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# JMCFD

JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

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**EDITORIAL**

**Prof. Pierre MALLIA**

Welcome to the fourth issue since we started the JMCFD. This issue has 'ethics' as a theme, not so much because of my personal interest in the area, but because there are a lot of topical issues around, some of which concern legislation and others which were the subject of seminars and conferences and therefore were the latest hot topics. In this issue we chose several authors who have given papers at seminars organised at the Medical School and also others who were involved in one aspect or another. Thus Dr Daniela Cassar, a lawyer specialized in bioethics discusses Advance Directives. Our Medical School guest speaker, Prof. John Saunders, who was at the time chairing the ethics group of the Royal College of Physicians, debunked some of the false accusations directed at the Liverpool (Palliative) Care Pathway (LCP). He recommended a changing of the name due to lack of training - a recommendation which has been taken up. It is interesting to note, in this regard, that the Royal College of General Practitioners has always supported the LCP as it was an initiative to extend what was being done in hospices around the UK to the general public (hospices depend on funding and therefore were found in areas of relatively better off populations). Nevertheless the lack of training and application of the pathway (such as removing artificial nutrition and hydration immediately) gave it a bad name. Dr Jurgen Abela also discusses palliative care in Malta. Furthermore Dr Bridget Ellul discusses recent legislative measures in organ donation and Dr Michael Asciak the Embryology Act which regulates In Vitro Fertilisation locally. One cannot have a journal without scientific contribution. We are proud and happy to be receiving quite a few. In this issue we had to limit ourselves to one. This guarantees continuity for the last issue of the year forthcoming in November 2013. I hope indeed that the journal will provide you with interesting reading and updates.

# The in vitro fertilisation law

**INVITED ARTICLE**

**Dr Michael ASCIAK**

After twenty years of unregulated in vitro fertilization (IVF) practice and nine years of political debate, Malta finally has a law regulating IVF practice. The Bioethics Consultative Committee played a significant part in reaching the social consensus necessary for the passage of this Act which needed to be in line with the social value norms held by Maltese society. The law does not only regulate IVF procedures but also touches on other bioethical issues such as embryo testing, gamete donation, cloning, hybrid and chimera use, germ line gene therapy and embryonic stem cell use which have all been made illegal. The title of the Act was inspired from the German Law and termed "Embryo Protection Act". Henceforth IVF will also be available on the National Health Service at Mater Dei Hospital.

The Act strives to allow IVF to treat infertility for married couples and those in stable relationships and will make the treatment available free of charge at state hospitals. It became active on the 1st January 2013. The Government has also now composed the Authority responsible for regulating IVF. One interesting feature about the Act is that it will not allow the freezing of human embryos as a regular part of the IVF procedure except in very rare life threatening contingent situations which would be a threat to the embryo's life itself. One such condition is the death or illness of the mother after fertilization has already taken place. Instead of embryo freezing a new technique called oocyte vitrification will become the norm used with no more than three oocytes fertilized and transferred in difficult cases but with a preferable option of one or two according to circumstances for both artificial insemination and IVF. Oocyte vitrification techniques have recently been shown to be equally effective as embryo freezing techniques in obtaining pregnancy rates. This avoids the high embryo destructive rates associated with embryo freezing, a rate which runs into hundreds of thousands in all centres which use this technique.

Maltese society holds dear the principal that a human being occurs after the oocyte has been fertilized by the sperm and that this human being ought to be protected. All parties in Parliament subscribe to this principle. Human embryology gives scientific credence to this position and rendering the sacrifice of human lives in order to solve the fertility problems of infertile couples would be deemed consequentialist at the least and a gross disrespect to human life at its most fragile moment. This Act shows that science and ethics can indeed move hand in hand! Information on the Act may be obtained from the www.gov.mt website by clicking on the Parliament link and downloading the published Act XXI of 2012.

**Dr Michael ASCIAK** MD, M.Phil., PhD
*Chairman Bioethics Consultative Committee*

# The Liverpool Care Pathway

**Prof. John SAUNDERS**

## AT THE END OF LIFE

For many practising doctors, especially in general practice or in general internal medicine, decisions at the end of life are often some of the most difficult. Not only is decision making difficult, but implementation may create a further set of problems. Most of us are orientated to *doing* something – usually something that is active, promoting life or health. Many end of life decisions demand something different: the acceptance that life is coming to an end and that the quality of the final phase of the patient's illness is to offer a good death. The doctor must reorientate his or her thinking to a different, less distinct target. Yet the old aphorism still rings true that the aim of medicine is to cure sometimes, to alleviate often and to comfort always, (*guérir quelquefois, soulager souvent, consoler toujours*) (Payne 1967, pp.47-48).

As an aside, the origin of this saying is uncertain; it is associated with Dr EL Trudeau and inscribed on his statue in the grounds of the Trudeau Institute at Saranac Lake New York and also on the fireplace beneath an oil painting in the library. But it is found too in a window in the New York Academy of Medicine and variously attributed to Oliver Wendell Holmes, Paré, Florence Nightingale and Hippocrates.

Within that aphorism, comes the need to understand 'comfort' in terms of ultimate aims and desires: the explanation or meaning attached to the illness experience. Comfort is different from alleviation in this respect. A book such as Jeremy Taylor's '*The Rule and Exercises of Holy Living, Holy Dying*' of 1651 sets out what is comforting in mortal illness. From Taylor's perspective, this is unashamedly religious: reflections on the brevity of life, length of years, charity and alms, fear of death, hope of heaven. Comfort is here not symptom relief, but a more positive view of life's ending. Similarly in Tolstoy's novella '*Ivan Illich*', the comfort is the light: 'In place of death there was light' 'So that's what it is! What joy!' And Illich escapes from his 'black hole'.

For a previous generation, the increased place of technology in medicine often seemed to have displaced the willingness to sit by the bedside and wait. Senior doctors in particular often rushed by, ignoring the needs of those who had moved beyond the stage of curative or even alleviative medicine. It was forgotten that 'they also serve who only stand and wait' (Milton 1655). The dying patient was moved into a side-ward where he or she would not be seen, sometimes ignored by all but the most junior doctor on the team. Outside hospital, it was the nurses in the community who played the key role in care. Medicine had forgotten something of its vocation. It was into the world of this (admittedly sweeping) generalisation, that the new specialty of palliative medicine was born – its chief midwife that remarkable nurse, social worker and doctor, Cicely Saunders (1996, p.1599). From a UK perspective, the hospice movement - spearheaded in the east end of London in St Joseph's Hospice and in south London in St Christopher's - rapidly gained momentum. It received strong support from the voluntary sector, especially Christian organisations, but as it grew also gained grant support from government. The work of Saunders in her concept of 'total pain' was important, as was the adoption of the World Health Organisation's (1990, p.11) subsequent definition of palliative care as 'total active care':

"*Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families*."

The benefits of hospice care, with support from dedicated professionals, became obvious enough. Yet it was clear that hospice provision could not be extended to all dying patients. In the UK, those dying in hospices make up less than 5% of total deaths. The lessons of the hospice had to extend beyond its walls to other institutions – principally hospitals, but also to those dying at home or in residential care homes or nursing homes. This led to the development of the Liverpool Care Pathway for the dying patient (LCP).

The LCP was the product of a collaboration in 2004 between the University of Liverpool, Marie Curie Cancer Care and the Royal Liverpool and Broadgreen University Hospitals NHS Trust – that is to say, a collaboration between the voluntary sector, academia and the UK's National Health Service. The pathway continues to

be a focus of collaborative work with various national organisations, including the National Council for Palliative Care, the Royal College of Physicians and the Care Quality Commission (The Marie Curie Palliative Care Institute Liverpool, 2013). The LCP has both a national and international programme and has a role in the provision of end of life care in at least 17 countries. Its primary aim is to improve care in the last hours or days of life – that is to say, it is not a programme for terminal illness overall, but for its final stages. Cicely Saunders herself said:

*"All the careful details of the pathway are a salute to the enduring worth of an individual life. Such an ending can help those left behind to pick up the threads of memory and begin to move forward"* (Saunders 2011, p.xiii).

As the Marie Curie Institute states, the LCP was recognized as a model of best practice in the NHS Beacon Programme – 2001 (Ellershaw and Wilkinson, 2011), incorporated into the NHS National End of Life Care Programme (2010) for 2004-7, recommended in the National Institute of Clinical Excellence guidance (2011) in 2004 and recommended in the End of Life Care Strategy by the English Department of Health (2008). For the dying patient, it was thought by those with expertise in palliative medicine to represent the best standard of care.

## THE PATHWAY

A pathway is a complex intervention for the mutual decision making and organization of care processes for a well defined group of patients during a well defined period – in this case, those with a prognosis of days or hours of life only. Its five key elements consist of

- An explicit statement of goals or of the key elements of care based on evidence and best practice;
- The facilitation of the communication among team members, with patients and families;
- The coordination of the care process by coordinating the roles and sequencing the activities of the multi-disciplinary team (MDT), patients and carers;
- The documentation, monitoring and evaluation of variances and outcomes;
- The identification of the appropriate resources.

The advice in the Liverpool Care Pathway (2013) document is entirely compatible with other end of life guidance, which it supplements. In the UK, this includes guidance from the General Medical Council (2010), the Royal College of Physicians (2010) and the British Medical Association (2007). Most of this guidance is now available free of charge online. The pathway aims not only to improve care in the last few hours or days of life, but also to improve knowledge related to the dying process. Research into end-of-life presents particular challenges, but there is a need for better knowledge on patient views on dying well as well as on techniques of palliative care. Better data on how people die, as opposed to what they die of, is required (Royal College of Physicians of London, 2007).

The LCP has *three key sections*: initial assessment, ongoing assessment and care after death; and *four key domains of care*: physical, psychological, social and spiritual; and *five key requirements* for organisational governance: clinical decision making, management and leadership, learning and teaching, research and development, governance and risk. Simply setting that out makes it immediately apparent that using the pathway will only be as good as the teams using it. It cannot be applied without education and training.

