NHS) England long-term plan focuses on implementing a digital-first primary care strategy, to enhance patient accessibility and reducing pressure on face-to-face services (NHS England, 2019).

While telemedicine offers clear benefits, critics argue that widespread implementation could exacerbate health disparities. The aim of this narrative literature review is to critically examine the impact of telephone and video consultations on the delivery of primary care. The three key objectives are:

1. to explore how telemedicine influences access to care, particularly regarding geographic accessibility, appointment availability and equity of access;
2. to examine key socioeconomic, technological, organisational and patient-safety barriers that influence equitable uptake of telemedicine in primary care;
3. to evaluate clinical outcomes associated with telemedicine in primary care, with a particular focus on chronic disease management.

Literature was sourced from PubMed, Scopus and Web of Science, focusing on meta-analyses and systematic reviews published between 2013-2025. This time frame was selected to ensure findings reflect contemporary clinical practice and the digital infrastructure in primary care (Mahdavi et al., 2025). Articles were included if they examined telemedicine interventions within primary care and reported on healthcare access, barriers or clinical outcomes. Studies limited to hospital-based care, non-English articles, or without full-text access were excluded. A total of 39 studies met the inclusion criteria. An example search strategy is provided in Table 1.

Table 1: The following search was conducted on PubMed in April 2025

Search terms: ("telemedicine" OR "telehealth" OR "digital health" OR "virtual consultation" OR "remote consultation" OR "video consultation") AND ("primary care" OR "general practice" OR "family medicine") AND ("access" OR "healthcare access" OR "accessibility" OR "barriers" OR "challenges" OR "facilitators" OR "clinical outcomes" OR "health outcomes")
Filters applied: English language articles, published between 2013-2025 with full text availability. Study designs included systematic reviews, meta-analyses and scoping reviews, restricted to human studies
Results: 202 articles reviewed
Inclusion criteria: telemedicine interventions within primary care and general practice, reporting on one of healthcare access, barriers or clinical outcomes
Exclusion criteria: Studies which focused on hospital-based care, non-English publications and articles without full-text access

ACCESSIBILITY TO TELEMEDICINE IN PRIMARY CARE

One of the key goals of telemedicine in primary care is to improve patient access through convenient and timely appointments, reduced geographical barriers, and greater flexibility in scheduling (Turner et al., 2022). Access can be defined as the ability to obtain and use a service as needed in line with one's healthcare needs. Levesque et al. describe five dimensions of access - approachability, acceptability, availability, affordability, and appropriateness - each paired with a patient 'ability' to generate access: to perceive, seek, reach, pay, and engage (Levesque, Harris and Russell, 2013). This framework highlights how both service design and patient capability determine whether care is equitable and effective. To apply it meaningfully, current use of telemedicine in primary care must be considered. Although utilisation data for Malta is limited, United Kingdom (UK) primary care trends provide a useful indicator of how remote consultations are being adopted in comparable health systems.

Prior to the COVID-19 pandemic, UK primary care practices under the NHS gradually introduced telephone consultations, while use of video calls was rare (Atherton et al., 2018). In May 2025, 39.9% of GP appointments in England were conducted via telemedicine; data shows that 31.7% (4.16 million) general practitioner (GP) appointments across England were conducted via telephone and 8.2% (1.07million) via video conference/online (Figure 1) (NHS England, 2025). Such utilization patterns help illustrate how telemedicine is currently functioning as a mode of access within primary care.

