



MALTA COLLEGE OF FAMILY DOCTORS

**SPECIALIST TRAINING PROGRAMME
IN FAMILY MEDICINE - MALTA**

MCFD Education Subcommittee 2003-6:
Mario R Sammut (Chairman), Jürgen C Abela,
Mario Grixti, Pierre Mallia & Philip Sciortino

Introduction

As the body responsible for developing Vocational Training in Family Medicine in Malta, the Malta College of Family Doctors has drawn up this programme entitled ‘Specialist Training Programme in Family Medicine – Malta’ in accordance to the title and headings specified by the Specialist Accreditation Committee of Malta. In some countries ‘specialist’ training signifies a higher level than ‘vocational’ training, while in others (including Malta) these are considered to be at the same level.

While it is planned that Vocational/Specialist Training in Family Medicine in Malta will take place under the auspices of the Primary Health Care Department within the Health Division, the College will be responsible for ensuring the quality of:

- the academic content of the programme and curriculum,
- the training of the trainers and trainees, and
- the final assessment of specialist training and recommendation to the Specialist Accreditation Committee for certification of completion of specialist training.

The College reserves the right to amend and develop this programme in the light of experience gained during the ongoing evaluation of the programme’s eventual implementation, and according to future recommendations by European and international bodies of academic family medicine.

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1. Title: -

Family Medicine

2. Entry Requirements: -

- Recognised First Degree in Medicine.
- Completion of General Professional Training
- Full registration with the Medical Council of Malta or equivalent qualifications obtained from EU member states (as approved by the Medical Council).

(Specialist Accreditation Committee, 2003)

3. Duration: -

The specialist training programme in family medicine in Malta shall be spread over a period of 3 years (European Community, 1993, 2001), which period was initially envisaged to be divided into 12 months in family practice and 24 months of dedicated training attachments in specific specialist departments in hospitals (Caird & Howard, personal communication, 2004; Director General (Health), 2000; JCPTGP, 2003b).

However, a single year's experience in the family practice setting has been termed "a major limitation" by the RCGP - Royal College of General Practitioners (1993). As far back as in 1966 (College of General Practitioners) and 1968 (Royal Commission on Medical Education), a five-year period of training for family practice was recommended, of which three years should be in family practice and two years in hospital posts (RCGP, 1993). Since 2000 a number of innovative programmes in the UK have extended the general practice training attachment beyond 12 months (JCPTGP, 2003b), as has also been proposed by the British Journal of General Practice (Van Zwanenberg, 2001). It has been shown that this extension leads to an increase in doctors' confidence and their capacity for independent practice, and also in their success in addressing self-identified gaps in knowledge and skills (McKinstry et al, 1999; Sibbett et al, 2003). Thus it is recommended that *at least 50%* should be spent in family practice (EURACT, 2002; ICGP, 2004; RCGP, 2000; UEMO, 2003a). This arrangement shall hold when the course is extended to 4 or 5 years as is the trend in most training programmes in Europe

So as to focus on the learning needs of family medicine, the **three-year specialist training programme** in family medicine in Malta will be:

- based in family practice and taught by family doctors,
- while supplemented by carefully planned attachments with appropriate hospital specialities for defined periods,
- in designated training posts throughout (with trainees being considered over and above the normal complement of staff).

(Caird & Howard, personal communication, 2004; Elwyn et al, 1998; MCFD, 1997; Standing Committee of European Doctors, 1991).

Such practice-based training will:

- provide appropriately trained family doctors (FDs), working with other health care disciplines in a general practice setting;
- be planned and supervised throughout by trainers who are established family

- practitioners;
- be one to one, with both trainee and trainer being involved in the training post allocation, and the trainer having responsibility for only one trainee at a time;
 - involve working in government primary health centres and in private family practice, so that the trainee gains experience of both systems;
 - be learner centred, representing adult professional education with flexibility in terms of content and length of individual posts;
 - allow adult learning methods to be used, such as portfolio-based learning;
 - be based on different training methods, including lectures, tutorials and group work;
 - address the core competencies of the family doctor (see Section 4).

In order to avoid the disadvantage of the out-dated traditional UK system (2 years in hospital, followed by 1 year in general practice) where the trainee only experiences family practice after 2 years in hospital specialities (Caird & Howard, personal communication, 2004; Pereira Gray, 1979), the following roster is recommended:

3 months: Family Medicine

3 months: Major Hospital Speciality (full-time)

2 months: Family Medicine (part-time) and Minor Hospital Speciality (part-time)

2 months: Family Medicine (part-time) and Minor Hospital Speciality (part-time)

2 months: Family Medicine (part-time) and Minor Hospital Speciality (part-time)

3 months: Major Hospital Speciality (full-time)

3 months: Family Medicine

3 months: Major Hospital Speciality (full-time)

2 months: Family Medicine (part-time) and Minor Hospital Speciality (part-time)

2 months: Family Medicine (part-time) and Minor Hospital Speciality (part-time)

2 months: Family Medicine (part-time) and Minor Hospital Speciality (part-time)

3 months: Major Hospital Speciality (full-time)

6 months: Family Medicine

The above schedule will also mean that the length of time in family medicine will comprise 12 months' part time attachment (equivalent to 6 months full time) besides the 12 months' full time attachment, in order to fulfil the recommendation made earlier that at least 50% of vocational training should be spent in family practice (i.e. 18 out of 36 months).

The hospital attachments, where training will focus on the needs of Family Medicine learning, will be made up from the following blocks with durations of 3 months (full time in a major speciality) or 2 months (part time in a minor speciality) (adapted from Director General (Health), 2000; Pereira Gray, 1979):

Major Hospital Specialities (full-time)

Medicine	3 months
Obstetrics & Gynaecology	3 months
Paediatrics	3 months
Accident & Emergency (including Minor Surgery)	3 months

Minor Hospital Specialities (part-time)

Dermatology & Venereology	2 months
Geriatrics	2 months
Psychiatry	2 months
Otorhinolaryngology and Head & Neck Surgery	2 months
Ophthalmology	2 months
Palliative Care	2 months

A three-year trainee-attachment roster drafted for twelve trainees (which may be adapted for more or less) is attached as Appendix 1 to this document.

A day-release programme (comprising at least four hours of academic activities) will be organised each week throughout the 3-year training period. This programme includes group and problem-based learning, with development of interpersonal skills.

(Caird & Howard, personal communication, 2004; Director General (Health), 2000; MCFD, 1997; MCFD, 2004, RCGP, 1993; RCGP, 2000; Specialist Accreditation Committee, 2003; UEMO, 2003b)

4. Main areas covered (competencies to be acquired): -

The European Definition of General Practice/Family Medicine (WONCA Europe, 2002) defines general practitioners/family doctors as specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care, or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.

