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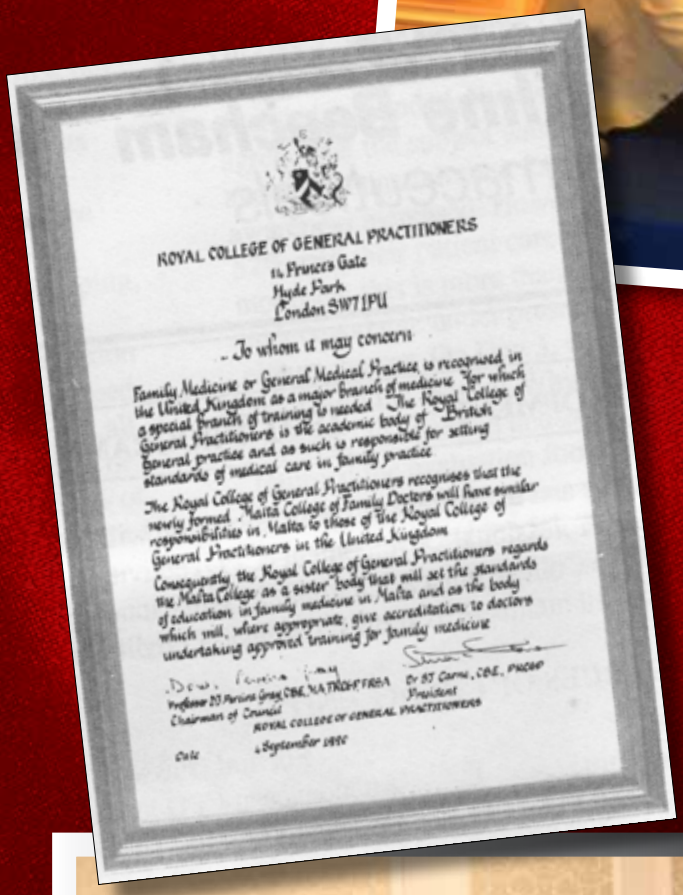

ROYAL COLLEGE OF GENERAL PRACTITIONERS
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To whom it may concern

Family Medicine or General Medical Practice is recognised in the United Kingdom as a major branch of medicine for which a special branch of training is needed. The Royal College of General Practitioners is the academic body of British general practice and as such is responsible for setting standards of medical care in family practice.

The Royal College of General Practitioners recognises that the newly formed Malta College of Family Doctors will have similar responsibilities in Malta to those of the Royal College of General Practitioners in the United Kingdom.

Consequently, the Royal College of General Practitioners regards the Malta College as a sister body that will set the standards of education in family medicine in Malta and as the body which will, where appropriate, give accreditation to doctors undertaking approved training for family medicine.

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JMCFD
JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

Journal of the Malta College of Family Doctors
The mission of the Journal of the Malta College of Family Doctors (JMCFD) is to deliver accurate, relevant and inspiring research, continued medical education and debate in family medicine with the aim of encouraging improved patient care through academic development of the discipline. As the main official publication of the Malta College of Family Doctors, the JMCFD strives to achieve its role to disseminate information on the objectives and activities of the College.

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25 years of the MCFD

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The 25th anniversary of the MCFD

Prof. Pierre MALLIA

This year marks the 25th anniversary of the MCFD and the editorial board has decided to dedicate this issue to give an historical overview of the past. Dr. Mario Sammut had already written a brief history of the College in the past and I asked him to kindly update it. Not only did he do this but he went through files to get details now somewhat obscure. It is impossible to give an account of everything. For example during my last tenure as president we had several meetings of what we then termed as a National Development Day, where the College looked into where we wanted to go. There were health centre doctors and private doctors in the seminars held. I had thought at the time that doctors would prefer to have a universal system but it turned out that both sides were appreciating the value of their turf; in that doctors actually wanted a status quo. What people did agree upon was that we should have a system whereby patients are registered with a doctor of their choice. But how can this be done in a dual system? Do you register with either a private doctor or a health centre; or conversely perhaps have a named private doctor and still be able to avail yourself of the health centres. Not an easy question and both sides saw some threats.

Later, under the last administration, people toyed with several ideas. These historical links go lost in time and one forgets how the MCFD was directly tied to them. At first ideas ranged from eliminating the health centres entirely to people saying that health should not be overall free. Of course many of us came out against this. Then a document, allegedly leaked to the pubic, said that private doctors will take on patients who would have been registered to them. How the health centres were going to fit in all this was unclear but it seemed they would provide some sort of specialised service. It was all confusing at the time. The Association of Private Family Doctors (APFD), which in general favoured the document, had arranged a meeting for its members with the Minister. One main point of contention was that doctors would again fall under the supervision of the Director General (Health). One also pointed out that he had left the health centres because his freedom was restricted. Even though doctors on night shifts had the right to ask people requesting home visits to come to the health centre unless it was an emergency, if they refused they would get reported and passed through the mill. Some doctors left the health centres because of such treatment. At the time one member of Council was actually accused of not doing a house call. He was called at night and told to go down from Mosta to St Paul's Bay. He legitimately gave advice over the phone as he was alone. It was a case of a boy with fever. He told the father to call in half an hour. The father did not call but in the morning the elected parliamentarian called someone, who called someone else, who called the doctor that he had been charged. Of course he was 'liberated', but not without a warning.

Then an about turn happened. If we could not get private doctors on board, then why not re-inforce the health centres. There was talk of handing over chronic disease management to the health centres – it had been documented that should private doctors have patients registered with them and accept to take on health centre patients, they would have been given chronic disease management themselves. This was good as it is your family doctor who should do so. But now to divide the health care of a person into several blocks – hypertension, diabetes, arthritis, etc – each to be handled by a different doctor deceived the end of family medicine. Talks started about raising the salaries of health centre doctors with a controversial contract being signed during the electoral campaign. For many it seemed that the Minister was paying back private doctors. Many felt threatened. If people feel they had to go to the government services in order to benefit from free medicines etc., then private doctors were going to lose patients.

This issue also has a collection of photos from our history, in particular the MMCFD graduation ceremony of the 10th May 2013 in which we also gave the Honorary

Tania van Avendonk's ceremony for the award of the Certificate of Commendation by the Royal College of General Practitioners for which occasion Prof. Valerie Wass, OBE visited us in Malta. Invited for the occasion were council members and spouses and her famly.

Fellowship to the first president of the College, Dr. Denis Soler. It was my honour to present him with the first fellowship and indeed I have been lucky with a lot of 'firsts', such as being president on both our 15th and 25th year anniversary. Indeed we recalled that day how the first council meeting took place in Denis's kitchen. So for posterity it is worth mentioning it here.

We have had differences of course, but I believe that strong organisations are built because we learn to appreciate fair times by knowing what it means to pass through dark times. We certainly have had them during the past three years. The trick is to continue to see the others for what they are worth and arising above individual idiosyncrasies. Strong councils are built on going beyond individual differences and recognising the strengths of others. Some are good at education, others good at the bargaining table and still others in diplomatic relations. We are certainly not a beehive; we are diverse and strength comes from acknowledging division of labour.

May I take this opportunity to congratulate our Lead for Clinical Skills Assessment, Dr. Doreen Cassar, who has recently been appointed to act as an examiner for the RCGP South East Asia MRCGP(INT) exam. This shows the excellence we can reach by doing things properly and by interacting with our external colleagues. Such appointments can only come because you have been recognized and trusted. I would also like to congratulate Dr. Tania van Avendonk who has received a Certificate of Commendation by the same RCGP. Prof. Valerie Wass was here for the occasion to present the certificate. Tania has worked very hard in the field, being not only Treasurer but an excellent logistics officer, does quality assurance for the Summative Assessment examination and indeed organises the College's CPD. She continues to do this even when the going became tough. I thank the RCGP for recognising our members in the work they do. The same body will recognise those who have worked to make this Summative Assessment what it is today.

Tania van Avendonk's ceremony for the award of the Certificate of Commendation by the Royal College of General Practitioners for which occasion Prof. Valerie Wass, OBE visited us in Malta. Invited for the occasion were council members and spouses and her famly.

Silver service - 25 years of activities by the Malta College of Family Doctors (1990-2015)

Dr Mario R SAMMUT

INTRODUCTION

The Malta College of Family Doctors is an autonomous academic institution that was formally set up in 1990 with the object to encourage, foster and maintain the highest possible standards in family medicine in Malta, and to sustain and improve the professional qualifications of members of the medical profession in Malta who are engaged in family medicine.

ORIGIN & DEVELOPMENT

The need for advancement of family medicine in Malta had been felt for a long time, but any such activities were not possible before the end of the ten-year medical dispute in August 1987. One exception was a 9-month intensive course for family physicians, conducted in 1987-88 by the late Prof. Douglas Johnson of the University of Toronto under the auspices of the University of Malta. Preparations for such course had been made by the Faculty of Medicine and Surgery prior to August 1987. In March 1988, three family doctors, namely Dr Denis Soler, Dr Wilfred Galea and Dr Ray Busuttil, were appointed to a General Practice Sub-Committee of the Postgraduate Medical Committee (PMC) of the University of Malta's Faculty of Medicine & Surgery. Their remit was to devise a development plan for family medicine in Malta.

In their report presented to the PMC in November 1988, four areas were outlined for future development:

(1) The development of a Department of Family Medicine within the Faculty of Medicine;
(2) The establishment of a programme of continuing medical education for family doctors;
(3) The development of a vocational training programme in family medicine;
(4) The setting up of a Malta College of Family Doctors.

As a result of intensive lobbying by these three doctors, Dr Alistair Donald and Dr Edwin Martin, chairman and member of the International Committee of the Royal College of General Practitioners, were invited to Malta in November 1989 to assess the situation and offer their advice. These five gentlemen worked hard together to produce a charter for a proposed Malta College of Family Doctors, and the formation of the College in fact was formally announced by Dr Soler in the presence of Dr Donald and Dr Martin during a Postgraduate Medical Committee Meeting in November 1989.

A provisional Committee was set up to draw up a College Statute, and both were formally endorsed during the College's first general meeting on the 4th April 1990, with Dr Denis Soler as College President, Dr Wilfred Galea as Vice-President and Dr Ray Busuttil as Honorary Secretary. Picture 1 shows members of the College Council and guests in 1994.

PLANS & POLICIES

The MCFD made an impact on the proposed reforms in primary health care services in Malta in the early 1990s, before these were eventually shelved for political reasons. It had earned itself representation on the Family Doctor Scheme Council, which had been envisaged as the body to run the general practitioner service. The College's role was to be not only an advisory one, but it would have been responsible for the organisation of the compulsory refresher course for doctors joining the scheme. Its functions would have included also the evaluation of the suitability of practice premises, the accreditation of doctors for the receipt of the CME allowance, and the assessment of practices for the receipt of the good practice allowance.