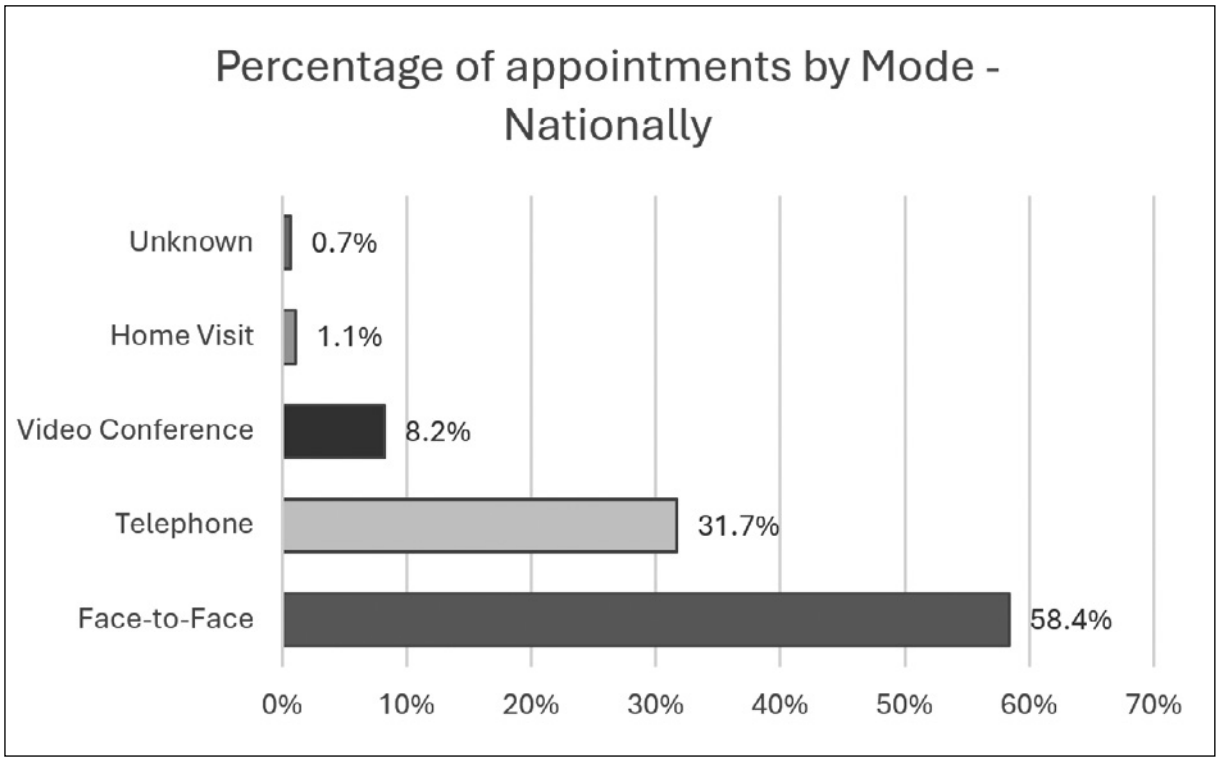

Figure 1: Percentage of general practitioner appointments in England by mode, May 2025. Adapted from NHS England, 2025.

Enhancing accessibility: addressing geographical and availability constraints

Telemedicine offers opportunities to widen access to healthcare by mitigating geographical limitations (Levesque, Harris and Russell, 2013). Patients in rural or underserved areas often face reduced access due to transport, time, and cost barriers, disproportionately affecting those with chronic diseases who require regular follow-ups (Barbosa et al., 2021). Telemedicine addresses these issues by improving appointment flexibility, reducing travel, and supporting follow-ups where needed (Ezeamii et al., 2024), enhancing affordability, approachability and availability. Evidence from a randomized control trial involving 70 paediatric patients with type 1 diabetes in rural Wyoming found comparable glycated haemoglobin (HbA1c) outcomes between telemedicine and face-to-face care, alongside fewer school absences, and parental work disruption (Wood et al., 2016). While this study demonstrates practical benefits, the small sample size and specific rural context limit the extent to which its findings can be applied elsewhere. Nonetheless, the outcomes highlight the potential of telemedicine to reduce logistical burdens and maintain clinical effectiveness in chronic disease follow-up, supporting integration alongside traditional care models.

Limited appointment availability due to staff shortages, restricted clinic opening hours and long waiting lists also impacts access to care. Telemedicine can reduce wait times and increase flexibility, with many services operating 24/7 (Anawade, Sharma and Gahane, 2024). In a Californian primary care practice, telemedicine consultations were scheduled 50% sooner than face-to-face appointments (Graetz et al., 2020). While based in the United States (US), these findings remain relevant to Maltese healthcare. Telemedicine can support quicker access, earlier interventions, greater patient self-management, and improved system responsiveness when used alongside traditional care (Beheshti et al., 2022; Darley et al., 2022). There remain challenges, however, to achieving equitable access to digital care, as complex barriers limit consistent implementation across diverse patient groups and settings.

BARRIERS TO TELEMEDICINE IMPLEMENTATION

Telemedicine offers innovative solutions to improve care accessibility; however, equitable uptake across diverse populations presents significant challenges. The most cited barriers to widespread telemedicine implementation include socioeconomic, technological, organisational, financial and patient safety challenges (Scott Kruse et al., 2018).