4.1 Competencies to be acquired during community training:

The above European Definition of General Practice/Family Medicine goes on to specify the core competencies that are essential to the general practitioner/family doctor, irrespective of the health care system in which they are applied. The complex but characteristic interrelationship of core competencies, implementation areas and fundamental features (Heyrman, 2004; WONCA Europe, 2002) - see A, B & C below - guides and is reflected in the development of the teaching agenda, together with the agendas for research and quality improvement.

A. Core Competencies:

The central characteristics that define the discipline relate to abilities that every specialist family doctor should master. They can be clustered into six core competencies:

1. Primary care management

Includes the ability:

- to manage primary contact with patients, dealing with unselected problems;
- to cover the full range of health conditions (see Appendix 2);
- to co-ordinate care with other professionals in primary care and with other specialists;
- to master effective and appropriate care provision and health service utilisation;
- to make available to the patient the appropriate services within the health care system;
- to act as advocate for the patient.

2. Person-centred care

Includes the ability:

- to adopt a person-centred approach in dealing with patients and problems in the context of patients' circumstances;
- to apply the general practice consultation to bring about an effective doctor-patient relationship, with respect for the patient's autonomy;
- to communicate, set priorities and act in partnership;
- to provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management.

3. Specific problem solving skills

Includes the ability:

- to relate specific decision making processes to the prevalence and incidence of illness in the community (see Appendix 2);
- to selectively gather and interpret information from history-taking, physical examination, and investigations and apply it to an appropriate management plan in collaboration with the patient;
- to adopt appropriate working principles, e.g. incremental investigation, using time as a tool and to tolerate uncertainty;
- to intervene urgently when necessary;
- to manage conditions which may present early and in an undifferentiated way;
- to make effective and efficient use of diagnostic and therapeutic interventions.

4. Comprehensive approach

Includes the ability:

- to manage simultaneously multiple complaints and pathologies, both acute and chronic health problems in the individual (see Appendix 2);
- to promote health and well being by applying health promotion and disease prevention strategies appropriately;
- to manage and co-ordinate health promotion, prevention, cure, care and palliation and rehabilitation.

5. Community orientation

Includes the ability:

- to reconcile the health needs of individual patients and the health needs of the community in which they live, in balance with available resources.

6. Holistic modelling

Includes the ability:

- to use a bio-psycho-social model taking into account cultural and existential dimensions.

B. Implementation Areas related to Competencies:

To practice the speciality, the competent practitioner implements these competencies in three important areas:

a) daily clinical tasks

- manage the broad field of complaints, problems and diseases as they are presented (see Appendix 2);
- master long-term management and follow-up;
- balance evidence and experience in an effective way.

b) communication with patients

- structure the consultation properly;
- provide information that is easily understood and to explain procedures and findings;
- deal adequately with different emotions.

c) management of the practice

- provide appropriate accessibility and availability to the patients;
- organise, equip and financially manage the practice, and collaborate with the practice team;
- cooperate with other primary care staff and with other specialists.

C. Fundamental Features related to Competencies:

As a person-centred scientific discipline, three background features should be considered as fundamental:

a) Contextual:

- use the context of the person, the family, the community and their culture in diagnosis, decision making and management planning;
- show personal interest in the patient and his environment and be aware of the possible consequences of disease for family members and the wider environment (including working environment) of the patient.

b) Attitudinal:

- based on the awareness of one's own capabilities and values;
- identifying ethical aspects of clinical practice (prevention/diagnostics/therapy/factors influencing lifestyles);
- justifying and clarifying personal ethics;
- being aware of the mutual interaction of work and private life and striving for a good balance between them.

c) Scientific:

- being familiar with the general principles, methods, concepts of scientific research, and the fundamentals of statistics (incidence, prevalence, predicted value etc.);
- having a thorough knowledge of the scientific backgrounds of pathology, symptoms and diagnosis, therapy and prognosis, epidemiology, decision theory, theories of the forming of hypotheses and problem-solving, preventive health care;
- being able to access, read and assess medical literature critically;
- adopting a critical and research based approach to practice and maintaining this through continuing learning and quality improvement.

4.2 Competencies to be acquired during hospital-based training:

The following general organisational principles and key principles of provision of the hospital-based component of specialist training in family medicine (see A & B below) are recommended (EURACT, 2000).

A. General principles of organisation:

<i>PROGRAMME</i>	<i>RESOURCES</i>
Written educational aims and teaching programme (for every attachment)	Hospital-specialist teachers who are prepared and accredited
Formative assessment of educational needs with regularly reviewed educational plan	Family doctor (FD) trainer as educational supervisor of each trainee
Appropriate clinical content, with balance between service and education needs, ambulatory patient experience and availability of clinical support services	<i>Protected</i> teaching time: daily – informal discussion of random/selected cases; weekly – formal tutorial (e.g. journal club), besides general practice release programme
Final appraisal of continuing learning needs provided to trainee	Periodic inspection visits by independent assessors (appointed by the Specialist Accreditation Committee, in consultation with the MCFD)
Educational audit: achievement of educational aims as quality markers	Postgraduate library and educational facilities

B. Key principles of provision:

<i>EDUCATION CONTENT</i>	<i>CLINICAL CONTENT</i>
Focussed on what FD trainees are expected to learn and on learning opportunities provided	Opportunity for more detailed investigation and more sophisticated management than possible in family practice
Hospital teachers adequately trained and supported	Reinforcement of clinical experience gained during internship
Input and guidance from FD teachers	Increasing responsibility for care through experience and confidence gained under supervision
Balance between educational and service components of training	Refinement of clinical skills of history-taking and examination, discrimination in use of further investigations, familiarity with use of various drugs and their side-effects
Sufficient formal and informal teaching in protected time	Appropriate experience in both in-patient and out-patient settings
Named educational supervisor to ensure formative assessment according to an appropriate, individual and periodically-reviewed educational programme	As members of hospital team, understanding of roles and relationships of professionals involved
Clinical audit to systematically review the quality of clinical care provided	Knowledge of life-threatening diseases, their complications and consequences
Education oriented towards the needs of the future FD	Practical experience in a range of management decisions
Contact maintained with family practice via a FD educational release programme and a training practice	Insight into the primary care – secondary care interface
Equal importance of FD-training and other specialist-training programmes	Exposure to and experience of serious morbidity

The objective of hospital-based training is for the FD trainee to learn some of the knowledge, routines, methods and fundamental techniques which are specific to the hospital specialty in question and in which training cannot be conducted in family practice (Standing Committee of European Doctors, 1991). During this period, the trainee is provided with:

- training in the specialty's approach, examination, and treatment routines (also during out-of-hours exposure) as well as in guidelines for continued treatment and follow-up of discharged patients;
- precise knowledge of the illnesses that are common in that specialty and of the symptoms of diseases which, although less common, are nevertheless important;
- training in problem formulation of the specialities and in the working methods to ensure that the trainee will be equipped as a family doctor to keep his knowledge up-to-date and communicate with other specialist colleagues.

