Ethical issues in Maltese General Practice – a look to the near future

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On the eve of Family Practice becoming a speciality, it is only appropriate to discuss the ethical implications and also the problems still seemingly unresolved in this area. I shall divide my short time between a reflection on family medicine as a speciality as expressed in the thought of Dr. Edmund Pellegrino, himself a specialist in internal medicine but who believed and advocated family medicine as a speciality before it became such in the United States, and the current state of affairs in Malta. Edmund Pellegrino was founder of the Kennedy Institute of Ethics in Georgetown University, Washington, D.C. Whilst the latter has become somewhat of a Mecca for bioethicists, Pellegrino himself is the guru, if not the father, of modern bioethics. A proponent of virtue-based ethics, he is a staunch believer in the tradition of medicine as based in the doctor-patient relationship. It is in this phenomenon that we should look for resolution of ethical dilemmas and not merely in the algorithmic invocation of principles and rules.

'By tracing a series of papers between 1965 and 1988, one may appreciate the evolution of Pellegrino's philosophy of family practice'[16]. Howard Brody[1] notes that Pellegrino began to address, in print, the 'academic base for family practice' four years before the new Board was established and the first family practice residency programs were begun. Here he stated clearly the theme to which he would frequently return, the need for the generalist physician:

> Human diseases do not come in neatly labelled categories nor are humans so tractable as to develop disorders in only one

[1] Brody, H., "Edmund D. Pellegrino's Philosophy of Family Practice", in *The Influence of Edmund D. Pellegrino's Philosophy of Medicine,* ed. David C. Thomasma, Kluwer Academic Press, 1997: 7-20, p. 9

> organ system at a time. The very development of specialization, while essential, only accentuates the need for a corresponding development of the integrative functions of the generalist.[2]

The sphere of activity for this generalist physician is that of first contact care for family members of all ages, with special attention to prevention and health maintenance. This activity, Pellegrino argued, was intellectually different but equally demanding as training in a more limited medical specialty. Here and elsewhere Pellegrino anticipates definition of 'primary care' offered by later experts – for example that, "Primary Care includes not only those services that are provided at first contact between the patient and the health professional but also responsibility for promotion and maintenance of health and for complete and continuous care of the individual including referral when required".[3]

Although there was a point in time where, after the establishment of the new specialty, he warned against having too much concern for research and academia, fearing a loss of reality from the community, he later made clear that there is no real dichotomy between the academic vs. the community 'base' for family practice. He also believed strongly that the name 'family practitioner' was no mere cosmetic re-naming of 'general practitioner', but that the designation 'family' is to be taken seriously in defining the content of this specialty. Adequate research and training on family dynamics was then lacking from most academic departments (in the seventies and eighties) of family practice. This is much the situation we are facing in our own department which is still in its infancy.

Pellegrino also addressed the unavoidable political questions of how family practice should relate to other medical and allied health specialties, urging family physicians to gain strength by increasing the

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[2] Pellegrino, E.D., "An academic base for family practice", in *Ohio Gen Practitioner*, 1965 (May): 8 (quoted in above)

[3] See for example, *Ontario Ministry of Health: Report of the Health planning task force*, Toronto, 1974, p. 27.

quality and sophistication of their work and not by fighting turf battles with other primary care providers, specialists or otherwise.

It is clear that Malta lags behind somewhat in the development of family medicine as a specialty. Many still laugh at the idea of GPs calling ourselves specialists. This fear is also a result of an inferiority complex within many family doctors – witness the unwillingness to hand out a membership of the college in the past few years, even after satisfaction of certain criteria, so as not to turn other specialists against us or at best to be made the laughing stock or standing joke of our MRCP-cultured colleagues.

Clearly this attitude has to stop. Only we, as family doctors, can and should establish criteria of what it takes to be a family doctor. We should not stand to be ridiculed or told what to do by others who, with all due respect, have never practised in the community full-time, or spent years seeing children grow and in turn get married themselves. Family medicine is a specialty in most of the developed world and if we are to offer the best primary care to our patients, then we must follow suit.

Hence outcries against Family Practice becoming a specialty is uncalled for and unfounded. Even where we not to enter the European Union, where GPs or family doctors are considered and paid as specialists, respect must start with self-respect. Family practitioners are more aware than ever before of their need for further professional development – witness the participants in courses and diplomas the Malta College of Family Doctors offers in collaboration with other European colleges.

There are problems to be ironed out and surely changes must occur in the logistics and infrastructure of the bodies which represent family doctors. Until there is general agreement with other specialists about our own status and respect as specialists, we need to be our own union and cannot allow bodies with other interests to take over talks at high level. Government and other specialists must understand that only we can and should define, according to international criteria, what a family

practitioner should be. Thus while it is understandable that a gastroenterologist, say, may also want to register as a physician in internal medicine, this request for double specialisation should not translate into an ability for someone caught in a registrar or senior registrar post in secondary or tertiary care to register as a family doctor as well without fulfilling the criteria of the specialty. Having an MRCP does not automatically grant you the status of a Family Doctor. We must move away from the idea that an MD alone is a sort of 'O' level which grants GP status and the MRCP or FRCS takes someone to 'A' level status allowing him to pursue his 'O' level interests. Conversely we should consider academics, such as epidemiologists and public health doctors, into the specialty because traditionally many come from the field of family medicine as well and can contribute considerably to its advancement.

Whilst there must definitely be a grandfather clause, as has occurred in Great Britain and other countries for long established family doctors, it would make the proposed Vocation Training futile if someone with a different specialist qualification be exempt from this training. For this reason Vocation Training must steer away from merely a rotation among specialties and focus directly on Family Medicine and Practice. The move by the government to sponsor GP-trainers and to put VT in the hands of the Malta College is thus a move in the right direction.