Socioeconomic barriers

Socioeconomic disparities remain a major challenge. Telemedicine use is lower among non-native English speakers, racial minorities, low-income individuals, and older adults (Eberly et al., 2020). An audit in Malta during the COVID-19 pandemic illustrated these gaps, with reduced accessibility among individuals from low-income and low-literacy backgrounds (Vassallo, Scerri-Harney and Abela, 2024). This audit suggests that while telemedicine may improve efficiency, competition for limited resources risks worsening inequalities.

The link between socioeconomic factors and the modality of telemedicine is another important consideration. Video consultations often yield higher satisfaction among patients and clinicians, due to visual cues that improve patient safety, communication and rapport, compared to the telephone modality (Payne et al., 2024a). However, when offered the choice, women, low-income individuals, older adults and those identifying as black or of latin ethnicity were less likely to select video calls (Eberly et al., 2020). This suggests that without the additional video component, patients who chose telephone over video due to socioeconomic factors are further disadvantaged.

Service-level differences also exist - a study in New York found that healthcare providers in high social vulnerability areas, marked by poverty, crowded housing and lower education, were twice as likely to offer telephone over video consultations. In contrast, providers in low vulnerability areas more frequently offered video, giving patients access to higher quality care, while disadvantaged communities faced exclusion (Chang et al., 2021). Socioeconomic

inequalities influence all dimensions of access (Levesque, Harris and Russell, 2013), shaping how patients perceive, seek, and engage with telemedicine. Evidence indicates that healthcare professionals should avoid assumptions about specific groups and instead recognise diversity, tailoring care to ensure telemedicine is accessible and appropriate for all.

Technological barriers

Digital access inequalities

Technological barriers can be provider- or patient-related, ranging from infrastructure to data security. Common issues include poor connectivity, software constraints, video/audio distortion, server outages and reduced platform performance at peak times (Scott Kruse et al., 2018). Before COVID-19, telemedicine infrastructure was underfunded, and smaller practices often relied on the telephone due to ease of scaling (Chang et al., 2021). Rapid adoption during the pandemic in an already pressurised health system meant some GP practices were better prepared than others. Deprived areas faced additional patient barriers - poor internet, lack of devices, outdated software and discomfort with technology - while wealthier areas more often encountered provider-related barriers such as insufficient staff training (Chang et al., 2021). This divide highlights the socioeconomic link to technological access, indicating that equitable and sustainable telemedicine requires targeted investment.

Disability, age, and digital health literacy

People with disabilities face unique barriers to telemedicine, including limited internet access, lack of assistive technologies and specialised communication equipment (Annaswamy, Verduzco-Gutierrez and Frieden, 2020). This digital divide further disadvantages deprived communities and older adults, particularly those with intellectual or communication impairments facing the greatest difficulties (Pettersson et al., 2023). A key factor is digital health literacy (DHL) - the ability to interpret information, use devices, create digital content and understand cybersecurity. Older adults often have lower DHL, linked to physical or cognitive decline and multiple co-morbidities (Oh et al., 2021). Higher DHL correlates with greater income, education and social connections (Estrela et al., 2023). To promote equity, governments should invest in infrastructure, and telemedicine platforms can enhance inclusivity through features such as sign language interpretation, captions adjustable text and contrast (Pettersson et al., 2023). Clinicians must create inclusive environments to support engagement, as many older adults report high satisfaction once provided with training (Mao, Mohan and Normand, 2023; Khanassov et al., 2024). Tailored DHL initiatives for disadvantaged groups are strongly recommended (Griese et al., 2020).

Data protection and regulatory challenges

Concerns over data protection remain a leading reason for telemedicine refusal, prompting recommendations for a government-mandated accreditation system (Barbosa et al., 2021). Malta's 2030 Health Systems Strategy promises a legal framework for telemedicine, alongside a National Digital Health Authority to oversee compliance under European Health Data Space regulation, with a focus on electronic patient record safety (Ministry for Health, Malta, 2022). This must explicitly extend to telemedicine. Since no dedicated accreditation body currently exists in Malta, establishing an independent regulator focused on telemedicine data security would strengthen public trust and ensure compliance.

Organisational and operational barriers

Safety risks and limitations of remote care

Organisational and operational barriers can impede telemedicine implementation in primary care. Key challenges include the need for effective staff training and systematic risk evaluation to maintain high-quality care. Telemedicine was rapidly scaled during COVID-19, but sustainable service delivery now requires ongoing quality and safety reviews. Serious incidents in remote primary care are rare; however, organisations must learn from incidents to avoid recurrence. Incidents which caused serious harm or death were investigated in a 2024 multimethod study by Payne et al (2024a). Safety I analysis of 95 incidents revealed causes including unsuitable modality

(e.g. telephone instead of video, or telemedicine instead of face-to-face), poor clinician–patient rapport, insufficient history taking and lack of clinical examination. Consequences included delayed or incorrect diagnoses, underestimation of urgency, inadequate safety netting, and in some cases, patient death (Payne et al., 2024a). While these findings highlight important safety risks, the retrospective study design with reliance on existing medical records introduces potential documentation bias due to inconsistent reporting or possible under-reporting of adverse outcomes. The extent to which the data reflects the true frequency and severity of safety incidents remains unclear.