The indicative **lists of competencies to be acquired during hospital-based training**, according to each speciality, are listed below (see 'Acknowledgements' for contributors). The weighting given to these competences should take into consideration the distribution of morbidity in family practice (see Appendix 2).

Medicine

During his/her attachment, the trainee will gain experience in different sections of the department in order to develop and achieve the following competences necessary for independent practice:

- During new patient out-patient clinics:
 - Dealing with general medical problems, and problems related to subspecialties: Neurology, Gastroenterology, Rheumatology, Respiratory Diseases, Diabetes, Infectious Diseases
 - Developing an idea of the spectrum of diseases and the standard of referrals
 - Recognising areas where hospital referral is more likely to be effective; and where referral is not only necessary, but possibly mandatory and urgent.
 - Learning about the general assessment of such common problems as headaches, abdominal pain, joint pain, cough, shortness of breath, etc.
 - Recognising aspects of such conditions that differentiate between a routine and a potentially serious complaint.
- New as well as follow-up clinics in diabetes:
 - Dealing with a diabetic patient in the first visit
 - Conducting a "routine" appropriate follow-up examination on a diabetic patient
- At specialty clinics, such as asthma, cardiology and rheumatology
 - Appreciating the existence of multidisciplinary services entailing both medical and paramedical staff and how such clinics coordinate them
 - Fostering the concept of shared care between hospital and community
- At investigational units: sessions in non-invasive cardiac investigations (e.g. stress testing, cardiac monitoring, echocardiography, as well as invasive cardiac investigations such as coronary angiography), as well as endoscopy (both bronchial and gastrointestinal)
 - Seeing how such techniques are carried out
 - Enabling the trainee to explain as a future family practitioner what such investigations entail to his/her patients.
- Ward-rounds and case discussions:
 - Experiencing exposure to acute infectious illness.
- Establishment of contacts between trainees and hospital staff:
 - To develop stronger links between the two disciplines in future.

Obstetrics & Gynaecology

During the period of training in gynaecology/obstetrics, the FD trainee should attain knowledge of the discipline's approach, examination, and treatment routines as well as working methods. By the end of his training, the FD trainee should have obtained sufficient knowledge to independently be able to carry out examinations and treatment of patients with those conditions most commonly seen in general practice, such as:

- adolescent problems of menarche: breast development, mittelschmerz, dysmenorrhoea, irregular bleeding, pregnancy;
- screening for breast, cervical cancer
- breast problems and their management
- pelvic pain, acute (pelvic inflammatory disease, follicle rupture, ovarian torsion, fibroid degeneration) and chronic;
- vaginal discharge, genital inflammations;
- problems of cycle (amenorrhoea, meno-metrorrhagia, intermenstrual bleeding, postcoital bleeding, polycystic ovary disease);
- hirsutism;
- problems with intercourse (frigidity, dysparunia, fear of intercourse, vaginismus)

- family planning, infertility, contraception, abortion;
- antenatal care, problems in pregnancy and postnatal care;
- prolapse of pelvic organs;
- marital problems, domestic violence, rape (counselling, liaison with social services and other professions);
- climacterium (HRT, psychological manifestations, vaginitis, post-menstrual bleeding, osteoporosis);

as well as knowledge of those conditions which require admission to hospital:

- cancer of the genital tract;
- sterility;
- urinary incontinence;
- extra-uterine pregnancy;
- life-threatening bleeds.

Paediatrics

At the end of his/her training period, the trainee should be proficient and comfortable enough with the following to practice independently:

1. Basic care of the newborn.
2. Infant feeding.
3. Basic child development and growth (including speech and foot problems)
4. Vaccination schedule
5. Asthma and its management.
6. Upper and lower respiratory tract infections.
7. Primary management of upper airway problems (croup and foreign body).
8. Gastroenteritis and dehydration.
9. Management of vomiting and diarrhoea.
10. Management of UTI.
11. First line management of suspected meningitis and septicaemia.
12. Management of acute seizures and broad outline of epilepsy.
13. Multidisciplinary approach to disability.
14. Eczema and atopy.
15. Basic knowledge of genetics/inheritance and endocrinology.
16. Primary management of common surgical conditions.
17. Males: phimosis / balanitis/ undescended testis; females: labial fusion.
18. Spinal problems: scoliosis.
19. Approach to the management of suspected non-accidental injuries.
20. Awareness of social problems and support services.
21. ADHD and its treatment.

Accident & Emergency

The trainee will gain experience of the following cases so that, at the end of the training period, s/he will be able to manage them independently:

- Cardiology:
 - Chest pain
 - Arrhythmias
 - Syncope
- Vascular:
 - Lower limb swelling
 - Lower limb ischaemia/gangrene

- Respiratory:
 - Dyspnoea
- Gastroenterology:
 - Vomiting/diarrhoea
 - Upper GI bleeding
 - Lower GI bleeding
- Metabolic:
 - Diabetic complications
 - Metabolic disorders
- Neurology:
 - Headache
 - CVA/TIA
 - Epileptic fits
 - Unconscious patient
- Blood disorders
- Specific infections/PUO
- Poisoning
- Surgery:
 - Abdominal pain
 - Back pain
- Trauma:
 - Major trauma
 - Minor head injuries
 - Fracture/dislocations
 - Soft tissue injuries
 - Wounds/burns
- Psychiatric emergencies

The trainee will also gain experience to be able to perform the following procedures independently:

- Emergency procedures:
 - Tracheotomy
 - Sutures

Dermatology & Venereology:

At the end of his/her attachment, the trainee will have gained the competence to be able to independently diagnose and manage the following (and know if and when to refer to dermatologist):

- Acne vulgaris.
- Eczema (atopic dermatitis, pompholyx, discoid eczema, lichen simplex, seborrhoeic dermatitis & contact dermatitis).
- Psoriasis.
- Common bacterial infections (impetigo & boils).
- Common fungal infections (tinea capitis / corporis / pedis, onychomycosis, pityriasis versicolor and candidiasis).
- Common viral infections (viral warts, molluscum contagiosum, herpes simplex & zoster).
- Infestations (pediculosis capitis & pubis, scabies and insect bites).
- Common idiopathic dermatoses (urticaria and pityriasis rosea).
- Common disease of hair and nails.
- Drug reactions.

- Leg ulcers.
- Lumps & bumps:
 - Moles and pigmented lesions, basal cell carcinoma, squamous cell carcinoma - know when to refer to dermatologist;
 - Solar keratoses, seborrhoeic warts, skin tags - should be competent in diagnosis and treatment;
 - Epidermal (sebaceous) cyst - know when to refer.
- Common presentations of sexually transmitted infections (STI's), mainly vaginal & urethral discharge (gonorrhoea, chlamydia and candida), cases of genital ulcer disease (herpes and syphilis) and genital warts. One also should be familiar with counselling prior to HIV screening.