Some of those features require emphasis in the light of recent controversy. The LCP is not designed to either hasten or prolong death and its application requires good communication with all involved: patients, professionals, families and carers. Not only does it not preclude a policy of no hydration or nutrition, but it considers a blanket policy of no artificial hydration or nutrition to be unethical. It does not recommend continuous deep sedation. Continuous reassessment is a feature with a formal full MDT meeting every 3 days. By law, all decisions must be made in the patient's best interests. A properly constituted advance refusal of treatment by a patient has full legal force in the UK and cannot be over-ruled. The emphasis on reassessment reflects little more than the uncertainties under which all medicine is practised (Saunders 2004, pp.97-110). Prognostication is often inaccurate, especially in the dying patient. The ability for self-care, oral intake, conscious level and so on, may all change and make a review of needs essential.

## THE CONTROVERSY

It was against this background that from 2010 onwards a series of concerns was expressed in the UK about the use of the LCP. For example, a psychiatrist expressed concerns that artificial nutrition and hydration was not given to patients on the LCP; another consultant alleged 'backdoor euthanasia' in a major broadsheet

newspaper, the *Daily Telegraph*. The *Telegraph* was joined by the *Daily Mail* and the two papers maintained a campaign of criticism against the "pathway of death". For example, in one widely publicised case, Susan Goold complained that her father had been placed on the LCP without permission and had suffered a "barbaric death" deprived of food and fluid for 8 days, without being able to say farewell to his wife and with no record in his case notes about the LCP (Watson, 2013). The daughter's claim was reported that "You wouldn't treat a dog the way my poor dad was treated. We are all devastated, the best interests of the patient was not starving him to death." The hospital, Addenbrooke's in Cambridge, was left to investigate. Similar reports of this sort appeared throughout this period and the press campaign widened to further allegations. Thus the *Daily Mail* reported that "Hospitals were bribed to put patients on the pathway to death…The incentives have been paid to hospitals that ensure that a set percentage of patients who die on their wards have been put on the controversial regime. At least £ 30 million in extra money from taxpayers has been handed to hospitals in the last three years to achieve these goals" (McCartney 2012, e7316). Addenbrooke's Hospital, involved in the Goold case, for example, had received over £1 million according to the *Daily Telegraph*. A BBC investigation reported that only 57% patients had their care plan discussed with relatives or carers. And in a story in November 2012, the *Daily Mail* ran a story on its front pages entitled "Now sick babies go on death pathway." The story (Arie 2013, f1273) claimed that NHS hospitals were discharging sick children and babies to hospices or their homes, where food and fluid were withdrawn until they died. The story was based on the testimony of a doctor practising in another country, never disclosed. Further criticisms followed against a well know UK children's hospital with as little substance. But the *Daily Mail* did not remove the story from its website or correct or clarify it. It was published in a different version in the *Daily Telegraph* and inspired scores of responses from readers expressing disgust that the NHS permitted such practice – which of course it doesn't.

A prominent *Daily Mail* columnist, Melanie Phillips, wrote rhetorically "Care?" and replied to herself, "No, this is a pathway to killing people that doctors deem useless" (Phillips, 2012a) Further inflammatory allegations and opinions followed from Phillips' pen: "In other words, they are killed. What's more, they are killed in a most cruel and callous way through starvation and dehydration." Patrick Pullicino, a consultant neurologist and professor of clinical neurosciences at Kent University, was reported as telling a conference that the LCP had become an 'assisted death pathway' for more than 100,000 patients each year. 'Very likely, many elderly patients who could live substantially longer are being killed by the LCP,' he said. "Horrifyingly, (Phillips went on) the LCP has become a self-fulfilling prophecy. When people are put on it, they are said to be dying. But they may not be dying at all — not, that is, until they are put on the 'pathway', whereupon they really do die as a result…. This really is an obscene abuse of people who expect the NHS to care for them, not kill them. And how appalling that this has made patients terrified that the hospitals supposedly taking care of them may try instead to kill them." The LCP was being driven both by crude economic calculations and by a wider brutalisation of our culture at the heart of which lay the erosion of respect for the innate value of human life supported by the "lethal arrogance" of the medical profession (Phillips, 2012b). Phillips had her sympathisers among doctors too. One wrote to the BMJ stating that she should be applauded for highlighting an area of practice that the letter writer thought "clearly" warranted investigation (Teo 2012, e7316).

## THE RESPONSE

There was a strong professional response. Doctors do not commonly write *en masse* to the press, but on November 6, 2012 a letter was sent to the *Daily Telegraph* signed by 1300 doctors who said that they supported the pathway. The Press Complaints Commission received 311 complaints about one of the *Daily Mail*'s article. Nevertheless, there were conflicting voices (O'Dowd 2012, e7644) even if few doctors would support the inflammatory critique advanced by Phillips. Most believed, along with a BMJ columnist, that end of life care had been transformed (Spence 2012, e7308). A group of organisations issued a consensus statement backing the LCP and reiterating that it was about excellence in care: "Published misconceptions and often inaccurate information…risk detracting from the substantial benefits it can bring to people who are dying and to their families" (Kmietowicz 2013, e6654). Those backing the statement included the Royal College of Physicians, the Royal College of General Practitioners, the British Geriatrics Society, charities, organisations representing care homes, social services, hospitals and palliative care services. It had already been pointed out that the alleged payments concerned incentives to achieve the

multiple targets and frameworks used to judge hospitals' performance; these were not bribes but typical sources of income and entirely usual. Moreover conversations were happening. The perception that patients were placed on the LCP without discussion reflected the failure to name the LCP rather than a lack of description of the care being offered.

An investigation of doctors' views was carried out by the BMJ in association with the television programme *Dispatches* on Channel 4 tv (Chinthapalli 2013, f1184). This surveyed 563 doctors who had used the pathway. They comprised 185 consultants in palliative medicine, 168 in training or career grade posts in palliative medicine and 210 doctors in other specialties. The survey demonstrated widespread concern and reluctance to use the LCP due to requests from relatives or apprehension about relatives' complaints. Negative press was leading to more distress and a fear that discussion would increase those anxieties. Almost none thought that bed pressures had led to LCP use. However only 13% of respondents thought that financial incentives should be used to encourage use of the LCP. As one said, "Setting targets for the use of a tool that was intended simply to ensure best practice was never wise and always open to misinterpretation." Training needs were often not met, but the respondents were clear in pointing out that the problem was not primarily with the LCP – it was as foolish as blaming insulin for the damage and deaths it has caused due to misuse. 91% thought the LCP represented best practice and 98% thought that it allowed patients to die with dignity. 90% said they would want the pathway themselves in a terminal illness (and some of the remaining 10% may represent confusion from the use of a modified version in Welsh respondents). "Scaremongering was putting end of life care back about twenty years, where dying patients were hidden in side rooms and not seen by a consultant."

## FURTHER CONSIDERATIONS

Certainly it is true that the LCP should not be used as a way to indicate that the patient's care is 'palliative' (or worse, 'patient is palliative'); or a way to ensure that appropriate medication is prescribed for patients *not* judged to be in last hours/days of life; or a way to stop clinicians thinking about that particular patients' needs, or avoid using clinical judgement; or a way to prescribe a syringe driver for a patient being on a syringe driver does not indicate that the patient is dying or on the LCP. Whether the patient is dying in hours or days is a clinical judgement which sometimes we will get wrong and the LCP should be discontinued if the patient's condition improves. The problem now is that patients, relatives, carers and some staff are worried about the LCP and may wrongly feel it is 'euthanasia', or to hasten death. There is the spectre of a belief that the LCP represents the concept of a 'pathway' to lead to death. And with successive versions, the LCP is now a large document, extended to avoid problems of earlier versions. For example, 'Variance' takes time to complete so nurses may just put 'A' for 'achieved' beside goals. If misapplied or misused due to lack of education or training that practice carries risks for patients. Already many proposals have been discussed about possible improvements. Some suggest getting rid of the terms 'pathway' and 'Liverpool'; considering whether there ought to be national guidance on care and prescribing for patients imminently dying but not in 'pathway' format. Others suggest that there are problems with the term 'care plan' as the latter is particular to a patient, and the term has multiple uses. Certainly if the LCP (or similar) continues, it must have dedicated mandatory training, with funding, to avoid known risks of misapplication and misuse. And financial incentives or penalties should be removed as they plainly lead to misunderstanding.

What was this heated debate about? Was it that there are fundamental problems with the LCP, despite the accolades that it has received by expert bodies? Was it improper use of the 'pathway', perhaps due to misapplication (to the wrong patient), or to misuse (not following it properly), arising, for example, in relation to a lack of the necessary specific training? Or was it misrepresentation and scaremongering by the media, especially the *Daily Mail* and *Daily Telegraph*? Certainly there has been evidence of patients put on the LCP without the specified MDT approval, patients who are terminally ill but not in the last few hours or days of life, and those who have not had all reversible pathologies treated. In a population of about 60 million in the UK, there are about 550,000 deaths each year. It would be surprising if everyone went according to plan, noble though that aspiration may be. Probably all of these factors have played their role.

## CONCLUSION

And it seems likely that some continued debate will remain even after the detailed inquiry that is now close

to reporting. National debate has led to government action – to reassure an anxious public or reform a faulty policy. Any provisional conclusion must await the inquiry set up by the health minister, Norman Lamb, under the chairmanship of Rabbi Baroness Julia Neuberger. This should report soon. In the meantime, LCP remains a valuable tool in end of life care. It is however only a small part – even smaller in delivering best care for all conditions. But it needs education, training and an adequate workforce.

**Acknowledgements**

I am grateful to my colleague, Dr Fiona Randall, consultant in palliative medicine, for discussion and advice; and to Professor Pierre Mallia for the invitation to present and discuss these issues at a conference in Malta in March, 2013.