The longitudinal safety II analysis by Payne et al. examined why serious telemedicine safety incidences did not occur more frequently, attributing this to the proactiveness of staff in delivering personalised care. Many incidents were averted through labour-intensive measures; however, relying on staff to exceed the scope of their role is inappropriate and contributes to burnout, ultimately compromising patient care (Hall et al., 2016; Payne et al., 2024a). Based on the evidence presented, organisations must implement robust systems that support consistent and safe care via telemedicine.

Training and workforce development for safe practice

Developing comprehensive training programmes is widely recommended to overcome organisational barriers, benefitting both patients and clinicians (Estrela et al., 2023; Greenhalgh et al., 2024; Williamson et al., 2024). For vulnerable patient groups, training should incorporate staff intermediaries to assist with platform navigation. Such experiential learning reduces barriers by explaining skills, providing positive reinforcement, and breaking-down instructions into simple steps (Williamson et al., 2024). Clinician training should cover essential technological skills, including platform navigation, triage functions, and ethics around consent and privacy. Advanced training should focus on refining verbal communication, history-taking, rapport building, and complex decision-making in remote consultations via telephone or video (Payne et al., 2024b). Experiential sessions through multidisciplinary team training days and case-based discussions should be implemented across primary care and incorporated into medical training. Such non-didactic approaches have been shown to improve efficiency and confidence in remote healthcare delivery (Greenhalgh et al., 2024).

Patient safety

Clinical limitations of remote assessment

A major concern in widespread telemedicine implementation is maintaining care quality and many critics argue it cannot match traditional face-to-face appointments (Rosen et al., 2022). Remote interactions rely entirely on history-taking and communication skills, as clinicians cannot perform physical examinations. Payne et al. (2024a) reported a serious incident in which a child's diabetes diagnosis was delayed because weight loss was missed and point-of-care urinalysis or blood glucose testing was not performed. This suggests that poor communication methods can limit clinical information, leading to delayed or missed diagnoses, which may further exacerbate health issues.

Quality of remote consultations

Research assessing the quality of remote consultations identified differences in how care is delivered. A comparative study found that video and telephone appointments were shorter than face-to-face encounters by an average of 3.7 and 4.1 minutes respectively. Telemedicine consultations involved less rapport building, fewer opportunities for patient advice, and insufficient probing for serious conditions (Hammersley et al., 2019). Study limitations include patient self-selection, with younger patients opting for remote modalities, and the Hawthorne effect, where awareness of being observed may alter behaviour. Considering the study was conducted before the COVID-19 pandemic, attitudes toward telemedicine may have since evolved. The findings, however, provide useful insight into differences between remote and in-person consultation quality.

Beyond this, telemedicine has shown to be an ideal tool for administrative tasks. The Maltese health service audit demonstrated how telemedicine is an ideal modality for sharing blood tests or imaging results, completing medical letters and certificates or advising on travel vaccinations. With appropriate infrastructure, future use could include issuing repeat prescriptions directly to pharmacies, improving workflow and easing pressure on overstretched primary care systems (Vassallo, Scerri-Harney and Abela, 2024).

Patient satisfaction

The future of telemedicine largely depends on patient experience. Evidence suggests that phone and video consultations are associated with high levels of satisfaction, with patients reporting ease of use, reduced travel time and costs associated with transport, ability to attend appointments more frequently, and greater sense of empowerment in managing chronic illness (Kruse et al., 2017). Research has also highlighted benefits for continuity of care, increased scheduling flexibility, and greater support for patients with mobility issues (Khanassov et al., 2024). Adoption of a hybrid care model is now recommended, balancing convenient remote appointments with face-to-face interactions when required. Health organisations should aim to regularly gain feedback from users to continually improve the effectiveness of interventions (Kruse et al., 2017).

