

Outcomes of First Meeting on Ethics in Family Medicine

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This meeting has produced papers by both members of the medical profession and pharmacists which have left us reflecting on the need to communicate at all levels. In the first instance at least three further meetings have been reflected upon and should finances and support from the relevant bodies continue, I personally would see that they take place during this workshop of ethics in family practice¹. They can be summarised as follows:

1. A meeting between pharmacists and family doctors to iron out issues of patient sharing and obligations of each profession towards patient empowerment. In particular questions relating to where the work of one profession interfere and/or enhance that of the other need to be discussed.
2. A meeting between primary health care doctors working in the government system and those in private family practice. This follows from my first talk on the first day of this meeting and the comments I received in the ensuing days. Definitely relating an experience can translate into it being communicated as though one were speaking against one group. This is definitely not the case and many of my best colleagues and friends work in the government health centres. What is evident though is that we have never got together as two groups to see how we can co-operate effectively.
3. Following Dr. Anthony Fiorini's talk, one can see also a need to see how family doctors and government services

¹ This workshop started this year and is an initiative I took on behalf of the Bioethics Consultative Committee on Ethical issues in family medicine. The workshop will last three years.

can work more closely together. If one can extrapolate from his talk on Geriatric medicine to the general government system, we must also be looking at what is the role of the family doctor in hospitals in general.

4. It pays to have our health care system based on primary care. Unfortunately, as Dr. Philip Sciortino's talk revealed, studies in this and other related areas are lacking in Malta. Although no workshop can solve this issue, it is hoped research in the future would focus in these areas.

On the third day there were three interesting talks on various aspects of family medicine as a speciality. Of course all these talks were personal and not necessarily reflective of what the word 'specialty' should mean. However, they were followed by a short discussion at the end which raised some interesting points.

Research in primary care has its advantages, as was pointed out by Dr. Jean Karl Soler, who, after giving a review of ethics in research, presented three interesting ongoing international studies in primary care in which Malta is participating. At least one, is in fact, being co-ordinated from Malta. Research is definitely a hallmark of a speciality, but it is not exclusive. There are many other things which define a speciality. One relates to its autonomy in deciding who we are and what we do as a speciality. Another is the provision of optimal standards of care in keeping with developments in other countries. My talk for instance described some special interests which family doctors may have, which although not obligatory, should indeed be encouraged by our associations and/or colleges as functions which do indeed lie within the aegis of family medicine as well. My intention was to drive in the idea that nobody can tell us that endoscopy, ultrasound, minor surgery etc, cannot or should not be done by family doctors. They indeed can be based on two reasons. The first is that only we as a speciality can and should decide if they can be practised by family doctors (of course in keeping with proper standards of care and training). Secondly, they are already trends which many family doctors are taking abroad, and which research has shown (in keeping with the first issue discussed)

that they enhance standards of care and are economically viable even to patients. As regards whether local departments should provide training, this should not be reflected upon as whether it will effect vested interest but whether it is economically viable for our health care system and whether it enhances the care we provide to patients – which would then translate into a patient rights issue. One can understand that the department of radiology, for example, has a high workload, as pointed out by Dr. Denis Soler, and thus has no obligation to train doctors with an interest, especially when it itself sends trainee radiologists abroad. But training a radiologist and training a doctor to do *primary care* ultrasound are two different things. One is a specialised instance, the other is training GPs to do basic screening. This in turn should even decrease the load on the department. In the UK many GPs go to community hospitals to help the specialists out on long lists. They provide the same quality of service.

One has to look at this also from an economic and practical point of view. It has been shown that an ultrasound done as part of a general physical examination will indeed detect pathology before any signs and symptoms have yet occurred. Thus one can detect renal or bladder tumours, or abdominal aneurysms. Therefore if someone goes to his or her GP and asks for a physical, the GP is obliged to examine the patient and also offer some tests. Of course one can offer a CT Scan, but this may expose the patient to radiation which has not been shown to balance the benefit of a yearly physical. Ultrasound however is simple, non-invasive and cost effective, even on a yearly basis. Yet there is no way, using the health care system, whereby a GP can offer an ultrasound as part of a physical examination (or check-up) to a patient. The only way would be to refer this patient to hospital out-patient, taxing on a secondary care system, which was not intended for primary care. The patient will then expend the time of a doctor who has to see him or her at out-patients, decide whether he wants to accede to the test. If so he will then probably order other basic blood tests and use up an hour of time to take a history and put it on a file, then refer the patient to the radiology department. This will in turn use up time of a department which is dedicated to secondary care. The patient would

then have to be seen again at out-patients for the result, again taxing on hospital time. All this for a basic simple ultrasound screen. This is not to mention that the whole process can take months for the patient and long waiting-room hours. Training doctors to do this simple ultrasound in the health centre setting, possibly co-operating with private family doctors, make sense when looked at from this point of view. Unfortunately, as Dr. Sciortino's paper has shown, we lack studies in Malta to show cost-effectiveness of our systems and many other things.

