ISSUE 03 | VOLUME - 24 | MARCH 2019

IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

PRESIDENTS MESSAGE

Dear Colleagues,

Our constitution says we have :

1. To safeguard and further the interests and status of its members as a body
2. To promote and encourage co-operation and loyalty among members in the best interests of the medical profession
3. To maintain professional and ethical standards of the medical profession, particularly relating to the science of medicine, surgery and medical clinical research

As the IMPA president I am going to propose a program which is in line with the above lofty ideals as well as a program with national interests.

First the DATA, DATA and DATA as Sherlock Holmes cried :

A. Morbidity data of patients attending the outpatient departments of government hospitals are not available. Data from the private sector are also not routinely collected.
   Quote from AHB 2016 Pa 13.
B. WE conduct 90 x 10^6 consultations annually (Estimate)
C. 57% of health care cost is private funding
D. Absolute ignorance of morbidity spectrum of Sri Lankan primary care (Compared with morbidity and mortality data of the indoor patients)
E. Gross health care inequality in - resource allocation, health care quality, service provision by geography
F. Only 3 institutes responsible for the private health sector are : IMPA, CGP, PHSRC
G. Blurred boundaries - there are many other government associations whose members provide primary care medical services as defined in the standard textbooks in Family Medicine
H. But the sole responsibility for the quality of the primary care medical services rests on the above three organizations

I am of the opinion that above arguments provided in the bulleted list should convince us to forge ahead towards achieving a continuous morbidity registration system for primary care in Sri Lanka. It is of course an arduous task. But that does not mean it is impossible. what is of note is that the necessary infrastructure is already in place. Are we ready for such a project with immense implications for the local health care industry ?

PS - An article on IMPA Morbidity Registration System - IMRS - is attached to this newsletter.

Dr Ananda Perera
President

Editor - Dr A L P de S Seneviratne

The Life Saving Treatment for Patents with CVD

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PROJECT PROPOSAL FOR IMPA INNOVATION ACTIVITY SMARTPHONE BASED MORBIDITY REPORT SYSTEM FOR PRIVATE PRIMARY CARE SERVICES IN SRI LANKA IMPA MORBIDITY REPORT SYSTEM (IMRS)

Dr. Ananda Perera

PROBLEM

- Morbidity data of patients attending the outpatient departments of government hospitals are not available. Data from the private sector are alsonot routinely collected. (Quote from AHB 2016 Pa 13).
- NO Outpatient data for Sri Lanka
- WE conduct approximately 90 x 10^6 consultations annually
- 57% of health care cost is private funding
- Absolute ignorance of morbidity spectrum of Sri Lankan primary care
- Gross health care inequality in - resource allocation, health care quality

IS IT A PROBLEM OF IMPA ?

There are only 3 institutes dealing with private medical practice in Sri Lanka.

1. IMPA - oldest, strongest, wider spectrum of membership, highly skilled pool of medical expertise
2. CGP - brainchild of IMPA
3. PHSRC - political
4. Private Hospital Owners' Association - commercial

DO WE HAVE A MANDATE ?

1. "...private health sector research has moved beyond classifying and counting providers and users, to the assessment of mechanisms for harnessing the private sector and identifying conditions for their successful application..." (WHO)
2. Evidence from other countries - India, Africa (WB data)
3. INTEGO from Belgium with a General Practice set up similar to ours Started in 1994 and the first research paper was presented in 2014 .
4. Nijmegen Continuous Morbidity Registration (CMR) Nijmegen was founded in 1967 by the founding father of Dutch general practice, Frans Huygen. Five other practices joined for this part of the data collection, and, since 1986, the CMR/NMP functions more like a practice-based research network (PBRN) in the North American and UK sense. The challenges of the four GPs in the early years in shaping the CMR must have substantial. There was no classification system available that genuinely covered the health problems presented in general practice. The practices had a combined list of about 12 000 patients, but there was no experience in handling such a large database. Theirs was a fundamental learning-by-doing experience. And, of the decisions they took, a surprising number have become state-of-the-art and characterize current, 2008, practice. (Loh LC, Ugarte-Gil C, Darko K. Private sector contributions and their effect on physician emigration in the developing world. Bulletin of the World Health Organization 2013;91:227-233. doi: 10.2471/BLT.12.110791)

IMPA CONSTITUTION - VISION AND MISSION STATEMENTS

1. To safeguard and further the interests and status of our members as a body
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3. To maintain professional and ethical standards of the medical profession, particularly relating to the science of medicine, surgery and medical clinical research

REFLECTION ON PROBLEMS IDENTIFIED AND OUR VISION AND MISSION

Are we on the correct path ?
Are we achieving the mission statements of the constitution ?
Are we satisfied with our status ?
Are we maintaining professional standards ?
Are we maintaining ethical standards ?
What is our contribution for the health care quality ?