CLINICAL OUTCOMES ASSOCIATED WITH TELEMEDICINE

Enhancing access and mitigating barriers to telemedicine can improve clinical outcomes in primary care, strengthening diagnosis, disease management, and overall patient satisfaction. Telemedicine is effective for managing chronic conditions such as type-2 diabetes (T2DM), hypertension, heart disease, asthma, mental health disorders and musculoskeletal problems (Carrillo De Albornoz, Sia and Harris, 2022). While outcomes can match face-to-face care, not all patients are suitable, with those at high risk requiring physical examination or unable to communicate effectively face safety concerns. Consideration of telemedicine's advantages and limitations is essential to optimise its role in chronic disease management (Payne et al., 2024b).

Telemedicine interventions for chronic conditions

Self-management of chronic conditions

Telemedicine demonstrates potential in supporting self-management of chronic conditions, offering a safe alternative to in-person care for patients with heart failure and T2DM. Reported clinical outcomes include reduced mortality and fewer hospital admissions in the heart failure group and improved glycaemic control with reduced HbA1c in the T2DM group. Evidence for asthma, chronic obstructive pulmonary disease and type 1 diabetes remains limited, although existing research reports no associated harm (Hanlon et al., 2017). It is suggested that further randomised controlled trials (RCTs) in primary care are needed to clarify clinical benefits across a wider range of conditions.

Type 2 diabetes mellitus

Research on telemedicine clinical outcomes in primary care largely focuses on T2DM, with HbA1c as the primary clinical outcome, reflecting its role as a well-established biomarker for monitoring disease control (Barbosa et al., 2021). T2DM is a prevalent chronic disease worldwide (Khan et al., 2020); complications associated with the condition contribute to increased healthcare utilisation, placing additional pressure on health systems. Telemedicine offers potential for regular follow-ups, patient education, and improved disease management, with lessons applicable to other chronic conditions. Evidence indicates that telemedicine is as effective as usual primary care in managing T2DM, particularly benefitting rural and underserved populations (Alfarwan et al., 2024). Improved outcomes are linked to high clinician engagement and interventions targeting self-management (Robson and Hosseinzadeh, 2021).

Timpel et al. (2020) found that telemedicine was most effective for newly diagnosed T2DM patients with a high baseline HbA1c, particularly when live consultations and real-time telemonitoring are used, although benefits are limited for hypertension and dyslipidaemia. Evidence quality among the RCTs included in this study remains low, due to methodological variability. Recommendations should therefore be applied cautiously, and future research should aim to identify specific intervention components that most effectively improve clinical outcomes.

Asthma

Effective asthma management in primary care relies on regular follow-ups, high-quality patient education, and adherence to medication. A meta-analysis found no significant difference in symptom control (wheezing, breathlessness, chest tightness) between telemedicine and face-to-face care, suggesting telemedicine could be a safe alternative (Zhao et al., 2015). Wider literature, however, reports mixed results on clinical outcomes for asthmatic patients. Multi-component approaches such as Short Message Service (SMS) medication reminders, remote monitoring of symptoms and lung function, combined with in-person care, can improve symptom control, adherence and quality of life (Almasi, Shahbodaghi and Asadi, 2022). The two key papers in this area, including 11 and 33 RCTs respectively, predate 2018 and therefore do not reflect post-COVID technological advances or increased telemedicine familiarity in primary care. Future research should incorporate standardised outcome measures, such as forced expiratory volume in one second (FEV1), alongside evaluations of the most effective interventions and their cost-effectiveness. More up-to-date evidence is needed to ensure accurate assessment of telemedicine's role and to support development of informed guidelines for asthma management in primary care.

Inappropriate applications of telemedicine

Telemedicine is unsuitable for conditions requiring physical examination, such as acute abdominal or chest pain, shortness of breath, breast lumps, diabetic reviews needing eye or foot checks, or unclear histories (Payne et al., 2024a). It is also inappropriate when symptoms have progressed since prior remote consultation or when acute illness occurs in patients with multiple comorbidities. Factors such as poor health literacy, extremes of age and language barriers further hinder safe remote assessment, limiting clinical information and impacting patient safety. Primary care should adopt hybrid models, integrating remote and face-to-face care, with telemedicine reserved for minor health issues and chronic disease management, guided by robust evidence rather than convenience (Beheshti et al., 2022; Khanassov et al., 2024).

Future of telemedicine research

Rapid technological advancements are outpacing high-quality telemedicine research, creating a gap between innovation and peer-reviewed evidence (Valencia-Arias et al., 2024). Most research concentrates on RCTs published before COVID-19, with a handful of studies evaluating early pandemic use. Future studies should focus on creating rigorous, well-designed methodologies to evaluate clinical effectiveness for specific patient subpopulations, considering factors such as socioeconomic status (Timpel et al., 2020). Based on this, robust assessment of study quality will be crucial in guiding future guideline development.