**Further reading**

The European Journal of Palliative Care published three articles discussing the Liverpool Care Pathway this May. A group of international co-authors, including Professor John Ellershaw, summarise the history of the LCP, how it came be acknowledged as best practice for the care of patients in the last days or hours of their life, and how it has been adopted by countries internationally. Dr Carol Davis and Chrissie Guyer, of University Hospital Southampton NHS Foundation Trust, seek to dispel the myths about the LCP, explaining what it is and what it isn't. Editor Dr Julia Riley addresses the need for better communication with the public and patients including raising questions of advance care planning in the wider debate surrounding palliative care.

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# End of life decisions and advance directives

**Dr Daniela CASSAR**

In a recent study conducted by Dr Saul Weiner, it was established that 'patients tend to do better when their doctors pay attention to their individual needs and circumstances' (Seaman, 2013). The health care system in general has been steadily shifting its approach from a paternalistic approach to one in which both the doctor and the patient work together to achieve the best possible results. This also applies for the local scenario where measures have been proposed to promote patient rights and patient autonomy, particularly through a new patients' charter for rights and responsibilities.

Advance directives for medical care, also known as living wills, have been advocated as a means of extending patient autonomy to those situations when a patient becomes incompetent. The term 'advance directive' is generic so as to incorporate an act whereby a competent person makes arrangements about his future healthcare decisions should he lose his ability to do so. Advance directives may take two forms – a living will or a lasting power of attorney for healthcare, which are not necessarily exclusive of each other but may be complementary (Andorno, 2009). A living will refers to a written document drawn up when the patient is in full possession of his faculties, giving instructions to his doctor or other healthcare providers regarding the circumstances under which he wants life-sustaining treatment to be provided, withheld or withdrawn (Andorno, 2009). The measures usually relate to the requesting or the refusal of certain forms of extraordinary treatment aimed at preserving or prolonging the person at the end of his life such as cardio pulmonary resuscitation (CPR). Advance directives may also serve as a means by which the patient expresses his wish to receive treatment such as artificial nutrition and hydration (ANH) (Andorno, 2009).

Conversely, a lasting power of attorney for healthcare allows individuals to appoint an agent to make healthcare decisions on their behalf in specified matters of healthcare, if and when they lose the ability to do so (Andorno, 2009). The power of attorney has the significant advantage of clarifying the patient's wishes when they have been formulated in ambiguous terms within a living will. It also allows the agent to address unexpected developments that were not specifically addressed by the patient (Andorno, 2009).

The difference between the two is that in a living will, the patient expresses his own choices, whereas when the patient grants a lasting power of attorney for healthcare, the patient delegates the authority to decide to another person. The power of attorney is an attempt to allow decision-making about treatment decisions to be influenced by the patient's own view through a substitute, who is chosen by the patient to make such decisions on his behalf, usually a person who has an in-depth knowledge of the patient, his history and his preferences. Certain codes of laws such as the California Natural Death Act requires that the person chosen is of a good moral character having a certain practical wisdom, is known to make sound decisions in difficult circumstances and someone who understands and is willing to fulfill the responsibility of acting in accordance with the patient's needs and wishes (California Health and Safety Code - The Natural Death Act, 1978).

In so far as the expressed wishes of the patient are in conformity with the law of the respective country, are still valid and there are no indications whatsoever that the patient would have changed his or her mind under the present circumstances, the medical practitioner is obliged to follow the patient's living will (Andorno, 2009).

Advance directives go back to tell the story of twenty-one year old Karen Ann Quinlan who passed out and ceased breathing for two fifteen minute periods after a night of drinking alcohol and ingesting tranquilizers. After it was determined that she was in a permanent vegetative state (PVS), her father requested the removal of the artificial ventilator which was the only means of keeping his daughter alive. Both Quinlan's primary physician and the hospital decisive board turned down his request. Quinlan's father took this up to be decided by the Court and a year later the New Jersey Supreme Court, on March 31, 1976, held that the father could authorize

the cessation of ventilation, and the hospital was bound to proceed with this order. After having the ventilator removed, young Quinlan continued to breathe until her death several years later. This prompted the enactment of the first living will statute in the USA, the Natural Death Act of California in 1976. This law established certainty about the legal position on advance directives in the United States.

More recently, another legal battle, fought in Italy's courts, was the case of Eluana Englaro. Nineteen year old Eluana was involved in a very bad car accident back in 1992. After spending two months in a coma, she started breathing spontaneously. She was subjected to ANH even though clinical reports by two prominent neurologists showed she would never regain consciousness again due to the severe brain damage she had suffered as a result of the accident. Notwithstanding all efforts, including attempts at sensory stimulation, Eluana's condition did not improve and in 1994, she was diagnosed as in a PVS (Moratti, 2012).

After a seventeen year legal battle fought by her father, the court ruled that ANH may be withdrawn in cases where the patient is in a PVS. However, two conditions must be present for this to apply: the patient's condition must be medically irreversible, and artificially prolonging the patient's life would be inconsistent with his or her express wishes, character, or outlook on life (Supreme Court, 2007). Evidently, not much attention was given to the futility of the treatment to which Eluana was subjected to, which treatment was not benefiting her.

Although such treatment was initially considered as 'basic care' by the court and therefore could not be withdrawn, in the year 2000 the Italian Minister of Health appointed a working group, the Oleari Commission, to analyse the nature of such medical treatment as ANH in PVS patients (Moratti, 2012).

The Oleari Report, which expressly refers to the Englaro case, concludes that ANH amounts to medical treatment and its withdrawal is legitimate if based on the will of the patient. The report further held that if the patient did not express his or her wishes before becoming incompetent, such as through a living will, decisions may be taken by the patient's guardian.

In an opinion issued by the Maltese Bioethics Consultative Committee (The Bioethics Consultative Committee, 2010), it was established that whilst ordinary treatment refers to life prolonging treatment which is available and offers 'a reasonable hope of benefit and do not cause unbearable pain and suffering', extraordinary treatment refers to such measures 'which are not usually available, do not offer a reasonable hope of benefit and cause unbearable pain and suffering' (The Linacre Centre for Healthcare Ethics, 2000). The Committee agrees that 'there is no obligation for a patient to take extraordinary or disproportionate measures to promote life and health if these measures will involve excessive burdens' (The Bioethics Consultative Committee, 2010).

With respect to the nature of ANH and whether it is considered as ordinary or extraordinary treatment, Malta's Bioethics Consultative Committee (The Bioethics Consultative Committee, 2010) held that ANH should be considered as an extraordinary medical procedure in those circumstances where a patient is at the end of his life, and as claimed by Agius, its withdrawal would be considered 'as a procedure done in order to let nature take its course' (1994, p. 29). To the contrary, where the patient is not considered as a 'dying' patient, then ANH shall be considered as ordinary and morally obligatory treatment, the omission of which would be inappropriate (Agius, 1994). The Committee advocates the presumption in favour of providing ANH to all patients; however, medical practitioners shall take individual characteristics of patients and their circumstances into consideration. Studies have shown that although ANH may benefit terminally ill patients, if carried out in inappropriate circumstances, it may actually also cause suffering and also itself be the cause for shortening life (The Bioethics Consultative Committee, 2010).

In the absence of an advance directive, the patient's consent to life-prolonging treatment is generally presumed. However, it is open to question whether any of us would actually consent to be kept alive artificially in PVS where there is no hope that the condition will reverse itself, a scenario that is at odds with our intuitive notion of a life worth living. But to what extent should advance directives for medical care be binding?

Advance directives are at times seen as controversial, with the main concern being that competent people when drawing up an advance directive, which, when the patient loses his competence, will have binding force on his medical practitioners, may not be well placed to make decisions concerning their future incompetent selves. It has been argued that giving advance directives binding force places all the responsibility for the decision on the patient whereas under arrangements in which they are not binding, doctors retain some discretion and assume responsibility for the decision. Others argue that advance directives reflect the will of the person at the time that

they are written and cannot anticipate how this may change as the illness develops. Everyone may experience changes of mind at any moment in time.

The need for a written document is not disputed as it produces certainty. Furthermore, the more binding advance directives are considered to be, the stricter the formal requirements become, including certain formalities such as the validation by the medical practitioner (attesting the patient's mental state and the reliability of his instructions). Another issue to be decided regards the storage of such documents and whether it should be kept by the patient or entrusted to the health authorities or recorded in a national register.

During a Medicine and Law conference organized by the Bioethics Research Programme of the Faculty of Medicine and Surgery in collaboration with the Medicine and Law Programme of the Faculty of Laws and the Faculty of Theology within the University of Malta entitled "End of Life Decisions" in March 2013, the need to address the gap in Maltese law when it comes to health was highlighted. In Malta, end-of-life decisions are generally taken in a legal vacuum.

Maltese law does not provide for situations where a health practitioner refrains from administering extraordinary treatment such as ANH or CPR to a terminally ill patient. Article 9 of the Convention on Human Rights and Biomedicine (Council of Europe, 1997) states that doctors must always 'take into account' previously expressed wishes and this implies that they have a duty to seek out any that exist once the decision-making process begins. In some legal systems, advance directives are legally binding, meaning that doctors are legally bound to comply with them. In others, they do not have any binding force and are considered only as indicators of the person's wishes which doctors 'take into account' in this light, without being bound by them; they retain some discretion in the light of the actual situation and the potential advances in medical knowledge by the time the decision must be taken.

Advance directives should be regarded as an instrument conducive to dialogue between the patient and his medical team, which goes beyond informed consent as part of their end of life care plan.

Fundamentally, medicine cannot remain detached from law, and in this respect the Minister of Health Dr Godfrey Farrugia at the end of the conference, augured 'the medical and legal profession to work together to create a law that respects our values and at the same time protects both the patient and the professional' (Dalli, 2013).

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# Organ donation in Malta – what's new?

**Dr Bridget ELLUL**

Malta transposed Directive 2010/45/EU of the European Parliament and of the Council of 7 July 2010 on standards of quality and safety of human organs intended for transplantation (European Parliament and Council, 2010) on 12th October 2012 through Legal Notice 345 of 2012, entitled Organ Transplants (Quality and Safety) Regulations, 2012, Subsidiary Legislation to the Human Blood and Transplants Act (Cap483), enacted in 2006.

