AFPI
Academy of Family Physicians of India

KARNATAKA

AFPI KARNATAKA QUARTERLY NEWSLETTER

President's Letter

Hello readers

This issue of Newsletter is a special one which is being released at the 4th National Conference of Family Medicine & Primary Care(FMPC-2019). It is a proud moment for AFPI Karnataka as we host the biggest event of Family Medicine in India at Indian Institute of Science (IISc), Bengaluru. The outcomes of any constructive efforts are highly dependent on the ensuing input and conviction by the team. I take pride in saying that our team has put in their best to make this event a most educative, innovative, and a pleasurable one. As you read this issue you would have realized that it is not an overstatement. Some of the highlights of the conference are Preconference satellite CMEs at hospitals partnering AFPI and Young Physicians conclave in addition to an elaborate scientific program at the main conference. We are having an innovative concept of "Inspiration Room" within this conference where you can hear stories of primary care doctors and leaders - in their own words . We wish that this endeavor of ours will provide an insight in to all that is happening from training to practice innovations to technology and research in the field of Family Medicine.

The specialty of family medicine innately and modestly transforms both the practitioner and the person cared for. This elemental truth makes Family medicine truly the "heart of medicine" and FMPC-2019 provides an ideal platform to embrace this unique specialty by all stakeholders. We sincerely hope that you take back a lifetime of wisdom, friends and memories from this event.

Last quarter saw two contrasting events one purely an academic feast at Sparsh Hospital with a high quality deliberations on the role of Family Physicians in Orthopedics and the other one a community engagement program- 'Cycling for safety'. We wish to continue from where we left with a new zeal and enthusiasm post FMPC.

Once again my sincere thanks to the editorial and earnest request to all readers to actively contribute in complementing the efforts of the editorial team.

Col (Dr.) Mohan Kubendra
President
AFPI Karnataka

Editorial Note

Right now the Bihar encephalopathy epidemic is in the news. The reason why this kind of problem keeps happening in our country is due to our crumbling primary care infrastructure and system.

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Let us first list these and later suggest some workable solutions:

1. There's is a huge urban rural divide with too few doctors in rural India and too many in urban India
2. Of the 50000 - 70000 doctors graduating each year, most try to become specialists of one system or the other. Only some 20000 PG seats are available. Of these there are only 250 or so for Family Medicine DNB!
3. Private medical colleges and hospitals are encouraged at the cost of government institutions.
4. Poor policy implementation regarding nutrition, maternal and child health programmes.
5. No status, adequate remuneration, or career opportunities for primary care doctors.

A transformational change can be brought about by following actions

1. Greatly strengthen primary care by creating a large number of MD/DNB (5000 - 15000) in family medicine and impart their training in the Community Health Centers (CHCs) mainly and partly in secondary care hospitals.
2. Employ them preferentially in PHCs/CHCs
3. Give these doctors same status and perks as you would give other specialists.
4. Groom these doctors to head the taluk, district, and state level jobs
5. Convert all community medicine departments in medical colleges into Family Medicine/Primary Care departments.
6. Ensure that there is interchangeable credit/promotion for positions in both the service sector/practice and academics.
7. Don't allow any more private colleges to come up (one can even think of nationalising existing medical colleges).
8. Subsidize medical education especially for those who are willing to become Primary care/ family medicine specialists.

To address many of the issues that are bugging our health care structure and delivery of services, Academy of Family Physicians of India (AFPI) is hosting a National conference from the 1st to the 4th of August here at Bangalore. The venue is Indian Institute of Science (IISc) campus.

It is critical for all stakeholders interested in strengthening primary health care, to participate and exchange ideas. As committed physicians, we request you to make time to be with us on these days and actively participate in this event.

With regards,

Editorial team

Disclaimer: the views expressed above are the personal views of the editors and do not necessarily represent the official position of AFPI.

AFPI-NEWS

AFPI Quarterly CME- an Orthopedic update for Family Physicians

I had the privilege of attending a CME on 12.5.19, organised by AFPI in collaboration with Sparsh hospital. It covered common orthopaedic ailments in clinical practice such as back pain, arthritis of knee joints etc. Dr. Jyotika demonstrated the clinical examination of the spine, shoulder, knee and ankle joints.

