MALTA COLLEGE OF FAMILY DOCTORS

SPECIALIST TRAINING PROGRAMME IN FAMILY MEDICINE - MALTA

3rd Edition

MCFD Education Committee 2016-19:

Edward Zammit

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Introduction

As the body responsible for developing Specialist / Vocational Training in Family Medicine in Malta, the Malta College of Family Doctors (MCFD) 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 Specialist Training in Family Medicine in Malta takes place under the auspices of the Primary Health Department within the Health Division, the College is 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, and according to future recommendations by European and international bodies of academic family medicine.

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Version:
3rd Edition (September 2017) approved by Malta's Specialist Accreditation Committee supersedes 2nd Edition.

Reference:
Sammut MR, Soler JK, Bonnici JJ & Stabile I. Specialist Training Programme in Family Medicine – Malta. 2nd Edition. Malta: Malta College of Family Doctors, 2011.

Contents

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 (STPFM) in Malta is 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 had 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 had 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).

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

- 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:

- provides appropriately trained family doctors, working with other health care disciplines in a general practice setting;
- is planned and supervised throughout by trainers who are established family doctors, have undergone training as teachers in family medicine, and are accredited as teachers in family medicine by the MCFD;
- is one to one, with both trainee and trainer being involved in the training post

allocation, and the trainer having responsibility for only one GP trainee at a time;
- involves working in government primary health centres and in private family practice, so that the trainee gains experience of both systems;
- is learner centred, representing adult professional education with flexibility in terms of content and length of individual posts;
- allows adult learning methods to be used, such as portfolio-based learning;
- is based on different training methods, including lectures, tutorials and group work;
- addresses the core competencies of the family doctor (see Section 4) and the MCFD's Curriculum for Specialist Training in Family Medicine for Malta (Falzon Camilleri & Sammut, 2009).

In order to avoid the disadvantage of the previous 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 roster in Table 3.1 is recommended

Table 3.1: Roster of family medicine / hospital speciality rotations

6 months:	**Family Medicine** *(full-time)*
3 months:	*Major Hospital Speciality (full-time)*
3 months:	*Major Hospital Speciality (full-time)*
6 months:	**Family Medicine** *(full-time)*
1 month:	*Minor Hospital Speciality (full-time)*
1 month:	*Minor Hospital Speciality (full-time)*
1 month:	*Minor Hospital Speciality (full-time))*
3 months:	*Major Hospital Speciality (full-time)*
1 month:	*Minor Hospital Speciality (full-time)*
1 month:	*Minor Hospital Speciality (full-time)*
1 month:	*Minor Hospital Speciality (full-time)*
3 months:	*Major Hospital Speciality (full-time)*
6 months:	**Family Medicine** *(full-time)*

The above schedule means that the length of time in family medicine comprises 18 months' full time attachment, in order to fulfil the recommendation made earlier that at least 50% of specialist training should be spent in family practice (i.e. 18 out of 36 months).

The hospital attachments, where training focuses on the needs of Family Medicine learning, are made up of blocks with durations of 3 months full time in the Medicine and Paediatric Departments, 2 months full-time in the Obstetrics and Gynaecology Department, 3 months full time in a minor speciality (adapted from Director General (Health), 2000; Pereira Gray, 1979), 6 weeks full-time in the Orthopaedics Department and 6 weeks full time in the Accident & Emergency Department (Specialist Training Committee in Family Medicine, 19 August 2010) as shown in Table 3.2.

Table 3.2: Major & minor hospital placements

Major Hospital Specialities (full-time)

Medicine	3 months
Obstetrics & Gynaecology	2 months
Paediatrics	3 months
Accident & Emergency	6 weeks
Orthopaedics	6 weeks

Minor Hospital Specialities (full-time)

Dermatology & Venereology	1 month
Geriatrics	1 month
Psychiatry	1 month
Otorhinolaryngology and Head & Neck Surgery	1 month
Ophthalmology	1 month
Palliative Care	1 month