This long awaited legislation provides a firm legal backing for transplantation services that are structured such as to ensure health and safety to both donor and recipient. The regulations apply to practices and procedures along the entire pathway from donation to transplantation of solid organs, and even beyond, to the collection of post transplant medical data.

Malta has a good track record of safe working practices in transplant services. These have been offered since the early 1980's, initially limited to corneal transplants, but soon followed by the first kidney transplant in 1983. Heart transplants are performed once a year, with the first being in 1996. (Transplant Support Group, Malta, 2013) Patients requiring liver transplants are referred to the UK while recently, in 2011, an agreement was reached with Palermo, Sicily for a lung transplant service. (ACCORD, 2012)

## NEW LEGISLATION

### Transplant Authority

The main impact of the legislation is to set up a formally recognized structural framework, with procurement organisations and transplantation centres being accountable to a transplant Authority (Organ Transplants (Quality and Safety) Regulations, 2012, Regulation 3), which is to ensure that international standards are maintained.

The lack of a specific organizational structure may not have been so obvious locally since there is only one transplant centre, but success stories increasing the availability of donor organs, led by Spain, (Matesanz, 2013) have strongly relied on restructuring of the organizational set up with co-ordination between the public, as potential donors, and the formal service providers.

Legislation provides for a Licensing Authority, to be represented by the Superintendent of Public Health, (Organ Transplants (Quality and Safety) Regulations, 2012, Regulation 3) who may delegate functions to other bodies. The Authority is empowered to license procurement organisations and transplantation centres and has a remit to ensure that appropriate operating procedures are in place, through regular adequate control measures, including site inspections. The Authority promotes safety through regulation of the use of facilities, equipment, instruments, materials and medical devices, in concordance with national and international standards of practice.

### Safety of Organs

The main emphasis is on the health and safety of both recipient and donor. The Organ Transplants (Quality and Safety) Regulations (2012) lay down a requirement for guidelines concerning procedures related to donor consent (Regulation 14), organ characterisation (Regulation 7), and adequate organ transport (Regulation 8), and in fact the Directive and the local legislation lay down the minimum data set required for organ characterisation (Regulation 7 and Schedule). All medical activities, from donation to transplantation, must be under the guidance and advice of suitably qualified medical professionals (Regulation 12). Regulation 4.3 empowers procurement organisations and transplantation centres to ensure appropriate qualifications and competency, and further requires training programmes to be set up and provided.

A formal mechanism needs to be set up to enable reporting of serious adverse events and reactions, occurring during or after transplantation, to the Authority. Procurement organisations and transplant centres must investigate and register the adverse events and are required to have operating procedures for the adequate management of such events (Regulations 11(1) and 11(2)).

Traceability becomes an important element in the follow up of the patients involved. Regulation 10 requires adequate identification data on the donor and recipient to be kept by the procurement agencies and transplant centres for a minimum of thirty years after donation. Data is confidential and collection and storage must comply with the Data Protection Act, Cap 440 (2001). Data may be kept as an electronic record and must be made available to all parties in an organ exchange system involving more than one state. (Organ Transplants (Quality and Safety) Regulations, 2012, Regulation 7(6)).

### Living Donor Registry

So far Malta has had an informal Registry through donor cards registered with the Transplant Support Group. It is now a legal requirement to have an official registry of live donors and to record events that affect the donor's health, even after transplant (Organ Transplants (Quality and Safety) Regulations, 2012, Regulations 15(3) and 15(4)). Such a registry must be coupled with the identification system of recipients, necessary for organ traceability. (Regulation 10(1)b). Details of the set up of such a registry are still to be formulated. One foresees an electronic register, which is easily accessible to all interested parties and which can be easily kept up to date.

### Compensation

The Organ Transplants (Quality and Safety) Regulations (2012) state in Regulation 13(1) that donation must be 'voluntary and unpaid'. The principle that the 'human body and its parts shall not, as such, give rise to financial gain' was formally established in article 21 of the Convention on Human Rights and Biomedicine (Council of Europe, 1997) and repeated in article 21(1) in the Additional Protocol (Council of Europe, 2002), where it also rules out 'comparable advantage' but does allow 'compensation of living donors for loss of earnings and any other justifiable expenses caused by the removal or by the related medical examinations; payment of a justifiable fee for legitimate medical or related technical services rendered in connection with transplantation' and 'compensation in case of undue damage resulting from the removal of organs or tissues from living persons'. Regulation 13(2) also allows compensation for loss of income and expenses related to the donation but guidelines have to be set up by the Authority for such compensation; these may be either in the form of monies or comparable benefits. Any adverts related to organ donation that include financial gain or comparable advantage are also prohibited by law (Regulation 13(3)).

### Confidentiality

An issue which is addressed in the law but will prove difficult to enforce in Malta is confidentiality. Procurement organisations are barred from revealing the identity of the recipient to the donor or the family and vice versa (Organ Transplants (Quality and Safety) Regulations, 2012, Regulation 16).

It has been the practice locally for the Transplant Support Group to facilitate meetings between donor and recipient, if they so wish. This will therefore not be possible if the organisation is also involved in procurement. It may however prove impractical to ensure anonymity of donations in the local scenario.

### Organ Exchange

The Authority may oversee agreements with European member states or third parties for the purpose of organ exchange (Organ Transplants (Quality and Safety) Regulations, 2012, Regulation 3(2)j). There is a willingness, and a necessity, to ensure this happens on an international scale to maximize use of donations. Malta already has experience in this field because there has been a reciprocal arrangement with Italy for some years and in fact over the past 10 years Malta has donated more than 50 livers to Italy. (ACCORD, 2012)

## FURTHER ISSUES TO BE ADDRESSED

### Consent

The EU Directive 2010/45/EU asks for proper informed consent from donors but leaves the decision as to the model of consent to the state (Directive, Article 14). The local legislation (Organ Transplants (Quality and Safety) Regulations, 2012, Regulation 14) requires the Authority to lay down the standards expected in obtaining consent, including the information to be imparted. Guidelines should be forthcoming in future, so presumably a decision has to be taken whether to have an 'opt in' informed consent or an 'opt out' presumed consent system and who can consent or object on behalf of the donor. Who legally 'owns' deceased donor organs, and therefore can take decisions as to their use, is not clear.

Malta has always practiced an 'opt in' system, with cadaver organs being retrieved only if permission is obtained from the family. Research into the attitude of the Maltese towards an 'opt out' system have been unfavourable (Lauri, 2006, p.27). 'Opt in' systems may be strengthened with introduction of Advance Directives specifically for organ donation. This may be coupled with introducing donor cards as legal evidence of registering as

an organ donor. At present donor cards have no legal status in Malta but they do provide relatives with an indication of the beliefs and wishes of the deceased.

## Criteria for Allocation

The law does not discuss criteria for organ allocation, which according to WHO (2010) should be guided by clinical criteria and ethical norms. However with improvements in medical management of organ harvesting and donor and recipient healthcare, it is now possible to transplant organs that are not a perfect match or that satisfy 'extended or expanded criteria' whether in terms of disease status, age or less than optimal immunological typing (Stratta, 2004). Thus older kidneys may be used for older recipients and Hepatitis B or C positive organs may be donated to positive recipients. Guidelines about such criteria should be issued.

## Definition of Death

Malta has no official legal definition of death although brain stem death is legally accepted for the purpose of certification of death. Till now most deceased donors have been patients declared brain stem dead following brain injury. This in itself is a controversial issue with brain stem death being accepted in only a few countries, as in Malta, which follows the UK practice. Most countries accept whole brain death, requiring evidence of loss of higher brain function prior to making the diagnosis and certification of death.

So far, locally, there has not been a move to follow the emerging practice of trying to maximise the number of deceased organ donations, by using organs, with informed consent, from the so called non-heart beating donor. These are patients dying following cardiac death with irreversible cardiac and circulatory arrest, without previously having been on life support systems. This practice is marked with ethical problems since in such cases the death has to be anticipated and almost witnessed by healthcarers such that harvesting of organs can start within five minutes of death.

## The Way Forward

Malta has already committed itself to the issues laid down in the law, before it was even enacted, when it joined as a project partner in ACCORD, 'Achieving Comprehensive Coordination in Organ Donation throughout the European Union', a Joint Action DG SANCO Consortium of 23 associated partners and 9 collaborating partners, under the leadership of the Spanish National Transplant Organization, ONT. The project is running from May 2012 to November 2015 and is concentrating on three main aims: live donor registries, cooperation between intensive care and donor transplant coordinators and joint projects between countries to share experiences and support learning from each other to improve performance on specific issues mentioned in the EU Directive.

The Maltese have a positive attitude to organ donation. In the Special Eurobarometer 2007 study, 75% of citizens in Malta were willing to donate one of their organs after death as compared with 10% who were against the idea (Eurobarometer, 2007, p.7). Seventy-one per cent of Maltese were in favour of donating an organ from a deceased close family member (Eurobarometer, 2007. p.12). Discussion of organ donation with the family and making one's views known to the family has a strong influence on willingness to donate relatives' organs. (Lauri, 2006, p.28) Therefore we should continue to promote awareness about organ donation through national campaigns.

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*First Hon. FMCFD and MMCFD Graduation ceremony*

**10TH MAY 2013**

# *Congratulations*

*College officials and graduates*

*Taking the College Oath*

*The audience*

*Dr Natasha Azzopardi Muscat, CMO, welcomed by Registrar Dr Adrian Micallef*


*Dr Melissa Borg Cauchi (left) receiving the Saviour Cilia Award from Dr Nadia Cilia*

College officials and guests

Palazzo Depiro, Mdina

Dr Natasha Azzopardi Muscat, CMO and Prof. Pierre Mallia

Prof. Pierre Mallia

First Hon. Fellowship recipient Dr Denis Soler (left) with Prof. Pierre Mallia

# Practical aspects of palliative care

**Dr Jürgen ABELA**

Palliative Care is a relatively young medical specialty. In fact, it was only in 1987 that it was recognised as such in UK. The aim of this contribution is to highlight some important but practical points in the practice of palliative care, especially with respect to the ethical aspects of palliative care.