Below is a report on the sessions:

1) **Back pain:** This topic was covered by Dr. Sudarshan (Family Physician) and Dr. Menon (Orthopedic Surgeon). Back pain is one of the most common complaints in clinical practice.

   Regular history should be taken. One should look for kyphosis, scoliosis, loss of lumbar lordosis, any swelling etc. The spine and paraspinal region should be palpated. Straight leg raising test and tests to rule out L4, L5 and S1 involvement need to be done (walking on toes and heels). Reflexes should be elicited.

   Blunt trauma is the most common cause for acute onset pain and spondylitis for chronic pain. Tuberculosis and tumors to be ruled out in chronic pain.

   Conservative treatment with analgesics and physiotherapy is the mainstay of therapy. Further investigations and referral are needed in case of finding red flag signs such as fever, neurological deficit, saddle anaesthesia, and fecal incontinence/anal sphincter waekness.

   A video on clinical examination of spine was shown.

2) Arthritis of the Knee : This topic was covered by Dr. Sharan, Chairman of Sparsh hospitals.

This is the second most common complaint in general practice.

The talk focused on knee replacement (arthroplasty). No age limitation exists for this. The artificial joint (prosthesis) lasts for 20-25 years. He mentioned that the global post-op sepsis rate is 0.8% whereas in Sparsh hospital it is 0.2%. A special emphasis was made on the Gurugamana program wherein a 100 free knee replacement surgeries are done every year by the Sparsh hospitals for teachers who may not be able to afford surgery otherwise.

3) Orthopaedic oncology: This topic was covered by Dr. Deepak.

Tumors of the bone are a rare occurrence. Surgery is the mainstay of treatment followed by chemotherapy and radiotherapy. Though rare, primary care physicians need to know about this so they may consider this diagnosis if confronted by case presenting as a swelling arising from a bone.

4) Osteoporosis: This topic was covered by Dr. Kavitha.

This is a particularly common in elderly especially women. Long term use of PPIs can cause this. Bisphosphonates are commonly used in its management. DEXA scanning is used for evaluation of bone mineral density. After DEXA scanning, point of care scoring systems like the Frax score can help to predict the risk of a fracture.

5) Ankle and foot problems: This topic was covered by Dr. Ananya.

He focused on plantar fasciitis which is common and at the same time difficult to treat. Using soft chappals even at home was advised for such patients. Sprain, strain and bunion were also covered. Sprain- ligament injury; Strain- muscle injury.

One funny comment made by the speaker was that in western countries people have to play football or some sport to have sprain, whereas in India walking on the footpath is enough to cause sprain .

6) Physiotherapy in Practice: This topic was covered by Dr. Bishnu. Many exercises were shown for back, knee and ankle.

Key take home points:

1. Refer patient to specialist when there is a red flag sign.
2. Take an X-ray always before ordering an MRI.
3. Good videos are available online for learning clinical examination of spine and joints.
4. Yoga is good for chronic spine and joint problems.
5. Long term use of PPIs and steroids causes osteoporosis.

While the emphasis of this CME was on the lower extremity, future CMEs could include upper limbs, neck and repetitive stress injuries.

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Being inclusive in our approach to patients: Gender identity as an example

All our lives we have learnt only the binary system of gender identity i.e. Male and Female, however now we know it's not true. Gender identity is a spectrum with maleness and femaleness on extreme sides of it. This spectrum includes identities such as gender-nonconforming, gender-affirming, gender-nonbinary, two-spirited, three-spirited, as well as people that are intersex. The term LGBTQIA+ is this umbrella term that encompasses all these different types of identities. For simplicity of understanding, the term transgender can be defined as- someone who is assigned a sex at birth that doesn't match with who they are as a person and their sense of self. Gender identity is very different than biological sex. Gender identity is sense of self. Biological sex is based on the person's genitalia. The third aspect is sexual orientation. Sexual