After recommending a standard Data Set for Computerised Medical Records in 1996, the College started planning for the development of a full Computerised Medical Records System for family

doctors. Its aim was to facilitate good quality continuing care, health screening through recall systems, the keeping and exchange of statistics, and the performance of research and audit. In 1998 the College signed an agreement with the Transition Project from the University of Amsterdam to use the Computerised Medical Records System - TRANSHIS, based on ICPC – the International Classification for Primary Care, and developed for family doctors by Prof. Henk Lamberts and Dr Inge Okkes (Picture 2). Transhis was launched during 2 workshops held in February 2000, with 17 doctors signifying their readiness to use the programme under the coordination of Dr Jean Karl Soler. By the end of 2003, Maltese users accumulated 3 full years of data on the system.

The MCFD has always pushed for the creation of a culture for research in family medicine, as it believes that it is through research that academic credibility and status can be developed further. In fact the College approved a Research Policy and Planning Document in 1997 to promote research in Family Medicine in an organised way, to improve the status of the specialty, and enhance:

- the academic development and career prospects of family doctors,
- knowledge and information on family practice, enabling plans for its future, and
- the health and well being of the population.

The College developed a Strategy for the Future of the Malta College of Family Doctors and of Family Medicine in Malta in 1998-99. The most important and urgent targets were identified as the accessing of members, a policy document, patient initiatives, the definition of standards, a patient charter, and a PR exercise. In fact, a Patient Charter, entitled 'You and Your Doctor', was presented to the College Council in March 1998. A Family Doctor Directory, initially drawn up in 1994, was revised and updated during 1998, when it consisted of 269 full-time and 34 part-time family doctors. Such a directory was intended as just an interim step towards the College's ultimate aim of establishing a proper Specialist Register of family doctors who have undergone Specialist Training in Family Medicine.

Although a Policy Document entitled 'The College - History and Future Development' was prepared for the College by (then) Honorary Secretary Dr Ray Busuttil in March 1993, this unfortunately was never published. Then, in line with the declared intention of the World Health Organisation to define a charter for General Practice/Family Medicine in Europe, a Policy Document on Family Medicine in Malta was drawn up and approved by the College in 1998. Its objective was to sensitise the public, the Government and University to the importance of family medicine, and to upgrade the status of the family doctor as a specialist in his/her own right. The publication of this policy document was intended to serve as a springboard for the launch of a Specialist Training Course in Family Medicine, which however did not materialise at that stage. The International Committee of the Royal College of General Practitioners (RCGP), the European General Practice Research Network (EGPRN) and the Royal Society of Medicine, amongst others, had confirmed their willingness to help in its implementation. What was lacking to bring it to fruition was the necessary funding, together with the support of the University, the Department of Health and the Government.

In 1998 the MCFD was invited by the Minister of Health to start discussions, together with the Department of Primary Health Care and the Medical Association of Malta, for the reorganisation of Primary Health Care. In 1999, the College President gave the College Council an overview of the ensuing document, entitled Reforms of the Primary Health Care Services. Three systems were to be proposed to the cabinet for a definite commitment by the government before one was developed. However the proposed reforms were turned down, reportedly due to financial reasons.

In 2001, the College Council agreed to the following strategic recommendations for the further development of the College:

- Marketing of the College through patient handouts, newspaper articles and multimedia presentations;
- Sub-committees to be set up regarding group practices, doctor-patient registration cards, and membership by examination;
- The introduction of membership/certificate courses;
- The seeking of strategic partner/s.

Other topics proposed included GP cooperatives, practice certification, a College archive, the Journal on CD, and small group meetings.

In 2001, the College Council agreed to develop a two-year course leading to membership by examination (MMCFD). However, in 2003, the Council noted that other countries around the world are negotiating with the RCGP for certain concessions to allow local trainee GPs to do the highly reputable MRCGP International.

Council thus agreed that the way forward for Malta should be for the MCFD to provide assistance (through a Teachers' Group) for local candidates to prepare for the MRCGP[INT], rather than to reinvent the wheel by developing an expensive local course and examination.

CPD PROGRAMME AND JOURNAL

There being no formal training in family medicine in Malta, the College launched a Continuing Professional Development Programme in September 1990, originally in the form of a three-evening meeting, with educational events to this day being held in each term of the academic year - Autumn, Winter and Spring - under the direction of a team currently led by Dr Philip Sciortino. Other ad-hoc meetings are also organised (Picture 3). A system of accreditation of CME activities was initiated in 2000, with continuing membership of the College depending on the accumulation of sufficient credit units within this scheme.

The credibility and status earned by the College in the first three years of its existence resulted in the Postgraduate Medical Committee of the University's Faculty of Medicine formally passing on to the College in 1993 the organisation of all postgraduate educational activities for family doctors. For a time, the College was also asked to act as coordinator of the whole CME calendar for the PMC.

In 2001, a Strategy for the College's CPD Programme was presented to the College Council, consisting of the following objectives:

- The presentation be improved as regards venue, publicity and refreshments;
- The academic content be improved according to the needs ascertained through research;
- The format of teaching be practice-based and informal, taking place in small groups;
- The topics be not always clinically based, but should also include other topics like academic family practice and practice management.

Highlights of early academic activities organised by the College include:

- 5-day Family Doctor Training Seminar on Community Psychiatry co-organised in May 1994;
- 3-day Joint Seminar on Paediatrics and Obstetrics & Gynaecology co-organised in November 1996;
- 6th Mediterranean Medical Congress & 2nd Mediterranean Summer School of the Mediterranean Medical Society, organised in Malta by the College on 5-10 September 2000;
- Brief Intervention Training Workshop on Smoking Cessation in General Practice co-organised with the Irish College of General Practitioners on 18 October 2003 (Picture 4).

In September 1990, the first issue of *'It-Tabib tal-Familja'*, the Journal of the Malta College of Family Doctors, was issued a humble four-page newsletter with Dr Godfrey Farrugia as editor (Picture 5). Dr Farrugia was replaced as editor by Dr Jean Karl Soler in 1993, with the newsletter being converted to a colour journal in 1995 and upgraded academically in 2000 with the appointment of three international peer reviewers, an international scientific advisory board to recruit papers from the Mediterranean region, and a change in name to *'The Family Physician - It-Tabib tal-Familja'*. In 2005, Dr Noel Caruana was appointed the new editor, and the journal was renamed *'The Maltese Family Doctor'*. In 2012, the College Council relaunched the journal under the name of the *'Journal of the Malta College of Family Doctors (JMCFD)'* which is being issued three times a year with Prof. Pierre Mallia as Editor (Picture 6).

The JMCFD is available online together with other resources useful for College members on the MCFD website at www.mcfd.org.mt/jmcfd. An MCFD website had been launched in February 1996 through the initiative of Dr Wilfred Galea, one of the College founders, courtesy of Grazio Falzon's 'Malta Virtuali' in the USA. In October 1996, the site exchanged its host for TheSynapse Network here in Malta, and subsequently was transferred to the current URL www.mcfd.org.mt by Dr Renzo De Gabriele. The website was later reconstructed by Dr Kenneth Vassallo and is currently maintained by webmaster Jan Willem van Avendonk.

INTERNATIONAL COLLABORATION

The Malta College of Family Doctors has maintained the excellent relationship it has had with the Royal College of General Practitioners since its inception. A certificate dated 4 September 1990 presented to the Malta College by the RCGP through Dr Edwin Martin (the RCGP's Malta Fellow during 1990-3) gives evidence to this (Picture 7). This certificate states that the RCGP *'regards the Malta College as a sister body that will set the standards of education in family medicine in Malta and as the body which will, where appropriate, give accreditation to doctors undertaking approved training for family medicine'*. Besides a Workshop on Counselling in Family Practice in 1995 (Picture 8), the RCGP's help resulted in a 5-day Teachers' Course in Family Medicine run with the Bedfordshire &

Hertfordshire Faculty in 1993 (Picture 9), the sponsorship of College representative Dr Philip Sciortino in an International Course for Teachers of General Practice in 1997-98 (Picture 10), and the following other teachers' courses:

- 2002-3: 9-day Teachers' Course held in collaboration with RCGP (Picture 11);
- 2004: 10-day RCGP-MCFD Teachers' Course (Picture 12);
- 2006: 5-day MCFD-RCGP Teachers' Course Module on 'Mentoring & Appraisal' (Picture 13);
- 2006: MCFD-RCGP Assessment Workshop.

These were the first steps in preparation for the local introduction of specialist training in family medicine.

Over the years the College developed affiliations and links with other important organisations:

- the Canadian College of Family Physicians, most especially with the late Professor Douglas Johnson who had given his unstinting help and support in all of the College's major projects;
- the Irish College of General Practitioners, through the provision of distance learning programmes and the organisation in Malta of a Brief Intervention Training Workshop on Smoking Cessation in General Practice during 2003;
- the World Organisation of Family Doctors – WONCA and the European Society of General Practice/Family Medicine - WONCA Europe with its various network organisations: the European Association for Quality in General Practice/Family Medicine - EQuiP, the European General Practice Research Network – EGPRN, the European Academy of Teachers in General Practice/Family Medicine – EURACT, and the European Network for Prevention and Health Promotion in General Practice/Family Medicine – EUROPREV.

The College's membership of the World Organisation of Family Doctors (WONCA) was boosted in 1996 when two Council members, Dr Wilfred Galea and Dr Jean Karl Soler, were appointed to the WONCA Working Party on Informatics. Moreover, in 1998 Dr Soler was appointed to the WONCA International Classification Committee. In 1995 the MCFD became a founder member of WONCA Europe and automatically a member of the WONCA Europe Council, and the College was also honoured by the WONCA Europe in 1997 when two Council members (Dr Denis Soler and Dr Mario R Sammut) were invited to chair sessions in its Prague Conference that year (Picture 14).

While the MCFD obtained affiliation with EQuiP in 1994 with whom it was ably represented by Dr Anthony P Azzopardi, local ties are especially strong with the other three WONCA Europe network organisations - EGPRN, EURACT and EUROPREV. No less than three workshops of EGPRN have taken place in Malta in 1996 (Picture 15), 2004 and 2013, with EGPRN research-methods courses also held in Malta in 1999 (Picture 16) and 2004. Former MCFD Council Members Dr Anthony Mifsud and Dr Jean Karl Soler were instrumental in the organisation of these activities in the role of Malta's national representative to EGPRN, with Dr Soler also being elected Chairman of EGPRN in 2013.

In 2008, EURACT held its Spring Council Meeting in Malta in 2008 (Picture 17) and also played a role in the organisation in Malta of courses and a workshop as follows:

- 2007: 5-day MCFD-EURACT-RCGP Teachers' Course (Picture 18);
- 2008: EURACT-MCFD International Workshop on Lifelong Learning in Family Practice (Picture 19);
- 2009: 5-day MCFD-EURACT Teachers' Course.

In his role as Malta's national representative to EURACT since 2004, former MCFD Honorary Secretary Dr Mario R Sammut facilitated the participation of local family doctors in various EURACT teachers' and assessment courses abroad, and in 2013 he was elected as Honorary Secretary of EURACT.