A three-year trainee placements roster drafted for twenty trainees is attached as an Appendix to this document (Appendix 1). The Obstetrics & Gynaecology placement is followed by 2 two week tasters in another hospital speciality according to the GP trainee's needs (such as primary health administration, radiology/ultrasound, research and pain medicine), while the Palliative Care attachment is to include a minimum of one morning a week placement with the Malta Hospice Movement so that the trainee is exposed to palliative care in the community. (Specialist Training Committee in Family Medicine, 19 August 2010)

Requests for suspension of training from GP trainees will be accepted in the training programme as long as only one period of suspension is granted and the duration of this suspension does not exceed the period of one calendar year. Further requests for suspension may be considered in case of special extenuating circumstances. However the cumulative period of suspension may not exceed the period of one calendar year. The process of pairing of the trainee and trainer when the trainee resumes training should be the same as that adopted for other trainees. (Specialist Training Committee in Family Medicine, 19 August 2010)

A half-day release course (HDRC) comprising four hours of academic activities is organised once a week throughout the 3-year training period from October to June, with two-week breaks for Christmas and Easter. This programme includes group and problem-based learning, with development of interpersonal skills. (Sammut et al, 2007)

(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 (GPs) / 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.

In 2009 the Malta College of Family Doctors published 'A Curriculum for Specialist Training in Family Medicine for Malta' that not only helps trainees acquire the necessary competences, but also become 'Good Doctors' and develop attributes of professionalism (Falzon Camilleri & Sammut, 2009). Section B of the Curriculum (entitled 'Key Features of Family Medicine') and Section C ('Clinical Medicine') both specify learning outcomes that the trainee is expected to attain by the end of the specialist training.

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 Curriculum for Specialist Training in Family Medicine for Malta - Falzon Camilleri & Sammut, 2009);
- 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 Curriculum for Specialist Training in Family Medicine for Malta - Falzon Camilleri & Sammut, 2009);
- 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 Curriculum for Specialist Training in Family Medicine for Malta - Falzon Camilleri & Sammut, 2009);
- 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 Curriculum for Specialist Training in Family Medicine for Malta - Falzon Camilleri & Sammut, 2009);
- 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 Tables 4.2.1 and 4.2.2 below) are recommended (EURACT, 2000).

Table 4.2.1: General principles of organisation

PROGRAMME	*RESOURCES*
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 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	*Protected* 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

Table 4.2.2: Key principles of provision

EDUCATION CONTENT	*CLINICAL CONTENT*
Focussed on what GP 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 GP 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 GP	Practical experience in a range of management decisions
Contact maintained with family practice via a GP educational release programme and a training practice	Insight into the primary care – secondary care interface
Equal importance of GP-training and other specialist-training programmes	Exposure to and experience of serious morbidity

The objective of hospital-based training is for the GP 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 (where relevant 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.

During hospital attachments, the GP trainees are to keep attendance sheets that are duly endorsed by their clinical supervisors.

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 Curriculum for Specialist Training in Family Medicine for Malta - Falzon Camilleri & Sammut, 2009).

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 & Endocrinology, Infectious Diseases, Renal Diseases, Cardiology;
    - 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 GP 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 GP 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 (hormone replacement therapy, 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 urinary tract infections.
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. Attention Deficit Hyperactive Disorder 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 gastrointestinal bleeding
  - Lower gastrointestinal bleeding
- Metabolic:
  - Diabetic complications
  - Metabolic disorders
- Neurology:
  - Headache
  - Cerebrovascular Accident /Transient Ischaemic Attack
  - Epileptic fits
  - Unconscious patient
- Blood disorders
- Specific infections / Pyrexia of unknown origin
- 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 the 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 Human Immunodeficiency Virus 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;
- Psoralen + Ultraviolet-A/ Ultraviolet-B (PUVA/UVB) sessions;
- Dermatological minor operation sessions.

Geriatrics

Trainees will be attached to the Geriatrics Department in the Rehabilitation Hospital (RH), Pieta', 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 Non-Government Organisations 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 and relevant skills 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.

DISORDERS:

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)

SKILLS

1. Clerking
2. Basic rating scales
3. Risk assessment
4. When to refer for specialist advice / management
5. Referral, consultation and liaison with other services

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 undergoes assessment (formative and summative) 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.

5.1 Formative Assessment:

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

- Educational portfolio (logbook).