orientation is simply who we are attracted to physically, emotionally, sexually or spiritually. These are three very different but important identity spectrums. As health care workers we need to understand these spectra as they are very essential in providing appropriate medical care to the patient. Most doctors who work with LGBTQIA+ patients learn it by trial and error. That means they figure it out with each patient, or the patient ends up spending their time trying to teach the doctor how to take care of them. Many doctors are uncomfortable asking about gender identities. Some feel like it's irrelevant in providing care to the person and others are just trying to avoid saying the wrong thing and offend anyone. Many doctors who say something inappropriate or they say something negative, they may not be coming from a malicious or mean place; it is because they have never been trained on how to care for these individuals. The education system has taken no steps in teaching students about cultural competency leading to ignorance in many health care professionals. But this can't be accepted as an excuse/norm anymore. These are some questions(1) that healthcare professionals should start asking their patients while taking history-

- What is your gender identity: male, female, transgender, other?
- What is your sexual identity: straight, gay, lesbian, bisexual, other?
- Orientation/attraction: Who are you attracted to? men, women, both?
- Relationships: Are you in a relationship? With who?
- Behavior: Are you sexually active with men, women, both? (they can also say neither)

After reading these questions, most of us will think- What if my heterosexual or non-transgender patients get offended at these questions? You can answer that by using the procedural defense: "I am required to ask these questions as part of procedure", or better yet, you can use this as an opportunity for education: "I can't tell by looking at someone whether they are gay or straight, transgender or not, so I have to ask everyone". You can even incorporate these questions in the personal details form to be filled out by the patient.

Coming to using appropriate pronouns with people of non-binary gender. Once you have answers to the above listed questions either through personal conversation with patient or through the form, you will get an idea on appropriate pronouns you can use. However, if there is any confusion then firstly you can politely ask the person how they would like to be addressed as. Asking this question will help you in building trust with the patient. Secondly, you can use the following few pronouns when you are not sure

- "They" – instead of "he or she"
- "People" or "Kids" – instead of "Men and Women"/ "Boys and girls"
- "Assigned male at birth (amab)" – instead of "born male"
- "Assigned female at birth (afab)" – instead of "born female"
- "Trans(gender) people" – instead of "transgenders"
- "Trans(gender) person" – instead of "transgendered"

Language is truly a mirror to one's own thoughts and perceptions. While ignorance of gender sensitivities may be one reason for thoughtless remarks, an equally possible reason could be one's own prejudices. Regardless of the answers you receive from your non-binary patients, your tone and facial expression should be non-judgemental. If an answer truly takes you by surprise, do not react with disgust or contempt. Importantly, take the time to reflect on your own reaction: why did something disgust you? What might be personal biases that may prevent you from calmly accepting certain facts? How might these biases be resolved? You may find that discussing your own reactions with a more inclusive or experienced doctor may help you identify and resolve these deep-rooted biases and enable you to respond with compassion and acceptance.

Together as a community we need to think out of the binary box and sensitize the people around us. It's not just a doctor's job, it is every healthcare professional, including nurses and others coming in contact with patients, who need to be educated. Only then can we build an all gender inclusive medical practice.

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Case Report 1

An unusual case of urinary bleed in a 60-year-old with comorbid conditions

Introduction

In the elderly men symptoms of frequency, urgency or hesitancy at urination needs to be investigated for enlarged prostate causing obstruction to the outflow. The investigation that gives the required information is an ultrasound scan of the abdomen with special emphasis on the urinary tract which includes the kidneys, ureters, bladder, prostate and urethra. Occasionally however one detects a condition unrelated to the symptoms of enlarged prostate which all the same requires intervention. One such case is described below.

Case Report

This 60-year-old male presented with history of feeling of incomplete emptying of the bladder of some week's duration on 14/11/18. There was no pain or frequency.There was also no fever. He gave a history of gallbladder stones dating back to 10 years. His diabetes, blood pressure, gout and hypothyroidism were under good control. He is a nonsmoker, uses alcohol socially and takes regular exercise. Nothing remarkable in the family history.