Dr Mario R Sammut also spent 14 years (1999-2013) as a member of the Coordinating Team of EUROPREV, and on behalf of the MCFD was the local coordinator of the EUROPREV survey on the attitudes and knowledge of GPs in prevention and health promotion held in 2000 and of the EUROPREVIEW Patient Study to elucidate the beliefs and attitudes of patients regarding preventive services and lifestyle during 2008-9.

UNDERGRADUATE AND POSTGRADUATE TEACHING IN FAMILY MEDICINE

The College over the years had repeatedly proposed to the relevant authorities the establishment of a separate Department of Family Medicine within the University Faculty of Medicine & Surgery. This would provide instruction in family medicine for undergraduate medical students, and was also envisaged to be involved, in liaison with the College, in the setting up and running of Postgraduate Vocational Training in Family Medicine.

Through such pressure from the College, the post of part-time lecturer in general practice within the Department of Public Health in the Faculty of Medicine was instituted on 1st January 1991 with the appointment of Dr Ray Busuttil.

After further lobbying by the MCFD, the Dean of the University Faculty of Medicine & Surgery, Prof. Mark Brincat, announced plans for the set up of a Department of Family Medicine during a meeting with a College delegation on the 3rd February 1999. Dr Denis Soler, as President of the College, was invited to chair an ad-hoc Advisory Committee on Family Medicine, whose main aim was to prepare an undergraduate and postgraduate programme for the new Department of Family Medicine. The Department was formally set up in April 2001 with the appointment of 7 lecturers (all College members), and Dr Denis Soler as Head of Department.

After his retirement in 2013, Dr Soler was replaced by Dr Philip Sciortino as Head and the department presently consists of 8 part-time lecturers who provide an undergraduate teaching programme of lectures, tutorials (face-to-face and electronic) and community placements for medical students in their 4th year. The Department of Family Medicine also runs a postgraduate MSc in Family Medicine, with the first cohort of candidates graduating in 2009.

Since 2001, MCFD members have participated through distance-learning in Diplomas in Therapeutics, Prevention and Women's Health, and a Certificate in Diabetes all held by the Irish College of General Practitioners (Picture 20). Then, during 2004-7, MCFD Council Member Dr Jean Karl Soler facilitated the participation of College members in the University of Ulster's distance-learning Diploma/MSc in Primary Care & General Practice (Picture 21). Last but not least, in 2005-7 the MCFD organised an inaugural Diploma in Family Practice coordinated by Prof. Pierre Mallia that was successfully completed by twenty-seven local doctors and was given recognition by the Medical Council of Malta (Picture 22). Kindly sponsored by St Philip's Hospital, it consisted of eighteen assessed modules and was the first diploma offered by the College and the first formal post-graduate diploma in family medicine organised by local doctors for local doctors.

SPECIALIST STATUS AND TRAINING IN FAMILY MEDICINE, THE MMCFD AND THE MRCGP [INT]

In 2000, a memo regarding the introduction of a 3-4 year course in Vocational Training in Family Medicine was approved by the Director General (Health), the Medical Association of Malta and the MCFD. In 2001, lists of criteria for the selection of twelve trainers and one coordinator for the course were approved by the College Council and forwarded to the Director General (Health). In 2003, an agreement on the subject was reached by the Health Division and the Medical Association of Malta, and a call for applications for a coordinator was issued in November 2003, to be followed by a call for applications for the posts of trainers.

In the meantime, in May 2002 the College was invited by the Health Division to form part of the interim Specialist Accreditation Committee (SAC). In November 2002, during meetings of College representatives with the Minister of Health and the Director General (Health), Family Medicine was guaranteed specialist status in the forthcoming Health Care Professions Act. This was confirmed in correspondence exchanged with the Medical Association of Malta, where it was agreed that Family Medicine is put at par with other specialties in the list of specialties, and that family doctors on the specialist list are nominated by the SAC on the recommendation of the MCFD. The new Health Care Professions' Act was passed through the Maltese Parliament in 2003 in preparation for Malta's accession to the European Union in 2004, thus ensuring specialist status for Maltese Family Doctors.

Malta's EU membership made Specialist Training in Family Medicine mandatory and a Specialist Training Programme in Family Medicine (STPFM) for Malta was drawn up by the College's Education Committee chaired by Dr Mario R Sammut and approved by the MCFD Council in 2005 and subsequently also approved by Malta's Specialist Accreditation Committee in 2006. A second version of the programme also edited by Dr Sammut was finalised and approved in 2011.

An Extraordinary General Meeting in 2006 approved an 'MMCFD Policy Document' setting up the Membership of the Malta College of Family Doctors (MMCFD) as a degree of excellence, to be awarded after an examination at the end of formal Specialist Training in Family Medicine (Picture 23). The document also set up an acquired rights provision, through which all Maltese Specialists in Family Medicine registered with the Specialist Accreditation Committee were awarded the MMCFD without the need for an exam on joining the College (Picture 24). On 10th May 2013, the first Honorary Fellowship of the Malta College of Family Doctors was bestowed on the founding President of the MCFD, Dr. Denis Soler (see pages 18-19).

Specialist training in family medicine was launched in 2007 following the appointment in 2005 of Dr Mario R Sammut as STPFM Coordinator, who was subsequently

joined in 2008 by Dr Gunther Abela; both still occupy the role of Postgraduate Training Coordinator in Family Medicine today. Within the 3-year programme, Maltese GPs who had undergone Training Courses in Family Medicine held by the MCFD / RCGP / EURACT in Malta and by EURACT abroad are utilised as GP trainers to whom GP Trainees are attached on a one-to-one basis. On-the-job training is provided 50% in family practice and 50% in hospital specialities, complemented by weekly academic group activities.

Concurrently, MCFD President Pierre Mallia and RCGP President Roger Neighbour signed a Memorandum of Understanding in 2006 on behalf of the two Colleges to enable Maltese family doctors to attain the MRCGP [INT] (Picture 25). In this respect Prof. Adrian Freeman, the RCGP's International Development Advisor (IDA) for Malta, worked closely with three successive MCFD Councils presided by Prof. Pierre Mallia (2003-6), Dr Mario Grixti (2006-9) and Dr Andrew P Zammit (2009-11) to ensure that the Malta College's first summative examination leading to the award of MMCFD would also qualify successful candidates to apply for the MRCGP [INT] (Picture 26).

As part of such preparations, a Curriculum Board (2008-10) appointed by the MCFD and made up of Dr Alessandra Falzon-Camilleri (Chairperson) and Dr Daniel Sammut finalised 'A Curriculum for Specialist Training in Family Medicine for Malta' (Picture 27). Moreover, the College also appointed an Assessment Board (2008-10) formed of Dr Andrew P Zammit (Chairman), Dr Doreen Cassar and Dr Patricia De Gabriele to set up the MMCFD summative examination.

Following an MMCFD Pilot Examination held in February 2010 and an MCFD-RCGP Assessment Course for Examiners in Family Medicine held in May 2010, the first MMCFD summative assessment took place consisting of the Work-Based Assessment, the Applied Knowledge Test and the Clinical Skills Assessment. All 11 candidates were successful and were awarded the MMCFD and recommended for certification as Specialists in Family Medicine (Picture 28). In August 2010, the RCGP granted formal accreditation to the MMCFD postgraduate licensing examination for the MRCGP[INT] (Picture 29), which accreditation has since been extended until 2016.

The College approved a proposal from Dr Jurgen Abela that the candidate who places first in the MMCFD summative examination be awarded the 'Saviour Cilia Award' in memory of the late former MCFD Secretary for Communication Dr Saviour Cilia who sadly passed away on 2nd June 2007, aged 40 (Pictures 21 and 30). That same year, on the 28th August 2007, the College sadly lost another former Council member, Honorary Treasurer Dr Michael Cordina, who passed away at the age of 56 years (Picture 31).

Another 39 GP Trainees (totalling 50 in all so far) have completed training to be certified specialists in family medicine after passing summative examinations held during 2011-2104 under successive MCFD Councils presided by Dr Jurgen Abela (2011-12) and Prof. Pierre Mallia (2013 to date). The Assessment Committee for the MMCFD exam of 2011 was formed by Dr Patricia De Gabriele (Chairperson), Dr Doreen Cassar and Dr Dominic Agius. This committee was replaced in 2012 by a Specialist Assessment and Training Board in Family Medicine (Dr Patricia De Gabriele – Chair, Dr Doreen Cassar, Dr Dominic Agius and Dr Renzo De Gabriele), and then in 2013 by an Assessment Board led by Dr Marco Grech (Assessment Lead) with Dr Doreen Cassar (Lead for Clinical Skills Assessment), Dr Patricia De Gabriele (Applied Knowledge Test Lead) and Dr Dominic Agius (Examiner Lead). After the latter two resigned in 2013 and 2014 respectively, Dr Grech took on the role of AKT Lead while Dr Philip Sciortino was appointed Examiner Lead. A Quality Assurance team led by Dr Tania van Avendonk was also set up to assure the quality of the AKT and CSA. In 2015 Dr Jeremy Stupple replaced Prof. Adrian Freeman as the RCGP's IDA to Malta.

In order to maintain the number of GP teachers and the quality of teaching and assessment being provided, the College organised an MCFD Assessment Course in 2012 and an MCFD Teachers' Course in 2014. Preparations are underway for more courses, both for new GP teachers and also for current ones, the latter in collaboration with the Health Division's Primary Health Care Department.

CONCLUSION

The four areas that had been outlined for future development in the General Practice Subcommittee's 1988 Development Plan for Family Medicine in Malta have all been achieved as follows:

- The Malta College of Family Doctors was founded in 1990;
- A programme of continuing medical education for family doctors was established in 1990;
- A Department of Family Medicine within the University of Malta was set up in 2001;
- Specialist training in family medicine in Malta was launched in 2007.

The family doctor in the European Union today is considered as a specialist and needs specialist training and registration to practise as such. The College has gone beyond the four areas listed in the 1988 Development Plan to fulfil the aim of its 1998 Policy Document towards upgrading the status of the family doctor.

ACKNOWLEDGEMENTS

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Call for Fellowship of MCFD

Dear Colleague,

As decided by the Annual General Meeting of 2015, the Malta College of Family Doctors will be offering a number of Fellowships.

The award of Fellowship shall be offered, upon application, to those members who satisfy the following criteria:

a. Have been registered on the Specialist Register for a period of at least ten years.
b. Have contributed to the work of the Malta College of Family Doctors for a minimum period of five years by being a member of council, or being a member of a subcommittee listed among those acceptable for Fellowship (see below), or having served regularly in a capacity, such as examiners, etc., which capacity must also be on the approved list (see below).
c. Show an interest in Family Medicine beyond their immediate work and practice.
d. Are in good standing with the MCFD, including being fully paid up members.
e. Have an acceptable record of CME attendance.

According to the statutes, the College shall award not more than ten Fellowships per year, unless there are special circumstances decided upon by council. Those college members who obtain fellowship shall have the designated letters FMCFD after their names and shall drop the letter MMCFD.