  Portfolio-based learning is 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. It serves to prepare the trainee to take responsibility for his/her future life-long learning. The portfolio (GP Trainee Educational Portfolio (Logbook), 2010) comprises the following:

  - Learning record
    - Educational agreement signed by the trainee and trainer
    - Self-rating scales (GP Trainee Self-Rating Scale [The Wolverhampton Grid, Version 3 1999], 2008). These serve to establish a baseline of the trainee's past experience to help develop an educational programme and, being repeated at 6 monthly intervals, will evaluate progress over the 3-year training programme
    - Educational plans
    - Tutorial Programme
  - Work-based assessment
    - Videoed consultations assessed using the Consultation Observation Tool (COT)
    - Case-based discussions (CBDs) assessed using the CBD form
    - Trainee reviews: by GP Trainer; hospital clinical supervisors; colleagues (doctor/s, nurse/s, receptionist/s, etc.) using Multi-Source Feedback (MSF) forms; and patients (through Consultation Satisfaction Questionnaires - CSQs)
  - Educational activities
    - Half-Day Release Course group teaching and learning attendance record (with the minimum rate of attendance set at 85%)
    - European Resuscitation Council (ERC) accredited Basic/AED & Advanced Life Support Certificates
    - Journal Club meetings.
    - Certificates of attendance to other educational activities
    - Teaching and learning at any other educational activities attended
    - Any papers published by the trainee
  - Clinical experience
    - Log of cases seen daily during hospital attachments
    - Problem cases log

        - Clinical diary for reflective practice; significant event analysis (SEA)
        - Emergencies dealt with; referrals for consultant opinion; acute admissions to hospital
        - Child health surveillance in Well Baby Clinics
        - Direct Observation of Procedural Skills (DOPS)
        - Minor surgical procedures – various
    - Trainee's evaluations of family medicine and hospital posts

- Research Project

  "Research and production of objective evidence is central for GPs to be able to deliver the best care possible to their patients." (RCGP 2017)

  The research project is intended to empower trainees with skills which allow them to search for and critically appraise research evidence and apply this to their daily practice and with the skills, knowledge and attitudes to perform basic research projects during their Family Medicine speciality training.

  GP Trainees are expected to undergo training in critical appraisal and research methodology and write up at least one basic research project or one research protocol.

  Family Medicine trainers shall be expected to confidently mentor their trainees in searching for and assessing research evidence and performing basic research, and direct them to appropriate resources, including skilled colleagues, as appropriate.
  The trainers and members of the MCFD Research group will provide supervision and feedback during the whole process, to enable ongoing learning.

- Annual appraisal (GP Trainee's Annual Appraisal, 2010).

  This consists of a 'One-to-One Appraisal' where the GP Trainee and Trainer together review progress of the former during the training year in question and make plans for future training. The Post-Graduate Training Coordinator/s then review/s the Educational Portfolio according to a list of objective requirements.

    - If both reviews are satisfactory, the GP Trainee progresses to the next year of the three-year programme. If the training year in question is the third and final year of the programme, the trainee will have completed the final-year appraisal and the educational portfolio.
    - If either or both of the 'One-to-One Appraisal' and the 'Review of the GP Trainee Educational Portfolio' are unsatisfactory, the case is referred to the *In-Programme Appeals Board* for review and the appropriate recommendation.
    - A GP trainee who does not satisfy the requirements for progression will be reviewed by a *second Appeals Board*. If this second appeal is again unsatisfactory, the trainee will be suspended from the Specialist Training Programme in Family Medicine in order to provide him/her with the time and opportunity to fulfil the requirements for progression.
    - If the *third and final Appeals Board* deems that such review is satisfactory, the trainee will be allowed to re-start the programme at the next rotation of posts, with

the missed post to be performed as an extension to the three-year programme. In the case of a final-year appraisal, the trainee will be certified as having completed the final-year appraisal and the educational portfolio. If the annual appraisal is unsatisfactory for a third time, the Board will recommend to the Specialist Training Committee in Family Medicine that the GP Trainee is dismissed from the Specialist Training Programme in Family Medicine.