The trainee will also have experienced hands-on exposure to:

- Cryotherapy wart clinic;
- Skin tag removal clinic;
- Leg ulcer clinic;
- Patch test (contact dermatitis) clinic;
- PUVA/UVB sessions;
- Dermatological minor operation sessions.

Geriatrics

Trainees will be attached to the Geriatrics Department in Zammit Clapp Hospital (ZCH), which deals with the frail elderly with medical problems who intend to return to live in the community. In order to gain competence in independent practice, trainees will:

- learn about the comprehensive assessment and management of the common medical problems;
- see a multidisciplinary team in action with weekly case conferences and the actual roles of various team members;
- note that rehabilitation forms an important part of the daily management and what it actually means;
- gain experience in inpatients, outpatients and the day hospital;
- learn about the importance of carers, family training sessions, team home assessment visits, the role of the community liaison nurses;
- deal with common diagnosis include strokes, post-fracture femur operations, parkinsonism, chest infections, cardiac failure, confusional states, incontinence, falls etc.;
- deal with common problems including mouth care, bed sores, faecal impaction, catheterisation and irrigation, contractures;
- experience care of the terminally ill and pain management;
- learn about rational prescribing;
- get to know how to gain access to special beds, lifters, etc. from NGOs to help families to keep their elderly relatives at home.

Psychiatry

The trainee will gain experience in a wide range of cases from the following list of disorder categories so that, at the end of the training period, s/he will be able to detect and diagnose such cases independently, provide treatment and know if and when to refer for psychiatric intervention.

1. Depression
 - a. Mild/depressive anxiety syndrome
 - b. Major/moderate/severe/psychotic

2. Bipolar affective disorders
3. Phobic/anxiety/panic disorder
4. Obsessive compulsive disorder
5. Substance misuse/dependence/co-morbidity
6. Alcohol misuse/dependence syndrome
7. Schizophrenia, schizotypal and delusional disorders
 - Other delusional states, e.g. morbid jealousy, etc
8. Deliberate self-harm, including cutting, overdose, risk of suicide
9. Organic brain syndrome
 - a. Acute
 - b. Chronic
10. Child and adolescent psychiatric disorder, including conduct and emotional disorder
11. Psychiatric disorder associated with mental subnormality and specific developmental disorders, including pervasive developmental disorder (autism)
12. Abnormal Illness Behaviour including: dissociative disorder, somatisation and somatiform disorder, hypochondriasis, fictitious illness and malingering
13. Personality disorder
14. Psychosexual problems including:
 - a. gender identity disorders (e.g. transexualism),
 - b. disorders of sexual preference (e.g. paedophilia),
 - c. sexual dysfunction disorders (e.g. erectile impotence, premature ejaculation, anorgasmia, vaginismus, decreased sexual drive)

Otorhinolaryngology and Head & Neck Surgery

During the attachment, the trainee will need to become thoroughly familiar with clinical practice to reach competence in independent practice, as follows:

- Acquisition of clinical examination and diagnostic skills (including diagnostic endoscopy) necessary for the early identification of the more serious conditions;
- Become familiar with some diagnostic procedures, e.g. audiometry;
- Perfecting the basic surgical skills required for the management of acute conditions, including the management of foreign bodies, control of epistaxis, and minor-intermediate procedures including tracheotomy;
- Exposure to most surgical procedures (through assisting in theatre) to improve understanding of the principles clinical indications, aims and results;
- A particular emphasis on otology and vertigo.

Ophthalmology

At the end of his/her attachment, the trainee will have gained experience to be independently competent in:

- Ophthalmoscopy and screening of diabetic / hypertensive retinopathy.
- Recognising types of retinopathy that need to be referred (retinal detachment) and also on the interval of follow-up.
- Glaucoma diagnosis (through use of meters), management as well as follow up for this common disorder.
- Minor trauma and eye emergency management.
- Management of ophthalmic infections.
- Management of squints.

Palliative Care

Palliative care has become an important part of family practice and is often quite challenging.

The trend is to move away from services depending on the hospital, to services provided by family doctors in the community in liaison with hospital specialists.

The provision of this type of care demands that the family doctor be able to provide optimum care, prescribing and counseling, not only to patients but also to their families. This programme would provide family doctors with the knowledge and skills for:

- Assessment for and identification of palliative care symptoms.
- Management of pain. Pain assessment, the analgesic ladder, morphine and alternative opiates, co analgesics, and alternative and complimentary medicines.
- Management of common medical problems. Constipation, diarrhoea, intestinal obstruction, anorexia, nausea and vomiting, cachexia and weakness.
- Management of respiratory symptoms. Dyspnoea and cough.
- Managing the terminal phase. Confusion, bronchial secretions, mouth care, stoma care.
- Prescribing. Ability to deal with and prescribe relevant drugs, including the use of a syringe driver.
- Managing psychological problems. Depression.
- Handling palliative care emergencies.
- Alternative and complimentary medicines.
- Counselling and communicating effectively with the terminal patient.
- Family support.
- Bereavement.
- Identification of resources with whom to liaise when needed.

5. Criteria for completion of programme and award of specialist certificate: -

The trainees' performance will undergo assessment (both formative and summative) by their trainers with regards to the fulfilment of the specialist training programme's aim of producing competent, reflective and self-educating family doctors. The quality of the training provided should be assured through establishing criteria (regarding form and content) that are then audited by peers (national and international) in family medicine.

Regular recorded *formative assessment* will support learning throughout the programme, identifying the trainee's educational needs and confirming progress:

- Pre-Course Assessment:
 - Phased Evaluation Programme – PEP, a diagnostic self-assessment of the strengths and weaknesses of participants to facilitate the construction of a phased learning programme.
- In-Course Assessment:
 - Direct Observation Rating Scales, reliable and valid means of assessment by the trainer of the trainee's competence through observation while at work.
 - Phased Evaluation Programme – PEP.
 - Portfolio-based learning, a technique of personal learning where a collection of evidence in a log-book emphasises the importance of experience as an opportunity for learning and recognising learning needs, and demonstrates that such personal learning needs have been fulfilled. The portfolio will also serve to prepare the trainee to take responsibility for his/her future life-long learning.
 - Small group activities, e.g. problem-solving sessions (presentation and discussion).
 - Practice assessment: through video and simulated surgeries (involving actors).

Final *summative assessment* will ascertain proficiency in family practice through the following methods:

- Written component:
 - Written Submission of Practical Work (e.g. a research project, an audit project, or a quality assurance project).
 - Trainer's Report (including Workplace Assessment). This would conform to a predefined structure to maintain objectivity and minimise subjectivity.
 - Modified Essay Questions (to test application of knowledge): usually present the clinical scenario of a single surgery session or a single working day during which a succession of problems are encountered.
 - Multiple Choice Paper, consisting of Extended Matching and Single Best Answer Questions (to test application of knowledge).
- Clinical component:
 - Video (of a number of consecutive consultations) and/or Simulated Patient Surgery (assessing performance 'in vivo').
 - Objective Structured Clinical Examination – OSCE (assessing performance 'in vitro'): multi-station timed examination in which a candidate is presented with brief segments of a clinic visit to complete.
 - Structured oral face-to-face examination, used to explore if the trainee understands topics important to general practice. In order to improve reliability, guidelines are provided for the topics to be covered or a series of agreed patient scenarios and questions are used.