As discussed in the AGM, the selection shall be done by a board nominated by the Council until such time as there is a sufficient number of fellows to form a selection board. The decision of the board will be final.

Interested members are to send a letter with due reference to the criteria above on the following address:
MALTA COLLEGE OF FAMILY DOCTORS,
127, Professional Centre, Sliema Road
Gzira, GZR 1633 MALTA (Europe)
or to email: **contact@mcfd.org.mt**
cc **secretary@mcfd.org.mt**
Closing Date: 15th October 2015

MCFD has the following subcommittees:
Education Subcommittee, Editorial Board for the Journal, and Subcommittee for revision of statutes

MCFD has had, along the years, representatives to:
EUROPREV, WONCA and EURACT

Prof. Pierre Mallia
President MCFD

Dr Jason Bonnici
Hon. Secretary MCFD

Silver service
25 years of activities
by the Malta College of Family Doctors (1990-2015)

Picture 1: MCFD Council members & guests at 5th Anniversary Dinner 1994

Picture 2: Transhis Introductory Workshop 1998

Picture 3: MCFD CPD Meeting 2005

Picture 4: MCFD-ICGP Brief Intervention Training Workshop in Smoking Cessation 2003

Picture 5: Issue 1 of 'It-Tabib tal-Familja' September 1990

Picture 6: JMCFD Issue 1, August 2012

Picture 7: RCGP certificate dated 4 September 1990

Picture 8: MCFD-RCGP Workshop on Counselling in Family Practice 1995

Picture 9: MCFD-RCGP Beds and Herts Faculty Teachers Course 1993

Picture 10: Dr P Sciortino (centre) with Dr M Jezierski and Dr JV Howard of the RCGP, 2002

Picture 11: MCFD-RCGP Teachers Course in Family Medicine 2002-3

Picture 12: MCFD-RCGP Teachers Course in Family Medicine 2004

Picture 13: MCFD-RCGP Teachers Course on Mentoring & Appraisal 2006

Picture 14: Dr V Benes, President WONCA Europe Prague Conference 1997, with Dr D Soler and Dr MR Sammut, MCFD

Picture 15: EGPRN Meeting Malta 1996

Picture 16: EGPRN Research Methods Course Malta 1999

Picture 17: MCFD hosts EURACT Council Meeting in Malta 2008

Picture 18: MCFD-EURACT-RCGP Teachers Course in Family Medicine 2007

Picture 19: EURACT-MCFD International Workshop on Lifelong Learning in Family Practice 2008

Picture 20: ICGP Diploma in Women's Health Graduation, Dublin 2005

Picture 21: Maltese graduates in MSc PC&GP (Ulster), 2004-7, including the late Dr Saviour Cilia (bottom left)

Picture 22: Diploma in Family Practice Coordinator Prof. P Mallia congratulated by EURACT President Dr E Zebiene, 2008

Picture 23: MCFD Membership Board 2006

Picture 24: MMCFD Awards Ceremony 2006

Picture 25: MCFD President Prof. P Mallia and RCGP President Dr R Neighbour signing a Memorandum of Understanding in 2006.

Picture 26: MRCGP(INT) Development Days, RCGP, London 2006

Picture 27: Presentation of STPFM Curriculum to RCGP IDA, Malta 2009

Picture 28: MMCFD Graduates 2010 of the Specialist Training Programme in Family Medicine

Picture 29: MCFD-RCGP visit to Postgraduate Medical Training Centre, Mater Dei Hospital, Msida 2010

Picture 30: Dr Nadia Cilia with the 'Saviour Cilia Award' and Prof. Pierre Mallia 2013

Picture 31: The late Dr Michael Cordina (bottom right) at the MCFD 15th Anniversary Dinner 2004

FMCFD & MMCFD Graduation 10th May 2013

Oath of the Malta College of Family Doctors

Aware of the importance in practicing family medicine I swear:

- To practice in freedom and independence of mind without undue influence
- To pursue the defence of life and to relieve suffering
- To treat each patient with the same care and commitment regardless of race, religion, nationality, social status and political ideology
- To eliminate any form of discrimination in health care
- Not to commit acts which can deliberately cause the death of a person
- to foster trust and fidelity with the patient
- to adhere to human solidarity in my activities
- to uphold my professional reputation even outside my practice
- to meet with colleagues in cases of conflict
- to respect and facilitate the right of patients to a free choice of doctor
- to provide emergency assistance to those in need
- to observe the rules of trust, confidentiality and privacy
- to pursue in my continuing professional development
- to observe the rites, ethics and laws of the medical profession
- to observe the fiduciary nature of the doctor-patient relationship


Saviour Cilia Award
2012

Working with patients - a new paradigm

Prof. Pierre MALLIA

As part of our 25th anniversary 'celebrations', Council has launched a number of activities. Amongst these we felt that we have to honour members who have contributed in some way to the advancement of family medicine through the MCFD. A call is being issued for the first group which will be chosen by a selection board. We will give these awards, along with the graduation certificates of trainees and other certificates, in the forthcoming gala dinner to celebrate the event (notice of the date will be given shortly).

Our successful work and collaboration with the Royal College of General Practitioners (RCGP) has led to us taking good example from the masters in the field. One of these is working with patients. How can working with patients improve the College? Well, it is obvious that understanding patients and helping them to participate can improve the delivery of health care. It is less evident that patient feedback can actually help us to improve training and the areas which define family medicine.

When we first conceived of the Diploma in Family Practice we thought about modules which define family medicine and distinguish it as a speciality. Each module lasted a month and there were eighteen modules. It was formulated on international diplomas as at the time the National Equivalence Board was not in existence. We already had a contention, incidentally, whether it was the first diploma. Actually it was not – the first people to obtain a diploma in family practice were those who had embarked with the University of Ulster, promoted here by the then member of council, Dr. Jean Karl Soler, who eventually become a visiting professor there. Those who wished could continue to a Masters. Also, Dr. Mario Sammut points out that there was a nine-month 'course' in family medicine offered in the late eighties. If we were to push it we should also mention actual diplomas and certificates brought in from the Irish College of General Practitioners through the efforts of Dr. Anthony Azzopardi and Dr. Mario Grixti. And so on.

But the Diploma in Family Practice was not only the first to be organised by the College but the first to be developed locally and delivered solely by local tutors, all expert in one of the eighteen modules. It is therefore rightly called in Mario Sammut's article as the first official diploma of the MCFD. Unfortunately it was not kept up. The good news is that there is talk on Council – and perhaps this will be one of the efforts of the next council – not only to have it again but also to collaborate with the Department of Family Medicine of the University of Malta in order to have a joint diploma recognised also for its European Equivalent Transfer Credits (ETCs).

This is where patients come in. I am participating along with patients' groups in a project which involves patients in the development of new drugs (European Patients' Academy on Therapeutic Innovation - EUPATI). This involves a process of developing drugs which target the symptoms patients wish to have targeted and not which only doctors perceive as disabling. Perhaps patients want a drug for Parkinson's Disease which tackles the Parkinsonian Facies. Collaborating with patient groups can help us understand, through quantitative and qualitative analyses and interaction with patient groups, what they would like doctors to be. Studies in the British Medical Journal have shown already that patients prefer compassion to competence in doctors. Now one cannot say that compassion is a more important quality in doctors than competence and someone can legitimately say that, with all due respect, it is the profession that is responsible for standards. But this does not mean that a module in what it means to be compassionate, with workshops on role play and counselling skills, cannot be introduced in such a diploma following important patient feedback such as this. A recent book issued by the Royal College of Psychiatrists on 'Intelligent Kindness' is a must-read for many doctors in this regard.

The Malta Health Network (MHN) is the local umbrella organisation for the many patient groups that exist. It is the organisation which is recognised by the government and at European level. My interaction with them came through two other heads of patient groups whom I had met in a meeting of the European Forum for Good Clinical Practice (EFGCP). Mrs. Gertrude Buttigieg and Vice-President Mr. Philip Chircop are very active people. With the former I have discussed having a meeting along the lines of EUPATI (whose patient platform already exists in Malta) to discuss ways in how the MCFD can be of service and understand patients in this regard. The RCGP also gives us a good example and I am following what work has been done in this regard. One feasible thing would be to have health references on our website and perhaps forums and blogs. But certainly the MCFD is a platform to apply for European projects, such as ERASMUS, in which we can work together with patients toward education and feedback. It is mutually beneficial.

In this regard I should mention that considerable progress has been made to renew the Memorandum of Understanding between the MCFD and the RCGP. I call by Skype our International Development Advisor (IDA) in this regard and we speak about several issues, including the recognition of our Fellowship. There are those who now have the MRCGP(INT) who will certainly wish in the future to have FRCGP(INT). The latter is still a novelty but any member, international or not, can apply for the Fellowship. My suggestion is that since MRCGP(INT) is contextual, that is it has to be done with local training and for the local scenario, then the FRCGP must follow the FMCFD. As we have defined in our statute, the FMCFD is contextual as well and dependent on an interest in Family Medicine beyond one's practice and academia, but with involvement to advance the medical field in this area through the MCFD. Working with patients to improve health care, outcomes and understanding is an area which can involve many doctors. Although academic papers will be involved, the overall aim would be enhancing the role of patients in health care. If this is not advancing Family Medicine, what is? Family Medicine has evolved like families themselves. It was a young field 50 years ago; a young 'family'. The family has grown. Patients are not subjects as children are in families any longer. Many patients educate themselves through the internet. Patient organisations are forming. We have to recognise that society has grown. Paternalistic attitudes are outdated. Just as many of us turn for help to our grown children who have studied in a particular field, just as we respect our children to be autonomous when they grow, family medicine has to do the same.

During its first 15 years, the College established its name and recognition internationally. It also put family medicine on the list of specialities. The next ten years established us as a recognized educational body for Vocational Training towards this speciality and we obtained the accreditation of the RCGP and also became a voluntary organisation so that we may benefit from education EU funds and others. The next stage is celebrating our status as part of the 'family'. This can only be done by collaborating with families, working with them and creating an environment for understanding. Family Medicine is the body for Patient Advocacy. To be an advocate you need to interact with those whom you are advocating for. The American Academy of Family Physicians, the RCGP, and others have recognised this value of patients. So have associations and colleges in other specialities. It is time for the Malta College of Family Doctors to do the same. What better way to celebrate our 25th Anniversary?

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If you have a Masters Degree

Why not follow a PhD programme?

Contact: pierre.mallia@um.edu.mt

Sociological framework applied to a case report of diabetes in adolescence

Dr Marthese GALEA

ABSTRACT

A case report concerning a 10 year old girl with Latent Autoimmune Diabetes in the Young is described. Diagnosis, prevalence in Malta, and patient support are described and followed by a discussion of how diabetes affects the family of similar cases. Research on a Sociological Paradigm describing Microsystems, Mesosystems, Exosystems, and Macrosytesms is discussed with reference to the case report.