SOLUTION

IMPA Morbidity Report System - IMRS for the above problem

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Fast Track for a Quick Show of Proof of concept.....
To do a research on primary care morbidity based on sound epidemiological principles
Long Term viability and sustainability of a Continuous Morbidity Reporting System
Design and develop a medical record for primary care practitioners

WHY ?

1. No OPD morbidity data for Sri Lanka

2. 95 x 10^6 wasted consultations in annually

3. Absolute ignorance statistically of population parameters

4. Primary health care has won the battle and the primary care medicine has lost the battle

   (Jayasekara and Schultz 2006), (Jayasekara, Rasika & Schultz, Timothy. (2007). Health status, trends, and issues in Sri Lanka. Nursing & health sciences. 9. 228-33. 10.1111/j.1442-2018.2007.00328.x.)

   Quoting : According to Sri Lanka National Health Accounts (2000 to 2002), in 2002, the total government health expenditure amounted to 43% of the total health-care costs of the people, while private sources financed Rs. 33.7 billion ($US0.33), equivalent to 57% (Institute of Policy Studies of Sri Lanka, 2005). (Private financing contribute 57% of helath care costs in Sri Lanka 2005) So there is a financial and moral obligation for IMPA to provide quality health care service to the nation

5. Grossly inequal resource allocation in the health care industry (See below). Quote …… Even though the National Health Policy of Sri Lanka (1992) was based on the principles of primary health care (MOH, 1992), the allocation of resources does not reflect it. The major portion of health expenditure is utilized by curative care services. In 2002, these services utilized 65% of the total public expenditure on health, while community health services accounted for only 9% (Ministry of Health, Nutrition and Welfare, 2003; Institute of Policy Studies of Sri Lanka, 2005). The remaining amount was for administration and staff services and 3% was for local and overseas training (MOH, 2002). The allocation of human resources for both sectors shows an even greater discrepancy between the distribution of health personnel in curative and preventive services (see Table 2). The Annual Health Bulletins of Sri Lanka indicate that, despite a great increase in resources devoted to the curative health sector in the last 10 years, there has been little improvement of health services provision for the majority of people. This is mainly related to inadequate resources allocation for preventive health services. from Jayasekara and Schultz]

6. Epidemiological transitions and the demographic transitions demand a continuity care based rather than a episode based care approach for primary care medicine. Double burden of disease burden turning into quadruple burden of NCDs, communicable diseases, violence/injuries, mental diseases

7. Epidemiological transitions require a dynamic model of EMR rather than a EMR for all times for all persons. We started life epidemiologically as single burden of communicable diseases, now it has come to the stage of double burden of non communicable and communicable diseases. Epidemiologists are telling us now we are on the verge of attaining triple burden of NCD, CD and RTA or some even go so far as to say we are already in the stage of the quadruple burden of CD, NCD< RTA and Mental Health problems. These epidemiological transitions require dynamic EMRs which are flexible for such fast changing picture of epidemiology. Manual methods of medical record keeping is certainly one of the best options in this backdrop.

8. Private sector has the responsibility to settle the health care inequalities which are too obvious in the health care industry in Sri Lanka - resource allocation, human resource distribution in Sri Lanka. Private health care and members of IMPA and all those part time GPs have a moral responsibility to contribute towards the levelling off of health care inequalities in Sri Lanka address the regional and urban-rural disparities in the quality of healthcare

9. Government and MOH is heavily committed to improve the maternal and child health and infectious diseases. This again calls for committment by private sector

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[Healthcare spending is likely to increase owing to changes in lifestyles and demographics. The share of the population aged 65 years or older rose to around 14% from around 8% in 2013. As the population ages, the demand for healthcare will increase and it will require changes to the current system, which is heavily geared to improving maternal and child health and fighting infectious diseases.