While research provides vital evidence on the safety and effectiveness of telemedicine, its practical application in routine primary care must also be considered. Guidance from the British Medical Journal emphasises verifying patient identity and privacy, maintaining clear communication, and using non-verbal cues to enhance rapport (Car et al., 2020). Since 2020, the term *website manner* - the digital equivalent of bedside manner - has emerged, highlighting the role of interpersonal skills in maintaining person-centred care and supporting positive clinical outcomes (Khanassov et al., 2024).

CONCLUSION

Telemedicine has become a key modality for healthcare delivery, with the COVID-19 pandemic accelerating its adoption. The current priority of healthcare systems is the sustainable, effective integration of the medium into primary care. This narrative review has demonstrated that telemedicine can improve access to care, although socioeconomic disparities, technological limitations and data security concerns remain significant barriers (Chang et al., 2021). Addressing these requires investment, clear operational procedures, robust training and independent oversight of platform security (Payne et al., 2024a). Clinical outcomes provide the strongest evidence supporting telemedicine, particularly in T2DM when hybrid models and synchronous consultations are employed (Alfarwan et al., 2024). Evidence outside T2DM remains limited, highlighting the need for broader, methodologically robust research across a wider range of chronic conditions to inform evidence-based guidelines. These findings show that the objectives of this review - understanding the impact on access and clinical outcomes and identifying key implementation barriers - have been achieved. Once these barriers are addressed, telemedicine has the potential to enhance service efficiency in primary care and deliver truly person-centred care.

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Thirty-five years of standards: the Malta College of Family Doctors, 1990–2025

Dr Edward ZAMMIT

ABSTRACT

Background

The Malta College of Family Doctors (MCFD) was founded on 4 April 1990 after early spadework by Drs Denis Soler, Wilfred Galea and Ray Busuttil on a bold premise: if family doctors taught, audited, published and held themselves to account, the system would in time recognise family medicine as a speciality.

Objective

To trace how, over 35 years, a voluntary professional body became a driver of standards, training and advocacy in Maltese primary care.

Method

Narrative historical review (1990–2025), organised into four phases: foundation (1990s), infrastructure and recognition (2000–2010), consolidation (2011–2018), and resilience and renewal (2019–2025).

Results

The College's early strategy - acting like a specialty before being treated as one - proved decisive. Milestones included formal recognition of family medicine as a speciality in 2003, academic anchoring at the University of Malta, and the launch of the Specialist Training Programme in Family Medicine (STPFM), which secured Royal College of General Practitioners (RCGP) accreditation at first visit. Subsequent years saw maturation of examinations, trainer development aligned with the principles of the International Association for Health Professions Education (AMEE) and the European Academy of Teachers in General Practice/Family Medicine (EURACT), and a stronger Journal. During the COVID-19 pandemic, the MCFD preserved standards through recorded consultations, hybrid CPD and online governance, achieving "continuity without compromise". The College also assumed a clearer public voice through submissions on euthanasia, recreational cannabis, mental health and the national health strategy, and by representing Malta in international family medicine fora.

Conclusion

The MCFD helped shift Maltese family medicine from isolated individual practice to an organised, internationally benchmarked speciality, with durable systems for training, assessment and professional leadership.

Key words

Family medicine; Malta; medical education; primary care; speciality training

INTRODUCTION

I'm deeply honoured to have been invited to write this piece for the Journal of the Malta College of Family Doctors on the occasion of our College's 35th anniversary. On 4 April 1990, a small group of determined family doctors chose to build standards before the system fully recognised our speciality. Thirty-five years later we can say, with evidence rather than nostalgia, that this choice changed Maltese healthcare. As Immediate Past President (and, until April this year, President on the very day of our official anniversary), I've had the privilege of seeing up close how a volunteer College became a quiet engine of progress: teaching and training, examinations and accreditation, research and reflection, advocacy and partnership.

Anniversaries are not only for looking back; they're for deciding what to carry forward. This article tells the College's story, its early convictions, its architecture, its tests and adaptations, not as a museum tour but as a living guide for the future. It's a celebration of what Malta's family doctors have built together, and a candid account of the challenges we met and turned into momentum. Most of all, it's a thank you to the trainers and trainees, the examiners and authors, and the colleagues in clinics and committees who kept the standard high and the door open for those who follow.

