SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

MAY 2017, VOLUME 10 , ISSUE 05

WORLD HYPERTENSION DAY

17th MAY 2017

WORLD NO TOBACCO DAY

31st MAY 2017

130th Anniversary
International Medical Congress
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CONTENTS

PRESIDENT'S MESSAGE

Dear Members,

I believe that most of our members had an enjoyable traditional New Year & Easter break with family and friends. Such socially related interludes are of paramount importance for busy medics, postgraduate trainees and hardworking students alike. No doubt there are those who have to be on call during such holidays. But the camaraderie displayed by fellow healthcare workers and patients alike during such seasonal holidays, when access to food for the overworked junior doctor may not be easy, is also a special experience that leaves us with many a fond memory. The mental and social wellbeing of today's busy and multi-tasking doctor is considered as of foremost importance worldwide. I hope that our members, through such social interactions at home and workplace, could revive themselves and think afresh on the current challenge faced by our profession with a view to finding a suitable resolution through open discussion and dialogue interwoven with dignity and decorum. Some senior colleagues lament and even say "it's too far gone" and beyond any form of resolution. I pledge to you that the Council of the SLMA is trying its very best to support the sustenance of our profession in maintaining its high rating in society by engaging in a non-partisan, apolitical and non-trade union discussion. My sincere hope is that all parties can take a more pragmatic course and try to find a long lasting solution. We must remain positive as the considered crème de la crème of society; we just cannot and must not fall into decay through self-destruction.

I share with you, with a degree of pleasure and pride, the proceedings and key outcomes of the recent international conference on "The changing face of medicine and the role of the doctor in the future" organized by the British Medical Association. Sri Lanka was the only Asian country to be represented by a National Medical Association alongside those from Canada, New Zealand and the European Union, with concurrent representation of leads in medical education, primary care and the corporate sectors from Israel, Spain and the USA. There were many panel discussions that had a good mix of speakers representing general practice and primary care, medical education, psychological medicine, the General Medical Council, the Royal College of Nursing, the chief editor of the British Medical Journal, other renowned and respected medical writers, representatives of the official lead of the National Guardian Office that represents the British NHS Staff, representatives of the junior doctors and medical students alongside key representatives of patient groups.

This presidential project of the BMA aimed to discuss in depth the role of doctors in a fast changing environment and determine how external influences may affect the doctors' sense of vocation, professional values and the doctor-patient relationship in the future. The basic question was "is the current day doctors' role likely to continue in the traditional accepted form or would it change?" My main contribution to this meeting was on "The situation in my country with regard to changes in society, healthcare and doctors." I recalled Sri Lanka's rich history of a national commitment to a free and state run healthcare system that aims for universal access and equity in distribution. The challenges faced by the 3 decades of civil conflict and the tsunami of December 2004 were revisited. The health sector's determined response in enabling a comprehensive mechanism to protect its people from epidemic diseases in these situations and achieve the highest level of health possible was reiterated. Our moving up socio economically to a lower middle income country although our health expenditure remaining at 3.6% of GDP with a 40% shortfall from the ideal but with considerable gain in immunization, MCH, and nutrition was reiterated. Access to free education from primary to postgraduate level with a high literacy rate that raises the question on what the return to society is by producing doctors for the "world at large" rather than the country alone was also highlighted. The need for the medical profession to aim at quality and safety with cost in mind was also addressed.

The challenges we face today highlighted were:

a) a rapidly ageing population with insufficient health system response for palliative care and elderly friendly services

b) an epidemic of chronic NCDs (with rapid urbanization and market oriented economy) and acute deaths from road traffic accidents - leading to a 18% chance of premature mortality - with an insufficient match of chronic primary care curative model and state of the art paramedic services and trauma centres respectively

c) the number of doctors graduating yet being short of target for the state and private sector health institutions with relatively insufficient funds for undergraduate state medical education.

The current crisis faced by our profession regarding privately funded (non-state) local medical education, the resistance from grade medical officers towards revalidation and some issues in attaining optimal multi-disciplinary integration and team work were mentioned. The 'controlled' out of hours private practice that contributes to an out of pocket expenditure to the public, particularly for chronic NCDs, with no state health insurance that requires greater discussion and planning for the future through SLMA's advocacy was highlighted. The questions asked by the group included the potential for a conflict of interest on the part of the doctors by working in two institutions, both free and fee levying - and the drawbacks of private medical institutions being profit oriented with 'fee for service' doctors. Sri Lanka's need to pay heed to a greater interaction with civil society and patient engagement for a more patient centred chronic out-patient care process was also highlighted.

The overall consensus was that today's doctors the world over wish to do their best with considerable pride.

Contd. on page 03

Contd. from page 02

PRESIDENT'S MESSAGE...