5.2 Summative Assessment:

Final summative assessment ascertains proficiency in family practice through the following four components (Cassar, De Gabriele & Zammit, 2009; Malta College of Family Doctors, 2010):

- Work-Based Assessment – WBA:

  The Work-Based Assessment is defined as the evaluation of a doctor's progress, over a suitable period of time, in those areas of professional practice best tested in the workplace. It is a process through which evidence of competence in independent practice is gathered in a structured and systematic framework. The areas of competencies assessed by the Work-Based Assessment are:

  - Communication and Consultation skills
  - Community Orientation
  - Practicing Holistically
  - Data Gathering and Interpretation
  - Making a diagnosis / Making decisions
  - Clinical Management
  - Managing Medical Complexity and Promoting Health
  - Primary Care Administration and Information Medical Technology
  - Working with Colleagues and Teamwork
  - Maintaining Performance, Learning and Teaching
  - Maintaining an Ethical Approach to Practice
  - Fitness to Practice

  This is covered by the completed GP Trainee Educational Portfolio and the Trainer's Report (Final Annual Appraisal). On the basis of an objective review undertaken by the Postgraduate Training Coordinator/s through the GP Trainee's Annual Appraisal, the GP Trainee is certified as having completed the GP Trainee Educational Portfolio, signifying that the WBA component of the MCFD Membership (MMCFD) Examination has been passed.

- Research Project:

  The research project will also serve a summative assessment function. Completing the project satisfactorily is a requirement for completion pf specialist training (CCST).

- Applied Knowledge Test – AKT:

  This component of the examination assesses the application of knowledge including decision making, evaluation of evidence and undifferentiated problems and decisions regarding patient safety. There are two types of questions in this Multiple Choice Paper:

  (a) Single Best Answer Questions:
  Each question consists of a clinical scenario which is followed by a number of options, only one of which is correct. These may include photo questions.

  (b) Extended Matching Questions:
  Each question consists of a clinical scenario which is to be matched to an answer from a list of possible options. There may be several possible answers but the most likely answer from the list of options must be chosen.

  There are 200 applied knowledge test questions to be completed in three hours. The material covered correlates to the MCFD Curriculum for Specialist Training in Family Medicine for Malta. The pass-mark for the Applied Knowledge Test component of the examination is set by a group of family doctors who have been trained and have experience in standard-setting using the Angoff method.

- Clinical Skills Assessment – CSA:

  The Clinical Skills Assessment assesses performance through simulated clinics involving actors. It aims at assessing the ability of the candidates to show and apply, in a coherent and comprehensive way, their clinical, professional, communication and practical skills to a level that is appropriate for a Specialist in Family Medicine.

  This component covers the following core competencies:
  - A holistic and comprehensive approach
  - Community orientation
  - Patient-centred care
  - Primary care management
  - Psychomotor skills
  - Attitudinal characteristics

  There are thirteen cases in this component of the assessment. Each case is covered in 10 minutes. The language for the CSA is generally Maltese but some cases are presented in English. The minimum pass for the Clinical Skills Assessment component is nine out of the total of thirteen CSA cases.

All GP Trainees who have successfully completed the three-year STPFM, are eligible to sit for the AKT and CSA components of the MMCFD examination. (The research project is still a requirement for completion of specialist training). Individual exceptions due to extenuating circumstances are considered on a case-by-case basis by the Malta College of Family Doctors (Malta College of Family Doctors, 2010).

An MCFD Examination Board considers all the evidence needed to approve a candidate or otherwise. A candidate must pass the research project and all components of the examination in order to pass the MMCFD examination overall (Malta College of Family Doctors, 2010).

On passing the MMCFD examination, trainees 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. Qualification & Selection of Trainers, Training Practices and Coordinator of Specialist Training: -

6.1 Trainers and Training Practices:

All general practitioners have the opportunity to apply to be a trainer for specific training in general practice (EURACT, 2002), as long as:

- applicants are established family doctors, have undergone training as teachers in family medicine, and are accredited as teachers in family medicine by the MCFD;
- applicants either work within the government health centres on a full-time basis or on reduced hours (at least 20 hours per week), or else practice in full-time or part-time private family practice (at least 20 hours a week);
- the proportion of trainers in health centre to trainers in private practice is as close to 50:50 as possible, with no discriminatory clauses between these two groups.