Keywords

Latent Autoimmune Diabetes in the Young, sociological model, family, psychologist

INTRODUCTION

Case report

The case report is about an adolescent girl with Latent Autoimmune Diabetes in the Young. This child presented at the age of 10 years with nocturnal polyuria. There was no family history of diabetes and the child was otherwise healthy. Repeated blood glucose tests were abnormally high during the night. Her urinalysis was negative. An oral glucose tolerance test was abnormal. Her C- peptide, anti-insulin, anti-islet and anti-GAD antibodies were normal initially, and then two years later, anti-insulin antibodies were positive. The child was managed with exercise and diet initially. Metformin was later introduced and later she also required glargine and short acting insulin.

The incidence of Latent Autoimmune Diabetes in the Young in Malta is increasing. Initially, there is an insulin independent period. This is similar to Latent autoimmune diabetes in adults which is often, wrongly, diagnosed as type 2 diabetes. Screening and early detection of these patients can lead to a significant reduction in the severity of onset and a better clinical outlook.

To make the diagnosis according to the American Diabetes Association, the fasting plasma glucose level needs to be more than 126mg/dl (7mmol/L) or a 2 hour plasma glucose level of more than 200mg/dl (11.1mmol/L) during 75g oral glucose tolerance test (OGTT) or a random plasma glucose more than 200mg/dl (11.1mmol/l) in a patient with classic symptoms of hyperglycaemia or hyperglycaemic crisis.

The American Diabetes Association states that treatment for type 1 diabetes mellitus (IDDM) involves careful control of blood glucose levels and regular blood monitoring is recommended. This also helps to adjust the dose of insulin accordingly. For the adolescent in the case report, care should be taken so that that insulin levels are balanced with meals, activities, stresses, and illnesses as these can affect blood glucose levels. Treatment also includes following an appropriate diet and getting the right amount of exercise. Caution is also taken that she does not become hypoglycaemic as this can be life threatening. It is vital that any hypoglycaemia is managed quickly and properly if it happens.

All the people involved with the adolescent's treatment in this case report are continuously updated on the condition.

Impact of IDDM on the adolescent and family members.

Parents of the adolescent suffering from type 1 diabetes mellitus need to be aware that adolescents are faced with a number of challenges due to the chronic condition they have (Davidson *et al.,* 2004). Treatment of IDDM involves several injections of insulin daily, self-monitoring of blood glucose, a prescribed meal plan, regular exercise and problem solving tactics to regulate blood glucose. This can cause psychological problems to the adolescent (Suhel *et al.,* 2013). Therefore, it is important to make everyone involved in the treatment of this adolescent, aware of the psychological impact of the condition and give the most significant emphasis to the strict maintenance of blood glucose.

Family behaviour and support are of the utmost importance. Hauser et al. (1990) mention that the parent and adolescent can be both to blame for family

problems, therefore it might be reasonable to address communication issues among family members to help in diabetes control and compliance. This has also been confirmed by the case report where during a period where family communication and conflict resolution were deteriorating, the adolescent found it difficult to adapt to the diabetes regimen.

It was also admitted by the family mentioned in the case report, that the burden of treatment affects their daily life and the regimen is often the reason of big conflicts between the parents themselves as well as between the parents and the adolescent. Conflict between the other siblings is also an issue, as the other siblings might see themselves less cared for, as the majority of the attention is given to the adolescent with diabetes.

As mentioned by the parents themselves, they are petrified at the consequences of managing their daughter's condition poorly. They believe that poor control can affect their daughter's personality, physical wellbeing, and the way she performs at school. This recalls the findings made by Anderson et al. (1981), where it was concluded that parents of children that do not have their diabetes well controlled are also concerned with the possibility that their child might develop personality problems. The adolescent in the case report stated that she felt under a lot of pressure due to the strict treatment regimen. She said that daily self-care behaviours can be tiring and difficult to adhere to.

Although a number of studies are available regarding the impact of IDDM on family and friends, large studies are limited, with very few being randomized, which might lead to bias in the conclusions. Also very few studies are qualitative with the majority being quantitative.

SOCIOLOGICAL PARADIGM

Diabetes is a difficult condition to live with and it requires a lot of self-discipline to keep the condition under control (Dovey-Pearce *et al.,* 2007). Adding to this is the constant worry and anxiety that affects the child, parents and people interacting constantly with the child.

The adolescent mentioned in this case report is like every adolescent who wants to live a happy and independent life. As Delamater (2007) mentioned, children in their teens underestimate the risks that neglected diabetes can cause to their health. Due to this attitude and combined with wanting to be independent the diabetes control of an adolescent can deteriorate.

The sociological paradigm that will be described, also involves psychologists that can include the family (Thompson *et al.*,2001).

In Thompson et al. (2001) one can notice that only mothers or female caregivers were included in the study while fathers or male caregivers were not. Furthermore no low income families were included in the study, which can make a significant difference in the results obtained. Adolescents that did not attend any clinic were not included. The sample used was relatively small especially for a condition like diabetes which is very common. Another point is that the children recruited had to be diagnosed for at least a year. Although a cut-off point needs to be done it could be argued that one year is too short a time. As these families would be at the beginning of the disease management, they could still be under shock resulting in either being very motivated to manage the condition well or the complete opposite as they might be in denial.

The family doctor and also a diabetes specialist need to be involved even more during the adolescent period supporting the even greater need for a sociological paradigm. Amiel *et al.* (2005) mentioned that, during adolescence, the changes that happen with the hormones can result in a lack of insulin sensitivity resulting in poor diabetes control.

Wysocki and Greco (2006) concluded that, for adolescents, the support that parents and extended family members can give is of utmost importance. Unfortunately, the older the child gets the less support she will get from the family. If the adolescent is not psychologically prepared for this independence their diabetes control can suffer (Hsin *et al.*, 2010). The independence that is gained by adolescents is quickly filled by the influence of their friends. This influence can have a positive effect on diabetes control as concluded by Bearman and La Greca (2002) or a negative effect as an adolescent with diabetes might not want to reveal to her friends that she suffers from diabetes resulting in lack of adherence to treatment and diet especially when in her friends' company.

Psychological support should not only be given to the adolescent but also to the parents. This can result in better diabetes management as the parents will be more prepared to deal with the child as they will be in a position to better understand her and adapt accordingly. Medical professionals can also offer support in the form of positive reinforcement and empathy and also by recommending the best treatments and monitoring available.

The adolescent in the case report can benefit from a sociological model. The ecological model gives the adolescent a structured support system. She knows where she can find the right support at the right time. The model can also help parents and other persons involved to know

who to rely on when they themselves need support. Ultimately, it is important to see the problems from the adolescent's point of view (Auslander *et al.,* 1993).

Types of Support

To better understand what is meant by support, it is first necessary to identify the different types of support that are mentioned in the studies. The literature emphasises mainly the social structure, tangible and perceived support.

According to Thomas *et al.* (2001) social structure can refer to the family structure and asks whether both parents are present, assuming that if both parents are present this can have a positive impact on the management of Type 1 Diabetes for the adolescent.

Social support can vary depending on the provider. For the support to have a positive outcome the adolescent needs to feel that she is receiving the support. Also the support needs to come from an entity that the adolescent respects otherwise it can have the opposite effect.

SOCIAL ECOLOGICAL MODELS

Human beings are influenced by their surroundings, the interactions and relationships that they experience throughout their lives.

According to Bronfenbrenner (2008) an individual develops thanks to the relationships that he or she builds along the years. He also adds that, for their relationships to have an influence, these interactions need to happen serially throughout the years and not as isolated events.

However, Bronfenbrenner (2008) also states that two persons who share the same environment and relationships might still have completely different characters. Therefore, another theory could suggest that every person has his own character and relationships and influences form his/her own perspectives which can be different from a person that is experiencing the same influences, leading to two completely different individuals although they were influenced by the same environment.

Microsystem

Microsystems involve the close relationships that adolescents have with their family, friends, etc. The adolescent is placed in the centre with every other person interacting with them. These relationships are not static and can change accordingly.

This adolescent, like the majority of her age, lives with her parents so it can be stated that primary support will be coming from them. This point has also been agreed by Hanna (2006). Anderson *et al.*(1997) showed how the parents' role to administer insulin and check the blood glucose is reduced significantly during adolescence. Wysocki and Greco (2006) stated that, during adolescence, the child will be learning how to administer insulin and take responsibility for the blood glucose monitoring herself. This is the case in this report. In contrast, this is not the case for diet where the parents, mainly the mother, still have control over what the adolescent eats.

Studies such as by Helgeson *et al.* (2009) strongly suggest that the higher the parental support the better the control of the child's condition. Therefore, having a decline in parental involvement with the control of their child's diabetes is not the ideal scenario. This can be the reason where mesosysytems can be very useful, as described further down below. Professionals such as psychologists can offer the support to parents, so they can understand their child, as well as supporting the adolescent herself. This can result in a better diabetes control.

Parents need to continue giving emotional support to their adolescents as is also the case in this report. This social support is of utmost importance if the parents want that their child's disease to remain under control. Studies such as those by Hsin *et al.* (2010) show that the control of the disease can diminish even if the adolescent takes proper care of their condition but is neglected by their parents.

In a number of studies the measurement of the support structure was not properly done as was the case in Anderson *et al.* (1999). In this study it was not the social support that was measured but the responsibility of every family member.

Friends play an important role during adolescence. However, to be able to give the best support the adolescent that suffers with diabetes needs to tell friends, a choice which is not preferred by the adolescent as concluded by Wysocki and Greco (2006). This is understandable as the adolescent thinks that she will not be understood by her friends, ending up with her being excluded. If this happens, according to La Greca *et al.* (2002), this can have a negative repercussion on diabetes control. The adolescent has to choose carefully who to tell.

To have good diabetes control it is important that at least someone in the group of friends knows about the condition and is willing to give emotional support. La Greca *et al*. (2002) stated that an adolescent with diabetes can become non-adherent when in the presence of her friends as she might not want to take insulin in their presence. In the case under discussion she has a greater chance of social support from her friends as, according to Helgeson *et al.* (2009), female friends are more inclined to offer emotional

support. In the same study it was concluded that females have a greater chance of developing psychiatric problems if conflict develops, leading to a reduction in diabetes care.

Greco *et al.* (2001) concluded that if adolescents with diabetes and their best peers were involved in training with the aim to improve the knowledge on diabetes and the social support that needs to come during diabetes care, the adolescent may have more positive support from friends for diabetes monitoring.

La Greca *et al.* (1995) concluded that the management of the condition had nothing to do with the support that friends give to the adolescent with diabetes. On the other hand, Skinner and Hampson (1998) concluded that greater support from friends can improve insulin administration.

During the study done by Helgeson *et al*. (2009) it is important to note that the measures used related to general support and not to support linked to the condition itself. Also, in La Greca *et al.* (1995), the study addressed the attitude towards the condition's management and failed to address the health status. Leaving key points out can be misleading when it comes to interpretation of the results in relation to the management of the condition and the health status specifically for diabetes.