However, they feel stifled, ill supported and come under immense pressure from changes in health policy, health budgets, healthcare targets, and increasing demands and expectations from their patients, and an ever-rising need for data entry and data interpretation. Doctors are experiencing burnout, experiencing mental health problems from their early years. In the West, many junior doctors have left the profession or changed their roles, torn between a job they love and a demanding work setting. The discussions identified the innumerable demands made on the current day doctors of the UK from their NHS managers and officialdom that often set difficult deadlines. Additionally, easy access to information, e-medicine and artificial intelligence were viewed as major determinants of the future role of doctors. The general agreement was that today's greater demand on a sustainable chronic healthcare model, most often at primary level, requires a greater flexibility and fashioning of the young medics to the actual work scenarios they would encounter, with a better understanding of the need for patient support and engagement. The need for generalists rather than super specialists was emphasized many a time. The commodification of healthcare with over medicalization of people was also addressed with much concern. It was also agreed that the provision of high quality end of life care may be in the hands of a doctor or a trained nurse. The Sri Lankan example of grass root level health promotion by health sciences graduates specially trained in behavioural change communication rather than for the provision of medication alone was highlighted. A holistic approach that also encourages self-management to improve health outcomes was considered desirable and a realistic goal. A newer concept of engaging patients by giving them direct access to treatment options and research such as clinical trials was also discussed at length. I am pleased to inform you that the President of the BMA, Prof Pali Hungin, will be SLMA's Guest of Honour at our Annual International Congress to be held in partnership with the National Science Foundation from 13th - 16th July 2017 at Hotel Galadari Colombo. Please keep the dates free and register early.

I also look forward to see your active participation at the SLMA Walk and Run on 4th June 2017 at 630 am at the BMICH premises. This year we have prioritized emphasis on World Environment Day in conjunction with Asthma and anti-Tobacco days commemorated in the month of May. Based on my observations on the meticulous planning by a dedicated team of our Council with all stakeholders, I am certain this activity will achieve the expected target of lobbying for clean air achieving healthy lungs from childhood.

Looking forward to joining you on the front lawn of the BMICH on Sunday 4th June 630 am in your sports gear!

Yours truly,

Chandrika Wijeyaratne
President SLMA

PSYCHOLOGY OF DEATH – PALLIATIVE CARE: A PROLOGUE

Dr. Mahesh Rajasuriya
Consultant Psychiatrist/Senior Lecturer
Faculty of Medicine, University of Colombo

Death is the ultimate outcome as well as the ultimate fear. However, death is certain. The commonest way to cope with fear of death is denial. We just don't believe that we die. Therefore we tend to reject, scoff at, hate or hide everything and anything connected with death. This behaviour is more marked in certain cultures (e.g. West) and less in others (e.g. Sri Lankan).

A death of a fellow human being reminds us of the inevitability. We don't want to be reminded. The reaction of the family to the death of their loved one reminds us of our loved ones. We don't want to be.

Hence we reject, scoff at, hate and hide everything connected to the death of a person, especially a patient of ours, as we are doctors, and the grief of the family. So, we refuse to let the wife talk to the husband just before he loses his consciousness; we discourage a leave for a day from the cancer ward for a patient to say good bye to his village; we reject the appeal to remove the dialysis tube by the patient who is on her deathbed.

We, ultimately, add to the suffering, which is already difficult to bear. Maybe it is time to make the suffering a bit less difficult to bear. For that, we have to address the psychology of death and dying.

MALARIA COUNT

As at 15th MAY 2017:

22

All are imported!

Let's keep Sri Lanka Malaria free

A TRIBUTE TO A GREAT LADY

The news of the demise of Chrissie Aloysius, the immediate past president of the Doctors' Wives Association, hit us all like a bolt out of the blues. God took her in the gentlest way, while she lay asleep. How can one ask for a better way to the life hereafter- our inevitable end?

Doctors of all specialties are tied down by their professional demands, leaving them with very little time for the niceties of life. To foster the bonds of family and friendship using the gentle feminine touch to lighten the stress of their job, the Doctors' Wives Association was formed in 1985 by a group of enthusiastic ladies. Taking the lead to steer the Association's multitude of projects undertaken, Aunty Chrissie remained the uncontested choice for presidency, a position she held for 25 beautiful years. She initiated many projects during her tenure, planning and executing them with meticulous care. Simple, calm passionate and loving, she gave direction in everything she did. We had many ad-hoc projects and annual projects "Tsunami Victims Project, the annual Book Donation Project every December, the annual Sinhala New Year Project giving dry rations to poor and needy families, Eye testing and spectacle donation project are just to name a few.

She instructed us to carry out certain tasks during each project but to our surprise we found that most of the duties were already attended to by none other than herself. Taking it further she expresses her gratitude to us for the other little things she gets us to do. One conspicuous event in the calendar was the annual members' get together of the Doctors' Wives Association, a fundraiser which brings doctors and their families to interact very closely through a variety entertainment show by the Doctors and their families with music and Dancing.

As a wife, her devotion and love to Dr. Denis Aloysius, the idol of her life, had no limits. He is affectionately known to us all as Uncle Denis.

She doted on him in the same fervor as any young lover would do. Once on our very first Association trip, she was found weeping uncontrollably. Puzzled by this unexpected outburst, when questioned by the ladies she replied that this was her first time away from her husband, and was missing him even before we left her hometown Rathmalana. Such was the love they shared. She used to unravel snippets of her love and life story to us during those trips, where she found in us a very eager and enthusiastic audience, truly revealing to us the wonder behind this personality. She used to always have a game for which she would bring a gift, she would ask us "who is the most handsome man in the world" The answer was so obvious that we ladies had to tussle to shout out "Dr Denis" to grab ourselves a prize.

As a mother and a grandmother she was the grand matriarch who nurtured her large family on true human values and her zealous Christian upbringing. She loved all her offspring in equal measures and showed affection to her many maids as well. She got actively involved in their lives, setting a golden example to all.

As a friend she personally reached out to all. She would call us on our birthdays and sing the entire birthday song in a melodious voice. She would prepare an entire lunch on days her driver came to Colombo and send it to me, saying that I need to take a break from cooking and relax a little. Such was her sincerity.