Allocation of trainees to trainers / training practices based on the above criteria is coordinated by the Specialist Training Committee in Family Medicine (formed by the Postgraduate Training Coordinator/s in Family Medicine as Chairperson/s, and representatives from the Trainers, Trainees, the MCFD and the Primary Health Department).

The Allocation Process of Trainees to Trainers follows the following steps:

(i) Eligible GP teachers are invited to complete a 'GP Trainer Application & Information Form' and submit it with a *curriculum vitae* (CV) to the Postgraduate Training Coordinator/s. On the form the applicant indicates whether or not s/he and her/his practice have the criteria for selection shown in Table 6.1.1.

Table 6.1.1: Criteria for selection as trainers & training practices

TRAINERS	*TRAINING PRACTICES*
A personal commitment to teaching and to keep updated on educational methodology by attending appropriate lectures and courses	Good quality premises and equipment, with access to library, Information Technology facilities and other teaching aids
Practical teaching skills acquired through appropriate preparation, and certification as trainers by a recognised European College of Family Doctors	Continuity of care with well organised medical records
Practising in the speciality for at least 5 years	Practice with adequate number of patients and workload to ensure the gaining of comprehensive experience for the trainee
A high professional qualification or equivalent as approved by the Malta College of Family Doctors (e.g. listing in the Family Medicine section of the Specialist Accreditation Doctor Register kept by the Medical Council of Malta)	Availability within practice of a clinic where the trainee can undertake 20 hours of independent practice per week under the trainer's supervision
Through active participation in Continuing Medical Education, full accreditation in the speciality with a recognised European College of Family Doctors	The trainee should practise independently in the same premises as the trainer during his/her training attachments, unless dictated otherwise by exigencies of service
A commitment to quality assurance	Good quality health care team
Presently active in family practice	Effective practice management
Audit activities	Access to a full range of laboratory and imaging investigations
Research activities	Audit, research activities

(ii) The applicants' Information Forms and CVs are passed to the GP Trainees concerned (while inviting them for a practice visit and mutual interview), and the GP Trainees' CVs sent to applicants.

(iii) The GP Trainees meet the prospective GP Trainers for a practice visit and mutual interview, while considering the mechanisms for selection listed in Table 6.1.2.

Table 6.1.2: Mechanisms for selection as trainers & training practices

TRAINERS	*TRAINING PRACTICES*
Assessment of the availability of the doctor, both from the point of view of his/her medical care of patients and also his/her educational responsibilities as a trainer	Practice visits (a pre-selection condition): ▪ clinical care ▪ practice culture ▪ learning environment
Consideration of the curriculum vitae	
Personal interview	
Evaluation of the practice	

(iv) Based on the specified mechanisms for selection (Table 6.1.2), the GP Trainees complete and submit a list of preferred GP Trainers in order of preference, while the prospective GP Trainers submit a list of GP Trainees they are willing to accept. All trainees entering the programme must accept that they may be assigned to any trainer in their preference list, while

all trainers entering the programme must accept that they may be assigned any of the trainees in their acceptable list.

(v) Under the coordination of the Specialist Training Committee in Family Medicine, each GP Trainee is then assigned (according to the order of merit obtained at the Public Service Commission Selection interview) to his/her preferred GP Trainer according to:

- the trainee's list of preferred trainers, and
- the prospective trainer's availability and list of acceptable trainees.

(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 is coordinated by a Coordinator or Coordinators 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).

Applicants for the post of Postgraduate Training Coordinator in Family Medicine must:
(i) be on the Specialist Register in Family Medicine of the Medical Council,
(ii) have at least seven years experience as a Specialist in Family Medicine, and
(iii) be certified as a postgraduate trainer in Family Medicine by the MCFD.
Eligible applicants are interviewed to assess their suitability for the position by a Selection Board that includes representation from the Health Care Services Division, the Department of Primary Health and the Malta College of Family Doctors. The appointment of Postgraduate Training Coordinator/s is made for a period of three years, subject to satisfactory performance. (Ministry of Health, the Elderly and Community Care, 2008).