Past history

In the year 1996 he had an MI and angioplasty done in1997.ECG done on 12/4/2000 showed evidence of old inferior wall infarct. An ultrasound revealed the presence of multiple gallstones. Presently he is on eltroxin, zyloric, simvastatin, hydride, amlong and 75mgs of ecosprin

On examination, he weighed 75kgs, with BP of 160/90, all the pulses were felt with normal heart beats. His RS, CNS were normal. Spleen and liver were not felt. Genitals were normal and there was no suprapubic fullness. There were no herniae. No palpable neck nodes and groin nodes were not enlarged.

Following tests were done.

Ultrasound scan of the abdomen done on 27/11/18 showed gallbladder with multiple calculi of 10 to 12 mm diameter. Kidneys were normal except for the left kidney which showed an upper pole calculus of 4.5mm size. Urinary bladder showed a thickened wall with posterior wall showing small papillary projections.

Though the prostate size was 21ml the post void urine was 60 ml. The impression was possibility of chronic cystitis/neoplastic with significant residual urine.

With these US findings it was decided to get a cystoscopy done to exclude possible bladder malignancy.

He was hospitalized on4/12/18 and after the usual pre surgery protocol, cystoscopy was done and a bladder and TURP [median channel] and TURBT [bladder biopsy] were done.

Cystoscopy findings

Normal urethra, grade one trilobar prostatomegaly, high bladder neck. Vesiculo bulbar lesions in the bladder involving trigone, both lateral lobes.

Appearance suggestive of **Cystitis Cystica.**

Biopsy findings

Urinary bladder [TUR-BT]

Cystitis Cystica Glandularis

Discussion

Cystitis glandularis is an uncommon proliferative disorder of the mucus-producing glands within the mucosa and submucosa of urinary bladder epithelium. There is some evidence for this being a premalignant condition. As the lesion resembles colonic mucosa, some recommend colonoscopy to screen for colon cancer. Follow up cystoscopy/colonoscopy is optionally recommended.

B C Rao

With inputs from Dr Amrith Raj Rao,Urologist

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Case Report - 2

Appendagitis epiploica

Abstract

A rare cause of acute pain in the left iliac fossa in a 55 year old male is presented

Introduction

Clinicians commonly see cases of pain and tenderness in the right iliac fossa but not many with pain and or tenderness in the left iliac fossa. Diagnostic difficulty was compounded by the fact that the patient was on long term medication for chronic anxiety and depression and preexisting congenital abnormality in the collecting system. In the 50 plus age group one first thinks of renal/ureteric colic, colonic malignancy, diverticulitis, iliopsoas and tuberculosis

Case report

History of present illness.

This 55-year-old male began having pain in the left lower abdomen on 8/3/19 which was mild initially which became severe with tenderness increased over the next five days. He reported to the author on12/3/19

He is a non-smoker, does not use alcohol and a vegetarian. He is given to attacks of anxiety and mood changes and is on sertraline and presently he is doing well on this medication. There was no history of fever, passing frequent stools, frequent urination or loin to groin radiation of pain. There was also no history suggesting inflammatory bowel disease. There was also no history of passing bloody urine. How ever a routine ultrasound abdomen done in 2007 showed bilateral extra renal pelvis and this was causing some anxiety to the patient as a possible cause for his pain.

On examination

His blood pressure was 130/80 and pulse was 80 per minute. His temperature was normal. Though he was complaining of pain, there was no restlessness nor was he breathless. His cardiovascular, respiratory, ENT, CNS were normal. General examination did not reveal any enlarged tender lymph nodes. His liver and spleen were not felt. Examination of spine did not elicit tenderness or any evidence of muscle spasm. Epigastrium, right hypochondrium, right iliac fossa were all normal to feel. In the left iliac fossa, there was acute tenderness over the mid portion of descending colon with some guarding. Proper palpation was not possible to exclude a mass lesion.

As there was point tenderness over the course of the ureter and the patient having an established congenital extra pelvic collecting systems, a clinical diagnosis of ureteric colic was made and he was sent for an abdominal scan.

The sonologist reported this to be a case of appendagitis epiploica

As the condition is self limiting, he was given a tablet of ibugesic to be taken on an as and when needed basis and report back in three days time or early if condition worsens.