Though your vibrant presence is no more, you leave behind the treasured memories we shall all hold close to our hearts. We grieve your loss and sympathize with Uncle Denis and your family. We miss you so deeply Aunty Chrissie! But then we take comfort that you are in a better place safely in the arms of Lord Jesus. May the Good Lord Bless and Keep You, Dear Aunty Chrissie.

Zamani Nazeem
President – Doctors' Wives Association Colombo

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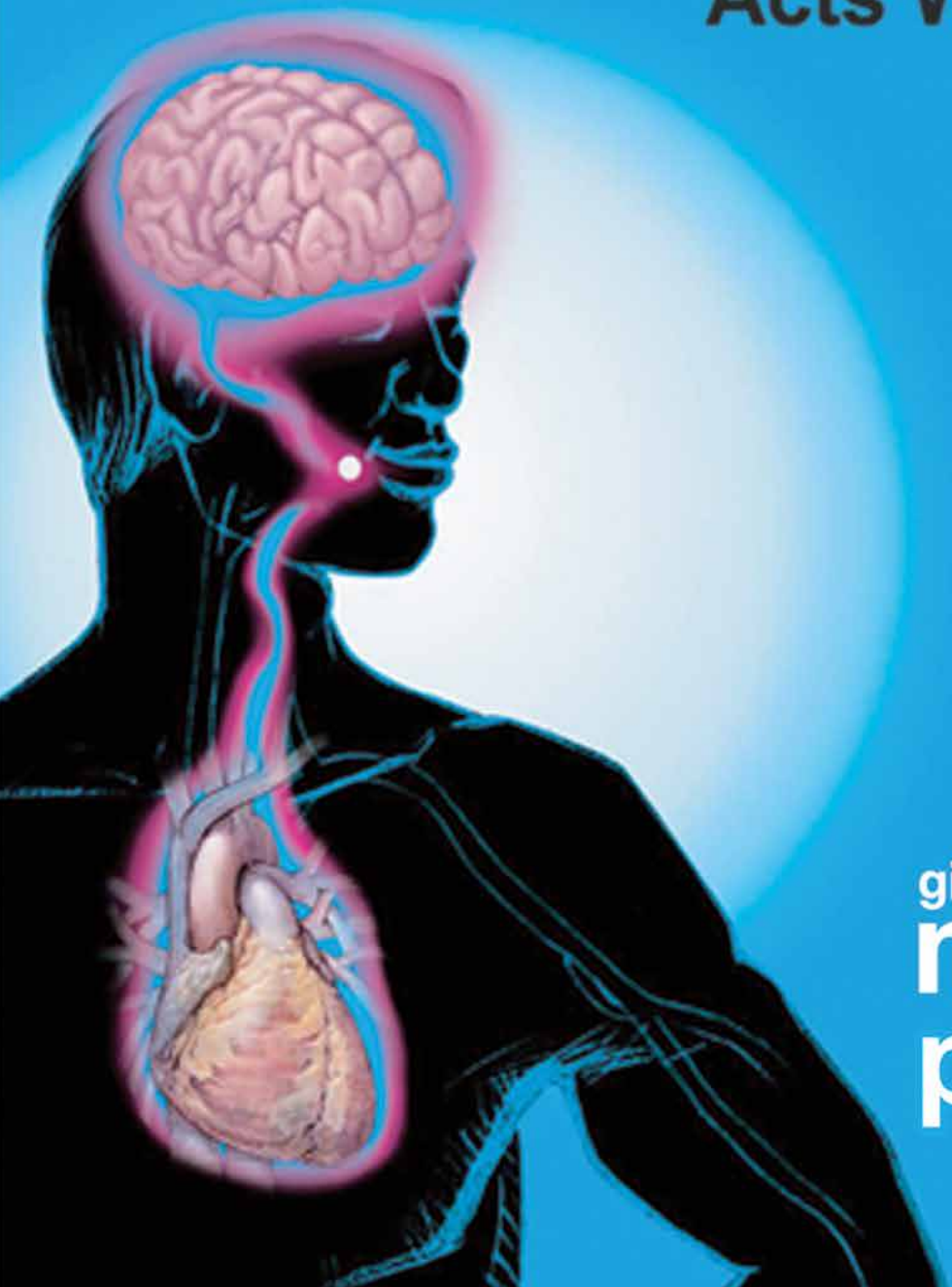

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Summary of the Dr C G Uragoda History of Medicine Lecture 2017

Delivered by Dr J B Peiris, Senior Consultant Neurologist, on 26th February 2017

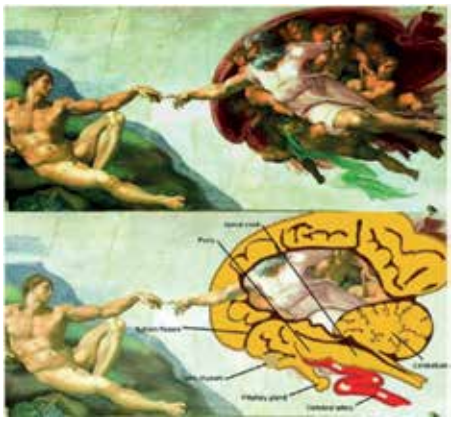
History is not a science but more a story that helps in analyzing events that follow. It may thus be a mixture of fact and imaginative fiction. History of Neurology commenced with the evolution of the human nervous system. Although even invertebrates had nervous systems adapted for function (Olfactory lobes well developed to smell prey and danger, well developed optic lobes to see prey and avoid danger and an organized cerebellum for directional motion), it took millions of years for the primate nervous system to be adapted to walk and talk. The biggest known neuron is that of the giant squid.