## GETTING DEFINITIONS RIGHT: WHAT IS PALLIATIVE CARE?

In a nutshell, it is an approach in which the focus of care is to improve the quality of life of the patient and family, through a holistic approach, due to the fact that the disease per se has a limited prognosis. Such approach involves addressing the physical, psychosocial and spiritual aspects of the patient. In addition, an important aspect of palliative care is the provision of bereavement support for the family (Charlton, 2002).

Palliative care is usually delivered by a team, comprising a variety of professionals. Conceptually, there is a lot of overlap between the specialties of palliative care and general practice – both of them look at the patient from a holistic perspective, and both of them are specialties not defined by diseases of a particular organ system, as opposed to say cardiology (heart), neurology (nerves), haematology (blood), etc.

As highlighted above, Palliative Care is provided for a variety of conditions; many times, it is associated with advanced cancer, but other (incurable) conditions are usually included like motor neurone disease and end stage respiratory failure amongst others. The prevalence of disorders also affects the development of palliative care services e.g. in the African continent, the majority of patients receiving palliative care suffer from HIV/AIDS.

At times, palliative care is considered to be equivalent to terminal care. However, put simply, terminal care *is part of* palliative care, whereas the latter comprises a wider part of the disease process, where the functional status of the patient is much better.

## TACKLING SYMPTOM CONTROL

Symptom control is certainly a hallmark of good palliative care. However, at times, this aspect of care is particularly challenging, especially in certain situations e.g. young patients or because of certain myths e.g. morphine accelerates the death process. Good symptom control entails first of all a thorough understanding of the symptoms the patient complains of; the concerns such symptoms raise; the effect these have on the family; and also what has been attempted so far to control such symptoms. It is only by going through such steps in a meticulous manner that symptom control can be addressed in a systematic and consistent manner. And it is only like that, that an agreed management plan can be drafted which suits patients and doctor alike.

## BASICS OF PSYCHOSOCIAL CARE

It is not uncommon that psychosocial issues arise in the palliative care setting. After all, they are one of the pillars of palliative care. What is commonly difficult is to dissect the past from the present – in the sense that many times, people exhibit a variety of responses to the disease and the situations arising from it, and deciding if they are the cause of the response (premorbid personality/disorder) or a consequence of the disease can be challenging at times.

Depression is fairly prevalent in this setting but diagnosing depression in the palliative care setting is immensely challenging, since many biological symptoms of depression would be more or less present. In addition, being appropriately sad is quite common ('normal') in such setting, contrary to most other areas of medical practice where such sadness would raise alarm bells on depression. Finally, from a social perspective, it is important to consider that in addition to the strictly administrative aspects e.g. sickness benefits etc, one needs to keep in mind the changing role of the patient both with respect to his family (moving from possibly being a carer to being cared for) and also with respect to the society, where many times, due to illness, people lose their role.

## TAKING DECISIONS AT THE END OF LIFE: HOW, WHO, WHEN AND WHERE?

For many people, palliative care is synonymous with end of life decisions such as artificial hydration and nutrition and the doctrine of double effect. However, it would be useful to consider a wider perspective. Indeed there are a variety of issues which come up and need to be tackled. Amongst these, for example, one finds the need to adequately inform patients about their diagnosis (and

possibly their prognosis) and also the need to discuss the preferred place of care of people. The latter is quite novel for Malta; however, on mainland Europe it is gaining more and more recognition as an important topic for discussion.

It is difficult to adequately address the end of life decisions that are common place in palliative care in such a short space. However, prior to discussing some issue, it is important to draw a distinction between the setting in palliative care and the setting in other commonly cited difficult ethical situations such as persistent vegetative state. In the latter, the medical situation of the patient is more or less static, whereas in the palliative care context there is always an *underlying and progressive* disease process which ultimately (or possibly) will lead to the demise of the patient. Certainly, such differing clinical contexts must be considered when considering aspects of care and decision making.

Many times, the doctrine of double effect (DDE) is mentioned as a major and important ethical aspect of care. Hence, I would like to go into some detail with respect to the doctrine of double effect. In brief, this line of thought is used in situations where a possible intervention might have unwanted side effects but is seen to be beneficial for the patient. Thus this concept is used to guide the clinician so that patients are not deprived of proper symptom control.

To clarify thoughts on the DDE, below are four clauses which need to be fulfilled and summarise the DDE well:

- The *nature-of-the-act condition.* The action must be either morally good or indifferent. Taking as an example a non-medical issue, this means that one cannot invoke the doctrine of double effect to justify stealing objects, for example, since stealing is a bad action per se.
- The *means-end condition.* The bad effect must not be the means by which one achieves the good effect. This means that to alleviate the dyspnoea of a person, for example, you cannot kill him so that you end his shortness of breath. This thought is diametrically opposite to the concept of euthanasia.
- The *right-intention condition.* The intention must be the achievement of only the good effect, with the bad effect being only an unintended side effect. In this respect, and as George and Regnard (2007) point out, the most important and unique point in highlighting / supporting the intent of the doctor is the dose of drugs being prescribed.
- The *proportionality condition.* The good effect must be at least equivalent in importance to the bad effect.

The above ethical consideration with respect to the doctrine of double effect should not be limited to the clinician. Although, at present, the legislation in Malta does not provide for advance directives, discussing such issues with the patient (if possible) and also the family goes that extra way to facilitate a good outcome for care. There are a lot of myths with respect to the end of life and the effect medications have. Indeed, discussion of such issues is one step in the right direction to increase the awareness and avoid misconceptions. Unfortunately, it is still quite common to find clinicians believing that using morphine shortens life – when this has been proven untrue time and time again. (Good and Cavenagh, 2005; Sykes and Thorns, 2003). Other considerations which are common place include the issue that opioids cause addiction, which yet again, is not relevant in the palliative care setting.

Living in a closely knit community, pressure from family members not to divulge the diagnosis is immense and at times, to be able to get access to patients, such situations need to be accepted. However, every effort should be made by the clinician to (sensitively) inform patients about their condition, more so if one accepts the fact that the way forward in medicine is agreed management planning between clinicians and patients.

Another issue, which should be high on the agenda for discussion is the preferred place of care. It is indeed challenging – but necessary – to discuss such issues. In so doing, one allows appropriate planning of the final days of the patient, avoids crises as much as possible and at the same time needs to consider what is manageable at home. The latter includes also the care being provided by the informal carers/family.

In conclusion, palliative care offers a myriad opportunity to tackle and experience challenging ethical situations. This contribution will hopefully increase awareness about this topic and facilitate discussions.

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# Education, the Fellowship, international activities, the statute and the Journal

**Prof. Pierre MALLIA**

This council has been formed in the beginning of this year; and it has been a very busy period indeed. As noted in our journal, enthusiasm seems to be at an all time low but we acknowledge that collegiate bodies do pass through these oscillations. In order to remedy this we will be offering incentives to members who help in college work. In fact I was the only person to throw in my nomination for president and those candidates for council were all automatically made council members as there were not enough nominations. I suggested that we use article 8.2 of the old statute and co-opt two members with voting rights. This decision, as provided by statute, fulfils the spirit of the aims and goals of council, and was subsequently approved by the AGM.

The following is a brief report of the activities going on. I would like to thank the Electoral Commission and the hard work of Dr Mario Rizzo Naudi in resolving several issues and suggesting options for co-option.

## EDUCATION

This is the main activity of the college, which offers CME of an excellent quality to members. But what takes up considerable time and effort on behalf of college members is indeed the final examination of the Specialist Training Programme in Family Medicine which the College organizes for the government. Indeed I have not only witnessed the agony and headaches that the organizers pass through, but we have had to deal with the Ministry of Health in order to ensure that the College membership obtained through Specialist Training will secure the Royal College of General Practitioners accreditation. Although this costs the government a substantial amount, the College, for the time being, waives its fees to the Dept. of Health (thus providing a free service) in order to bring in the prestigious MRCGP(INT) award to those who qualify. Indeed, if there is any doubt about its value, it was shown by a petition written by the trainees themselves to the department (and copied to us) that one of the main reasons that they follow the Specialist Training Programme is indeed to obtain this prestigious membership. *We continue to emphasize that the MRCGP(INT) is tied to the MMCFD*. They are not separate qualifications and should one stop being a member of the MCFD, one loses the MRCGP(INT) automatically, according to our memorandum of understanding. This would mean should MRCGP(INT) holders seek FRCGP(INT) in the future, the fellowship of the Malta College would be necessary. This would keep MRCGP(INT) in perspective – that of being the partial property of the MCFD.

We also intend to re-open negotiations of the MRCGP(INT) qualification for College members who are on the Specialist Register by grandfather clause. Although the opportunity of a portfolio we had in the past is now lost, we hope to be able to negotiate a programme which would at least give members the opportunity.

May I take this opportunity to thank Drs Doreen Cassar, Dominic Agius and Marco Grech for their fine and hard work in preparing this year's examination taking place in July; the support of Drs Jason Bonnici and Daryl Xuereb; and last but not least Dr Tania von Avendonk for her excellent logistic support in graduation, CME, AGM, and many other events including the place for the examination. I would also thank the CME team (DrsTania von Avendonk, Philip Sciortino, Edward Zammit, Daryl Xuereb) and the Registrar Dr Adrian Micallef for their hard work in this regard as well.

## COLLEGE FELLOWSHIP (FMCFD)

This brings me to the College Fellowship. This year the council decided it was high time that, given the provision of the statute, which has been there

over twenty years, the MCFD should start conferring Fellowship on members. My suggestion to council, which was unanimously approved, was to confer the first life Honorary Fellowship to the first President of the College, Dr Denis Soler. This was awarded during the Graduation ceremony of the Specialist Trainees held earlier this year. It was a special occasion and since we are now at the same level of specialist status, reinforced by the assessment of trainees with full recognition of the RCGP, we decided to make the occasion more formal as is done by specialist colleges abroad. This indeed removed any doubts for VIPs present regarding the status and prestige of such awards.