A COLLEGE BEFORE ITS TIME (1990s)

The Malta College of Family Doctors (MCFD) began with a simple, ambitious wager: if we conducted ourselves like a speciality, teaching, auditing, publishing and holding ourselves to account, the system would eventually catch up and treat us as one. In a landscape where primary care was fragmented and family medicine had little formal recognition, a small group chose to build the centre of gravity that Malta lacked. Between 1988 and 1990, Dr Denis Soler, Dr Wilfred Galea and Dr Ray Busuttil did the hard spadework—drafting the statute, convening meetings and shaping the vision. This culminated in the first general meeting on 4 April 1990, which endorsed the statute and elected the College's first Council. Wise counsel was sought from the Royal College of General Practitioners (RCGP) to shape a college that could stand up to scrutiny from day one. They deserve our lasting gratitude for the courage and fortitude of those arduous first steps.

Traditionally family doctors were, and sometimes still are, solitary by habit, working largely alone. Gradually we learned to be a community of practice, not just a list of names, where learning was communal, accountability was mutual, and "good" was something we modelled as much as we taught. The College gave these simple ideas a home, a rhythm and, slowly but surely, higher standards in our speciality.

FROM VISION TO ARCHITECTURE (2000–2010)

The 2000s turned conviction into infrastructure. Family medicine was formally recognised as a speciality in Malta in 2003—no small feat for a field long treated as the underdog. Family medicine found a home in the University in 2001, not as a guest but as a department with a curriculum, modules and academic staff. Medical students got a brief but eye-opening glimpse into the fascinating fields of community care and primary health care, and discovered that there is a whole world of medicine outside the hospital. Many realised that a prestigious and fulfilling career could be had in family medicine.

The Specialist Training Programme in Family Medicine (STPFM) was the logical next step taken in 2007. The STPFM is, and remains, a masterclass in speciality training. From the outset it was distinctive: a deliberate balance between theory and practice, academic content and clinical practice. It didn't just follow recognition; it made recognition real. That combination, of an academic base, a training pathway and independent assessment, was transformative. For the first time, Malta had a reproducible method for forming family doctors: not just apprenticeship by goodwill, but education by design.

External benchmarking through the RCGP was crucial for the STPFM to gain its badge of excellence, secured at first accreditation; a standout result in the history of the RCGP's international work. It ensured that what we were building at home stood up to scrutiny locally and internationally. Maltese family doctors had once again shown their mettle.

CONSOLIDATION (2011–2018)

With the scaffolding up, we settled into the work of keeping standards alive and progress ongoing. The two are not mutually exclusive, but they do require a deft hand: evolving and improving while guarding our good reputation, our values and our non-negotiable integrity. Examinations matured, quality assurance tightened, trainer development became routine, and the journal stepped up its ambitions. Internationally, Malta showed up not only to learn but to contribute - to conferences, networks and collaborations that kept our perspective wide and our practice grounded.

By the end of the decade, family medicine in Malta felt less like a path you drift into and more like a discipline you train for. We had a shared language for competence, a shared calendar for learning, and a shared expectation of what good looks like. It was also the period when I found my way into the College, where I was mentored, encouraged and gradually entrusted with roles I was honoured to serve. Coming straight from the STPFM, I had only just been a trainee; working on the other side opened a world of meaning and purpose. It let me give back to the trainers, examiners and colleagues who invested in me, and to help build for others the pathway that built me.

RESILIENCE & RENEWAL (2019–2025)

These years will always be linked to the COVID-19 pandemic, and the College was tested like everyone else. Almost overnight, we had to do our work under new rules and new constraints. Activities that depend on close collaboration, including examinations, calibration sessions, continuing professional development (CPD) events and committee work, had to move, adapt or both. We kept the standard and changed the format: recorded consultations in place of in-person exams, hybrid CPD instead of crowded halls, governance conducted online with the same care for fairness and confidentiality. Travel stopped; accreditation did not. With the RCGP we maintained benchmarking and renewed agreements. The result was simple and hard-won: continuity without compromise: training progressed, assessments remained credible, and learning reached further than before.

COVID-19, though a major test, was not the first and won't be the last. These years coincided with my two terms as President. And they were as much a personal test as a test for the MCFD. I have been active in the MCFD since 2012. Fresh from the STPFM, my enthusiasm exceeded my experience, but it carried me through those first steps and, I hope, served the College and family medicine. In 2019, the outgoing President, Prof. Pierre Mallia, a good friend and exemplary professional, asked me to step into the role. I was both surprised and humbled, and quietly wondered whether he overestimated me. He did not; he simply trusted the team.