Diseases of the brain have been known for centuries. Lord Buddha (around 600 BC) recognized epilepsy and debarred men and women with epilepsy from becoming monks, as monks also practiced as physicians. Hippocrates about 2 centuries later linked epilepsy to the brain and also described a stroke as 'Apoplexy'.

The first recorded pictures of the brain are by Michelangelo (1475-1564). At 17, he began dissecting corpses from the church graveyard and documented anatomy by painting. It was assumed that his paintings were destroyed. However, between the years 1508 and 1512 he painted the ceiling of the Sistine Chapel in Rome.

Now 500 years after he drew them, his hidden anatomical illustrations have been found—painted on the ceiling of the Sistine Chapel, in the Vatican, cleverly concealed from the eyes of Pope Julius.

Michelangelo surrounded God with a shroud representing the human brain to suggest that God was endowing Adam not only with life, but also with a brain – seat of supreme human intelligence. He hid the human brain stem, eyes and optic nerve of man inside the figure of God directly above the altar.



Painting on the ceiling in the Sistine Chapel in the Vatican

A better illustration of the brain was by Leonardo da Vinci, who lived around the same time as Michelangelo.

Leonardo da Vinci's illustration of the brain

For the medical profession learning by dissection was important. However, in Britain, dissection was prohibited until the 16th century.

Medical students had to find cadavers on their own. By the 19th century the supply of cadavers proved insufficient, a thriving black market arose in cadavers and the creation of the profession of body snatching.

The resulting public outcry led to the passage of the Anatomy Act 1832, which increased the legal supply of cadavers for dissection.

I shall present the history of Neurology in 3 segments:

(i) Evolution of the Human Nervous System,
(ii) the World Scene,
(iii) the Sri Lankan Scene.

(i) Evolution of the Human Nervous System

Darwin, who based his studies on fossils, was silent on the evolution of the nervous system as the nervous system does not fossilize, which prompted me to present Darwin's missing chapter as the E M Wijerama lecture in 2011. We are uncertain as to when we started walking on two feet. It is unlikely that the Homo erectus spoke 1 million years ago but the Neanderthal man may have done so 100,000 years ago. Anatomically modern humans first originated in Africa about 200,000 years ago. In Europe, they first appeared about 35,000 years ago and full behavioural modernity appeared around 50,000 years ago. Speech and Language? About 100,000 years ago – still uncertain of its evolution. We have some evidence of a prehistoric man living on the Horton plains about 30,000 years ago.

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Contd. from page 06

HISTORY OF...

The foetal brain went through millions of years of evolution, from the premature brain to the adult brain.

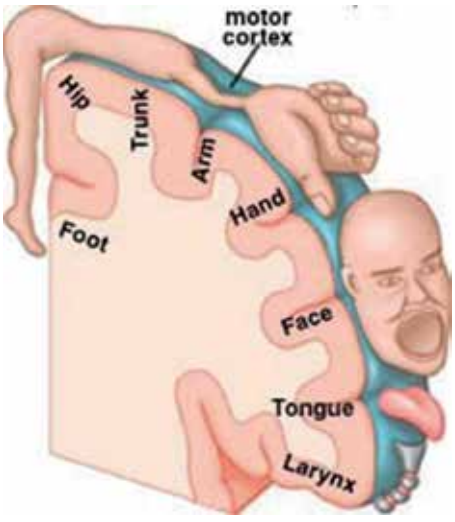
Weight of the brain does not matter, but the ratio of brain to body weight appears to matter. In humans it is 1.9% and in lions 0.1%. The nearest to humans is the rat at 1.5%.

(ii) The World Scene

Thomas Willis, an Englishman, was the first to use the word "neurology", in 1664. Willis removed the whole brain from the body and published his Anatomy of the Brain, followed by Cerebral Pathology in 1667. The separation of psychiatry and neurology was also in Britain, The Reports of the West Riding Asylum later became the journal 'Brain'.

In 1886, the Neurological Society of London was formed with John Hughlings Jackson as first President – he described Jacksonian epilepsy in his wife.

ABN – Association of British Neurologists was formed in 1933. (ASN – Association of Sri Lankan Neurologists, was formed in 2006).



Map of the body, to scale, is found only in the BRAIN.

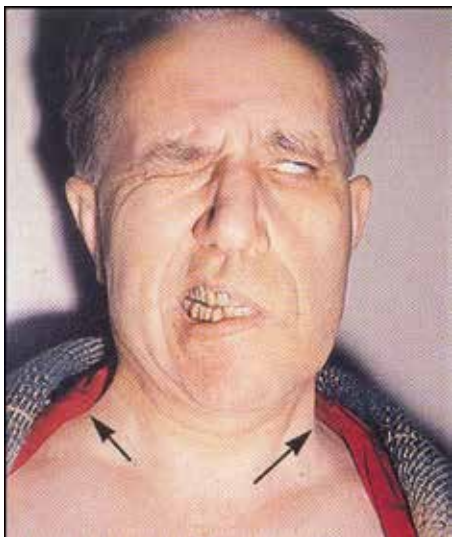
(There is no map in any other organ – NOT in the heart, lungs, liver, intestines). This is called the homunculus and in Jacksonian epilepsy parts of the body convulses in the order it is represented in the brain.