A Certification Steering Committee (made up of representatives from an MCFD Examination Board, representatives from the Trainers and of the Coordinator) will be set up to consider all the evidence needed to approve a candidate or otherwise. Successful conclusion of both the training programme and of the formative/summative assessment process is deemed necessary for satisfactory completion of training.

On successful completion by trainees of the training programme and the formative/summative assessment, they will be recommended on behalf of the Malta College of Family Doctors to the Specialist Accreditation Committee for *certification as having completed the Specialist Training Programme in Family Medicine*, and will be considered as having fulfilled the training requirements to work in Family Practice in Malta.

(Caird & Howard, personal communication, 2004; Calleja, 1997; Director General (Health), 2000; JCPTGP, 2003a; MCFD, 1997; RCGP, 1993; RCGP, 2000; Smee, 2003; UEMO, 2003b; University of Manchester, 1988)

6. Qualifications for Trainers, Training Practices and Coordinator of Specialist Training: -

6.1 Trainers and Training Practices:

It is recommended that all general practitioners should have an opportunity to apply to be a trainer for specific training in general practice (EURACT, 2002). Selection of trainers and training practices should be coordinated by a Selection Committee (formed of a Chairman, the Coordinator of Specialist Training, and representatives from the Trainers, Trainees, the MCFD and the Primary Health Care Department) and follow clearly defined mechanisms and be based on a list of clearly defined criteria (see A & B below).

A. Mechanisms of selection should include:

<i>TRAINERS</i>	<i>TRAINING PRACTICES</i>
Assessment of the availability of the doctor, both from the point of view of his medical care of patients and also his educational responsibilities as a trainer	Practice visits (a pre-interview condition): <ul style="list-style-type: none"> ▪ clinical care ▪ practice culture ▪ learning environment
Consideration of the curriculum vitae	
Personal interview	
Evaluation of the practice	

B. Criteria for selection should include:

<i>TRAINERS</i>	<i>TRAINING PRACTICES</i>
A personal commitment to teaching and to keep updated on educational methodology by attending appropriate lectures and courses	Good quality premises, equipment, library and IT facilities and other teaching aids
Practical teaching skills acquired through appropriate preparation, and certification as trainers by a recognised European College of Family Doctors	Well organised medical records
A high standard of clinical competence, practising in the speciality for at least 5 years	Adequate number of patients and workload to ensure the gaining experience for trainee
A high professional qualification or equivalent as approved by the Malta College of Family Doctors	Good quality health care team
The ability to communicate effectively	Effective practice management
Through active participation in CME, full accreditation in the speciality with a recognised European College of Family Doctors	Access to a full range of laboratory and imaging investigations
A commitment to quality assurance	Others (audit, research activities, continuity of care)
Adequate time in active family practice (at least two working days a week or equivalent time)	
Others (audit, research activities)	

(EURACT, 2002; MCFD, 1993a&b; MCFD, 2004; Specialist Accreditation Committee, 2003; UEMO, 1992)

6.2 Coordinator of Specialist Training:

The Specialist Training Programme in Family Medicine will be coordinated by a Coordinator who will be appointed by the Health Division in consultation with the Malta College of Family Doctors (MCFD, 2004). Besides being an organiser, the coordinator should be an educationalist, a professional and a practising family doctor, and needs to make use of resources external to family medicine to facilitate the provision of a comprehensive scheme (Pereira Gray, 1979). The criteria for selection will be similar to the criteria for selection for trainers (see Section 6.1 above).

7. Duties of trainers and coordinator: -

The **Trainers and Coordinator** shall undergo regular training in teaching and medical education and professional development as assessors/examiners (Specialist Accreditation Committee, 2003). This would enable them to:

- Through a one-to-one trainer-trainee relationship, and in negotiation with the trainee, determine the trainee's educational needs and, in order to meet them, organise:
 - teaching (through a wide range of adult learning methods, including practice-based learning, one-to-one mentoring sessions, regular small-group problem-based tutorials, interactive lectures, research and critical reading projects) and
 - assessment (subjective/objective and initial/formative/summative);
- Organise training according to a set curriculum (to establish uniformity between each trainer-trainee team) that will include appropriate supervised experience in all areas of primary medical care (management of acute and long-term problems; out-of-hours and emergency care; preventive medicine and health promotion; appropriate prescribing; rehabilitation);
- Provide support for the trainee and his/her career through
 - provision of personal counselling,
 - encouragement of the trainee to participate in a support group of peers,
 - allowing the trainee to access an independent counselling team of other trainers in the event of a problem with his/her trainer.
- Help the trainee to develop:
 - communication skills appropriate to family practice;
 - teamworking with other health professionals and doctors;
 - appropriate use of health resources for the benefit of the patient;
 - knowledge of both private and public health systems;
- Participate in regular Trainers' Meetings:
 - one evening a month
 - two weekends a year

In addition to the above, the **Coordinator** of the specialist training programme in family medicine will be responsible for:

- day-to-day administration of the programme,
- defining the curriculum in collaboration with the Trainers and the MCFD,
- co-ordinating the audit of the programme (evaluation and assessments) and feeding this information back to the Trainers and the MCFD, and
- liaison between the clinical Departments, the Trainers' Group, the Health Division and the MCFD.

The Coordinator and Trainers will be responsible for the appraisal, evaluation and assessment processes for the Trainees, Trainers, and the specialist training programme itself, to allow continuous change and improvement.

(MCFD, 1993a; MCFD, 2004; UEMO, 1992)

8. Obligations of trainee: -

After each trainee is paired with a trainer, trainees are obliged to make the best use of their specialist training through becoming involved in their training process by identifying their learning needs in collaboration with their trainers (MCFD, 2004; UEMO, 2003b).

8.1 Learning objectives:

- By the end of the three-year training programme, the trainee should have acquired the competences outlined in Section 4.
- The fulfilment of the specialist training programme's aim of producing competent, reflective and self-educating family doctors through assessment of performance (both formative and summative) by the trainer.

8.2 Obligatory requirements:

- The trainee shall:
 - a) Record all stages of training and activities related to training in a logbook or portfolio specific to the training programme including on-call hours worked. The portfolio will serve as:
 - a record of training experiences,
 - a list of perceived learning needs,
 - documentation of the process of satisfying those needs on an ongoing basis,
 - the basis of appraisals and assessments during training, and
 - training in taking responsibility for own future life-long learning.
 - b) Have sufficient linguistic capabilities to communicate with patients and colleagues as recommended by the Union Europeene des Medecins Specialistes.
 - c) Participate in a day-release programme for a minimum of 4 hours per week protected time in academic activities.
 - d) Sign an agreement (incorporating a code of ethics) to respect the relationship between the patients and the trainer.
- The trainee and trainer shall:
 - a) agree to and sign an educational contract.
 - b) agree to and sign financial arrangements.
 - c) make the necessary insurance requirements.
 - d) make mutual arrangements for leave.