He reported on 18/3/19. He was pain free and there was no tenderness on deep palpation

Discussion

Epiploic appendagitis (EA) is an uncommon, benign, self-limiting inflammatory process of the epiploic appendices. It most commonly occurs in the descending colon and comes in the differential diagnosis of pain in the left iliac fossaEpiploic appendices are small, fat-filled sacs or finger-like projections along the surface of the upper and lower colon and rectum. They may become acutely inflamed as a result of torsion (twisting) or venous thrombosis. The

inflammation causes pain, often described as sharp or stabbing, located on the left, right, or central regions of the abdomen depending on where the lesion is. There is sometimes nausea and vomiting. The symptoms may mimic those of acute appendicitis, diverticulitis, or cholecystitis. The pain is characteristically intense during/after defecation or micturition (espec. in the sigmoid type) due to the effect of traction on the pedicle of the lesion caused by straining and emptying of the bowel and bladder. Initial lab studies are usually normal. EA is usually diagnosed incidentally on CT scan which is performed to exclude more serious conditions.

Although it is self-limiting, epiploic appendagitis can cause severe pain and discomfort. It is usually thought to be best treated with an anti-inflammatory and a moderate to severe pain medication (depending on the case) as needed. Surgery is not recommended in nearly all cases.

Conclusion

A case of Epiploic appendagitis is presented. Though rare one should keep the possibility of this condition when dealing with pain and or tenderness in the abdomen especially in the colonic area.

Dr B C Rao

The author acknowledges inputs from Dr Suguna Devi, Sonologist.

Miscellany

Sir Godfrey Hounsfield

While discussing with my urologist friend,the choice of treatment for large stones in the urinary tract, the name Hounsfield units came up. The Hounsfield scale (HU) also known as CT numbers is a measurement for determining radio density and is named after Godfrey Hounsfield. Knowledge of the density of the tissue in question greatly helps the treating doctor in the choice of treatment or intervention.

Who is this Hounsfield? Curiosity made me look up and I came across the fascinating life of an extraordinary man. Godfrey Hounsfield was a self-taught electrical engineer who made, probably, the most important single contribution to the advancement of medicine in the 20th century by inventing the CT machine and brought it into clinical use.

Godfrey Hounsfield came from a rural background and was the youngest of five children of a Nottinghamshire farmer, the farm was not only the playground of the young Godfrey but also his outdoor workshop! He tinkered with the electrical machines and nearly

blew himself up using water-filled tar barrels and acetylene to see how high they could be propelled by water jet.

At grammar school in Newark he was only interested in physics and mathematics, though in his later life his interest extended to music. He left school at 16 and his service in the years of the second world war helped him to further his interests in the fields of physics and electricity. He never went to any college and had no formal training as an electrical engineer and the only degrees he received were honorary.

While out on a walk he got this idea of doing a two-dimensional x ray of an object inside a solid box. Back in his workshop at the EMI research laboratories in Hayes, Middlesex, he began work on a computerized device that could process hundreds of x ray beams to obtain a two-dimensional display of the soft tissues inside a living organism. By recording on sensors rather than x ray film and taking multiple pictures from a rotating photon source, a series of “slices” could be photographed that showed the different density of tissues. By making a series of such photographs at close intervals, it was then possible to have a three-dimensional image. The mathematics behind this

was phenomenal, and other more powerful and better resourced research teams had, unknown to Hounsfield, considered the idea and had dismissed it as unworkable.

Soon he was practicing on the head of a cow that a colleague obtained from a kosher slaughterhouse in east London, and he submitted his own brain for the first live human scan. The first patient was scanned in September 1971 at Atkinson Morley's Hospital in Wimbledon with the radiologist James Ambrose. The patient had a suspected brain cyst of uncertain location. Dr Ambrose recalled that the scan gave a clear indication of its whereabouts, and that he and Hounsfield felt like footballers who had just scored the winning goal. It should come as no surprise that within the next couple of years this machine came to be used all over the world.