Now ultrasound does not make us a specialty, as has been pointed out. Neither does research, and neither does anything else. So what makes us a specialty? The answer seems to have been 'Vocational Training'. However many at the meeting were left with open questions which the forum was supposed to answer. Indeed the government, as pointed out by Dr. Denis Soler, has put the College on the Speciality Accreditation Committee (SAC) to decide what and who can be classified as a family doctor. Dr. Soler insisted that anyone with an MD has a constitutional right to practice as a GP. This leaves two cold questions: what is the difference between a GP and a Family doctor in practice? We all know they practice the same thing in the same field. They are performing, in other words, the same ball game. Secondly what significance does it have to be able to put on your card 'Specialist in Family Medicine' if at the end of the day anyone can practice family medicine? In other words what does the so-called 'specialist' do more than the non specialist? The answer is simply that they do *the same thing*. So why all the trouble of putting some doctors through Vocational Training when others still can do the same job legally without going through vocational training? If we had a shortage of GPs this would be feasible. But does a constitutional right make it moral? Even herbalists, chiropractors, osteopaths and Chinese Medicine, have a constitutional right in Malta to perform as they are not regulated as in any other country. I can open shop tomorrow and call myself a nutritionist because I obtained a three-week correspondence certificate which has no type of assessment and nobody can stop me. We all know that what is moral is not necessarily legal and what is legal is not necessarily moral.

It is here where I feel the Malta College should work hard . And may I take the opportunity to heed a word of warning which hopefully would not fall on deaf ears. This was also Dr. Fiorini's message (which was used in a different context but which applies here):

*Communicate, Communicate, Communicate,
Communicate, Communicate, Communicate,
Communicate, Communicate, Communicate,*

Omit this to the Colleges' peril. We have to decentralise decision-making. When the government empowers a body to decide who is to be considered a specialist, that is a very good thing, but also a very vulnerable position. If decisions are taken by a group of twelve people or even less, then other members and non-members may feel threatened. Creating a dichotomy now would be perilous to family practice in Malta.

I think the person who drove a strong message during these three days was Dr. Jean Karl Soler. Research indeed tells us a lot and contributes to our becoming a specialty. But we now need research which would benefit us all as a country. Research should be directed to doctor's feelings about the College, about the dichotomy in family medicine between State and private practices, about what defines us as a specialty, about whether it is cost effective to run health care from primary care in order to produce evidence to our politicians. In other words we need what we have come to call, *Patient-Oriented Evidence that Matters (POEMs)* – and I emphasise 'that matters'. Someone needs to coordinate studies which would make a difference to our future. I augur that the presidency of the Malta College of Family Doctors be more open to suggestion. We are not any more those few people who once met in a kitchen. We are now a body given government power. Power can empower some but may make others feel threatened. We need to embrace all in one big family of family doctors.

Finally the question relating to *who should practice family medicine* was raised. Of course, as pointed out by the President of the College,

anyone who has an MD has a constitutional right to practice medicine in Malta. But then again, in Malta, anyone who has even a correspondence diploma obtained in six weeks can practice anything. This abuse is more than evident in alternative medicine. The word 'quack' is simply not on our vocabulary. People go to so called 'nutritionists' even in Pharmacies. Moreover there is no council to regulate people practising legitimate alternative practices such as Osteopathy, Chiropractic, and Acupuncture. We even have so-called 'Chinese Medicine' doctors. Now what is Chinese Medicine? It is not listed on Woodham and Peters' *Encyclopaedia of Complementary Medicine*. Yet we allow people to operate with no control at all. I have seen patients going to 'nutritionists' who gave them advise to stop steroid treatment. Beauticians advice patients constantly to stop medical treatment for Acne. Why cannot these 'professions' be held liable?

But the point we are trying to reach here is whether only *specialists* in family medicine are to be allowed to do General Practice, or whether anyone can do so. What would be the point of being able to call yourself a specialist in family medicine, having been obliged to go through three years of vocational training, when then someone who opted not to do this would be able to do the same work in the same pool of patients that you work in?

There is a lot of work ahead. It is hoped that those who take on the responsibility will not shy away from change. Sometimes you have to step on people's toes; especially if they go against principles which you strive to implement. As yet having an NHS based on a sound primary care is only a dream. It is not even on the horizon. We have a dichotomy which our politicians have shied away miserably from changing. We still send people to hospital out-patients if they cannot afford a full check-up privately – something which the health centres are not equipped to give. To do a routine ultrasound or endoscopy people have to take up the time of at least two consultants on three occasions. This costs money. On a recent interview with the hospital's chief administration officer and superintendent, it was estimated that of the new cases which are referred to hospital every year, between

twenty to thirty percent of people could have been dealt with at primary care level. If one were to calculate how much these patients cost and how much can be saved from health centres, one would find that it pays financially to base one's health care on a primary level. This is where we have to focus our forces. It is good to have research, but this research must be effective and has to have something worth saying. Whilst it is interesting to have studies which participate internationally, it is hoped that these studies would have served as an exercise to focus our energies on convincing politicians and public alike on where we want to go. Otherwise we would fall into a category of people the Bakutu tribe, which lives in the Congo region of Central Africa, call *lolema djola feke*, "the bat that flies intensely but knows not where to go". This is how they have always seen the white man's logic.