CGPSL

MY COLLEGE

NEWSLETTER OF THE COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA

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THE 17TH PRESIDENT PROF. M. S. A. PERERA CEREMONIALLY INDUCTED

The ceremonial induction of the new President of the College, Prof. Antoinette Perera was held at HNB Towers on 13th June 2015. The new President was inducted by the immediate past President Dr. K Chandrasekher.

This ceremony was attended by past Presidents of the College, members of the Council, Fellows and members of the College and many distinguished invitees and guests.

In the Presidential address, she explained her vision for the College for the coming year and the role of the GP in the current society.

Thereafter Prof. Leela Karunaratne, a past President and a senior Fellow of the College invoked blessings on the new President.

The gathering was entertained with music and singing by a group of doctors and medical students who are past and present students of Prof. Antoinette.

The evening ended with fellowship dinner.

CONGRATULATIONS Prof. Antoinette

In This Issue

MESSAGE FROM THE PRESIDENT

Dear colleagues,

First of all, I would like to thank the members for electing me as the 17th President of the College of General Practitioners of Sri Lanka. After many years of patient care and teaching, it is indeed an honour to be able to give leadership to this prestigious body. I will carry out my duties and responsibilities to the best of my ability and strive to promote the family practice approach in patient care..

I am thankful to the new council for extending their support to work as a team to achieve the objectives laid down in the constitution. We also warmly welcome Dr. Titus Fernando from the North Western Chapter of the College into the Council who indeed would add strength to our efforts.

This year, our focus is on capacity building for those who are in General /Family Practice. A mini academic session and a joint meeting with the Sri Lanka Association of Geriatric Medicine is planned for August and several teacher training workshops are also being planned. The members are invited to join the Faculty of Teachers of the College.

We have undertaken to organize a South Asian Regional Conference of Family Doctors in February 2016 and hope to bring together family doctors from the Region. Experts from other Regions will also be invited to share experiences and strengthen patient centered care.

The College of General Practitioners of Sri Lanka was established in 1974 by an Act of Parliament .We would like to invite all doctors in general practice to join the College and take part in all its activities to improve skills and enjoy the comaraderie. At the heart of our College lies its motto, "Arogya Parama Labha" meaning greatest of all gains is good health. Let us commit ourselves to help our people to achieve good health.

Prof. Antoinette Perera
President, CGPSL

VERY IMPORTANT

The Ministry of Health has sent the following circulars to the College.

1. Clinical Guidelines, Circulars Notifications and Information of drug withdrawals
2. Directive to Private Medical Institutes (PMIs) conducting pre departure health assessments for outbound migrants
3. Guidelines on Management of Dengue Fever and Dengue Haemorrhagic Fever
4. Guidelines on malaria chemotherapy and management of patients with malaria
5. Revised guidelines on clinical management and laboratory investigations of patients with seasonal influenza virus infection
6. Revised Guidelines for Clinical Management of Patients with Middle East Respiratory Syndrome-Corona Virus (MERS-Cov) Infection
7. Revised Notification and Investigation System for Adverse Events Following Contraceptive Usage, Contraceptive Failures and Suspected Quality Failures of Contraceptive Commodities

All circulars will be emailed to members. If you need a hard copy, please collect it from the College office.

TRAINING FOR GENERAL /FAMILY PRACTICE

Extracts from the Presidential address 13.06.2015

Family medicine, is a clinical specialty related to ambulatory care of patients. The speciality concentrates on the person who has the illness rather than only the illness itself.

"It is not a case we are treating; it is a living, palpitating, alas, too often suffering fellow creature. " John Brown

At the heart of healthcare delivery, lies our patient. People can become ill at any time of the day and they come to us doctors with their stories which may either fit into a disease pattern that we know of or one that needs much more understanding of the patient in totality. We see illness mostly in the early stages of disease but there are also patients presenting for the first time in later stages of the illness. We also see conditions that rapidly progress. A core clinical skill that we need to master is accurate diagnosis and correct management in the context of other conditions they may have and the impact on the life they lead. Management requires good communication with the patient, family and sometimes the secondary or tertiary care specialist. The appropriate plan of management could be even to support the patient in self management. This entire process needs a system of high quality generalist care and requires formal training of doctors going to General/ Family Practice.

The Sri Lanka Medical Council recognizes MBBS with internship covering only two disciplines as adequate to function as an unsupervised GP. With the vast improvement in the provision of healthcare, it is time that the policy makers thought of introducing specialty training for General Practice.