9. A key driver of the fourth industrial revolution is EMR/PHR or medical records without which there is no digitization of health. Furthermore, healthcare data record is being directly advanced by digital transformation. Healthcare Information Systems are steadily moving from paper-based to Electronic Medical Records (EMRs) and this is a key benefit and driver of the digital revolution. This makes up the seven-stage process recommended by the Healthcare Information Management Systems Society (HIMSS) for hospitals to earn the right to be called "paperless hospital".

Solution ?

Cluster sampling of all MOH areas in Sri LankaOdd numbered clusters - random sample of private practices - weekly returns demographic dataEven numbered clusters - random sample of private practices - weekly returns of symptom data

Why IMPA ?

1. To safeguard and further the interests and status of its members as a body (IMRS - will safeguard our financial and professional status - Increasing the quality of care is the primary mechanism. Better quality will give a competitive edge to a practice.)

2. To promote and encourage co-operation and loyalty among members in the best interests of the medical profession (IMRS - what are the best interests of the medical profession - provide high quality medical care. High quality medical care needs dynamic ongoing CPD. One of the most interactive, dynamic and an ongoing CPD activity is maintaining medical records. Medical records maintained individually when used in research will output knowledge. This ongoing dynamic generation of new knowledge will increase the care quality delivered. So for the quantum leap from individual record to the new knowledge you need the cooperation and loyalty of our membership to contribute to new knowledge generation)

3. To maintain professional and ethical standards of the medical profession, particularly relating to the science of medicine, surgery and medical clinical research (IMRS will maintain high professional and ethical standards of the IMPA membership by the very fact of being responsible dedicated clinicians who maintain records and clinical activities of the clinical counters)

THE MAIN REASON WHY IMPA?

It has been estimated that in near future there will be an annual input of 250 medical graduates into the private practice as full time medical practitioners. These are our potential new recruits. If IMPA is to survive we need to convince these new recruits that IMPA is a vibrant and dynamic medical society living true to its constitution. (From : Does Sri Lanka need more doctors ? By the 'Academic Circle on HRH' of the Colombo Medical Faculty Published by the Sunday Times Sunday March 26th 2017). Quote :

"Furthermore, if we assume the estimate of the 15 percent migration rate to remain constant and the Ministry of Health continues to absorb 70 percent of the new SLMC registrants, there will be more than 250 graduates opting to join the private sector annually as full-time practitioners. This is in addition to the government doctors who will continue to join the private sector as part-time practitioners"

Are we that is IMPA is ready for this juggernaut of new doctor input to our health care system annually ?

Research aspect of the IMRS - IMPA Morbidity Report System

Implementation research study on adoption of EMR among Sri Lankan Private Sector Doctors

1. MONTHLY, WEEKLY OR DAILY RETURNS OF PRIMARY CARE ACTIVITY PROJECT
2. SYMPTOM DATA ENTRY PROJECT OF PRIMARY CARE - CAMEOS FOR SYMPTOM DATA ENTRY IN PRIMARY CARE http://pcdg.info/cc.php

Second Part of this Article will continue in the Next Newsletter.

Management of Common Infections With Antimicrobials Guidance Clinical Practice Guidelines (2019)

National Institute for Health and Care Excellence (NICE)

This is a quick summary of the guideline without analysis or commentary. For more information, go directly to the guideline by clicking the link in the reference. March 01, 2019

Management of common infections with antimicrobials guidance clinical practice guidelines were released in February 2019 by the National Institute for Health and Care Excellence (NICE).

Acute Sore Throat
For low-risk patients, use acetaminophen (first choice) or ibuprofen for pain. The decision for antibiotics is based on the Fever PAIN or Centor score.

High-risk patients should receive immediate antibiotic therapy. Preferred antibiotics include penicillin VK (first choice) or clarithromycin (if penicillin allergy) or erythromycin (in pregnant patients).

Influenza
Annual vaccination is essential in at-risk patients. Oseltamivir is the first-line antiviral. Zanamivir is an alternative. In otherwise healthy patients, antivirals are not recommended.

Scarlet Fever
Prompt antibiotic therapy reduces risk of complications. Preferred antibiotics include penicillin VK (first choice) or clarithromycin (if penicillin allergy).

Sinusitis
Use acetaminophen or ibuprofen for pain.

Do not use antibiotics in patients with symptoms for 10 days or less. In patients with symptoms for more than 10 days with no improvement, use either no antibiotic or back-up antibiotic depending on likelihood of bacterial sinusitis. Consider high-dose nasal corticosteroid in patients older than 12 years.