My first thought was that I needed to grow fast to serve well, to become "ready" overnight. Experience, and the MCFD, taught me a better lesson: readiness is built. You grow into the role by listening, learning and leaning on your team. In truth, I grew with the College, not before it and certainly not apart from it.

So yes, mistakes were made. They hurt in the moment; they taught in the long run. I wouldn't trade a single one. As Wilde had it: "Experience is simply the name we give our mistakes".

People often assume that once a system is set up it becomes a *fait accompli*, launched at the push of a button and left to hum in the background. In reality, good systems need tending - feedback, calibration and the occasional course correction - or they drift.

The MCFD is no exception. Between 2019 and 2025 it faced a long series of challenges, and, ironically, some were born of success. The STPFM's growing popularity and prestige started to attract more doctors, even from other specialities. The needs of a growing population demanded them. The task was clear: keep the standard, grow the capacity. We worked with our partners, the Primary Healthcare Department and the Postgraduate Training Centre, to do just that. The MCFD reworked its trainers' course around contemporary medical education frameworks (the International Association for Health Professions Education [AMEE], the European Academy of Teachers in General

Practice/Family Medicine [EURACT]) and a robust focus on the STPFM, curriculum, supervision and assessment, and made it a standing fixture, run annually in most years.

The constantly shifting healthcare landscape, and the needs of a growing, changing population in the wake of a pandemic, meant that the MCFD had to adapt quickly. People, including professionals, discovered that online meetings had a legitimate place even after COVID-19: a welcome antidote to traffic, parking and the simple shortage of time. Continuous professional development followed suit. Hybrid CPD was not a stopgap; it became a way to keep offering value to members while meeting our obligation to society. However, the human connection, the inherent social fabric of being in the same room, proved essential. The nuance of a case discussed face to face, the side conversation that solves a problem, the chance encounter that becomes a collaboration: these are hard to replicate on a screen. So we kept what works online and made in-person time count. We reserved physical gatherings for what they do best, workshops that need hands-on practice, examiner calibration, trainer development, mentoring, and the simple act of belonging to a community.

Family doctors, and by extension the MCFD, have become more visible in our society, not only as the friendly village doctor who comforts us when we are unwell (and that matters), but as professionals with a finger on the pulse of the community, listening for the missed beats and the erratic patterns, and offering ways to steady them. Patients, the media, politicians and other specialities are beginning to accept a simple truth: any serious recipe for a high-performing health system needs family doctors as a main ingredient. Leave us out and you get a broth without stock – thin, bland and unsustaining.

Our value is practical. We make prevention routine, not rhetorical. We turn fragmented care into comprehensive, continuous care. We translate policy into practice and feed practice back into policy. In recent years, that has meant showing up in public, with timely press releases to allay anxiety and plain-language updates that put risk in context, and making submissions to public consultations on issues of high importance: euthanasia, recreational cannabis, the national health strategy, mental health, and more. We have spoken at local conferences and represented Malta abroad, at World Organisation of Family Doctors (WONCA) forums and RCGP exchanges, bringing home ideas that work and sharing our own. The aim is the same in every venue: answer questions, correct myths, and keep the conversation anchored to what helps patients most.

CONCLUSION

The history of the Malta College of Family Doctors is deeply intertwined with the broader evolution of family medicine in Malta. From 1990 to 2025, the College navigated political hesitations in health reform, the fight for specialist status and a pandemic, yet consistently moved the discipline forward. Its achievements are tangible: an established College and journal, a culture of continuous professional development, academic integration at the University, an internationally accredited training programme, and a seat in the councils of global family medicine. Maltese family doctors, once isolated in a system that gave them little structure, are now recognised as specialists and better organised to provide high-quality primary care.

Today, the Maltese family doctor stands where our founders hoped we would: on the front line of healthcare, serving their community as teacher, healer and trusted guide through a complex system.

The work ahead asks us to keep faith with the public: explain what family medicine is and why it matters, uphold professionalism without fear or favour, and remain a College that serves the common good. It asks us to build and strengthen partnerships with the pillars around us: other professionals, government, the University and, not least, our patients - who are the reason we exist. It asks us to keep opening the door for those who follow, so the next generation inherits not just a College, but a living tradition of excellence, integrity and service.

Thirty-five years on, the Malta College of Family Doctors remains what it was at the

beginning: a community of practice built on conviction, sustained by collaboration, and accountable to the people we serve. The journey continues.

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