Some of the famous neurologists who imprinted their names on the Brain and neurological diseases include: Brodmann (a German anatomist 1909) identified 42 functional areas of the brain – no longer used, though. Paul Broca 1824-1880 (French) identified the speech area which has been confirmed by functional MRI, and is known as the Broca's area.

Over the years neurological diagnosis depended on a good relevant history and a focused clinical examination. Investigations like CT, MRI, and EEG are used to confirm the clinical diagnosis.

There have been many good clinical neurologists responsible for brilliant diagnosis but my favorite is Sir Charles Bell – the original 'Sherlock Holmes' who was able to make many accurate deductions by mere observation.

One such was Bell's palsy where he explained that the eyeball moves upwards when we blink to clear the cornea we all have this physiological phenomenon.



Another is the 'wash basin sign or Romberg's sign'. To maintain balance while standing at least two of the three following senses: Proprioception (the ability to know one's body position in space Vestibular function (the ability to know one's head position in space) and Vision (which can be used to monitor and adjust for changes in the body). If for instance you have loss of position sense due to a peripheral neuropathy and you take the corrective element of vision out by shutting the eyes you tend to fall as may happen when a patient with peripheral neuritis washes his face. The commonly used instruments are the ophthalmoscope and the tendon hammer.

There is an attachment which allows the optic fundus to be seen on an i-phone.

The pin is not used now for testing sensation due to dangers of spreading infection like HIV and serum hepatitis.

The EEG was invented by Hans Berger a German in 1924, and the angiogram by a Portuguese (Moniz) also in the 1920s. The CT scan was invented in London by Hounsfield in 1974 and MRI in 1977.

Hippocrates first described a stroke as apoplexy and Alzheimer's the commonest form of dementia in 1906. Parkinson's was first described by an English GP in 1817 but the beneficial effects of L dopa discovered only in the 1960s.

There have been many famous people with neurological illnesses. Among them are epileptics – Alexander the Great, Julius Caesar, Napoleon Bonaparte, Tchaikovsky, Dostoevsky, Agatha Christie, Richard Burton, Elton John, Charles Dickens, Jonty Rhodes and Tony Greig. A new entity coming into prominence is Autism and autism spectrum disorders (ASD) where there are difficulties in social interaction, verbal and nonverbal communication and repetitive behaviors.

About 40% with ASD excel in visual skills, music, math and art.

Contd. on page 09

Contd. from page 08

HISTORY OF...

Another condition recently getting much attention is Asperger's syndrome – a developmental disorder characterized by significant difficulties in social interaction and eye contact and non-verbal communication, along with restricted and repetitive patterns of behavior and interests. Language development is not delayed unlike autism.

(iii) The Sri Lankan Scene

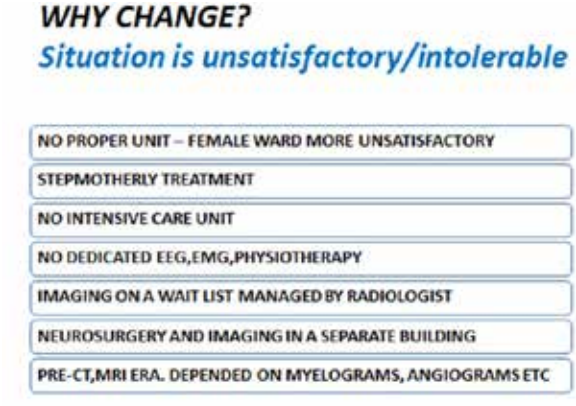
In the 1950s and 1960s, Neurology was essentially a clinical field - diagnosis was at the bedside by a good relevant history and focused examination of the nervous system.

It was partially true that Neurology provided an exciting exercise in diagnosis, with little diagnostic aid and hardly any effective treatment. Dr S A Cabraal was the first neurosurgeon and Dr G S Ratnavale the first Neurologist. The NSU occupied the whole of the 4th floor of the new impressive Bandaranaike building of the then General Hospital, Colombo. The medical neurology patients were given step motherly treatment - males with medical neurology ailments were in the Professorial Medical Unit, while female patients were accommodated together with cardiology and dermatology patients in ward 58 in the old Ragama section. Patients with strokes were often managed in bar beds at the end of the ward. However, in the Neurology ward, though there was no designated 'stroke unit' with a board, they received the same care as present day stroke units with a team consisting of the neurologist, nurses, physiotherapists, dietitian and later a British trained speech therapist.

In the 1960s worldwide neurological investigations were simple, cheap and straightforward. For nerve and muscle –EMG- electromyography, for spinal cord – it was myelography - now obsolete, brain – angiography - now refined, plain X rays – chest, spine - cervical, thoracic, lumbo–sacral regions.

For nerve and muscle disease it was electro-physiology. First commercially available electromyography (EMG) was in 1950. EMG continues to be the most important investigation for nerve-muscle disease.

In 1984, all this changed with the establishment of the Institute of Neurology at the National Hospital of Sri Lanka (then General Hospital Colombo)



My dream was to have an all-inclusive place of work with neurology, neurosurgery, neurophysiology, physiotherapy, op clinics, a pharmacy, a lecture theatre and teaching rooms – in short an institute of neurology. For this there were several requirements

1. A suitable location within the General Hospital,
2. Ministry approval,
3. A builder,
4. A committee to solicit funds
5. A good architect and engineer to manage the project

The very cooperative Director of the hospital gave us an ideal site opposite the De Soysa Maternity home.

