

Graduation, specialisation and future initiatives

Prof. Pierre MALLIA

During November we had our annual graduation ceremony. As time goes on this is becoming a main event every year. It is a time for celebrating several things. First and foremost of course a celebration for the graduands, who, after three years of training and an intense assessment have graduated. But more importantly it is a reminder of where we are coming from. More than a decade ago we opted to put Family Medicine on the Specialist Register and soon afterwards we decided that specialisation should come with a well-recognised specialised programme which is externally reviewed. It was natural, as I usually point out, following our 'Royal college' culture, that we should follow the path of the MRCGP(INT).

We now have more than fifty members with this qualification and the qualification process for existing members is in process. This is certainly a cause for celebration. Being called a speciality, for us, is not merely a term which is deserving of the speciality; it also follows a path of appropriate specialisation. As some of the graduates, who had done also the MRCP, realise, this exam is of an equivalent standard.

During the ceremony, I elaborated on what this specialisation means for us. I explained, as I have often done in this journal, that being listed on the specialist register is not an automatic process. Even doctors coming from the European Union cannot automatically apply. They can, as doctors who graduate here, be recognised to practice by the medical council. Due to the collective agreement that health centre doctors have with the Medical Association of Malta, only those on the specialist register can work in these places. Therefore EU doctors cannot automatically work in the government health sector. They can of course work in the private health sector – even those which are outsourced by the government; such as the new Gozo system being proposed. If a specialist register exists in the country from which the doctor comes, then we would have to accept him or her. But having a vocational training programme

on its own which does not lead to being registered as a specialist, such as the system that exists in Italy, is not sufficient. This is important to maintain our standards.

We introduced a ceremony which is appropriate for a collegiate and educational body. The graduations at the RCGP are done with robes. The significance of a robe is that of showing a higher educational level. And therefore we are proud to carry out the ceremony with robes which reflects the well-earned reputation. Those who worked hard to establish the vocational training programme, especially the exam, will hopefully all soon be recognised by the Royal College.

POLICY COMPENDIUM

During last council we recognised that the College is often called by the Parliamentary Social Affairs committee to give its position on various issues being discussed. This was done recently on the issue of emergency contraception and on the euthanasia debate. It would be appropriate that these issues are discussed in time and that the College has official positions on various issues. Slowly we will build a compendium of policies of the College for the public to be able to refer to.

Another important issue discussed during the last council was the younger generation of doctors who are becoming members (through the vocational training programme). These members come from the information technology (IT) age – something which for many of us was built during our careers. These doctors grew up in this age and we have recognised that their 'world-view' is rather different. Luckily we have many young doctors on council who have pointed this out and together we will create opportunities which will be attractive to them. More IT use is important but social activities which meet their needs are also important. It is for this reason that I suggest that we form a group of young doctors to design programmes ranging from continuing professional development activities to social activities which are attractive to this younger generation of doctors.

We are looking also into the curriculum which will guide future continuing medical education (CME). In this way, when the medical council decides to introduce re-validation, one need not fear doing extra evaluations other than attending a recognised CME programme which follows a curricular design. This way one would ensure that doctors are kept up-to-date without the need for exams. I believe that we should be giving members value-for-money. CME is only a small part. We have now introduced the opportunity to support research initiatives for those who wish to apply for EU projects. Those who are interested may contact me on bioethicscentre@onvol.

net. But I would also ask those who have ideas for the College to come forward. One cannot expect that council does everything and one must be willing also to help find the manpower for initiative. But the more we build the collegiality, the stronger will be our College.

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GUEST EDITORIAL

The interphase between family medicine and mental health

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DeGruy (1996) stated that “it is fundamentally wrong to speak of mental health as if it is distinct from physical health or health in general”. Generally speaking, and across the world, primary care clinicians deal with mental symptoms as part of a larger more general problem and conversely mentally distressed patients often present with increased physical symptoms. However, and more so within Malta, whilst most patients with common mental illnesses (depression, anxiety, adjustment disorder, alcohol dependence) attend their general practitioner (GP) for help, the more severe and enduring end of the psychiatric spectrum is largely addressed by specialist services, with GPs acting largely only as conduits for referral (McDaid, 2013).

De Hert et al. (2011) reported that the rates of undiagnosed and untreated medical illnesses are higher in individuals with a serious mental illness (SMI) when compared to the general population. In many instances the only contact of SMI patients with health services is through specialised mental health services, and by virtue of their condition they are less able to recognise their own signs of physical illness, solve their problems or care for themselves. Extant literature acknowledges a higher rate of morbidity and mortality in SMI patients (Bailey et al.,

2012) but, as DeHert et al. (2011) observed, this is mostly due to modifiable health risk factors.

Wittchen et al. (2003) asserted that primary care doctors are the cornerstone of recognition, diagnosis, treatment and specialist referral for all types of disorders, be they of a somatic or psychological nature. McDaid (2013) stated that “the best use of both specialist and primary mental health services occurs when an individual can get the help they need at the lowest level of support appropriate for them”. This is a view that has been gaining ground in recent years with an increasing international trend towards integrating mental health services into primary care services. The World Health Organisation (WHO) has stressed the key role that primary care can play in the treatment of mental health conditions (WHO, 2001). GPs have the advantage of knowing their patients holistically, being aware of their interpersonal, social and domestic circumstances, as opposed to addressing a specific disease or condition. This is extremely relevant in the context of dealing with mental disorder which very often is impacted by social factors and family support. Significantly, robust primary care has been correlated with greater organisational efficiency and better patient outcomes, and consequently primary care is acknowledged