Hounsfield, a non-graduate, received the prestigious MacRobert award from the Council of Engineering Institutions in 1972, a Lasker award and fellowship of the Royal Society in 1975, a CBE in 1976, a Nobel prize in 1979, and a knighthood in 1981. He shared the Nobel prize with the South African nuclear physicist Allan Cormack, who had worked on similar lines and had published a paper in 1957 suggesting a reconstruction technique called the radon transform.

He was a modest man who lived modestly, enjoying country walks and his work. He had no interest in power, position, or possessions. He had a sense of fun and he loved music. His colleagues found him enthusiastic, gentle, delightful, inspiring, “the nicest and most genuinely good person you could hope to meet”. That he found the public interest generated by his inventions, most embarrassing, was true to his character.

On the day he won the Nobel prize in 1979, Hounsfield had some home-spun words of advice for all would-be Nobel prizewinners: "Don't worry too much if you don't pass exams, so long as you feel you have understood the subject. It's amazing what you can get by the ability to reason things out by conventional methods, getting down to the basics of what is happening."

He remained a bachelor and unattached. Whatever he had was left to research in engineering. He passed away on 12th August 2004. He was 84.

Dr. B. C. Rao

Varicella Vaccine - To Give or Not Give

Vaccination in children is among the highest priorities in India. There is also significant effort to reduce the mortality and morbidity due to infectious diseases among adults like tetanus, diphtheria, pertussis, hepatitis A, hepatitis B, human papillomavirus, Japanese encephalitis, measles, mumps, rubella, meningococcus, pneumococcus, typhoid, influenza, and chickenpox through adult vaccination strategies. But the vaccine penetration in the adult community is far lower than ideal even in developed countries like the US.[1] The reasons are plenty - varying from the lack of adequate supply, to low importance given both among the health care professional as well as the community. Adding to this, are the complexities of indications and contraindications in certain conditions in adults, and controversies regarding the efficacy of the vaccines that create confusion and make it hard to analyse the benefit-risk ratio for individual patients in our day to day practice.

In this context, here is a description of a dilemma faced in practice whether to vaccinate a 55 yrs old female to prevent varicella zoster.

Case details:

The patient, a 55 year old female with a history of Hodgkin disease who had undergone autologous bone marrow transplant, had a history of recurrent episodes of allergic bronchitis. She was advised adult immunizations as she was immunocompromised because of the history of transplantation.

As per recommendations, I confidently vaccinated her for pneumococcal vaccine (PCV13) and influenza vaccine.

However, since varicella infection in adults can cause severe pneumonia, I considered vaccination for varicella. But her history was perplexing.

She had developed Hodgkin's disease in 2006, treated with chemotherapy and radiotherapy. In 2011 she had her first relapse and underwent autologous hematopoietic stem cell transplantation (HCT). In 2015, she had experienced 2nd relapse and was treated with immunotherapy.

Since then, she has been following up regularly with her oncologist with no relapse and has been healthy, not on any chemotherapy, or other drugs except for thyronorm for hypothyroidism.

She had never suffered from chickenpox as far as she could remember. Vaccination for DPT, Hemophilus influenza B, hepatitis B vaccines were given to her post BMT.

Now the questions that arose were-

1. Given her condition of Hodgkin's lymphoma, and the possibility of her having risky immune status, can I vaccinate her for varicella, the vaccine being a live-attenuated one?

2. If at all I can vaccinate, do I vaccinate her with chicken pox (Varilrix vaccine) or the vaccine for shingles? (Zostavax) Has she ever been infected with chickenpox during childhood? It wasn't clear.

On literature review of the existing guidelines on vaccination among patients with Hodgkin's lymphoma, and people post-BMT, it became clear that Zostavax (vaccine for shingles) was not recommended as it contained higher concentration of live-attenuated virus increasing the risk of vaccine induced varicella infection among those with compromised immune status.

Since infection is reported as the primary cause of death in 8% of autologous HCT patients and 17 – 20% of allogeneic HCT recipients[3], infection control including prophylaxis through medications and vaccines are routinely recommended in them. These include, diphtheria, pertussis, tetanus, pneumococcal vaccine, HiB vaccine, hepatitis B vaccine. And these are given within one year following hematopoietic stem cell transplant. But live vaccines like measles, Mumps, varicella are not given until 24 months post transplant and they are optional vaccines given with judgement regarding risk versus benefit for each patient.