Greco *et al*. (2001) used a limited number of adolescents in the study. Also, since the peers accepted to take part in the study, this already showed a high level of interest in the wellbeing of their friend suffering with diabetes. One cannot generalize that the same method can work on the other friends, as not everyone will have the same relationship with the adolescent suffering from diabetes.

Mesosystem

When more than one microsystem becomes related the system becomes a Mesosystem.This means that parents start interacting with the adolescent's friends, with the psychologists and even with their teachers. These relationships, as in the Microsystem, are not static.

Psychologists can play an important role in the management of diabetes during adolescence (Chawla *et al.,* 2009). Psychologists can also help parents by using specific therapies to help them adapt to pressures from society (Chawla *et al.,* 2009). However, it is still important to support the adolescent herself as psychological issues affecting the adolescent with diabetes can considerably affect glycemic control (Rose *et al.,* 2002).

If by this support the parents can better understand the adolescent, they might start to see the condition from her point of view and the adolescent can start to relate much better with her parents and accept their support more willingly, resulting in an improved management of their diabetes.

A support group could optimise this support for the parents. Friends can also be involved if they are willing. As discussed previously, friends play an important role during the adolescent period. Research is limited regarding the outcome of having social support for the family and adolescent suffering from diabetes. Lewandowski and Drotar (2007) concluded that the adolescents' type 1 diabetes control improved significantly because the mother was getting needed support

Psychologists in Malta are rarely involved in the treatment of adolescents with diabetes. Fortunately this is changing, with more diabetologists becoming aware of the benefits of having specialized psychological care in their team of health care professionals as has also been concluded by Steven *et al.* (2004).

It has also been noted that the support does not need to come from outside of the family unit. As with this study, the support came from the mother's partner. Horton and Wallander (2001) have demonstrated that support also has a positive effect on the person looking after the adolescent by reducing their stress and anxiety.

It has been noted in Lewanddowski and Drotar (2007) as well as in Horton and Wallander (2001) that only the mother is considered as being the care giver. There is no reference to the male partner who might give a significant support or even more support than the mothers assessed.

Exosystems

This system involves more than 2 relationships connected together but they do not need to be related to the adolescent. Decisions can be taken which can affect the adolescent but she is not involved in the decisions taken, such as decisions taken by neighbours, the community or even politicians.

For example, if in Malta, politicians decide to make the fight against diabetes a priority, this should positively affect the adolescent mentioned in the case report. Politicians also decide which medications are listed on the National Formulary. This decision affects both the adolescent and their parents, especially those who have to struggle financially when buying the medications and monitoring devices needed. Neighbours can also be supportive by taking care of the adolescent and her siblings when the parents need to have a break from everyday life or when an emergency occurs. Ideally, the neighbours need to be familiar with the diabetes treatment and monitoring especially to identify hypoglycaemia.

Macrosystems

Culture, values and principles play an important part. These are considered factors that influence the adolescent in an indirect way.

Family values in Malta are very strong, therefore, adolescents can be significantly influenced by their families even at an older age. This can be positive for adolescents suffering from diabetes as they have unconditional support available. Malta, being a small island, offers the advantage that families live close to each other and consequently support is always available at a few minutes' notice. Unfortunately, when it comes to the adolescent mentioned in this case report their immediate family members are either dead or abroad so they can only rely on their neighbours and close friends.

Being an island in the Mediterranean the diet that the Maltese eat can also be of benefit for the patients that suffer from diabetes. Unfortunately, like the majority of adolescents the girl mentioned in this case report prefers to eat fast food rather than fresh fish. Therefore, the Mediterranean diet does not really apply to her way of life, currently.

Culturally, the Maltese are not very physically active. Exercise is very important for patients suffering from diabetes. However, because the parents of the adolescent never regarded exercise as a priority for their child, with the reason they gave being that they were too busy with other issues, the adolescent is not involved in exercise.

Psychologists in Malta are normally associated with mental disease so the idea of going to a psychologist for support for diabetes care could be seen as a stigma for the Maltese parents of children suffering from diabetes.

CONCLUSIONS

The ecological framework raised awareness that, although it is normal that the parents come along with the child to the clinic, it is not only the parents that are affected by their child's chronic condition. This framework helped to understand that the social life of both the parents and siblings of the adolescents suffering with diabetes are shaped around the chronic condition that this child suffers from as discussed in Brown (2002). Apart from the parents, the older siblings in this case report are also asked to care for the adolescent; this is what usually happens as explained by Loos and Kelly (2006). Due to this, the adolescent with diabetes is seen as being preferred over her siblings thus creating conflict.

Economic problems are also an issue which affects the families of adolescents suffering from diabetes. The family in this case report is well off but they also complained about the extra expenses. This raises the constant struggles that are experienced by families with a child with diabetes. Apart from the burden of the condition itself with all its physical, psychological and emotional problems these families also need to worry about the financial situation. This inevitably increases the stress level as also mentioned by Canning *et al.* (1996).

Friends and teachers also need to be involved. In this case report friends and teachers are mentioned briefly. It could be argued that more effort needs to be made to involve friends and especially teachers in the care of the adolescents' diabetes. As mentioned by La Greca *et al.* (2002), having peers involved can increase the chances of managing the condition. A suggestion could be to involve the adolescent with other diabetic children of the same age. This can help to share experiences from which the adolescent can learn. These adolescents and their families can also support each other. Teachers also need to be well educated about diabetes. Apart from helping the adolescent and her family cope with the management of the condition, a teacher that is well informed about the condition can save the adolescent's life in cases of hypoglycaemia.

The ecological frame work also indicates how important it is for a health care provider to give ample time, not only to the adolescent but also to the parents or anyone else interested in the wellbeing of the adolescent. This time is needed to encourage more communication so the health care provider can better understand the issues that the parents are going through and, therefore, be able to give more focused and relevant advice.

In this case report there is no mention of any psychological support. This is because it was never offered. As discussed during the ecological framework, having this kind of support is fundamental to increasing the chances of optimal diabetes control. These supports can also alleviate the stress that the family, as a whole, passes through day in, day out.

Another level of support that is missing is financial support. It is important that health care providers can facilitate this burden. A way that could be done is by trying to make the Health Department pay for the majority of the expenses or even involve charitable organisations to support those families in need.

Baumrind (1966) describes the Baumrind Theory where he mentions four parenting styles. Parenting style is something that should be looked into when treating adolescents with diabetes. However, considering the influences that the macrosystem can have on the child, parenting style is important to examine. The way that parents react with the adolescent can be a result of the

cultural environment and belief that they were brought up in. Taking this family as an example, the mother is very calm and allows the adolescent to manage her diabetes most of the time, while her father is constantly showing the adolescent how worried he is about her condition and is constantly monitoring her. The result seems to be that the adolescent reacts more to the treatment and monitoring when her mother is looking after her then when her father is, agreeing with what Ellis *et al*. (2007) concluded.

The mother uses the Authoritative style which is the best style for encouraging tighter diabetes control especially in adolescents, as can be confirmed by this case report. Parents that adopt other styles such as the Authoritarian style should be referred to a psychologist so they can be guided to consider other styles as this one could lead an adolescent to be more rebellious which is counterproductive for diabetes monitoring and better outcomes.

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Minutes MCFD Annual General Meeting

held on Tuesday 13th May 2015 at the Professional Centre, Sliema Road, Gzira at 8:00pm

Present: Azzopardi Anthony; Bonnici Jason; Calleja Frank; Casha Frank; Cassar Doreen; Cauchi Jean Pierre; Grech Marco; Mallia Pierre; Micallef Adrian; Joseph Portelli-Demajo; Saliba Joseph; van Avendonk Tanya; Xuereb Anthony; Zammit Edward.

Members present: 13
Quorum not needed as this was the second take.

1. Reading of minutes of previous AGM

The minutes of 2014 AGM, including amendments/ corrections received by members via email, were forwarded to MCFD members in the call for AGM 2015.

2. Amendments and approval of minutes

A vote for the approval of the AGM 2014 minutes was taken as follows:

In favour: 13

The minutes where thus approved.

3. Matters Arising

Once again quorum for AGM was not reached and this second take was needed. During AGM 2014 a proposal was suggested so that the AGM can take place at the first take but this was not approved. President reflected on the arguments that arose last year. He proposed that further thoughts on the issue will be worked upon during the next months and then come back to the AGM with new proposals so that the AGM can take place at the first take.

4. Secretary's Report

Dr. Jason Bonnici read the Secretary's report.

Comments:

Dr. Anthony Azzopardi proposed a mechanism to facilitate the Registrar's work: an Excel sheet run by the office secretary at the CPD meetings.

Discussion ensued about membership of the MCFD and membership of the SAC. A number of issues need to be looked into. The President pledged that this will be one of the top items on his agenda for the coming term.

A vote for the approval of the Secretary's report was taken as follows:

In favour: 13

As such the Secretary's report was approved.

5. Treasurer's Report/Accounts

Mr. R. Micallef Attard presented the Accounts of MCFD.

Comments:

Dr. Anthony Azzopardi enquired whether the MCFD Funds can be invested to gain more than would be gained in a fixed account in a bank. MCFD needs to check issue with the Office of the Commissioner of Voluntary Organisation: Mr Roland Micallef Attard will check this out. Statute was checked and 14.1 gives the go-ahead to the Council to move in this direction.

A vote for the approval of the Treasurer's report/Accounts was taken as follows:

In favour: 13

As such, the Treasurer's report/Accounts was approved.

6. President's Report

Professor Mallia read the President's report.

Comments: Nil

A vote for the approval of the President's report was taken as follows:

In favour: 13

As such the President's report was approved.

7. Appointment of Accounant / Auditor.

A vote for the appointment of Mr. Rolan Micallef Attard was taken as follows:

In favour: 13

As such, the appointment of Mr. Micallef Attard as the auditor was approved.

8. Approval of Statute

Proposal 1: Fellowship of the Malta College of Family Doctor

Dr Marco Grech queried whether previous board members who did only 1 term should be eligible. Prof Pierre Mallia suggested that the remaining years be supplemented by involvement in subcommittees. Dr Joe Portelli-Demajo commented that the Royal College of Physicians get their Fellowship though academia and regular involvement in their profession. Dr Joe Portelli-Demajo suggested that the board that bestows Fellowship should have the powers to remove Fellowship. A discussion ensued, prompted by Profs Pierre Mallia and Dr Doreen Cassar, on the structure and the criteria for removing the Fellowship. Dr Joe Portelli-Demajo suggested that this function is taken up by the Board itself. Profs Pierre Mallia was more for fixed criteria. Dr Anthony Xuereb proposed for a Brotherhood of Fellows to review applications and removals.

The discussion led to changes in the proposal as follows:

1. <u>Fellowship of the Malta College of Family Doctor</u>

1.1. The Malta College of Family Doctors will be offering an Honorary Fellowship, which is the highest award of the College and which can be given to non-members and lay people who have contributed to Family Medicine.