8.3 Recommended requirements:

- The trainee is strongly encouraged to:
 - a) Participate in research and submit publications.
 - b) Participate in, and present scientific contributions at national and international meetings.
- Trainees and trainers are strongly encouraged to participate in social activities for them and their families.

(MCFD, 2004; Specialist Accreditation Committee, 2003; UEMS, 1993).

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- Accident & Emergency: Dr Robert Camilleri
- Medicine: Prof. Carmel Mallia
- Obstetrics & Gynaecology: Standing Committee of European Doctors, 1991
- Paediatrics: Dr Simon Attard Montalto
- Dermatology & Venereology: Dr Lawrence Scerri
- Geriatrics: Dr Anthony Fiorini
- Ophthalmology: Mr Thomas Fenech
- Otorhinolaryngology and Head & Neck Surgery: Dr Mario E Said
- Palliative Care: Dr Mario Grixti
- Psychiatry: Dr Joseph R Saliba

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- Dr Roar Maagaard, Former Chairman Vocational Training Committee, European Academy of Teachers in General Practice
- Dr Margaret O'Riordan, National Director Specialist Training in General Practice, Irish College of General Practitioners

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Appendix 1: - Three-year Trainee-Attachments Roster

Family Medicine (FM)	12 months full-time & 12 months part-time
Medicine (Med)	3 months full-time
Obstetrics & Gynaecology (O&G)	3 months full-time
Paediatrics (Paed)	3 months full-time
Accident & Emergency (A&E)	3 months full-time
Dermatology & Venereology (Der)	2 months part-time (3 attachments per 6-day week)
Geriatrics (Ger)	2 months part-time (3 attachments per 6-day week)
Psychiatry (Psy)	2 months part-time (3 attachments per 6-day week)
Otorhinolaryngology (Oto)	2 months part-time (3 attachments per 6-day week)
Ophthalmology (Oph)	2 months part-time (3 attachments per 6-day week)
Palliative Care (Pall)	2 months part-time (3 attachments per 6-day week)

	Trainee 1	Trainee 2	Trainee 3	Trainee 4	Trainee 5	Trainee 6	Trainee 7	Trainee 8	Trainee 9	Trainee 10	Trainee 11	Trainee 12
Oct	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Nov	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Dec	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Jan	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E
Feb	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E
Mar	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E
Apr	FM/Der*	FM/Ger*	FM/Psy*	FM/Der^	FM/Ger^	FM/Psy^	FM/Der*	FM/Ger*	FM/Psy	FM/Der^	FM/Ger^	FM/Psy^
May	FM/Der*	FM/Ger*	FM/Psy*	FM/Der^	FM/Ger^	FM/Psy^	FM/Der*	FM/Ger*	FM/Psy	FM/Der^	FM/Ger^	FM/Psy^
Jun	FM/Ger*	FM/Psy*	FM/Der*	FM/Ger^	FM/Psy^	FM/Der^	FM/Ger*	FM/Psy*	FM/Der*	FM/Ger^	FM/Psy^	FM/Der^
Jul	FM/Ger*	FM/Psy*	FM/Der*	FM/Ger^	FM/Psy^	FM/Der^	FM/Ger*	FM/Psy*	FM/Der*	FM/Ger^	FM/Psy^	FM/Der^
Aug	FM/Psy*	FM/Der*	FM/Ger*	FM/Psy^	FM/Der^	FM/Ger^	FM/Psy*	FM/Der*	FM/Ger*	FM/Psy^	FM/Der^	FM/Ger^
Sep	FM/Psy*	FM/Der*	FM/Ger*	FM/Psy^	FM/Der^	FM/Ger^	FM/Psy*	FM/Der*	FM/Ger*	FM/Psy^	FM/Der^	FM/Ger^
Oct	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med
Nov	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med
Dec	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med
Jan	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Feb	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Mar	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Apr	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G
May	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G
Jun	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G
Jul	FM/Oto^	FM/Oph^	FM/Pall^	FM/Oto*	FM/Oph*	FM/Pall*	FM/Oto^	FM/Oph^	FM/Pall^	FM/Oto*	FM/Oph*	FM/Pall*
Aug	FM/Oto^	FM/Oph^	FM/Pall^	FM/Oto*	FM/Oph*	FM/Pall*	FM/Oto^	FM/Oph^	FM/Pall^	FM/Oto*	FM/Oph*	FM/Pall*
Sep	FM/Oph^	FM/Pall^	FM/Oto^	FM/Oph*	FM/Pall*	FM/Oto*	FM/Oph^	FM/Pall^	FM/Oto^	FM/Oph*	FM/Pall*	FM/Oto*
Oct	FM/Oph^	FM/Pall^	FM/Oto^	FM/Oph*	FM/Pall*	FM/Oto*	FM/Oph^	FM/Pall^	FM/Oto^	FM/Oph*	FM/Pall*	FM/Oto*
Nov	FM/Pall^	FM/Oto^	FM/Oph^	FM/Pall*	FM/Oto*	FM/Oph*	FM/Pall^	FM/Oto^	FM/Oph^	FM/Pall*	FM/Oto*	FM/Oph*
Dec	FM/Pall^	FM/Oto^	FM/Oph^	FM/Pall*	FM/Oto*	FM/Oph*	FM/Pall^	FM/Oto^	FM/Oph^	FM/Pall*	FM/Oto*	FM/Oph*
Jan	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed
Feb	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed
Mar	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed	A&E	Med	O&G	Paed
Apr	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
May	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Jun	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Jul	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Aug	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
Sep	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM

* - Hospital speciality attachments on Mondays, Wednesdays & Fridays

^ - Hospital speciality attachments on Tuesdays, Thursdays & Saturdays

Acknowledgement: Dr Jürgen C Abela, personal communication, 25th August 2004

Appendix 2: - Top 200 Episode Titles seen in Family Practice from the Maltese Transition Project 2001-2003

Subdivided into chapters as recommended by the International Classification of Primary Care – Version 2 (ICPC-2) and ranked according to incidence

Ref.: Soler JK, Okkes IM, (2004). Sick leave certification: an unwelcome administrative burden for the family doctor? *Eur J Gen Pract*; 10(2): 49-54.