Some facts to support this statement of mine.

1. The global electronic medline indexes 900,000 clinical articles every year. The disease patterns and their management are changing the generalist doctor needs to keep abreast of new developments.
2. Public now have direct access to specialist care as well as internet facilities and as such their expectations are also changing.
3. There is a fast growing ageing population with multiple co morbidities needing home based care with very little training provided either in the medical school and during internship.
4. Constantly emerging new interventions and treatment schedules have altered the course of some rapidly fatal illnesses. Some of these have become chronic conditions.

At present, the family doctors who work full time delivering primary care are in the private sector. Few universities also have model family practice centres. However, the majority of doctors delivering primary care are part time practitioners while being employed by the state. There are also a few specialists in family medicine who have undergone or undergoing clinical training to obtain board certification as specialists in the Ministry. According to the Annual Health bulletin, 100 million consultations take place every year in out patient settings, 50 million in the state sector and 45 million in the private sector.

All these doctors who work as generalists need to be given due recognition as general practitioners as they too are responsible for the care they deliver. To achieve this the College of General Practitioners of Sri Lanka (CGPSL) is now in the process of discussing with different stakeholders, the establishment of a General Practice register.

The registration will require training in general practice at least at some point in their career once they have set up their practice. The western countries are looking at enhancing their already existent training programmes which give people the license to practice as a GP in their countries.

The Royal College of General Practitioners UK in the recent years has brought in a new concept called modern medical generalism which encompasses patient care at all levels of care be it primary secondary or tertiary. This is quite new and new to us as well.

According to the RCGP the definition of medical generalism is as follows.
"Medical generalism at its root, is a way of thinking and acting as a health professional and more than that, a way of looking at the world. They argue that that it is possible to be a generalist in any specialty or profession and equally one can work as a GP without being a true generalist. The essential quality here is that the generalist sees health and ill health in the context of peoples wider lives recognizing and accepting the wide variation in the way their lives are lived, and in the context of the whole person." This takes me towards the patient centeredness in Family Practice. Family Medicine is centered round this. However, to say that patient centeredness is peculiar to a generalist is untrue and unfair. A specialist may well be patient centered. In fact most of my senior colleagues in the Faculty are truly patient centered. Particularly when in contact with a persons with long standing illness.

From a patient ……

" To me the ideal doctor would be a man endowed with profound knowledge of life and of the soul, intuitively divining any suffering or disorder of whatever kind, and restoring peace by his mere presence" Quote by Henry Amiel

In this new model, there is integrated care where patients are always put first and the professionals work closely together irrespective of specialty or location be it the community or hospital. Medical generalism is not a synonym for general practice. Eventhough it is the essence of good general practice it is needed in secondary care as well.

One would look at a generalist as a person who takes an interest in all parts of the body and in the mind. This enables a generalist to act as the point of first contact to deal with acute and chronic conditions and to mange illness which is undifferentiated. Thus a generalist needs to be competent in the coordination of care and to have an understanding of the variable impact in a persons life course. More demands are made on the 21st century GP. It demands a deeper and richer interpretation of a generalist's role. An approach oriented to individual family and community, provision of coordination of care over a long period of time leading to promotion of health and well being of individuals, families and a cohort of people followed up over long term.

The generalist then is trying to look at patients health or illhealth from the patients perspective through the patients lens .This is the biopsychosocial approach . An emerging refinement of this is the biology of biography, which takes a whole life view of the patient and trace much illness to childhood and even to prenatal experience. This is a more complete approach and enhances clinical management strategies. This needs responsibility for a cohort of patients. This population focus is important for maintenance of health and well being. According to Sri Lankan statistics for 2012, there is one medical officer per 1278 population. As we go along producing over 1000graduates an year, I see no great difficulty in allocating the responsibility of care to a particular GP in the long term.

Training for General practice

Challenges and Opportunities

The training courses available at Diploma level at present are.

1. The newly SLMC recognised Diploma for the membership conducted by the CGPSL,
2. Diploma in Family Medicine at the Post Graduate Institute of Medicine. Even though there are over 1000 Diplomates, these doctors do not go into primary care situations in the Ministry of Health nor into Private general practice thereby causing a loss of manpower for primary care. Also the selection into the course does not give any weightage for doctors working in the primary care situations or want to continue in GP.
3. MRCGP (INT) conducted by the CGPSL in collaboration with the Royal College of General Practitioners UK.
4. The MD in Family Medicine by clinical training and Examination and by Theses recognized by the MOH for specialist staus.