1.2. The Malta College of Family Doctors will be offering a Fellowship to College Members which is to be awarded on grounds of merit listed in 1.3 below

1.3. The award of Fellowship shall be offered, upon application, to those members who satisfy the following criteria:

a. Have been registered on the Specialist Register for a period of at least ten years.
b. Have contributed to the work of the Malta College of Family Doctors for a minimum period of five years by being a member of council, or, being a member of a subcommittee listed among those acceptable for Fellowship (appendix), or, having served regularly in a capacity, such as examiners, etc., which capacity must also be on the approved list.
c. Show an interest in Family Medicine beyond their immediate work and practice.
d. Are in good standing with the MCFD, including being fully paid up members.
e. Have an acceptable record of CME attendance.

1.4. There shall be a board set up for a period of three years and which shall be approved at an AGM.

a. The Board should have the power to withdraw Fellowship for any serious reason they deem fit.
b. There shall be a right to appeal the decision of 1.4a to the Council who shall refer to an appointed Board of Fellows."

1.5. The College shall award not more than ten Fellowships per year, unless there are special circumstances decided upon by council.

1.6. Those who obtain fellowship shall have the designated letters FMCFD after their names and shall drop the letter MMCFD.

Dr Doreen Cassar, Dr Joseph Portelli-Demajo, Prof Pierre Mallia pointed out need to change point 5.8a of Statutes by introducing the word "fellow" alongside "member". It was proposed that point 5.8a of statutes be changed to read:

"Any Full Member / Associate Member of the College who ceases to be a registered medical practitioner for any reason, or as outlined in 11.2.4, shall ipso facto cease to remain a member/ fellow of the College."

A vote for the approval of the proposal as amended and for approving the amended point 5.8a of Statutes was taken as follows:

In favour: 13

As such the proposals for change in statute were approved.

Proposal 2: Obligations of contractual agreements in case of a care-taker council

Dr Edward Zammit queried the penalties for a council which does not satisfy the contractual obligations. Dr Joseph Portelli-Demajo pointed out that the President-Elect can be responsible for the care-taker council if the issue happens in the third year of a mandate. Points arose that contractual agreements e.g. the GP Licensing Exam are run by sub-committees and by people who are paid for the job. The discussion led to changes in proposal to be suggested, such that the full proposal now reads as follows:

2. Obligations of contractual agreements in case of a care-taker council

"In order to ensure the smooth running of contractual obligations, in case, for any reason, council resigns, there shall be a care taker council. The care-taker council must see to all contractual obligations, which include:

2.1. Preparation of a new election

2.2. Oversee other contractual obligations and ensure the smooth running of duties such as the summative assessment exam of Vocational Trainees, courses to which participants have paid, CME for which sponsorship has already been committed, the publication of the Journal of the MCFD (JMCFD) when there are commitments to advertisers.

2.3. The implementation of 2.2 shall take place by the persons who already occupy the positions at the time, unless they resign or are forced to resign.

2.4. Preparation of payments will continue to be effected by those who are signatories with the bank until they are duly and formally replaced according to rules of statute.

2.5. Oversee any other obligations of care-taker councils which are obligatory under the law and under the regulations of Voluntary Organizations.

2.6. Those who resign or are forced to resign must assume professional responsibility and give a proper hand over, failing which the new council may take the action allowed by law."

A vote for the approval of the proposal as amended was taken as follows:

In favour: 13

As such the proposal for change in statute was approved.

9. Appointment of Electoral Commission.

A vote for the appointment of the same Electoral commission was taken as follows:

In favour: 13

As such the Electoral Commission was approved.

Discussion arose what would happen in the scenario that the DH-MCFD-RCGP agreement for vocational training is not renewed. After 2016 there is 1 year where no GP Licensing Exam will be needed and there is a possibility that there could be another year of no GP Trainees if the current court cases continue. Public-Private partnership for vocational training was aired. The issue of the MRCGP(INT) was aired.

The AGM was concluded at 23.30 hours.

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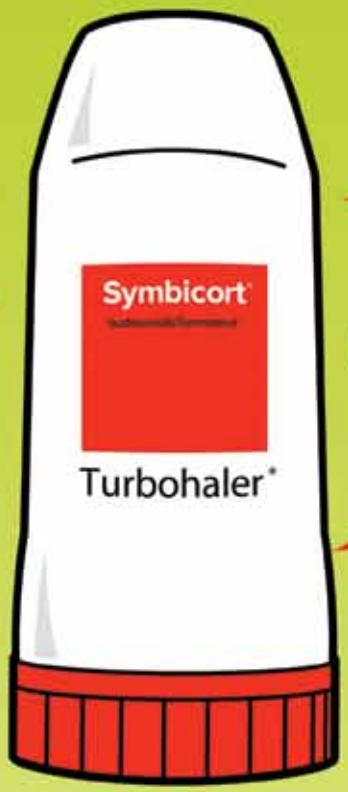

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Presentation Inhalation powder. ***Symbicort Turbohaler 100/6*** Each metered dose contains 100 mcg budesonide/inhalation and 6 mcg formoterol fumarate dihydrate/inhalation. ***Symbicort Turbohaler 200/6*** Each metered dose contains 200 mcg budesonide/inhalation and 6 mcg formoterol fumarate dihydrate/inhalation. Refer to the SmPC for information on the method of administration.
Dosage and Administration Asthma Not intended for the initial management of asthma. Dose should be individualised. If a patient requires dosages outside recommended regimen, appropriate doses using individual inhalers should be prescribed. When long-term symptoms are controlled, titrate to the lowest effective dose, which could include a once daily dosage. **Symbicort maintenance therapy – regular maintenance treatment with a separate rescue medication: *Adults (≥18 years, including elderly)*:** 1–2 inhalations twice daily (maximum 4 inhalations twice daily). ***Adolescents (12-17 years)*:** 1–2 inhalations twice daily. ***Children 6–11 years (Symbicort 100/6 only)*:** 2 inhalations twice daily. ***Children under 6 years*:** Not recommended.
Symbicort maintenance and reliever therapy – regular maintenance treatment and as needed in response to symptoms: consider for patients with (i) inadequate asthma control and in frequent need of reliever medication (ii) previous asthma exacerbations requiring medical intervention. ***Adults (including elderly)*:** 1 inhalation twice daily or as 2 inhalations once daily. 2 inhalations twice daily may be appropriate for some patients (200/6 strength only). Patients should take 1 additional inhalation as needed in response to symptoms. If symptoms persist after a few minutes, an additional inhalation should be taken. Not more than 6 inhalations should be taken on any single occasion. A total daily dose of more than 8 inhalations is not normally needed; however, up to 12 inhalations a day could be used for a limited period. Patients using more than 8 inhalations daily should be strongly recommended to seek medical advice and should be reassessed; their maintenance therapy should be reconsidered. Patients should be advised to always have Symbicort for reliever use. ***Children and adolescents under 18 years of age*:** not recommended. **COPD *(Symbicort 200/6 only)*: *Adults (≥ 18 years)*:** 2 inhalations twice daily.
Contraindications Hypersensitivity to active substances or excipient.
Warnings and Precautions If treatment is ineffective, or exceeds the highest recommended dose therapy should be reassessed. Sudden and progressive deterioration in control requires urgent medical assessment. Treatment should not be stopped abruptly. Patients should have their appropriate rescue medication available at all times i.e. either Symbicort or a separate reliever. If needed before exercise a separate reliever should be used. Therapy should not be initiated during an exacerbation. Serious asthma-related adverse events and exacerbations may occur. If asthma symptoms remain uncontrolled or worsen patients should continue treatment but seek medical advice. If paradoxical bronchospasm occurs Symbicort should be discontinued. It responds to a rapid-acting inhaled bronchodilator and should be treated straightaway. Systemic effects may occur, particularly at high doses prescribed for long periods e.g. Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, cataract, glaucoma and more rarely a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). Height of children should be monitored. Potential effects on bone should be considered especially in patients on high doses for prolonged periods that have co-existing risk factors for osteoporosis. Prolonged treatment with high doses of inhaled corticosteroids, particularly higher than recommended doses, may also result in clinically significant adrenal suppression. Additional systemic corticosteroid cover should be considered during periods of stress e.g. severe infections or elective surgery. Transfer from oral steroid therapy to Symbicort may result in the appearance of allergic or arthritic symptoms which will need treatment. In rare cases, tiredness, headache, nausea and vomiting can occur due to insufficient glucocorticosteroid effect and temporary increase in the dose of oral glucocorticosteroids may be necessary. To minimise risk of oropharyngeal candida infection patients should rinse mouth with water. Observe caution in patients with thyrotoxicosis, phaeochromocytoma, diabetes mellitus, untreated hypokalaemia, or severe cardiovascular disorders. Re-evaluate need for Symbicort in patients with active or quiescent pulmonary tuberculosis, fungal and viral infections in the airways. Hypokalaemia may occur at high doses. Particular caution recommended in unstable or acute severe asthma. Monitor serum potassium levels. In diabetic patients consider additional blood glucose monitoring. The small amounts of milk proteins present may cause allergic reactions.
Drug Interactions Concomitant treatment with potent CYP3A4 inhibitors should be avoided. If this is not possible the time interval between administration should be as long as possible. Symbicort maintenance and reliever therapy is not recommended in these patients. Not recommended with beta adrenergic blockers (including eye-drops) unless compelling reasons. Concomitant administration with quinidine, disopyramide, procainamide, phenothiazines, antihistamines (terfenadine) and TCAs can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-Dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with MAOIs, including agents with similar properties such as furazolidone and procarbazine, may precipitate hypertension. Elevated risk of arrhythmias in patients receiving anaesthesia with halogenated hydrocarbons. Hypokalaemia may increase the disposition towards arrhythmias in patients taking digitalis glycosides
Fertility, Pregnancy and Lactation No data available on the potential effect on fertility. During pregnancy: use only when the benefits outweigh the potential risks. Budesonide is excreted in breast milk, however at therapeutic doses no effects on the child are anticipated.
Undesirable effects Common: headache, palpitations, tremor, Candida infections in the oropharynx, coughing, mild irritation in the throat, hoarseness. Uncommon: tachycardia, muscle cramps, nausea, dizziness, bruises, aggression, psychomotor hyperactivity, anxiety, sleep disorders. Rare: hypokalaemia, cardiac arrhythmias including atrial fibrillation, supraventricular tachycardia and extrasystoles, bronchospasm and immediate and delayed hypersensitivity reactions including exanthema, urticaria, pruritus, dermatitis, angioedema and anaphylactic reaction. Very Rare: depression, behavioural changes (predominantly in children), angina pectoris, prolongation of QTc interval, hyperglycaemia, taste disturbance, Cushings syndrome, adrenal suppression, growth retardation, decrease in bone mineral density, cataract, glaucoma and variations in blood pressure. As with other inhalation therapy, paradoxical bronchospasm may occur in very rare cases.
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URN No: 13/0125
Date of preparation: April 2015

Reference: 1. Adelphi Respiratory Disease Specific Programme 2009. **2.** Olof Selroos et al. *Treat Respir Med* 2008; 5 (5): 305-315. **3.** Engel et al. *Br J Clin Pharmacol* 1992; 33(6): 439-44.