Details of the College Fellowship will be discussed in the near future. There is general agreement however that it should be tied to involvement in college council, subcommittees and other activities. A number of years of such activity and CME accreditation will of course be required and a proper conduct clause may be included. We hope to put on the website a suggestion 'box' in this regard. It should be mentioned that slowly the college will confer Fellowship also on those members who have already dedicated a number of years in the past to the MCFD.

## INTERNATIONAL ACTIVITIES

The MCFD will again start sending council members to international events of which the College is or will be a member. These include WONCA, EQuiP and EUROPREV. I have suggested that this should be reserved to council members, not only as is proper, but also to encourage people to contest for council. This does not mean that other college members cannot participate in such meetings however. Should funds allow we can suggest bursaries in this regard for younger doctors.

## STATUTE

The draft revision of statute had been approved last year. This year we decided that it is approved during the AGM. We however suggest it be adopted as a working document as experience has shown some limitations which are only learnt through experience. In this regard in fact I proposed to council, who subsequently approved, that we do not elect the President of Council during the same year as the election of council but elect a President-elect a year before in order for this person to learn the activities of council. Since the last time I was president a lot has been going on, and especially in the education process it took me some time to learn about all the committees, including those on which the College has members, such as the Specialist Training Committee in Family Medicine, and their functions. The president-elect would be obliged to attend all meetings but will not have a vote or in any way try to influence decisions during the final year of council. This proposal was put on the website several weeks ago according to present statute regulations and was approved in a separate vote following approval of the statute during this year's AGM.

## COLLEGE JOURNAL

The name of the journal has been change to *The Journal of the Malta College of Family Doctors* (JMCFD) and so has its layout. Whilst we are seeing an increase in the amount of scientific papers submitted, we are allowing space for a theme in each issue with guest articles. We also have a 'back pages' commentary article. The journal has become a not-for-profit entity and an adequate number of adverts to subsidize artwork, printing and distribution are being requested so as to maintain the target of three publications per year. Since I am now President I asked the Secretary to issue a call for applications for editor. There was only one expression of interest which did not materialize and so I will continue to be editor for the time being. However most of the hard work is really done by the editorial team whom I thank: Drs Dominic Agius, Mario R Sammut and Anton Bugeja; Dr Lara Gerada also continues to provide assistance as well.

What is close to heart is the involvement of members - only in this way is there proof of a collegiate body – and work on the MRCGP(INT) for members as well as the Fellowship. There are plenty of opportunities but Council cannot do everything. I augur that College members, especially those who through the hard work of present and past Councils obtained their MRCGP(INT), continue to build their college and to maintain a high status of our specialty of Family Medicine. We are proud of our College and proud to have elevated Family Doctors to specialist status. In this regard we will continue to strive that the numbers of trainees be increased as only through this path can doctors become members of the MCFD.

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# Works in progress

**Dr Jason J BONNICI**

Much of the last months have been dedicated to putting the house in order. To be honest this is still works in progress and one may argue that there is never an end to this. Of note is that there are building blocks on which to rebuild and there are organisational structures in place which are working well. This is of course thanks to the dedication and energy of a number of MCFD activists, volunteers and representatives who left their stamp during the years. The remit of the present council is to move forward.

## THE 2013 GP LICENSING EXAMINATION

Most of the house keeping has been devoted to the 2013 GP Licensing Examination. It is a tribute to all MCFD officers and to all the volunteers who were and/or are active in the College that they are striving with determination to make things happen. A board responsible for seeing out the execution of the examination and its logistics was formed: Dr Marco Grech (Assessment Lead), Dr Doreen Cassar (Lead for Clinical Skills Assessment [CSA]), Dr Dominic Agius (Examiner Lead and Psychometrician) and Dr Patricia De Gabriele (Applied Knowledge Test [AKT] Lead) supported by the three ex-ufficio members Prof. Pierre Mallia (President), Dr Philip Sciortino (Vice-President) and yours truly. However, Dr Patricia De Gabriele resigned in May 2013 and, despite that a resignation so close to the examination is a major set-back to the process, due credit needs to be given to the MCFD activists who filled in her shoes at the 11th hour.

When the present council came on board, the contract between the MCFD, the Department of Health and the Royal College of General Practitioners (RCGP) was due to expire in June 2013. The negotiations to renew the contract with the Department of Health and the RCGP were a time of anxiety and ordeal. To date signing of the renewed contract is still pending but the direction from Minister for Health Dr Godfrey Farrugia is positively in favour of continuing the working relationship.

The preparations for the examination itself (set-up, personnel and logistics) took a lot of time, effort and energy. This includes meetings with training co-ordinators; on-site meetings with the officers responsible for the facilities where the separate parts of the examination take place; issuing calls for candidates, examiners, marshals, AKT writers, CSA writers, and members of the Angoff team; training sessions for the colleagues involved in all these processes; preparation of the examination material; carrying out the examination, including the coordination and organisation of the visit by the RCGP representatives for accreditation and eventually issuing the results.

Part of the work of the MCFD council was, and to an extent still is, to see what is owed to who for whichever part they have done linked to vocational training. The college will honour its contractual obligations … some progress has been made in this regard, but there is more to come.

By the time of publication of this edition of the journal, the 2013 GP Licensing Examination will have taken place. Then will be time to reflect on proceedings and plan for the coming session …

Most of the above is in fact contribution in-kind by the MCFD for the financial feasibility of the GP Licensing Examination; and the lion's share of this contribution is on the shoulders of a few - Dr Marco Grech, Dr Doreen Cassar, and Dr Dominic Agius. Getting due recognition for the College's contribution in-kind and distributing further the responsibility will be a major task for the council in the months ahead.

But I feel encouraged by colleagues, graduates of the previous years. They, who have been examinees a short while ago, have come forward and made the contributions they desired to their peers beckoning to enter our profession … this is their time and they are taking their opportunity! I am looking forward for the MCFD to reap the benefits of this approach in the upcoming sessions.

## GRADUATION OF GPs

All of the above is in itself a big task, but the end result gives the due professional and personal development. The satisfaction is there, the gleam in the eyes of the MCFD activists, GP Representatives, GP Trainers and all present is there for anyone to see every time new GPs take centre stage in their graduation. The latest graduation took place on May 10th 2013 in a nice evening organised on the occasion. This year for the first time, an oath for GPs was read out by those involved and it says brilliantly what a GP is to stand for. This was the initiative of Dr Joseph Portelli-Demajo and refined by Dr Adrian Micallef and Prof.

Pierre Mallia. The activity, nice as it was (and Dr Tania van Avendonk deservedly takes the laurels for this, as she does for many other activities), is food for thought for an even nicer evening next time around …

## CONFERMENT OF THE HONORARY FELLOWSHIP OF MCFD

On the same occasion, the first Honorary Fellowship of the Malta College of Family Doctors was bestowed to one of the founders of the MCFD, Dr Denis Soler. As family doctors I think we are indebted to all colleagues and friends, who have dedicated yesterday and will dedicate tomorrow, time and energy to achieve milestones in our everyday reality of family medicine. The time is overdue for proper recognition to be bestowed and an Honorary Fellowship of the Malta College of Family Doctors (FMCFD) is an official step in that direction.

## THE JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

You are reading this report in the latest edition of the Journal of the Malta College of Family Doctors. This continuity is a credit to the efforts of its Editorial Board - Prof. Pierre Mallia, Dr Anton Bugeja, Dr Mario R Sammut and Dr Dominic Agius. All this was possible thanks to the support of the sponsors. A call for a new Editor of the Journal of the Malta College of Family Doctors was issued; this post was and is presently occupied by Prof. Pierre Mallia, now MCFD President. Unfortunately, despite an early interest, no application for the post was received. Prof. Mallia has retained the post for the present time. But the door is always open for colleagues to come forward to join the Editorial Board.

## THE VACANT COUNCIL POST

After the resignation of Dr Patricia De Gabriele a post on council was vacated. A call has been issued. Unfortunately, despite an early interest, no application for the post was received. Having said this, the opportunity of co-option to council of colleagues who would like to taste the experience is there, as provided by the statute.

## THE CONTINUED MEDICAL EDUCATION ACTIVITIES

The College has made a good reputation for itself with its Continued Medical Education activities. This time around the committee made up of Dr Philip Sciortino, Dr Tania van Avendonk, Dr Edward Zammit and Dr Daryl Xuereb has kept the sterling work going strong. Due thanks go to the sponsors who make these activities possible, and to the colleagues who attend in recognition of the worth of these CME activities to their professional development. It is an additional credit that recent graduates are in the picture too and I am looking forward for the MCFD to reap the benefits of this approach in the upcoming sessions.

## THE ANNUAL GENERAL MEETING

The Annual General Meeting is the fulcrum of a membership-driven organisation such as the MCFD. The AGM of this year was, for me yet again, a case in point: a poorly attended meeting despite its second convening which has nonetheless set the benchmark for moving further.

The much awaited new version of the statute was approved, with the proviso of further changes to be suggested in the coming months and to be discussed by future general assemblies. This includes the suggestions brought forward by the officer in charge of the statute, Dr Jean Pierre Cauchi, during the meeting to cater for circumstances not yet provided for by the approved version and which the recent past has shown the need for. Amongst all the General Assembly gave the go-ahead for the introduction of the concept of President-Elect. I am myself a firm believer that evolving structures within an organisation are a basis for sustained improvement and hence my satisfaction that a step forward has been attained.

Another positive note has been the contributions during the meeting of the self-described "story-tellers". The "story-tellers" are colleagues who recounted the ordeals linked to the vision they had of making family medicine a specialty and the meaning of what it took and still takes today to keep family medicine at par with other branches of the medical profession. The story so told left the assembly with the routine (of the AGM proceedings) and with … the future!

In the coming weeks the proceedings of the AGM will be on the website, thanks to the endeavour of the College Secretariat Ms Lorraine Gauci, and the efforts of the webmaster Dr Kenneth Vassallo.