We have the expressed support of the International Chair of the RCGP who have been working with us over a decade. We also have the support of the World Organisation of Family Doctors and those in the Region. It was our own Dr Preethi who was the President of the South Asia Region of World Family Doctors for 6 years. And In fact we have won the bid to host the next SAR world conference in Sri Lanka in February next year.

Preparing the future GP

Basic generalist skills could be taught in medical school by different specialists in collaboration with generalists in Depts. of Family Medicine. The curricula should be drawn up to focus on learning to deal with problems seen in general practice in consultation with the Dept. of Family Medicine. The breadth of general practice could be covered to some extent this way.

At the second level, skills specific for general practice should be learnt in the natural setting of general practice. If the trainee is attached to the MOH, The GP trainee could select to work in a primary care situation under the supervision of specialists in the Departments of Family Medicine or be attached to training centres now manned by the Consultants in Family Medicine properly trained and board certified .This would not be a burden on the MOH as the said trainee would mann a PMCU or work in a divisional hospital and carry out assignments in family practice under a supervisors guidance who is not physically near them. There could be an exit exam after this. These doctors then should be given preference when selecting doctors for Family Medicine diploma courses. The 4th level will be specialist level which is already in place.

Those going into full time general practice have the CGP backing with the Diploma for the MCGP, MRCGP (Int) and a mentoring programme by a senior general practitioner.

The College of GPs is willing to provide expertise to train many doctors in general practice if the Ministry provides the infrastructure and resources. It was the College members headed by Prof Nandani de Silva who established the first online course for the Diploma in Family medicine at the PGIM. There are many doctors trained to carry out Distance education. We could reestablish one. We have now committed members of the CGP and over 20 doctors from the MOH and universities having finalized their MD or waiting to do so next year. These doctors are enthusiastic about family medicine and will work with commitment. I will do my best to establish or initiate a course of training during my year at the CGP which would take in many doctors.

PHOTO GALLERY

TREMOR IN GENERAL PRACTICE

Tremor may be described as involuntary, rhythmic, oscillatory movements. It may be physiological or pathological, with varying degrees of severity.

It may involve the head and neck area, the trunk or the limbs. There may be voice changes or writing difficulties.

Tremor may be caused by pathology affecting the brain stem, the cerebellum and/or the extrapyramidal system. A patient may delay presenting with tremor, mistakenly believing it to be a normal part of ageing. Up to 4% of people aged over 65 years are affected by essential tremor (action or postural tremors).

Physiological tremor may affect both hands equally and may become apparent with anxiety, fatigue, hyperthyroidism, hypoglycaemia, alcohol or other drug withdrawal, and caffeine consumption.

The most common pathological tremors include resting tremor associated with parkinsonism, essential tremor and intention tremor, which may be due to cerebellar dysfunction. In the latter, possible causes include MS, spinocerebellar degeneration and stroke.

Tremor may be described as having slow or fast oscillations that vary in amplitude.

Tremor may be described as having slow or fast oscillations that vary in amplitude.

- Resting tremor occurs at rest and may not be apparent during physical activity
- Action tremor is exacerbated on movement
- Intention tremor also occurs during voluntary movement when directed towards a target, with the tremor becoming worse as the target is approached
- Complex tremor may have components of the aforementioned types of tremor. For example, Holmes tremor may occur in MS if the midbrain is affected

Essential tremor tends to be symmetrical and may affect the voice. It may be suspected if there is a positive family history of this condition.

If Parkinson's disease is suspected, there may be other symptoms, such as cogwheel rigidity and a shuffling gait. Extrapyramidal symptoms and cognitive problems may be suggestive of progressive supranuclear palsy.
Some medications may cause tremor, including salbutamol, haloperidol and metoclopramide.

Possible causes	
Resting tremor Parkinson's disease Secondary parkinsonism, often drug-related **Postural tremor** Essential tremor Alcohol withdrawal Hyperthyroidism Hypoglycaemia	**Intention tremor** Stroke Cerebellar space-occupying lesions Multiple sclerosis **Flapping tremor** Acute hepatic failure

Clinical assessment

It is important to evaluate tremor by taking a thorough history, which should include its onset and the body part affected.