It is understandable that many specialists will feel the need to protect their ground, but just as some specialties do their own share of primary care, so should it be accepted that GPs, as abroad, be able to train in tools and services which render primary care more amenable and effective. Many GPs in the UK perform endoscopy lists. Ultrasound has been shown to be an effective tool in the primary care physical examination, detecting pathology before any signs and symptoms. Thus it should enhance the quality of care we provide to our population. Government should thus make radiology and endoscopy departments as training centres where family doctors may also participate as GPs are not exempt from providing the same standard of due care and quality of results as specialist counterparts. Many private Family Doctors, who

are the only source of family medicine, can dedicate such time to their practice once government takes considerable load of patient attendance.

This brings me to Health Centres. Only the private family doctor provides a true family practice in Malta. Primary care centres are walk-in clinics in which one does not choose a doctor, nor is one able to continue seeing the same doctor over a long period of time. If we are to hold on to these centres there must definitely be more co-operation between the two. I have spoken at length in the past on this issue and find no need to elaborate here but I wish to re-iterate an experience which happened to me a few weeks ago which speaks for itself. A patient of mine turned up at a health centre one evening. She suffers from a migraine-like headache which recurs every two or three months. No medication works on her and we had tried everything. The only thing which works wonders is an intra-muscular injection of Aspegic or a NSAID – a recognised remedy in this situation. The health centre doctor refused to give her this treatment. No one can blame him, as it was his first contact with this patient. Moreover, the aggressive personality of this woman did not help at all so that when she contacted me on my mobile from the police station I immediately realised the problem. I was too far away to go and tend to her myself so she begged me to call the health centre to ask them to give her the injection. We both thought that an explanation from her doctor would solve the issue. The health centre doctor did not accept my explanation. Still recovering from the verbal abuse he had suffered, he disagreed with my treatment and said that he would not give her the injection anyway because of the way she had treated him. Understanding his position I asked him if there was another doctor who may give her the injection and he passed me a to a colleague who after listening to my explanation said she agreed with her other colleague. Now why on earth she came to the phone therefore is beyond me. But to cut a long story short, the chief then came who made me state that I was taking full responsibility and acceded to giving the blessed intra-muscular.

Yet health centre doctors persist in telling people to 'call their family doctor' in cases of death certification and refuse to prescribe certain

drugs unless a green card is filled by the family doctor who should take the responsibility of any drug prescribed. Yet they too have complaints against some private GPs. We should be able to resolve these issues if the two systems are to persist in parallel to provide a service in primary care. Otherwise, such a dichotomy can hinder the progress of Family Practice to the level of a specialty.

There is great scope for family practice in the near future. With the advent of the new hospital it is hoped that the role of the family doctor will increase in the continuation of treatment and in communication during in-stay of patients. Family Doctors can and should be patient advocates. We still have to introduce the idea of an Advance Directive which allows the patient to participate in future treatment when he or she is unable to act autonomously. With the advent of genetic screening, it has been suggested that the family doctor is the most strategically placed individual to provide counselling on tests such as for breast cancer. Not only are specialist genetic counsellors not enough to cope with the envisaged increase in demand, but they should remain the professionals to continue seeing to the cases needing specialist counselling.

I augur that this and similar conferences will speed the recovery of family medicine in Malta and elevate it to the status it deserves. With Pellegrino I pray that rather than fighting turf battles with specialists or between private GPs and health centre doctors, we dialogue together to know where we are and where we want to go. We need to choose carefully those among us who are willing to go the extra mile and disinterestedly fight on our behalf to introduce the change that is much needed. We have been drinking out of the stagnant water of a status quo and many of us have come to believe it is wine, thinking that the Maltese patient has a good deal. They do not see that since the introduction of polyclinics general practice has changed very little in Malta and has definitely not kept up to date with the status that family practitioners share abroad.

Surveys show that there is a strong correlation between what family physicians do and what patients want. Moreover, if you have a serious

problem then internal medicine might be better for you, but if you have a lot of serious problems together, then the family physician is by far your best bet[4]. Family physicians may be better at pulling up aggregate data for Hb A1c, blood pressure and lipid level for the diabetic population of a practice telling them if they are really making a difference in their community[5]. The AAFP has made it its goal to assess the future of Family Medicine in a project; goals that we would do well to take up. Stoever says these can be boiled down to three questions: What is the role of the family doctor today? What can we do different in the future to meet the needs of people and society? And how do we grow as a discipline? Moreover, he says, 'we want to make it a joy again to practice family medicine'.

Some of our older colleagues refer nostalgically to the era when they delivered babies and had extremely busy practices – sometimes taking patients to hospital themselves. It should be the aim of the new department and college to restore pride in family medicine – a pride based on interaction with patients, reliability of care and economic and financial viability for both physician and patient. At a recent award giving ceremony, a family physician who made it his goal to train and to provide training in critical care for patients, after having practised for twenty years, said: "Because I've been in the same place forever, these patients are friends. They're people who I go to church with. They're people I see on the street. It's really rewarding to be able to treat people through some of their life crises. Family physicians, in general, have that luxury that many other physicians do not. People grow to depend on you for all kinds of help and all kinds of guidance. That is a very rewarding life"[6].

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[4] Stoever, J., "Town hall meeting explores specialty's future", in *FP Report,* November, 2002, pp. 1-14.

[5] Ibid., p. 14.

[6] Young, D., "Critical care training crucial for rural professionals, says FP of the Year", in *FP Report,* November, 2002, p. 11.