The MCFD has the potential to be better and to do more. With the help of people of goodwill this is possible … the door is open for colleagues of goodwill to have a role that fulfills their talents, enhances their personal and professional development, respects their experience in college matters and suits the needs of the specialty and its College.

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# Training, status and migration of General Practitioners/Family Physicians within Europe

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## ABSTRACT

### Objective

The survey intended to explore and identify the training background and status of general practitioners/family physicians (GPs) in member countries within EURACT (European Academy of Teachers in General Practice/Family Medicine), and to gain an overview of processes involved when GP-trained doctors migrate to work in another member country.

### Method

A questionnaire, with closed and open-ended questions, was sent to representatives of all 39 EURACT-member countries in 2009. The main outcome measures were the training background and status of GPs in public/private settings in each country and the requirements of additional training and testing when migrating to another country.

### Results

Forty-one completed questionnaires were received from 31 (79%) of the EURACT countries. The data indicate that specialist training for General Practice/Family Medicine (GP/FM) is well established throughout and generally required for appointment to public career posts. The data also indicate that European Union-trained GPs can move freely to most countries with usually no tests of medical knowledge or language proficiency. Orientation to the healthcare system in the destination country is usually not provided.

### Conclusion

The survey indicates that non-GP trained doctors work in public/private GP/FM posts in many European countries, although new appointments to public posts in nearly all countries require specialist GP training. It was not possible to identify a uniform or agreed approach applied by employing agencies to confirm the medical competence and language skills of migrant doctors and to provide them with orientation to healthcare systems. In the high-context dependent discipline of GP/FM this is of concern.

## KEYWORDS

General practice/family practice; education, medical; employment; emigration and immigration; Europe

## INTRODUCTION

EURACT, the European Academy of Teachers in General Practice/Family Medicine, is the education and training network organisation of WONCA Europe, the European regional branch of the World Organisation of Family Doctors. In 2009 EURACT had 39 member countries, each country having one representative in the EURACT Council. The Specialist Training Committee of the EURACT Council gathers data and publishes recommendations and guidance on matters relevant to specialist training in General Practice/Family Medicine (GP/FM).

The migration of doctors from their country of training to another has become a common occurrence, not only within Europe (Williams and Baláz, 2008; Young, Weir and Buchan, 2010), but also in the USA (Chen, Nunez-Smith, Bernheim et al., 2010) and Canada (Zulla, Baerlocher and Verma, 2008). Migrating doctors face the challenge of integrating in a foreign country or state where there may be differences of disease prevalence, language, professional and social culture and importantly, a different health service

infrastructure. These differences present important barriers to both doctor migration and successful integration, in particular in the high-context dependant discipline of GP/FM where the setting of both the patient and the doctor is of importance (Heyrman, 2005).

### Objectives of study

As general practitioners (GPs)/family physicians form a significant proportion of such migrating doctors, the EURACT Specialist Training Committee conducted a survey in 2009 on this matter among EURACT member countries of which the majority are members of the European Union/European Economic Area (EU/EEA). The first main objective was to explore and identify the training background and status of GPs in public/private practice in EURACT-member countries. With specialist training for GP/FM already well established (EURACT, 2013; Sammut, Lindh and Rindlisbacher, 2008), the study set out to discover if training is necessary for a career in GP/FM. The second main objective was to gain an overview of the processes involved when doctors trained in GP/FM in a EURACT member country migrate to work in another member country, exploring if any additional educational interventions should be proposed in order to support their professional integration.

## METHOD

### Study design

A questionnaire-based descriptive survey using closed and open-ended questions was designed by members of the EURACT Specialist Training Committee. A pilot study, conducted in 2008, helped in shaping the final format. The two-part questionnaire, one part per main objective, consisted of 14 main questions designed to explore any differences between public/private practice and between EU/EEA and non-EU/EEA countries. After approval by the EURACT Council in 2009 the questionnaire was e-mailed to all 39 Council members. Council members were asked where possible to identify a second informant in their country to also complete the questionnaire. The second informant was asked to return his/her reply to the Council member for them to identify and resolve any differences before returning all questionnaires to the study team for analysis. As the data required was not confidential, collection did not need to be done on an anonymous basis. Ethical approval or informed consent was not needed as this study was not on human subjects.

### Analysis

Data was entered on a Microsoft Excel® spreadsheet to facilitate interpretation and analysis. Areas of non-concurrence were not included in the result where two replies were available from a country (except where specified). A preliminary analysis of the partial results was presented during a workshop at the WONCA Europe Conference in Switzerland in September 2009, where participants from nearly 15 countries found them quite useful.

## RESULTS

Forty-one completed questionnaires were received from 31 (79%) EURACT Council members in the 39 member countries (ten countries submitted two replies each). Of the eight non-respondents four were EU/EEA and four were non-EU/EEA countries. The 31 participating countries included 25 within the EU/EEA (Austria, Belgium, Bulgaria, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Malta, the Netherlands, Norway, Portugal, Romania, Slovenia, Spain, Sweden, Switzerland and the United Kingdom [UK]) and six non-EU/EEA countries (Bosnia & Herzegovina, Croatia, Moldova, Russia, Serbia and Ukraine). No data was received from the Czech Republic, Latvia, Poland and Slovakia within the EU/EEA, or from Albania, Georgia, Israel and Turkey outside the EU/EEA.

### Training and status

Specialist training for GP/FM is firmly established internationally and is a pre-requisite for becoming an "Official/Licensed/Specialist" GP in all EU/EEA countries except Norway, and in five of the six non-EU/EEA countries surveyed (Table 1). Specialists in another discipline usually have to undergo a training process (re-training) similar to other doctors to become a GP. In nine EU/EEA countries and four non-EU/EEA countries, doctors trained in another medical discipline must undertake full GP training, while for the remainder some credits are given for previous relevant experience (Table 2).

**Table 1:** Specialist training for GP/FM and GP status

| | | Yes | No |
|---|---|---|---|
| Specialist training for GP/FM is a pre-requisite for becoming an "Official / Licensed / Specialist" GP | EU/EEA countries | Austria, Belgium, Bulgaria, Cyprus, Denmark, Estonia, France, Finland, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Malta, Netherlands, Portugal, Romania, Slovenia, Spain, Sweden, Switzerland, UK | Norway |
| | Non-EU/EEA countries: | Bosnia & Herzegovina, Moldova, Russia, Serbia, Ukraine | Croatia |
| Re-training is required by other specialists to become a GP | EU/EEA countries: | Austria, Belgium, Bulgaria, Cyprus, Denmark, Estonia, France, Finland, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Malta, Netherlands, Portugal, Romania, Slovenia, Spain*, Sweden, Switzerland*, UK | Norway, Spain*, Switzerland* |
| | Non-EU/EEA countries: | Bosnia & Herzegovina, Moldova, Russia, Serbia*, Ukraine | Croatia, Serbia* |

* Different replies from two respondents

**Table 2:** Details of specialist re-training in GP/FM

| | Re-training entails completion of training programme | Re-training entails partial training with credits for previous relevant experience | Re-training entails other arrangements | No answer |
|---|---|---|---|---|
| EU/EEA countries | Belgium, Estonia, Ireland, Italy*, Lithuania, Malta, Romania, Spain*, UK* | Austria*, Bulgaria, Cyprus*, Denmark*, France, Finland, Germany, Greece, Hungary, Iceland, Italy*, Netherlands, Portugal, Slovenia, Sweden, Switzerland | Austria*, Cyprus*, Denmark*, Spain*, UK* | Norway |
| Non-EU/EEA countries | Moldova, Russia, Serbia, Ukraine | Bosnia & Herzegovina | None | Croatia |

* Multiple replies received

**Table 3:** Specialist training for GP/FM and GP posts in public/private practice

| | Non-GP trained doctors working in | | GP training now essential for appointment in | |
|---|---|---|---|---|
| | Public posts | Private posts | Public posts | Private posts |
| EU/EEA countries | Bulgaria, Cyprus, Denmark, France, Finland, Germany, Greece, Hungary, Iceland, Ireland, Italy, Malta, Norway, Portugal, Romania, Slovenia, Spain, Sweden, Switzerland, UK | Bulgaria, Denmark, France, Finland, Germany, Greece, Iceland, Ireland, Italy, Malta, Norway, Portugal, Romania, Slovenia, Spain, Sweden, Switzerland, UK | Austria, Belgium, Bulgaria, Cyprus, Denmark, Estonia, France, Finland, Germany, Greece, Hungary, Ireland, Italy, Lithuania, Malta, Netherlands, Portugal, Romania, Slovenia, Spain, UK | Austria, Belgium, Cyprus, Denmark, Estonia, France, Finland, Germany, Lithuania, Netherlands, Slovenia |
| Non-EU/EEA countries | Bosnia & Herzegovina, Croatia, Serbia | Croatia, Serbia | Bosnia & Herezegovina, Moldova, Russia, Ukraine | Bosnia & Herzegovina, Russia, Ukraine |

**Table 4:** Ability of GPs trained in GP/FM abroad to work without further traininge

| | Ability of GPs trained in GP/FM abroad to work without further training | | | |
|---|---|---|---|---|
| | Public Posts | | Private Posts | |
| | From EU/EEA country | From non-EU/EEA country | From EU/EEA country | From non-EU/EEA country |
| In EU/EEA countries | Austria, Belgium, Bulgaria, Denmark, Estonia, France, Finland, Greece, Iceland, Ireland, Italy, Lithuania, Malta, Netherlands, Norway, Portugal, Slovenia, Sweden, Switzerland, UK | Estonia, France, Greece, Lithuania | Austria, Belgium, Bulgaria, Denmark Estonia, France, Finland, Greece, Ireland, Lithuania, Malta, Netherlands, Portugal, Slovenia, Spain, Sweden | Estonia, France, Greece, Ireland, Lithuania, Portugal, Switzerland |
| In non-EU/EEA countries | Bosnia & Herzegovina, Moldova, Serbia | Bosnia & Herzegovina, Moldova, Serbia | Bosnia & Herzegovina, Serbia | Bosnia & Herzegovina, Serbia |

**Table 5:** Requirement in destination country of medical knowledge test, language test and orientation training for migrating GPs

| | | GP trained in EU/EEA country | GP trained in non-EU/EEA country |
|---|---|---|---|
| Tests of medical knowledge | Entry to EU/EEA country | Germany | Belgium, Bulgaria, Denmark, Estonia, France, Finland, Germany, Greece, Iceland, Ireland, Malta, Norway, Portugal, Slovenia, Sweden, UK |
| | Entry to non-EU/EEA country | Bosnia & Herzegovina, Croatia, Moldova, Russia | Bosnia & Herzegovina, Croatia, Moldova, Russia |
| Language test | Entry to EU/EEA country | Belgium, Cyprus, Estonia, Greece, Lithuania, Portugal, Romania, UK | Belgium, Cyprus, Denmark, Estonia, France, Greece, Ireland, Lithuania, Netherlands, Norway, Portugal, Romania, Slovenia, Sweden, UK |
| | Entry to non-EU/EEA country | None | None |
| Orientation to healthcare system | Entry to EU/EEA country | Germany | Denmark, Finland, Germany, Slovenia, Sweden |
| | Entry to non-EU/EEA country | Bosnia & Herzegovina, Russia, Serbia | Bosnia & Herzegovina, Russia, Serbia |

NB: The countries that replied 'sometimes' are not included in this table.