So, we decided to check her varicella IgG ELISA/ELFA levels to see if that would come positive and solve some dilemma. But as expected it turned out to be negative suggesting that she was not immune to varicella zoster.

With dialogue with her oncologist and senior family physicians, the idea of giving the vaccine was dropped. It was decided that the vaccine benefitting her was not clear.

In a tropical country like ours, the seroprevalence of chicken pox increases as age increases (16% of children aged 1–4 years, compared with 54% of children aged 5–14 years, and 72% of those aged 15–25 years)[4].

Whether the incidence rates have reduced or not in South India is not known, so practically our patient still has chances of getting chicken pox. But her adolescent kids don't stay with her and neither does she have significant contact with children like a school teacher. Infact, guideline suggests that the family members of the person undergoing hematopoietic stem cell transplant should be tested for IgG levels and immunised if negative in order to prevent infection spread from them to the person of interest.

So the lessons learnt from this experience are:

1. Adult vaccination is challenging with some grey areas in evidence, literature, documentation and practice leaving us practitioners to use our judgement

2. In such complex situations, decision making can be made effective and satisfactory by the family doctor engaging the patient and her specialists in dialogue.

Dr Swathi S Balachandra

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Practice Experience

Integrating EMR into a rural PHC: from the perspective of a rural primary care physician

Abstract:

I am a rural primary care physician. In my PHC, we have recently introduced Electronic Medical Records (EMR). In this writeup I share a few illustrative cases, my experience and reflections, and summarize the pros and cons of integrating EMR into a rural practice.

Illustrative Case 1:

Mrs. K, a 60 year old lady from a village came to check her blood pressure and sugar. Her BP was 140/90 mmHg and random blood sugar was 170 mg/dl. She reported screening her BP and sugar 2-3 times previously, but does not know whether it was normal or abnormal. She was asked to come for repeat check but never returned.

Illustrative Case 2:

Mr. A, a 70 year old man from a rural area came to check his BP. The reading was 150/100 mmHg. He said he is taking a small round tablet once a day in the morning since 6 months.

Illustrative Case 3:

Mr. M, a 65 year old gentleman showed a pea size single tablet, white in colour, wrapped in a paper and said he is taking that for sugar twice a day before food since 1 year. He wanted to know whether his sugar was under control or not. The reading was 270 mg/dl.

Illustrative Case 4:

Mrs. G, a 50 year old lady from a rural area showed an empty sheet of diclofenac tablets and said she was prescribed by a physician for high BP and she has been taking this for the past 3 months and is now having a headache and wants to check her BP. The reading was 180/100 mm Hg.

All the cases above are from a rural area and most of my cases are such since I work as a medical officer at a rural primary health center (PHC). Treating these patients in my setting is challenging due to information gaps.

My experience integrating EMR into our PHC:

This is the time when I remembered electronic medical records, something which I came across many years back when I was working with a corporate hospital. Technology is something that is really needed in rural set up where most of the patients are illiterate and backward. They neither remember the names of the drugs nor carry the prescription.

Cerner, a digital platform of many hospitals and physicians worldwide, introduced EMR in our PHC in collaboration with Karuna trust in March 2019 with the objective of digitization of PHCs. Doctor, nurse and pharmacist were provided with new shining and glistening laptops to work with. 3 days training and extended support for 1 week was given and any time on call support was available.

With high spirits, we opened the laptops. Since it is a remote village, the internet was so fast that the system got hanged 😆. It took 20-30 minutes to enter each patient's data! Each one of us used to enter 30-40 patients' data per day. Few of the patients couldn't wait and left without consultation. To avoid this, we started to enter the data first into register and then into laptop. This not only doubled our work but also consumed a lot

of time. Many elderly patients don't remember their phone numbers and with such patients, duplication of data is possible. And also additional economic burden for internet access. When personnel not available, data entry will be incomplete. Frequent power cuts didn't interrupt the work flow since all PHCs are provided with UPS to store vaccines. EMR is continuously monitored based on a scorecard which included daily login, number of entries, real time data entry etc.