General Rank	Code	Label	N	p1000py	%
		Total	46565	1946.4	100
		RESPIRATORY			
1	R74	Upper respiratory infection acute	5819	243.2	12.5
5	R78	Acute bronchitis/bronchiolitis	1501	62.7	3.2
7	R76	Tonsillitis acute	987	41.3	2.1
8	R05	Cough	940	39.3	2
9	R80	Influenza	938	39.2	2
10	R96	Asthma	892	37.3	1.9
11	R29	Respiratory symptom/complaint other	703	29.4	1.5
13	R97	Allergic rhinitis	627	26.2	1.3
14	R75	Sinusitis acute/chronic	548	22.9	1.2
15	R77	Laryngitis/tracheitis acute	542	22.7	1.2
38	R07	Sneezing/nasal congestion	218	9.1	0.5
105	R21	Throat symptom/complaint	77	3.2	0.2
125	R81	Pneumonia	60	2.5	0.1
131	R23	Voice symptom/complaint	56	2.3	0.1
168	R06	Nose bleed/epistaxis	41	1.7	0.1
181	R03	Wheezing	37	1.5	0.1
		Sub-total	13986	584.5	30
		GENERAL			
2	A98	Health maint/preventive medicine	2703	113	5.8
4	A97	No disease	1581	66.1	3.4
16	A85	Adverse effect medical agent	537	22.4	1.2
42	A77	Viral disease other/NOS	200	8.4	0.4
43	A92	Allergy/allergic reaction NOS	196	8.2	0.4
50	A03	Fever	169	7.1	0.4
51	A72	Chickenpox	168	7	0.4
63	A04	Weakness/tiredness general	139	5.8	0.3
77	A91	Abnormal result investigation NOS	108	4.5	0.2
86	A75	Infectious mononucleosis	93	3.9	0.2
103	A76	Viral exanthem other	80	3.3	0.2
124	A87	Complication of medical treatment	60	2.5	0.1
128	A96	Death	57	2.4	0.1
150	A23	Risk factor NOS	48	2	0.1
151	A06	Fainting/syncope	48	2	0.1
152	A88	Adverse effect physical factor	48	2	0.1
		Sub-total	6235	260.6	13.4

General Rank	Code	Label	N	p1000py	%
		DIGESTIVE			
3	D73	Gastroenteritis presumed infection	2071	86.6	4.4
26	D87	Stomach function disorder	327	13.7	0.7
31	D70	Gastrointestinal infection	297	12.4	0.6
40	D12	Constipation	211	8.8	0.5
46	D06	Abdominal pain localized other	185	7.7	0.4
53	D83	Mouth/tongue/lip disease	165	6.9	0.4
61	D93	Irritable bowel syndrome	146	6.1	0.3
68	D82	Teeth/gum disease	126	5.3	0.3
78	D19	Teeth/gum symptom/complaint	105	4.4	0.2
79	D03	Heartburn	104	4.3	0.2
82	D95	Anal fissure/perianal abscess	100	4.2	0.2
83	D08	Flatulence/gas/belching	98	4.1	0.2
89	D89	Inguinal hernia	90	3.8	0.2
90	D91	Abdominal hernia other	89	3.7	0.2
94	D88	Appendicitis	86	3.6	0.2
95	D01	Abdominal pain/cramps general	84	3.5	0.2
102	D98	Cholecystitis/cholelithiasis	80	3.3	0.2
123	D84	Oesophagus disease	60	2.5	0.1
134	D90	Hiatus hernia	55	2.3	0.1
137	D99	Disease digestive system other	54	2.3	0.1
142	D86	Peptic ulcer other	51	2.1	0.1
147	D11	Diarrhoea	50	2.1	0.1
149	D25	Abdominal distension	49	2	0.1
162	D20	Mouth/tongue/lip symptom/complaint	44	1.8	0.1
171	D92	Diverticular disease	41	1.7	0.1
		Sub-total	4768	199.2	10.2

General Rank	Code	Label	N	p1000py	%
		MUSCULOSKELETAL			
6	L18	Muscle pain	1232	51.5	2.6
25	L86	Back syndrome with radiating pain	327	13.7	0.7
29	L02	Back symptom/complaint	314	13.1	0.7
36	L99	Musculoskeletal disease other	262	11	0.6
48	L79	Sprain/strain of joint NOS	180	7.5	0.4
49	L77	Sprain/strain of ankle	175	7.3	0.4
62	L78	Sprain/strain of knee	143	6	0.3
74	L04	Chest symptom/complaint	111	4.6	0.2
75	L83	Neck syndrome	109	4.6	0.2
76	L90	Osteoarthritis of knee	108	4.5	0.2
81	L03	Low back symptom/complaint	103	4.3	0.2
91	L15	Knee symptom/complaint	89	3.7	0.2
93	L17	Foot/toe symptom/complaint	87	3.6	0.2
99	L91	Osteoarthritis other	83	3.5	0.2
106	L14	Leg/thigh symptom/complaint	77	3.2	0.2
108	L01	Neck symptom/complaint	76	3.2	0.2
110	L92	Shoulder syndrome	72	3	0.2
114	L98	Acquired deformity of limb	68	2.8	0.1
116	L08	Shoulder symptom/complaint	66	2.8	0.1
115	L76	Fracture: other	66	2.8	0.1
120	L84	Back syndrome without radiat pain	64	2.7	0.1
135	L81	Injury musculoskeletal NOS	54	2.3	0.1
139	L87	Bursitis/tendinitis/synovitis NOS	53	2.2	0.1
146	L93	Tennis elbow	51	2.1	0.1
144	L96	Acute internal damage knee	51	2.1	0.1
166	L74	Fracture: hand/foot bone	43	1.8	0.1
177	L85	Acquired deformity of spine	39	1.6	0.1
189	L95	Osteoporosis	35	1.5	0.1
192	L72	Fracture: radius/ulna	34	1.4	0.1
		Sub-total	4172	174.4	8.9