7. Duties of Trainers and Coordinator: -

7.1 Duties of Trainers:

The **Trainers** should keep up-to-date with medical developments, maintain high standards of clinical practice and undergo regular training in teaching and medical education and professional development as assessors/examiners (Specialist Accreditation Committee, 2003). This would enable the Trainer to fulfil the following duties:

- Organise training according to the Curriculum for Specialist Training in Family Medicine for Malta (Falzon Camilleri & Sammut, 2009) 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);
- Through a one-to-one trainer-trainee relationship, and in negotiation with the trainee, determine the trainee's educational needs using self-rating scales and, in order to meet them:
    - produce with the trainee an educational plan for each placement to meet the objectives defined in the needs assessment, with the plan being reviewed at the end of each placement;
    - organise with the trainee teaching and formative assessment using adult learning methods, including weekly one-to-one tutorials, practice-based learning, one-to-one mentoring sessions, regular small-group problem-based tutorials, interactive lectures, research and critical reading projects;
- Hold formative assessments and give feedback regularly through formal appraisal sessions at appropriate intervals (at least at the end of every attachment) throughout the training programme;
- Keep a record of all needs assessments, formative assessments and appraisals and use such to facilitate completion of the 'One-to-One Appraisal' section of the GP Trainee's Annual Appraisal Report;
- Actively participate in the weekly Half Day Release Course group-teaching programme as requested, according to a rotation system;
- Collaborate in the evaluation of the training programme as required;
- Provide advice, constructive criticism and guidance as needed by the GP trainee, within an appropriate environment for learning General Practice;
- Accept constructive criticism and appraisal of his/her own performance;
- Ensure that relations with the trainee are kept at a professional level throughout the course;
- Discuss with the trainee at any time possible concerns regarding inappropriate education, experience or development in the trainee-trainer relationship, and should these concerns continue, seek the advice and support of the Coordinator/s of Training;
- 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;
    - team-working 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.

7.2 Duties of Coordinator:

The implementation of the Specialist Training Programme in Family Medicine as approved by the Specialist Accreditation Committee is coordinated through the Specialist Training Committee in Family Medicine and is supported and supervised by the Director General, Health Care Services. In order to fulfil the necessary role and responsibility, the Postgraduate Training Coordinator/s work/s closely with their Director of Primary Health, with the Lead Training Coordinator and with the Clinical Chairpersons and the Postgraduate Training Coordinators of other Clinical Departments to ensure that postgraduate training is delivered. The Postgraduate Training Coordinator/s remain/s accountable to the Director of Primary Health for all other clinical activities. (Ministry of Health, the Elderly and Community Care, 2008)

The Postgraduate Training Coordinator/s' duties include:

i. setting up a Specialist Training Committee in Family Medicine (whose membership shall include the Director of Primary Health or his/her delegate, a representative of the Malta College of Family Doctors, and representatives of the trainers and trainees) that is responsible for the setting up, management and administration of the Specialist Training Programme in Family Medicine. Apart from contributing to strategy and policy development, the coordinator/s is/are responsible for day to day management of the Training Programme.
ii. liaising with the Malta College of Family Doctors as the professional association recognised to represent specialists in family medicine.
iii. coordinating annual appraisal and the final assessment of trainees as part of the process leading to the award of the Certificate of Specialist Training. The coordinator/s work/s with the appropriate authorities on manpower planning relating to trainee numbers and appropriate rotation of trainees so as to achieve a quality standard of postgraduate training.
iv. working with trainers in family medicine and trainers from other relevant specialities in the organisation and / or delivery of regular training for specialist trainees.
v. working with the Lead Training Coordinator in the organisation and / or delivery of regular training for trainers.
vi. working with the Lead Training Co-ordinator in the organisation and / or delivery of training for specialist trainees on core matters such as Effective Teaching Techniques, Clinical Audit methodology, Epidemiological methods, Statistical skills, Critical Appraisal Skills, Evidence based Medicine and any other appropriate core training skills deemed necessary.
vii. chairing the Specialist Training Committee in Family Medicine so that appropriate policies are developed, delivered and monitored on a regular basis in order to deliver a high standard of post-graduate training.
viii. ensuring and supervising assignment of trainees to trainers.
ix. establishing appropriate mechanisms to ensure quality assurance of the training programmes.
x. preparing an annual report on the workings of the training programme.