### Training and eligibility for GP posts

Among the 31 participating countries, there were non-GP trained doctors working in public and private posts in 23 and 20 countries respectively during 2009 (Table 3). In order to be appointed to public GP posts in EU/EEA countries, GP training is now essential in 21 of the 25 EU/EEA member countries surveyed and four of the six non-EU/EEA countries. The same table also reveals that entry to permanent GP posts in the private sector is less restricted with specialist training being essential in 11 of 25 EU/EEA countries and three of six non-EU/EEA countries. In this respect an appreciable difference is identified in EU/EEA countries between public posts and private practice with regard to the need for specialist GP/FM training.

### Re-training for non-specialist trained GPs

Non-GP trained doctors working as general practitioners are offered additional specific training in GP/FM in only a minority (albeit noteworthy) of countries - 12 countries for public posts (Bulgaria, Croatia, Cyprus, Denmark, Finland, Greece, Norway, Romania, Serbia,

Slovenia, Switzerland and the UK) and eight for private posts (Bulgaria, Croatia, Finland, Norway, Romania, Serbia, Slovenia and Switzerland), with such training more often than not being optional.

### Integration of trained GPs moving to another EURACT member country

Doctors trained in GP/FM from the EU/EEA can work in public and/or private GP/FM posts without further training in 24 of the countries surveyed (21 EU/EEA and three non-EU/EEA), compared with ten countries (seven EU/EEA and three non-EU/EEA) for trained GPs from non-EU/EEA countries (Table 4).

Family physicians trained in their country of origin may be asked to undergo tests of medical knowledge, language tests and orientation courses to the medical system when migrating to another country. The prevalence of such tests/courses varies within the EURACT member countries (Table 5).

General practitioners/family doctors trained in the EU/EEA face a test of medical knowledge on entering the GP system in only one nation (Germany) of the 25 EU/EEA countries and four of the six non-EU/EEA countries. Eight EU/EEA countries and none of the non-EU/EEA countries require EU-trained GPs to undergo a language test. Official orientation to the healthcare system in the destination country occurs in only one state (Germany) of the EU/EEA countries and in three non-EU/EEA countries (Table 5). Migrating GPs from non-EU countries have a higher probability of requiring a test of medical knowledge, a language test and official orientation training, especially when migrating to EU countries. As there was little difference between such entry requirements into the public and private services in countries where both services exist, this distinction was not made.

## DISCUSSION

### Main findings

Despite well-established specialist training in GP/FM for physicians in EURACT member countries, in many of them there were non-GP trained doctors working in public/private posts during 2009 (Table 3) in contravention of Article 29 of EU Directive 2005/36/EC (The European Parliament and the Council of the European Union, 2005). However GP training is now essential for appointment in all but four of the EU/EEA countries and about half of non-EU/EEA countries.

Migrating GPs from EU/EEA states are not likely to be required to undergo further training to ensure medical competence (Table 4). However, family physicians trained outside the EU/EEA zone are more likely to be required to demonstrate medical and language competences and sometimes also to undergo orientation relevant to the country in which they wish to practice (Table 5). On the other hand, the data presented show that during 2009 there was an appreciable number of European healthcare systems with migrating GPs in practice posts who were not certified in language competency, which eventuality contravened Article 53 of EU Directive 2005/36/EC (The European Parliament and the Council of the European Union, 2005).

The study thus indicates that there is presently no uniform approach, which is identified or consistently applied by employing agencies across Europe, to confirm the medical competence and language skills of migrant doctors and to provide them with orientation to healthcare systems.

### Strengths and limitations

A strength of the survey is that it was completed by known experts in the area of Specialist Training in GP/FM, who are elected by their peers on the basis of their general practice teaching experience. Although the modest number of participants is a limitation of the study, and despite the occasional disagreement between two respondents within a country, the uniformity and consistency of responses is nonetheless convincing, and reflect important realities in service delivery. The omission from the results of the few countries where two replies were available may have discriminated against these countries. While the information reported was collected in 2009, the authors are not aware of any subsequent major change in training, status, or the systems of recruitment. No similar studies are known to have been published.

### Interpretation

The absence of a uniform or agreed approach to confirm either the competence or the language skills of migrant physicians recruited to work in GP/FM by employing agencies in Europe is an important and pressing issue. This situation may represent a risk to patients throughout the EU/EEA area and particularly to those treated within the private sector, both on the basis of uncertainties in the abilities and training of the physicians concerned, and also regarding their competence to safely and consistently provide acceptable personal / holistic care to patients. In the high-context discipline of GP/FM, this is of particular importance (Heyrman, 2005).

## Implications

In the short term, it would appear prudent and necessary for any recruiting agency, whether governmental or commercial, to provide orientation to the healthcare system of the country where any migrant physician has arrived to work as a GP. This would include familiarity with the system's medical laws and regulations, and with the country's cultural issues and patients' rights. The absence of such a process of orientation may not only lead to inefficiencies due to the newly-arrived doctor having to find his/her way through the system in an unstructured and unsupported manner (Williams and Baláz, 2008), but may also create an increased risk of serious medical errors. Examples of such orientation schemes include those established by the Clinical Assessment Practice Program (CAPP) in Nova Scotia, Canada (Maudsley, 2008) and currently underway by the Australian Healthcare Professionals Regulatory Agency (Australian Medical Council Limited, Medical Board of Australia and AHPRA, 2012).

While there is no agreed standardised system available for accrediting the competence of family physicians moving within Europe, some healthcare systems and training entities have previously put in place special routes to accreditation which may be relevant and applicable to migrant GPs. These include the Interim Membership by Assessment of Performance (iMAP) route to membership run by the Royal College of General Practitioners (Baker and Pringle, 1995; Naido, 2010), the Alternative Route to Certification (ARC) devised by the Royal College of Family Physicians of Canada (The College of Family Physicians of Canada, 2013), and the Independent Pathway set up by the Australian College of Remote and Rural Medicine (Australian College of Rural and Remote Medicine, 2011).

In the context-dependent discipline of GP/FM, the recruiting agency is advised to assess the ability of migrating physicians to communicate safely and effectively in the local language as this is of critical importance. Agencies are also advised to ensure that the training and work experience of the migrating candidate are accurately described, confirmed and relevant to the spectrum of clinical responsibilities of the post. Further enquiries with medical indemnity insurance agencies would be useful in excluding reported/actual adverse medico legal claims and/or reported patient harms by migrant physicians in their native healthcare system.

In the longer term, consideration in Europe should be given to the establishment of a Common European Specialist Licensing Examination as an alternative to the national requirements of the host healthcare system, which examination could be closely based on the EURACT Educational Agenda of General Practice/ Family Medicine (Heyrman, 2005). A discussion regarding this matter was initiated by the EURACT Council in 2012.

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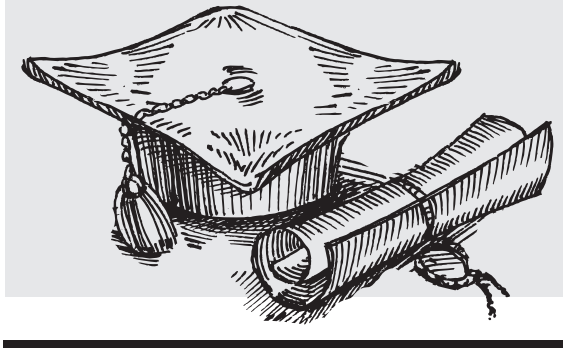

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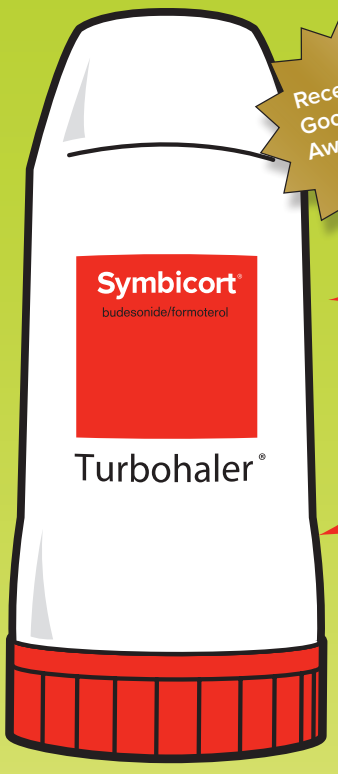


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**Reference: 1.** Adelphi Respiratory Disease Specific Programme 2009. **2.** Olof Selroos et al. *Treat Respir Med* 2006; 5 (5): 305-315. **3.** Engel et al. Br J Clin Pharmacol 1992; 33(4): 439-44.

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