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COMPOSITION: Triplixam 5mg/1.25mg/5mg film-coated tablets 5 mg perindopril arginine (per)/1.25 mg indapamide (ind)/5 mg of amlodipine (amlo); Triplixam 10mg/2.5mg/5mg film-coated tablets: 10 mg per/2.5 mg ind/5mg amlo; INDICATIONS: Substitution therapy for treatment of essential hypertension, in patients already controlled with perindopril/indapamide fixed dose combination and amlodipine, taken at the same dose level. DOSAGE AND ADMINISTRATION: One tablet per day, preferably in the morning and before a meal. The fixed dose combination is not suitable for initial therapy. If a change of the posology is required, titration should be done with the individual components. Paediatric population: should not be used. CONTRAINDICATIONS: Dialysis patients. Patients with untreated decompensated heart failure. Severe renal impairment (Clcr < 30 mL/min). Moderate renal impairment (Clcr 30-60 mL/min) for Triplixam 10mg/2.5mg/5mg and 10mg/2.5mg/10mg. Hypersensitivity to the active substances, to other sulphonamides, to dihydropyridine derivatives, any other ACE-inhibitor or to any of the excipients. History of angioedema (Quincke's oedema) associated with previous ACE inhibitor therapy. Hereditary/idiopathic angioedema. Second and third trimesters of pregnancy (see Warnings and Pregnancy and lactation sections). Lactation (see Pregnancy and lactation section). Hepatic encephalopathy. Severe hepatic impairment. Hypokalaemia. Severe hypotension. Shock, including cardiogenic shock. Obstruction of the outflow-tract of the left ventricle (e.g. high grade aortic stenosis). Haemodynamically unstable heart failure after acute myocardial infarction. Concomitant use with aliskiren in patients with diabetes mellitus or renal impairment (GFR < 60mL/min/1.73m2) (see Warnings and Interaction(s) sections). WARNINGS: Special warnings: Neutropenia/agranulocytosis/thrombocytopenia/ anaemia: caution if collagen vascular disease, immunosuppressant therapy, treatment with allopurinol or procainamide, or combination of these complicating factors, especially if pre-existing impaired renal function. Monitoring of white blood cell counts. Hypersensitivity/angioedema, intestinal angioedema: stop treatment and monitor until complete resolution of symptoms. Anaphylactoid reactions during desensitization: Caution in allergic patients treated with desensitization and avoid if venom immunotherapy. Temporarily withdrawal of ACE-inhibitor at least 24 hours before desensitization. Anaphylactoid reactions during LDL apheresis: Temporarily withholding ACEinhibitor prior to each apheresis. Haemodialysis patients: consideration to use a different type of dialysis membrane or class of antihypertensive agent. Pregnancy: no initiation during pregnancy, stop treatment and start alternative therapy if appropriate. Hepatic encephalopathy: stop treatment. Photosensitivity: stop treatment. Precautions for use: Renal function: In certain hypertensive patients without pre-existing apparent renal lesions and for whom renal blood tests show renal insufficiency, stop treatment and restart at a low dose or with one constituent only. Monitoring of potassium and creatinine, after two weeks of treatment and then every two months during therapeutic stability period. If bilateral renal artery stenosis or single functioning kidney: not recommended. Risk of arterial hypotension and/or renal insufficiency (in cases of cardiac insufficiency, water and electrolyte depletion, in patients with low blood pressure, renal artery stenosis, congestive heart failure or cirrhosis with oedema and ascites): start treatment at low doses and increase progressively. Hypotension and water and sodium depletion: Risk of sudden hypotension in presence of pre-existing sodium depletion (in particular if renal artery stenosis): Monitoring of plasma electrolytes, re-establish blood volume and pressure, restart treatment at a reduced dose or with only one of the constituents. Sodium levels: More frequent monitoring in elderly and cirrhotic patients. Potassium levels: Hyperkalaemia: Monitoring of serum potassium if renal insufficiency, worsening of renal function, age (> 70 years), diabetes mellitus, intercurrent events, in particular dehydration, acute cardiac decompensation, metabolic acidosis and concomitant use of potassium-sparing diuretics, potassium supplements or potassium salts, or other drugs associated with increases in serum potassium. Hypokalaemia: risk for elderly and/or malnourished subjects, cirrhotic patients with oedema and ascites, coronary patients, patients with renal failure or heart failure, long QT interval: monitoring of serum potassium. Calcium levels: hypercalcemia: stop treatment before investigating the parathyroid function. Renovascular hypertension: if renal artery stenosis: start treatment at hospital at low dose; monitor renal function and potassium. Dry cough. Atherosclerosis: start treatment at low dose in patients with ischaemic heart disease or cerebral circulatory insufficiency. Hypertensive crisis. Cardiac failure/severe cardiac insufficiency: Caution if heart failure. Severe cardiac insufficiency (grade IV): start treatment under medical supervision with reduced initial dose. Aortic or mitral valve stenosis / hypertrophic cardiomyopathy: Caution if obstruction in the outflow tract of the left ventricle. Diabetic patients: If insulin dependent diabetes mellitus, start treatment under medical supervision with reduced initial dose; monitor blood glucose during the first month and/or in the case of hypokalaemia. Black people: higher incidence of angioedema and apparently less effective in lowering blood pressure than in non-blacks. Surgery / anaesthesia: stop treatment one day before surgery. Hepatic impairment: Mild to moderate: caution. Stop treatment if jaundice or marked elevations of hepatic enzymes. Uric acid: hyperuricemia: Increased tendency to gout attacks. Older people: testing of renal function and potassium levels before treatment start. Dosage increase with care. INTERACTION(S): Contraindicated: Aliskiren in diabetic or impaired renal patients. Not recommended: Lithium, Aliskiren in patients other than diabetic or impaired renal patients, Concomitant therapy with ACE inhibitor and angiotensin-receptor blocker, Estramustine, Potassium-sparing drugs (e.g triamterene,amiloride,...), Potassium salts, Dantrolene (infusion), Grapefruit or grapefruit juice. Special care: Baclofen, Non-steroidal anti-inflammatory medicinal products (included acetylsalicylic acid at high doses), Antidiabetic agents (insulin, hypoglycaemic agents), Non-potassium-sparing diuretics and Potassium-sparing diuretics (eplerenone, spironolactone), Torsades de pointes inducing drugs, Amphotericin B (IV route), glucocorticoids and mineralocorticoids (systemic route), tetracosactide, stimulant laxatives, Cardiac glycosides, CYP3A4 inducers, CYP3A4 inhibitors. To be taken into consideration: Imipramine-like antidepressants (tricyclics), neuroleptics, other antihypertensive agents and vasodilatators, tetracosactide, Allopurinol, cytostatic or immunosuppressive agents, systemic corticosteroids or procainamide, Anaesthetic drugs, Diuretics (thiazide or loop diuretics), Gliptines (linagliptine, saxagliptine, sitagliptine, vildagliptine), Sympathomimetics, Gold, Metformin, Iodinated contrast media, Calcium (salts), Ciclosporin, Atorvastatin, digoxin, warfarin or ciclosporin, Simvastatin. PREGNANCY AND BREASTFEEDING: Not recommended during the first trimester of pregnancy. Contraindicated during the second and third trimesters of pregnancy and lactation. FERTILITY: Reversible biochemical changes of spermatozoa in some patients treated by calcium channel blockers. DRIVE & USE MACHINES: May be impaired due to low blood pressure that may occur in some patients, especially at the start of treatment. UNDESIRABLE EFFECTS: Common: dizziness, headache, paresthesia, vertigo, somnolence,
dysgeusia, visual disturbances, tinnitus, palpitations, flushing, hypotension (and effects related to hypotension), cough, dyspnoea, abdominal pain, constipation, diarrhea, dyspepsia, nausea, vomiting, pruritus, rash, maculopapular rashes, muscle cramps, ankle swelling, asthenia, fatigue, oedema. Uncommon: eosinophilia, hypoglycaemia, hyperkalaemia reversible on discontinuation, hyponatraemia, insomnia, mood changes (including anxiety), mood disturbances, depression, sleep disorder, hypoesthaesia, tremor, syncope, diplopia, tachycardia, vasculitis, bronchospasm, rhinitis, dry mouth, altered bowel habits, urticaria, angioedema, hypersensitivity reactions, mainly dermatological, in subjects with a predisposition to allergic and asthmatic reactions, alopecia, purpura, skin discoloration, hyperhidrosis, exanthema, photosensitivity reactions, pemphigoid, arthralgia, myalgia, back pain, micturition disorder, nocturia, increased urinary frequency, renal failure, erectile dysfunction, gynaecomastia, pain, chest pain, malaise, oedema peripheral, pyrexia, weight increase, weight decrease, blood urea increased, blood creatinine increased, fall. Rare: confusion, blood bilirubin increased, hepatic enzyme increased. Very rare: agranulocytosis, aplastic anaemia, pancytopenia, haemoglobin decreased and haematocrit decreased, leucopenia, neutropenia, haemolytic anaemia, thrombocytopenia, allergic reactions, hyperglycaemia, hypercalcaemia, hypertonia, peripheral neuropathy, angina pectoris, arrhythmia (including bradycardia, ventricular tachycardia and atrial fibrillation), myocardial infarction, possibly secondary to excessive hypotension in high risk patients, stroke possibly secondary to excessive hypotension in high-risk patients, eosinophilic pneumonia, gingival hyperplasia, pancreatitis, gastritis, hepatitis, jaundice, abnormal hepatic function, erythema multiform, Stevens-Johnson Syndrome, exfoliative dermatitis, toxic epidermic necrolysis, Quincke's oedema, acute renal failure. Not known: Potassium depletion with hypokalaemia, particularly serious in certain high risk populations, torsades de pointes (potentially fatal), possibility of onset of hepatic encephalopathy in case of hepatic insufficiency, possible worsening of pre-existing acute disseminated lupus erythematosus, electrocardiogram QT prolonged, blood glucose increased, blood uric acid increased. OVERDOSE. PROPERTIES: Perindopril is an inhibitor of the angiotensin converting enzyme (ACE inhibitor) which converts angiotensin I to angiotensin II. Indapamide is a sulphonamide derivative with an indole ring, pharmacologically related to the thiazide group of diuretics. Amlodipine is a calcium ion influx inhibitor of the dihydropyridine group (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac and vascular smooth muscle. PRESENTATION: Box of 30 tablets of Triplixam 5mg/1.25mg/5mg, and 10mg/2.5mg/5mg. LES LABORATOIRES SERVIER, 50 rue Carnot, 92284 Suresnes cedex France. www.servier.com For complete information, please refer to the Summary of Product Characteristics

1.Toth K, on behalf og the PIANIST Investigators. Am J Cardiovasc Drug 2014;14:137-145
2.Chalmers J. et al. Hypertension 2013;63:259-264