(Ministry of Health, the Elderly and Community Care, 2008)

(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 of this document and in the Curriculum for Specialist Training in Family Medicine for Malta (Falzon Camilleri & Sammut, 2009).
- The fulfilment of the specialist training programme's aim of producing competent, reflective and self-educating family doctors through assessment of performance (both formative by the trainer and summative by the Malta College of Family Doctors).

8.2 Obligatory requirements:

- The trainee should:
  a) Have sufficient linguistic capabilities to communicate with patients and colleagues as recommended by the Union Europeene des Medicins Specialistes.
  b) Work diligently to achieve his/her learning within the trainer's practice through a mixture of service provision (including consulting both in the clinic and at home), one-to-one teaching, and participation (where available) in multi-disciplinary learning and practice activities.
  c) Through a one-to-one trainer-trainee relationship, and in negotiation with the trainer, determine his/her educational needs using self-rating scales and, in order to meet them:
     - produce with the trainer an educational plan for each placement to meet the objectives defined in the needs assessment, with the plan being reviewed at the end of each placement;
     - organise with the trainer teaching and formative assessment using adult learning methods, including weekly one-to-one tutorials, practice-based learning, one-to-one mentoring sessions, regular small-group problem-based tutorials, interactive lectures, research and critical reading projects.
  d) Record all stages of training and activities related to training in an educational portfolio required as evidence for completion of the Work-Based Assessment (see Section 5.1 for details of portfolio).
  e) With the trainer, jointly complete and sign the 'One-to-One Appraisal' as part of the GP Trainee's Annual Appraisal Report.
  f) Participate in the half day release course for a minimum of 4 hours per week protected time in academic activities.
  g) Formally evaluate training using prescribed feedback forms, at the end of each attachment.
  h) Accept constructive criticism and appraisal of his/her performance.
  i) Ensure that relations with the trainer are kept at a professional level throughout the course.
  j) Discuss at any time with the trainer possible concerns regarding inappropriate education, experience or development in the trainee-trainer relationship. Should these concerns continue, then it would be appropriate to seek the advice and support of the Coordinator/s of Training.
  k) Take responsibility for self-directed learning by reading regularly in a planned and programmed manner, identifying and planning to correct weaknesses, and regularly

examining his/her own work in a critical manner.

l) Sign an agreement (incorporating a code of ethics) to respect the relationship between the patients and the trainer.

- The trainee and trainer should also:
  a) agree to and sign an educational agreement.
  b) agree to and sign financial arrangements (where applicable).
  c) make the necessary insurance requirements (where applicable).
  d) make mutual arrangements for leave (as far as possible).

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 encouraged to participate in social activities for them and their families.

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

Acknowledgements for the 2nd Edition: -

The members of the MCFD Education Subcommittee 2003-6 as authors of the 1st Edition (2006) of this document:

- Dr Mario R Sammut (Chairman), Dr Jürgen C Abela, Dr Mario Grixti, Dr Pierre Mallia & Dr Philip Sciortino

Acknowledgements for the 1st Edition: -

Regarding competencies to be acquired during hospital-based training:

- 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
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Appendix 1: - Three-year Trainee Placements Roster

Family Medicine (FM)		18 months full time
Major Speciality	Medicine	3 months full-time
	Obstetrics & Gynaecology #	2 months full-time + 2 tasters (total of 1 month)
	Paediatrics	3 months full-time
Accident & Emergency (A&E) *		6 weeks full-time
Orthopaedics		6 weeks full-time
Minor Speciality *	Dermatology & Venereology (D)	1 month full-time
	Geriatrics (G)	1 month full-time
	Psychiatry (Ps)	1 month full-time
	Otorhinolaryngology - ENT (E)	1 month full-time
	Ophthalmology (O)	1 month full-time
	Palliative Care (Pa) $	1 month full-time