This dedicated Institute is a 4-floor building with medical and surgical wards, neurology ICU, operating theater, neurophysiology department, physiotherapy department, lecture halls, and a paying wing.

The building was put up entirely with public donations spearheaded by me. In the early 1980s a second neurologist, Dr J C Wijesekera, was appointed to the new center established in the hill capital of Kandy.

To solicit funds we formed a small committee with the cooperation of the hospital welfare services of the All Ceylon Buddhist Congress. We requested for funds big and small, and had donations of Rs. 50 and over acknowledged in the Ceylon Daily News and Dinamina.

Our big donations were from Mrs. Milina Sumathipala for the ground floor, the Senanayake family for the male ward, Mr. and Mrs. DP Jayasinghe for the female ward, an anonymous donor for the Children's ward, the Colombo Commercial Company, the Ceramics Corporation.

Contd. on page 10

Contd. from page 09

HISTORY OF...

There was a donation of 25 acres of coconut which we vested with a public trustee to be sold by public auction. The fund raising committee and the building committee met separately weekly for 4 years to monitor the progress.

With permission from the NLB we had a Hospital lottery selling tickets at Rs. 100 to friends and well-wishers. We had a meagre profit of Rs. 300,000 because the first prize was not claimed!

After 4 years of toiling and heartburn the Institute was declared open at a glittering ceremony by Hon R Premadasa, the Prime Minister. With the improved conditions and facilities available, more trainees have taken up Neurology as a specialty. We now have an Association of Sri Lankan Neurologists and subspecialties of Neurophysiology and Paediatric neurology. We look forward to further expansion and special care in strokes and epilepsy.

Currently a neurology center exists in each of the 9 provinces of the country, including the Eastern and Northern provinces, where there was civil strife for decades. More than 40 board-certified neurologists serve in different parts of the country.

Many postgraduates are taking up neurology as a career and are in different stages of training.

A LETTER TO ALL MEDICAL STUDENTS

My dear students,

It is four months since you started (09/01/2017) your temporary exclusion from academic work. I think it is time for you to reassess the situation and reconsider your position and decide on what to do next. Your action has made SAITM a national issue and has led to serious discussions regarding private medical education in the country. For me these are the major positive outcomes of your action.

I am sure the last four months, without the pressures of keeping up with the tight schedules of life as a medical student, would have given you enough time to think and reflect about many aspects of life. Those of you who were actively involved in informing the general public about the reasons behind your action would have had many memorable and enlightening encounters. Participation in protest activities would have given you many unique experiences not usually encountered by medical students.

By now you may have realized that most people in public life in our country are rather devious and have their own hidden agenda. Whether they support or oppose you is not because they agree with you or disagree with you. They do it (either support or oppose you) because by doing that they are expecting some personal gain for them or their (political) group. The other important thing we should realize is that most people are selfish including us. SAITM is not the only instance where unfair/ irregular activities have been ignored and money and connections lead to 'respectability'. Why is it we are protesting against SAITM, but not against other irregularities?

We live in a democracy and in a democracy the people elect their representatives to govern them. If we don't agree with the government we could tell them that we don't agree or even organize demonstrations and protests. We cannot go on protesting forever against a democratically elected government, but we can always vote them out at the next elections! The obvious problem with that option in our country is whom do we vote for, but that is altogether a different issue that cannot be tackled in this short letter.

I asked some students who came to meet me in January or February to 'enlighten' me about the situation whether they have an escape route planned – how to return to work if the demands are not met by the authorities. I was told that if/ when the students feel that the struggle had been hijacked by politicians then they will stop and return to work. I think we have reached that stage. Let the others continue with the struggle, you come back and complete your degree. This doesn't mean you have been defeated or you are accepting defeat. During the last four months you have achieved a lot. I will not consider that you have wasted four months of your life, but if you keep away any longer then you may start wasting valuable time.

You can do a lot to protect free education and free healthcare as qualified doctors if you don't forget these days once you start working as doctors!

See you soon.

Pathmes

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LETTERS TO THE EDITOR

I have been a Doctor working in Sri Lanka for more than 53 years. In the old days there were major epidemics of Smallpox, Malaria and Polio. Despite not having all the facilities that the present generations have – like transport, communication and modern technology these illnesses were totally eradicated. Fortunately, vaccines for Smallpox and Polio contributed greatly to eradicate these illnesses.

They did not have "Smallpox Week, Malaria Week and Polio Week" once in two or three months to eradicate these illnesses. All steps were taken daily in all corners of the country to eradicate these illnesses.

I wish to request the WHO, the UN Organizations, the Sri Lanka Government, the Ministry of Health, the Sri Lanka Medical Association and all the Medical Associations of this country including the GMOA to give the highest priority to find ways and means to eradicate Dengue as soon as possible.

I wish to make the following points:

1) For the prevention of Dengue, instead of having a Dengue Week once in two or three months please have "Dengue Day Everyday".

2) Early detection of Dengue - Between 12 and 24 hours of any fever the Dengue Antigen Test must be done. This will give a warning to the Doctor, the Patient and the Family. The Dengue Antigen Test is quite an expensive test ranging between Rs.1,500/- to Rs.2,000/- in the Private Sector. The Private Hospitals and Laboratories must reduce this charge considerably to allow patients to get this Test done. The Ministry of Health must provide all financial assistance to all Government Hospitals and Laboratories big or small to have facilities to do this Test for every patient in this country when requested by the Doctor. Most patients do not know about this Test and the value of this Test.