Possible exacerbating factors include rest, movement, stress, anxiety and alcohol.

In the case of a sudden onset of tremor, recent illness or addition of a new medication should be considered.

A neurological disorder may be responsible, depending on the presence of other symptoms, such as weakness, numbness, dysarthria, confusion, postural problems, shuffling gait and cogwheel rigidity. Weight loss, palpitations and diarrhoea may point towards hyperthyroidism.

It is relevant to ask about a positive family history of tremor in first- degree relatives. It is also important to ask about alcohol and/or drug misuse and caffeine consumption. The effect on activities of daily living should be elicited.

Physical examination should include a full neurological assessment of the CNS and peripheral nervous system, as well as routine observations, such as temperature. Lying and standing BP measurements may be helpful.

Cerebellar function should be tested. This may be done by heel-to-shin and finger-to-nose testing.

It may be relevant to examine the neck to assess the thyroid gland and to assess for any associated eye signs.

Other useful tests include asking the patient to write a sentence to evaluate their handwriting, as well as asking them to hold a glass of water.

It may be relevant to look for cognitive dysfunction; for example, Lewy body dysfunction may present with resting tremor, cognitive dysfunction and visual hallucinations.

The tremor should be assessed at rest, with the arms outstretched and when the patient is distracted.

Parkinson's disease may be suspected in the presence of a resting.

Cerebellar dysfunction is more likely in the presence of intention tremor. Physiological or essential tremor is more likely to be postural.

Clinical evaluation is likely to reveal the underlying aetiology, although neurological referral may be necessary. TFTs, calcium and glucose levels may be checked. Brain imaging may be required.

Management

Management can include avoiding known triggers, such as caffeine and anxiety. Essential tremor may respond to beta-blockers.

Occupational therapy and physiotherapy may be helpful in cerebellar tremors. Specific therapy may be considered in patients who have Parkinson's disease.
For severe tremor, surgical management, such as thalamic deep brain stimulation, may be appropriate.

Dr. Maithri Rupasinghe

Up Coming Events & Plans for the Year

* *4th July 2015 : Workshop on workplace based assessment*
* *15th July 2015: MRCGP OCSE Training workshop*
* *09th August 2015: Annual Academic Sessions in collaboration with Sri Lanka Association of Geriatric Medicine (SLAGM)*
* *3rd week of August 2015: Capacity building in IT related to research (Await details)*
* *September 2015: MCGP 2015/ 2017 Batch Intake*
* *October 2015: Joint regional meeting in Polonnaruwa with SLAGM*
* *November 2016:Workshop on management of common mental problems in general practice in collaboration with College of Psychiatrists.*
* *January 2016:OSCE Training Workshop*
* *February 2016: WONCA SAR 2016*
* *March 2016 : Regional Meeting in Chilaw with North Western Chapter*

* *25th & 26th July 2015: Certificate Course for Doctors in Palliative Medicine organized by Palliative Care Association of Sri Lanka*

CGPSL FELLOWSHIP

Dear Members

The annual academic sessions of the College of General Practitioners of Sri Lanka will be held on the 9th of August 2015. According to the tradition, we will be awarding the fellowships at the inauguration ceremony.

The members, who wish to apply for Fellowships, please contact Ms Dimuthu at the college office.
(TP - 0112698894)

Requirements to become a Fellow

1. 5 years of being a Member of the College of GPs and 1000 marks from the score card (Score card can be obtained from the office)
   or
   20 years of being a Member
2. You have to get the Life membership
3. A payment of Rs 10,000 has to be paid to the College if you are selected.

Please submit your applications before **17th July 2015**. No late applications will be entertained.

Thank you
Best regards
Dr Shyamalee Samaranayaka/ Secretary/ CGP

College of General Practitioners of Sri Lanka
MCGP Course 2015

Lectures on every other Sunday of the month, 9am to 4.30 pm - commencing September 2015
Duration – Two years
Eligibility – Medical degree registrable under section 29 with SLMC. Should have two years or more of work experience in General Practice after completion of internship in Sri Lanka during the 5 years preceding the date of application
Apply to
The Secretary
MCGP Board
College of General Practitioners of Sri Lanka
No 6, Wijerama Mawatha,
Colombo 7
Inquiries – Ms. Upeksha: 2688775/ Ms. Dimuthu: 2698894
Apply before 07th August 2015

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