High-risk patients should receive immediate antibiotic therapy. The preferred antibiotic is penicillin VK. In patients with a penicillin allergy, use clarithromycin (if ≥12 years), clarithromycin, or erythromycin (preferred if pregnant). Amoxicillin/clavulanate is the second choice or first choice in high-risk patients.

Community - Acquired Pneumonia
Antibiotic therapy depends on CRB65 parameter score. Antibiotics for a score of zero include amoxicillin, clarithromycin, or doxycycline. Antibiotics for a score of 1-2 include amoxicillin plus either clarithromycin or doxycycline

Lower Urinary Tract Infection
Advise acetaminophen or ibuprofen for pain.

In nonpregnant women, prescribe antibiotic as a back-up or immediately. Preferred antibiotics include nitrofurantoin (first choice if estimated glomerular filtration rate [eGFR] ≥45 mL/min) or trimethoprim (low risk of resistance). Second-line choices include nitrofurantoin (if eGFR ≥45 mL/min), pevmecillinam (not available in the United States), or fosfomycin.

In pregnant women, men, or children, prescribe an antibiotic immediately.

In pregnant women, the preferred antibiotic is nitrofurantoin (avoid at term) if the eGFR ≥45 mL/min. Second choices include amoxicillin or cephalexin.

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In men, preferred antibiotics include trimethoprim or nitrofurantoin (if eGFR ≥45 mL/min).

In children older than 3 months, first choices include trimethoprim or nitrofurantoin (if eGFR ≥45 mL/min). Second-line agents include nitrofurantoin (if eGFR ≥45 mL/min and not used as first choice), amoxicillin, or cephalexin.

Acute Prostatitis
Advise acetaminophen (with or without a low-dose weak opioid) or ibuprofen for pain. Preferred antibiotics include ciprofloxacin, ofloxacin, or trimethoprim. Second-line agents include levofloxacin or cotrimoxazole.

Suspected Meningococcal Meningitis
The preferred agent is IV or IM penicillin G.

Oral Candidiasis
Preferred agents include miconazole oral gel (first choice), nystatin suspension (if miconazole not tolerated), or fluconazole capsules.

Chlamydia Trachomatis/Urethritis
The first-line agent is doxycycline. Azithromycin is the second-line choice and is preferred in pregnant or breastfeeding women or in patients with an allergy or intolerance to doxycycline.

Epididymitis
Preferred agents include doxycycline, ofloxacin, or ciprofloxacin.

Vaginal Candidiasis
Preferred agents include clotrimazole, fenticonazole, clotrimazole, or oral fluconazole.

Bacterial Vaginosis
Preferred agents include oral metronidazole, metronidazole 0.75% vaginal gel, or clindamycin 2% cream.

Genital Herpes
Preferred agents include oral acyclovir, valaciclovir, or famciclovir.

Gonorrhea
Preferred agents include ceftriaxone or ciprofloxacin (if known to be sensitive).

Trichomoniasis
Preferred agents include metronidazole (first choice) or clotrimazole (in pregnancy to treat symptoms).

Pelvic Inflammatory Disease
The first-line combination is ceftriaxone plus metronidazole plus doxycycline. Second-line agents include (1) metronidazole plus ofloxacin or (2) moxifloxacin monotherapy (first line for Mycoplasma genitalium pelvic inflammatory disease [PID]).

Impetigo
Preferred agents include topical fusidic acid, topical mupirocin (if methicillin-resistant Staphylococcus aureus [MRSA]), or, for more-severe infections, oral flucloxacillin or oral clarithromycin.

Eczema
Avoid antibiotics if there are no visible signs of infection.
If signs of infection are visible, use oral flucloxacillin or clarithromycin or topical treatment (as in impetigo).

Scabies
The first-line agent is permethrin. Use malathion in patients with permethrin allergy.

Mastitis
S aureus is the most common pathogen. Flucloxacillin is preferred for treatment. In patients with penicillin allergy, use erythromycin or clarithromycin.

Varicella Zoster/Herpes Zoster
For chickenpox and shingles, the first-line agent is acyclovir. Second-line choices in cases of poor compliance include famciclovir (not in children) or valaciclovir.

Tick Bites (Lyme Disease)
Use doxycycline for prophylaxis. For treatment, the first-line choice is doxycycline. The first alternative is amoxicillin.

PUBLISHED BY
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