   Many patients do not realize until the 3rd or 4th day that they are having Dengue Fever.

3) If the Dengue Antigen Test is positive, a Full Blood Count must be done everyday from the second day for 6 days to give an idea of the seriousness of this illness and to help in the treatment.

4) All Doctors in this country, I am sure, know how to treat Dengue Fever if they have the warning that the patient may suffer from all the ill effects of this deadly illness.

5) The eradication of Dengue Fever must be given Top Priority above everything else in this country.

Dr. K. Rajendra
21st March 2017

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Sri Lanka.
2017/03/11

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No.565/6A, Mihindu Mawatha,
Malabe. Sri Lanka.

Through
The Director, De Soysa Maternal Hospital For Women / Director General of Health Services

Dr Chandrika Wijeyaratne,
President,
Sri Lanka Medical Association.
Dear Madam,

RE :- IMPROVING AND MAINTAINING MEDICAL EDUCATION AND PROTECTING SAFETY OF PATIENTS

Appreciating the protest against SAITM and the public interest on quality of doctors in our country, as an independent consultant I thought of writing this letter.
It is Paramount important to maintain good standards of the quality of medical education and care for patients. This kind of huge demonstration shows that profession is at risk and need actions to protect it.
In addition to taking appropriate action regarding SAITM, I strongly believe this is the best time to start other very important processes which are lacking in our health care system to maintain standards of doctors education and maintaining their competency up to date.

1. Maintain standards though revalidation

Way of showing all Practicing doctors to show their competency and their knowledge and skills are up to date. Such as annual appraisal and every five years revalidation in an appropriate manner will help to do this.

2. Serious incidents requiring investigations.

All serious incidents taking place in health institutions need proper investigations at institutional level. You may find examples from any good health care systems in the world. Example - NHS - United Kindom.

I believe SLMC will be the governing body regarding these process and ministry of health need appropriate contributions to make this processes practically possible.
I hope my suggestions will be given appropriate and serious consideration.

Thank you.
Your Truly

Dr M. A. K. Perera
Consultant Obstetrician and Gynecologist.
De Soysa Maternal Hospital For Women

Your opinion matters.....!

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E: office@slma.lk / sharminigunawardena@hotmail.com

P: Editor-in-Chief *SLMA News*,
Sri Lanka Medical Association,
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Colombo 07,
Sri Lanka

SHAPING INPUTS OF PROFESSIONALISM IN SRI LANKAN MEDICAL SCHOOLS: POINTS TO PONDER

Dinithi Fernando
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Senior Lecturer in Physiology
Faculty of Medicine
University of Colombo

How Sri Lankan doctors and medical students conduct themselves in front of their patients, colleagues and the public is a phenomenon that often kindles interest in the observer. Analyses of such observations bring forth mixed reactions, frequently positive and not so infrequently, negative. One conclusion is clear. Our conduct as doctors, which is an integral part of being a professional, has room for improvement, be it the way one speaks to and handles a sick human being or a family member, or the way one responds to a query from a news reporter, among many dozens of similar situations we encounter on a daily basis. Those of us who have the yearning to be a better professional tomorrow than we are today, frequently develop upon groundwork that has already been laid during our medical student and postgraduate days.

So where are we now, in our medical schools? There is indisputable evidence coming from affluent parts of the world that positive learning experiences in professionalism makes a person a better doctor. Evidence also tell us that professionalism should be introduced during early undergraduate years. Backed by such evidence and in accordance with accepted frameworks on professionalism such as The Physician Charter, GMC Good Medical Practice and Tomorrow's Doctors, most medical schools in Sri Lanka have assimilated teaching of professionalism into their curricula. The learning environments in local medical schools have undergone considerable change from mid- 90's with regard to teaching of behavioural aspects whereas the developed world started it in 70's.

Personal and professional development that was learnt in an informal 'monkey see, monkey do' manner is now formalized. Teaching does begin in early years. However, it is possible that these inputs are viewed as external, artificial constructs that are learned as separate elements and not necessarily linked to day to day learning, conduct as a medical person and life outside it. In fact, in a series of focus group discussions that was carried out with the second year medical students in Colombo, it emerged that students were reasonably familiar with the theoretical jargon on medical professionalism but had difficulty in linking it with actual happenings in the undergraduate medical career. "Learning' professionalism was perceived as a 'burden' because of the stressful, content-overloaded, competitive learning environment.

How do medical schools across the world profess professionalism to their students? Glimpses of research on student and teacher perceptions on the subject show role modelling and mentoring by teachers and facilitators to be the top influencing factor promoting professionalism, placing the onus on medical teachers and teacher assistants, both clinical and preclinical. Role modelling occurs as part of the 'hidden' curriculum in which the students learn the rules, regulations and routines that they're expected to follow, by observing. However, medical educators nowadays believe that role modelling alone is insufficient. Small group activities related to clinical scenarios, real or simulated, with reflective practice were some other preferred methods, as shown in literature. In many studies, tutorials, checklists, and portfolios turned out to be less popular factors. Some schools have white-coat ceremonies, orientation sessions, student charters, policies and codes that tell them what to do and what not to do. In our local curricula, we use a combination of these methods to teach professionalism. But in the last 20 years, we have rarely looked to see how efficient and effective these methods are, in getting our students where we want them to be.

