Ethical issues in Vocational Training and quality with Patient Registration

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Vocational Training is an obligation in all specialties under the EU Health laws. This means that if a specialty is listed on the specialist register of a country, it is not only an exam which is required to work, but specific Vocational Training (VT). The EU obliges governments to guarantee for patients that anyone working with the National Health Services should have VT.

The consultation document on the proposals for the Reform in Primary care in Malta has been published earlier this month. And patient registration is on the agenda of the primary care reform. What is suggested here is however solely my responsibility and ideas. It is good that the Association of Private Family Doctors (APFD) will be involved in this. It would be wise however that the APFD asserts its rights that those who can accept people to register with doctors must be on the specialist register. This asserts not only their right to practice in a field which has now been shown to require specialization but it gives the government a guarantee of quality.

Tied to this however must come a strong proposal that those who hold an MD alone, unless they qualified for the specialist register by the one-off grandfather clause, will not be allowed to practice. There are varying opinions on this. Some continue to assert that an MD degree should be an exit degree allowing one to practice; others consider it a basic 'entrance' degree which enables one to specialize in a particular field. With family medicine considered as a specialty at EU level and in the rest of the Western World, one has to question the legitimacy of practicing in the community without having completed specialist training (unless one qualified for a grandfather clause). If one obliges VT, then it will only be an entrance degree. One cannot not argue for other areas, but certainly, if we feel that VT is not only a guarantee, but it is worth something extra, then it is about patient rights, and as patient advocates, doctors must uphold this principle.

It is a question of who is competent to work in the community as happens in other specialties. Although I may take the risk and remove an appendix, I would be in a very tight position if I were to defend myself in front of a medical council. I cannot see how someone can escape negligence and malpractice. Although there are instances where countries require GPs to work in areas of specialization, they would not be on the specialist register and there is a limit to what they can do. This means in effect that what they do is still regulated and the MD qualification would not be enough.

We must also consider that we are in the EU and that by giving registration to private family doctors, *the government has in effect acknowledged that private Family Doctors are now part of the NHS and ties itself with this directive.*

Actually this directive binds countries even if family medicine is not considered a specialty. In Italy the government has taken to control primary care and employs a fixed quantity of doctors calculated on a thousand patients per doctor. VT is imposed, even though family medicine is still not on their specialist register. It is not merely about the register. It is about quality, and about asserting that before we send doctors working in the community, they have been exposed to the local situations and know how to deal with non-manifest agendas, which often are not seen in the hospital setting. One must be astute to detect domestic violence, and offer treatment to substance abuse and help the family to cope. Being versant with all the available services does not come that quick. If one is to be registered with a doctor, this doctor must cover a comprehensive care – from children to elderly and from palliative care to offering some minor procedure and investigations. All WONCA core competencies must be satisfied.

The key therefore, for a successful implementation of patient registration, is to make sure that the doctors are adequately qualified and uniformly distributed according to population density. This does not mean that someone who works in a government health department may not form part of a group or network, so long as he or she is on the specialist register. But it does mean that doctors should not be allowed to be following one specialty and be allowed to sit in a pharmacy seeing patients which they will abandon as soon as they pass their membership exams. Having Vocation Training is about patients' rights. It is not about the right to chose to do VT or not. The government has now taken in and acknowledged the important role private doctors play for our NHS. With this come moral responsibilities to our patients.

It will also mean making a jump in quality assurance, pharmacovigilance, infectious disease surveillance etc. If we have doctors who do not have patients registered with them practicing in parallel, this may mean that these quality improvements will not occur. For example, patients who hold a Schedule V card often have drugs which have been prescribed by specialists within the secondary setting. They go to primary care for prescriptions. Although hospital specialists and primary care specialists may be held to a different standard of care for certain drugs, the primary care physician writing the prescription still has responsibility of pharmacovigilance and other monitoring and examination duties.

When patients do not have one doctor, one finds that several may be writing out a prescription within a period of time. This may lead to decisions by different people to change a dose or to a related drug without proper communication and records. Patient registration will put more responsibility on the doctor to ascertain any necessary changes and to monitor their conditions; it is often the case that a patient comes for a prescription and refuses examination or testing because he claims to have had them recently at another doctor or the health centre. If one is taking responsibility for prescribing drugs, it would make medico-legal and ethical sense to monitor the patient as well.

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Certainly conditions must be satisfied for GPs to have patients registered with them. The first is a minimum number of hours in their practice – usually 20 hours have been suggested. Secondly they should be networked to cover for out-of-hours and emergency calls and when one is on leave. Networking works just as good in other countries as group practices, which have not proved popular yet. This has been the case in Italy from where colleagues have explained their system. It will also prevent business-like services, bringing in doctors from other countries who are not on the specialist register of their own country or have not done vocational training to practice here at the expense of quality and due care.

But the fact we are seeing a silver lining is indeed a step forward for patients and doctors alike. The effort invested by many over the years and especially in recent months is paying off.