Conclusion: Is the EMR a boon or bane?

Despite certain drawbacks (data is accessible only for healthcare personnel and not for patients), EMR still remained a helpful tool especially for non communicable disease [NCD]patients who need frequent and long term follow up care. Since the data will be available online, the patients burden to memorize the values or carrying hard copies of reports is decreased. Just with a glance, we can see the variations in the readings and can easily come to a conclusion regarding management.

EMR is successfully implemented already in certain corporate and private hospitals in India. State governments like Karnataka, Rajasthan, Haryana, Tamil Nadu etc. use it for maternal and child population. Whereas outside India like in US, UK, Australia etc., more than 90% of physicians and hospitals use EMR.

It can be improvised by giving the patients, access to the information through specific I.D number, sending sms alerts for abnormal lab values and reminders for follow up.

Finally I recommend EMR as a solution worth implementing in rural PHCs especially for NCD patients.

Dr Subhashini Chitrala

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Doctors club. An experiment in education.

All of us doctors must continually update our knowledge and skills to deliver effective health care to our patients and also to earn an honest and decent living. After leaving the institution that trained us in our respective field of activity, most of us become members of one professional body or the other. The purpose of these societies is to two-fold. One is learning and the other is socializing. Socializing involves meeting friends and some times families and having [a drink] and a meal later.

Some forty years back I realized that there were some inherent problems which I felt impossible to solve in these meetings. First is the learning part. The learning needs of us GPs is broad based and covers a whole range of sub specialties. It soon became apparent to me that the organizers rarely took the learning needs as a priority, but were more interested in looking after the interests of the sponsor which was usually a pharma company and rarely a device manufacturer. Rarely, however the learning needs of the doctors and the selling needs of the sponsors were the same.

Except for a few of us, most others did not mind this dichotomy and for most the monthly outing with dinner and drink thrown in was a welcome relief from their stressful lives.

This was the time, 35 years ago, the idea of starting a study group of doctors occurred to me. My practice those days was semi urban, though today it is fully urban and, in the vicinity, there were four general practitioners and two of them senior to me. I felt I should moot the idea with them first. First worthy I went to, thought I was a patient and I could see the disappointment on his face when he came to know that I am a fellow GP and possibly a competitor. He was polite but dismissive of the idea and told me to my face that he gets enough update from pharma company representatives. I later came to know that he never attends any professional meetings but still was quite successful and no wonder he felt mine was a wasteful venture. The other senior was also luke warm to the idea but felt he may not be able to attend given his busy schedule.

The other two agreed and we set up a meeting at my home. For want of an appropriate name we called it doctors club.

With in a few years the club grew to 15 members who lived in different parts of the city. We decided to put a cap at 15 as we found it difficult to host more than this number in our homes. From the beginning we were clear, the meeting will be in our homes and the expenses will be borne by the member doctor and the hostess and no outside agency will be involved. As the meeting is held on Sunday afternoons, once a month followed by high tea, alcohol use rarely came into the picture.

The two hours are spent on difficult case discussions, journal updates and some times another specialist is invited as a guest, especially if he is involved in treating a case that is being presented.

Are all the original members still active? Sadly, some seniors have passed away and new ones, by invitation have taken their place. There is a waiting list and I suspect they expect us seniors to vacate our seats!

This monthly activity has led this group of doctors to become good family physicians and I suspect their rate of referrals and needing specialist help is far less than others. It has fostered friendship, based on respect and affection to each other and their families.

Don’t we attend the professional meetings organized and sponsored by pharma companies? Of course, some of us do, even I did occasionally when I found something of use in the agenda. Lately however, with the advent of internet-based learning and start of the Karnataka chapter of the academy of family physicians of India, I have found no need even for this.

B C Rao

Masala

A snippet from practice

A patient came to see his doctor. The doctor asked, “What is your problem?” The patient said, I have wireless fever.” The doctor enquired about the medicine he was taking. The patient said, “Kerocine”.

4th National Conference on Family Medicine and Primary Care

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