

Promoting family medicine

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The year 2002 saw the publication of a landmark white paper in the United Kingdom entitled “Shifting the balance.” It proposed redistribution of funds with the lion’s share of the NHS budget going towards Primary Care services. Soon after, the white paper was approved, and at present 75% of the NHS budget is directed towards primary care.¹ This underpins the importance and priority which the government in the United Kingdom gives to primary care in order to have an effective health system.

Family medicine is the medical specialty involved in Primary Care. With its broad knowledge base, distinct area of practice and associated skills base, it fulfils all the criteria defining a specialty listed by Randall and Downies.² Indeed, family medicine has been included in the list of recognised specialties by the local Specialist Accreditation Committee.

An important aspect of family medicine is the need to adopt a patient-centred approach.³ For this to happen, the General Practitioner should be equipped with good consulting skills. Recognising this fact long ago, the Royal College of General Practitioners has repeatedly stressed the importance of attaining these skills in its membership examination, both in the content of the written assessment, as well as in the oral and practical sessions. In this sense, family medicine, can be seen to be a pioneering specialty, since later on other colleges, among them the Royal College of Physicians, have followed suit in importing these concepts in their membership examinations

The bulk of patient consultations take place in primary care. As Barbara Starfield points out in one of her keynote speeches, dealing with disease in the primary care setting is cheaper (cost-effective) when compared to secondary care.⁴ In addition, the impact of family medicine is quite strong when dealing with disease patterns; every additional primary care physician reduces total mortality by 34 per 100,000. Further to this, it is becoming more evident that guidelines developed in a secondary care setting cannot be extrapolated to primary care, since both the population and the settings are different. In response to such issues, guidelines are now starting to be directed purposely for primary care physicians, recognising the increasing importance and recognition that family medicine is gaining worldwide.

Locally, family medicine has a private and public interface. There is no registration system as in other EU states and people are free to use both the public or private family practitioner.

Traditionally and historically, Malta has been linked to the United Kingdom. However, it seems that in Malta, family medicine (and Primary Care in general) is not being given its due recognition, in contrast to the situation prevalent in the United Kingdom. During these last few years, the development of the Mater Dei hospital has completely overshadowed primary care. Indeed one can claim that there has been no significant project undertaken in primary care over these last few years. It is very unfortunate since a strong and supported primary care service is needed for the efficient running of Mater Dei Hospital. Without an effective “gate-keeping” service, this hospital will not function effectively (i.e. dealing with cases which “deserve” to be seen in hospital) or efficiently (i.e. making the best use of the financial resources).

The fact that family medicine is locally recognised as a specialty is hailed by many as a big step forward; indeed it is an important step in the right direction. However, it can only achieve its full potential and credibility once the general practice Training programme starts. Unfortunately, nearly three years after becoming members of the EU, the training programme has not yet started and this is causing a general sense of uneasiness and uncertainty amongst general practitioners. The financial aspect of the training programme poses a problem. However other issues have also contributed to this situation. Potential trainees are being seen by policy planners merely as added manpower in health centres, where numbers have been slowly dwindling due to a variety of reasons. No actual consideration is being given to the educational aspect of their employment. This should not be so, since these trainees are in a training post and should be allowed time and space to learn and practice their skills without undue hassle. The plight of these future trainees is even more worrying. Some of them have been waiting in earnest for well over a year, being promised that the vocational training is starting in the “near future.” This is unjust, since these doctors need to have a structure on which to plan their career. Closely related to this issue, is the extreme frustration felt by potential trainers; these, who together form the Teachers’ Group, have been involved in discussions with the Department of Health for months. However, many of these trainers feel helpless that one day they will be presented with a *fait accompli*, despite their efforts to push forward the educational agenda of the training programme. The Malta College of Family Doctors may play a more active role in this sense by pushing forward a common agenda with the Teachers’ Group.

Another contributing factor to the standstill of the training programme is the situation at the health centres, which is getting worse as time passes. The shortage of doctors in health centres is no surprise, given the poor working conditions and also lack of proper administration of these health centres. Many house-officers on rotation at health centres are appalled by the lack of planning and working conditions in health centres and will not seek to return to health centres in the future. The lack of continuity of information (let alone continuity of care), lack of IT support, lack of appropriate motivation, lack of appointment system and lack of financial commitment from higher powers are but a few reasons for the current situation at the health centres. Indeed a rudimentary appointment system for repeat prescription has recently been introduced only after pressure from the Medical Association of Malta (MAM).

The GPs currently employed at health centres are not being empowered to do their work appropriately. Primary care physicians are well equipped to deal with the management of many chronic conditions. However they are frustrated by the lack of appointment system to follow-up patients and also by the current system for provision of free-of-charge medications (Schedule V system). The latter needs a major overhaul, both as regards to its actual workings and the list of drugs available in view of the latest clinical trials. It is a time-wasting exercise having to refer to a hospital-based consultant to have approval for certain basic run-of-the-mill medication. This is a short-sighted method of cost containment; no weight is given to the benefits of treating these conditions in preventing (costly) hospital admissions. A thorough revision of the Schedule V system should also cut down on the need for out-patient attendance. In doing so, secondary care physicians are relieved off some of their huge load, and are given more time to address the more complex cases seen in the secondary sector.

Running parallel to the government funded primary care system is a closely intertwined private primary care system. This consists of solo GPs and two group practices. The Association of Private Family Doctors was set up a few years ago with the intent of presenting a common agenda for these GPs. One of the issues which will certainly need tackling in the future is burnout for these doctors, who need to work round the clock to offer their service. Other issues relate to certain anomalies in administrative policies. To this day one fails to understand why these doctors can order a blood count, and other routine investigations but are not allowed to order thyroid function tests (TFTs) or a prostate specific antigen test (PSA).

So where is general practice moving to? Importing the universal registration system as prevails in the UK is not the only model which can be adopted locally. Indeed, having the health centres turned into large group practices is another solution. In addition, by improving working conditions for GPs, certain private doctors could be tempted to work in the health centres again, thereby increasing the workforce. However, a serious conscious effort is needed to push forward family medicine. Admittedly certain family doctors may fall in a state of apathy and *laissez faire*, given the present situation, and indeed this is usually used as an argument why not to invest in primary care. However, every specialty will have its black sheep, and certainly they contribute only to a small minority of professionals.

A fundamental step in improving the status of a specialty is to invest in its training and education programmes. The Department of Family Medicine, within the Faculty of Medicine and Surgery was established in 2001. However, due to a variety of reasons, it failed to play a major role as a catalyst for the development of family medicine. It is hoped, that a greater collaboration with the Malta College of Family Doctors will lead to more tangible results in the future.

The general practice training programme is a top priority for the survival of family medicine in the Maltese islands. The urgency to start this training programme is as important as the need to ensure a good educational context and appropriate space where the trainees may develop their skills and knowledge. With a good training programme up and running further initiatives such as research could be entailed which will give further impetus to family medicine. Many family doctors have been yearning for years to see a major change in policy with regards to primary care. Maybe this could be the first and most important step forward.

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