		2016 intake				
		Group1	Group2	Group3	Group4	Group5
YEAR	MONTH	*4 trainees*	*4 trainees*	*4 trainees*	*4 trainees*	*4 trainees*
1	Oct	FM	FM	FM	FM	FM
	Nov	FM	FM	FM	FM	FM
	Dec	FM	FM	FM	FM	FM
	Jan	Med	FM	FM	FM	FM
	Feb	Med	FM	FM	FM	FM
	Mar	Med	FM	FM	FM	FM
	Apr	DGPs	A&E/Orth	Paed	Med	O&G
	May	DGPs	A&E/Orth	Paed	Med	O&G
	Jun	DGPs	A&E/Orth	Paed	Med	2 tasters
	Jul	O&G	Paed	Med	DGPs	EOPa
	Aug	O&G	Paed	Med	DGPs	EOPa
	Sep	2 tasters	Paed	Med	DGPs	EOPa
2	Oct	EOPa	FM	FM	A&E/Orth	Paed
	Nov	EOPa	FM	FM	A&E/Orth	Paed
	Dec	EOPa	FM	FM	A&E/Orth	Paed
	Jan	Paed	FM	FM	EOPa	DGPs
	Feb	Paed	FM	FM	EOPa	DGPs
	Mar	Paed	FM	FM	EOPa	DGPs
	Apr	FM	DGPs	EOPa	FM	FM
	May	FM	DGPs	EOPa	FM	FM
	Jun	FM	DGPs	EOPa	FM	FM
	Jul	FM	O&G	A&E/Orth	FM	FM
	Aug	FM	O&G	A&E/Orth	FM	FM
	Sep	FM	2 tasters	A&E/Orth	FM	FM
3	Oct	FM	EOPa	DGPs	O&G	Med
	Nov	FM	EOPa	DGPs	O&G	Med
	Dec	FM	EOPa	DGPs	2 tasters	Med
	Jan	Orth/A&E	Med	O&G	Paed	A&E/Orth
	Feb	Orth/A&E	Med	O&G	Paed	A&E/Orth
	Mar	Orth/A&E	Med	2 tasters	Paed	A&E/Orth
	Apr	FM	FM	FM	FM	FM
	May	FM	FM	FM	FM	FM
	Jun	FM	FM	FM	FM	FM
	Jul	FM	FM	FM	FM	FM
	Aug	FM	FM	FM	FM	FM
	Sep	FM	FM	FM	FM	FM

* - A&E placements (6 weeks) will be followed/or preceded by Orthopaedics (6 weeks)
- Obstetrics & Gynaecology placement (2 months) will be followed by 2 tasters of 2 weeks each (such as , primary health administration, radiology/ultrasound, research and pain medicine) according to the GP trainee's needs
$ - Palliative Care attachment to include a minimum of one morning (8am-1pm) a week placement with the Malta Hospice Movement

Acknowledgement: developed from original proposal by Dr Jürgen C Abela, personal communication, 25th August 2004 and further modified by Dr.Natalie Psaila and Dr. Edward Zammit (2017)

Addendum 25 September 2012: - Training Flexibility – Reduced hours of work

Requests for training involving reduced hours of work may also be made. The circumstances leading to such requests are first to be approved by the employer. Once the request is approved, the Malta College of Family Doctors (MCFD) accepts that trainees' training is tailored such that all the academic requirements are satisfied. The three year educational programme will be extended so that the total equivalent hours of training is maintained.

The appraisal of each educational year will therefore not be the chronological year but the planned extended year for each trainee applying for reduced hours. It is only after the satisfactory completion of such planned extended academic year that progression from one year to the next is possible. During the academic year the Half Day Release Course (HDRC) will be ongoing. The trainee applicant for reduced hours is expected to continue the HDRC programme as scheduled for the cohort he or she belongs to. The extension of academic hours to make do for a reduced hors trainee applicant does not apply for HDRC.

Reference: attachment to e-mail from Dr Doreen Cassar sent on 25 September 2012 to Dr Gunther P Abela at MHEC-Primary Health Care and Dr Myriam Farrugia, Secretary MCFD, with subject: 'RE: Reduced hours' and reading as follows: *'Dear Gunther and Mario, Please find MCFD Council approved statement on Training Flexibility – reduced hours of work. Kindly consider this as an update to the STPFM 2nd edition. It will be introduced after 'Requests for suspension of training from GP Trainees'. This follows Table 3.2 of the said document. Kind regards, Doreen'.*