General Rank	Code	Label	N	p1000py	%
		SKIN			
27	S10	Boil/carbuncle	325	13.6	0.7
34	S88	Dermatitis contact/allergic	270	11.3	0.6
37	S74	Dermatophytosis	247	10.3	0.5
41	S16	Bruise/contusion	210	8.8	0.5
45	S87	Dermatitis/atopic eczema	186	7.8	0.4
54	S03	Warts	161	6.7	0.3
55	S18	Laceration/cut	161	6.7	0.3
56	S12	Insect bite/sting	160	6.7	0.3
59	S09	Infected finger/toe	150	6.3	0.3
69	S75	Moniliasis/candidiasis skin	124	5.2	0.3
72	S93	Sebaceous cyst	116	4.8	0.2
87	S17	Abrasion/scratch/blister	91	3.8	0.2
92	S99	Skin disease other	88	3.7	0.2
97	S84	Impetigo	84	3.5	0.2
96	S98	Urticaria	84	3.5	0.2
98	S96	Acne	83	3.5	0.2
118	S06	Rash localized	66	2.8	0.1
117	S79	Neoplasm skin benign/unspecified	66	2.8	0.1
121	S82	Naevus/mole	61	2.5	0.1
136	S76	Skin infection other	54	2.3	0.1
140	S20	Corn/callosity	52	2.2	0.1
141	S86	Dermatitis seborrhoeic	52	2.2	0.1
153	S70	Herpes zoster	47	2	0.1
155	S94	Ingrowing nail	47	2	0.1
158	S78	Lipoma	45	1.9	0.1
163	S04	Lump/swelling localized	44	1.8	0.1
172	S02	Pruritus	40	1.7	0.1
176	S71	Herpes simplex	40	1.7	0.1
179	S14	Burn/scald	38	1.6	0.1
182	S07	Rash generalized	37	1.5	0.1
185	S15	Foreign body in skin	35	1.5	0.1
198	S21	Skin texture symptom/complaint	33	1.4	0.1
		Sub-total	3297	138.1	7
		CIRCULATORY			
12	K86	Hypertension uncomplicated	695	29.1	1.5
39	K88	Postural hypotension	216	9	0.5
44	K85	Elevated blood pressure	188	7.9	0.4
60	K96	Haemorrhoids	147	6.1	0.3
80	K76	Ischaemic heart dis without angina	103	4.3	0.2
84	K95	Varicose veins of leg	95	4	0.2
85	K74	Ischaemic heart dis with angina	94	3.9	0.2
88	K77	Heart failure	90	3.8	0.2
119	K94	Phlebitis/thrombophlebitis	64	2.7	0.1
132	K87	Hypertension complicated	56	2.3	0.1
173	K07	Swollen ankles/oedema	40	1.7	0.1
191	K90	Stroke/cerebrovascular accident	35	1.5	0.1
188	K92	Atherosclerosis/periph vascular dis	35	1.5	0.1
200	K83	Heart valve disease NOS	32	1.3	0.1
		Sub-total	1890	79.1	4.1

General Rank	Code	Label	N	p1000py	%
PSYCHOLOGICAL					
20	P17	Tobacco abuse	429	17.9	0.9
21	P76	Depressive disorder	395	16.5	0.8
32	P74	Anxiety disorder/anxiety state	297	12.4	0.6
35	P01	Feeling anxious/nervous/tense	267	11.2	0.6
100	P06	Sleep disturbance	80	3.3	0.2
126	P02	Acute stress reaction	59	2.5	0.1
130	P15	Chronic alcohol abuse	57	2.4	0.1
145	P03	Feeling depressed	51	2.1	0.1
183	P22	Child behaviour symptom/complaint	37	1.5	0.1
186	P79	Phobia/compulsive disorder	35	1.5	0.1
Sub-total			1707	71.3	3.6
EAR					
19	H71	Acute otitis media/myringitis	438	18.3	0.9
22	H82	Vertiginous syndrome	376	15.7	0.8
24	H70	Otitis externa	332	13.9	0.7
33	H81	Excessive ear wax	290	12.1	0.6
57	H73	Eustachian salpingitis	155	6.5	0.3
169	H72	Serous otitis media	41	1.7	0.1
187	H13	Plugged feeling ear	35	1.5	0.1
Sub-total			1667	69.7	3.5
METABOLIC, ENDOCRINE					
23	T93	Lipid disorder	363	15.2	0.8
28	T90	Diabetes non-insulin dependent	321	13.4	0.7
30	T82	Obesity	307	12.8	0.7
104	T86	Hypothyroidism/myxoedema	79	3.3	0.2
107	T83	Overweight	77	3.2	0.2
127	T89	Diabetes insulin dependent	57	2.4	0.1
143	T08	Weight loss	51	2.1	0.1
157	T92	Gout	46	1.9	0.1
195	T99	Endocr/metab/nutrit disease other	34	1.4	0.1
Sub-total			1335	55.7	3
EYE					
18	F70	Conjunctivitis infectious	458	19.1	1
52	F71	Conjunctivitis allergic	167	7	0.4
67	F72	Blepharitis/stye/chalazion	126	5.3	0.3
161	F99	Eye/adnexa disease other	45	1.9	0.1
178	F76	Foreign body in eye	38	1.6	0.1
180	F92	Cataract	37	1.5	0.1
Sub-total			871	36.4	2
NEUROLOGICAL					
64	N95	Tension headache	135	5.6	0.3
65	N17	Vertigo/dizziness	132	5.5	0.3
71	N89	Migraine	116	4.8	0.2
73	N01	Headache	114	4.8	0.2
112	N93	Carpal tunnel syndrome	71	3	0.2
113	N99	Neurological disease other	69	2.9	0.1
190	N88	Epilepsy	35	1.5	0.1
196	N06	Sensation disturbance other	34	1.4	0.1
Sub-total			706	29.5	1.5

General Rank	Code	Label	N	p1000py	%
UROLOGICAL					
17	U71	Cystitis/urinary infection other	466	19.5	1
66	U95	Urinary calculus	130	5.4	0.3
159	U06	Haematuria	45	1.9	0.1
197	U99	Urinary disease other	33	1.4	0.1
Sub-total			674	28.2	1.5
FEMALE GENITAL					
47	X72	Genital candidiasis female	184	7.7	0.4
109	X11	Menopausal symptom/complaint	72	3	0.2
111	X78	Fibromyoma uterus	71	3	0.2
133	X02	Menstrual pain	55	2.3	0.1
138	X06	Menstruation excessive	54	2.3	0.1
148	X99	Genital disease female other	49	2	0.1
156	X07	Menstruation irregular/frequent	46	1.9	0.1
165	X19	Breast lump/mass female	43	1.8	0.1
170	X05	Menstruation absent/scanty	41	1.7	0.1
174	X84	Vaginitis/vulvitis NOS	40	1.7	0.1
Sub-total			655	27.4	1.5
BLOOD, IMMUNE SYSTEM					
70	B02	Lymph gland(S) enlarged/painful	119	5	0.3
101	B80	Iron deficiency anaemia	80	3.3	0.2
160	B82	Anaemia other/unspecified	45	1.9	0.1
193	B70	Lymphadenitis acute	34	1.4	0.1
Sub-total			278	11.6	0.7
SOCIAL PROBLEMS					
154	Z12	Relationship problem with partner	47	2	0.1
164	Z29	Social problem NOS	43	1.8	0.1
184	Z20	Relationship problem parent/family	36	1.5	0.1
194	Z15	Loss/death of partner problem	34	1.4	0.1
199	Z05	Work problem	32	1.3	0.1
Sub-total			192	8	0.5
WOMAN'S HEALTH, PREGNANCY, FAMILY PLANNING					
58	W78	Pregnancy	154	6.4	0.3
129	W11	Contraception oral	57	2.4	0.1
Sub-total			211	8.8	0.4
MALE GENITAL					
122	Y75	Balanitis	61	2.5	0.1
167	Y81	Phimosis/redundant prepuce	42	1.8	0.1
175	Y85	Benign prostatic hypertrophy	40	1.7	0.1
Sub-total			143	6	0.3