How can the learning experiences on professionalism be made better for our students? Can the Western frameworks and learning methods be harvested and grafted as they are? Probably not. May be this is one of the reasons why our students seem to dissociate the theoretical and practical aspects of the subject.

Going further into the focus group discussions mentioned earlier in this write- up, it was interesting to note that there was a definite cultural flavour to the model our students perceived as a good doctor! There are fundamental differences in the ways our people think about health, sickness and death from the ways the Western, Middle Eastern, Far Eastern or African people may think. To most of our patients, a close family member hearing bad news on the patient's behalf for the first time is quite acceptable and sometimes actually the preferred way, whereas in the West, the doctor is bound to tell the patient before anyone else in the family as per the societal norms. These differences should be given due consideration when imbuing our curricula with professionalism teaching. Our physicians in the making need to be convinced that our 'core values' do not stop at doctor-patient encounters but have to permeate into hospital corridors, canteens, common rooms, hostels, social media and 'wherever' they happen to relax and live.

It seems easier to deliver inputs in professionalism in patient-centred settings, such as wards and clinics, for it's easier for the student to make connections between theory and actual practice. But the early years, before clinical exposure is a challenge. In our preclinical curricula, there is competition for time to teach basic biomedical sciences, community and behavioural sciences.

Contd. on page 13

Contd. from page 12

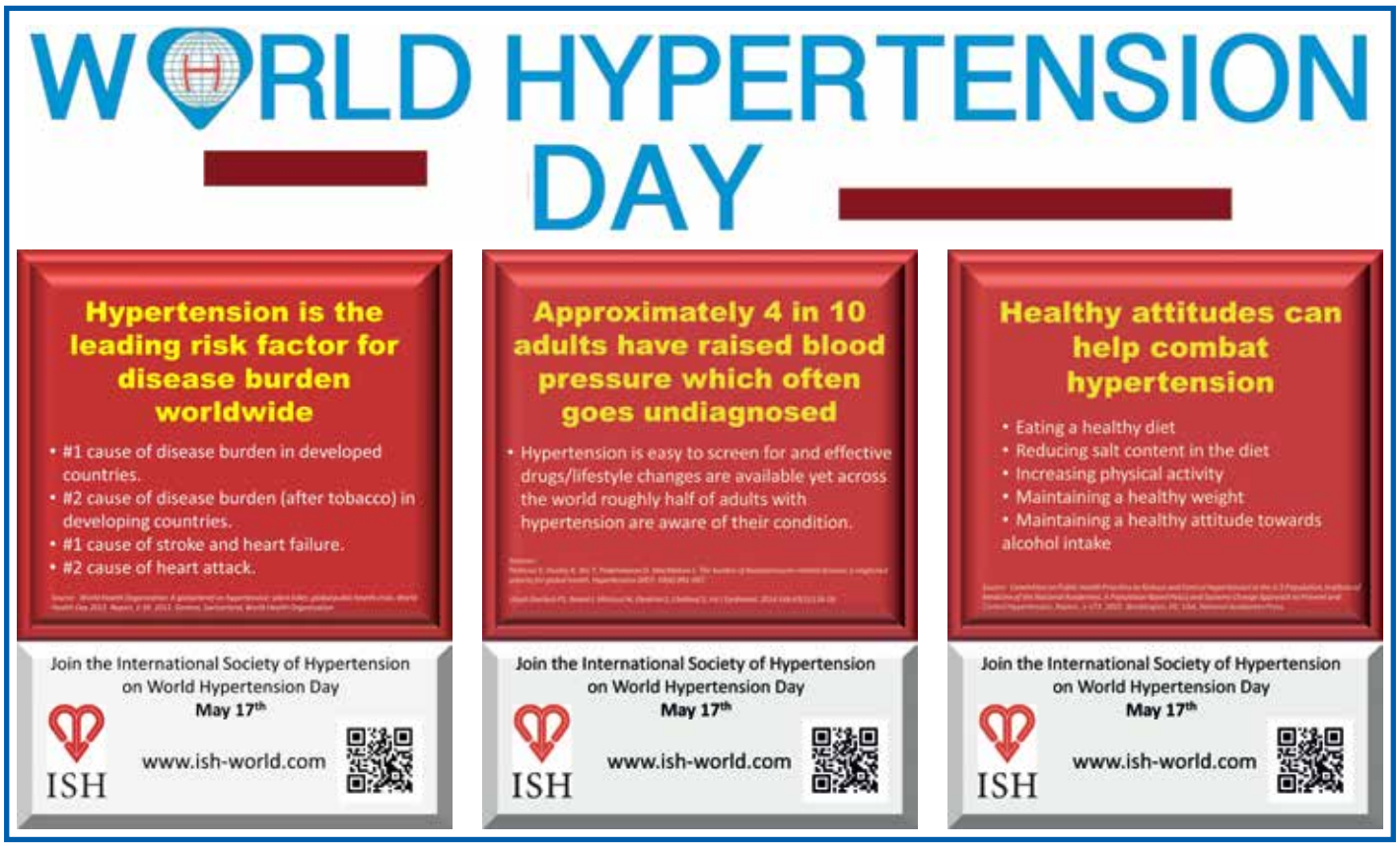
SHAPING INPUTS OF...

Our students struggle with content overload, as well as the additional burden of learning it all in a second language. While agreeing that integration of disciplines is needed to keep up with the rest of the world, concerns about consolidating knowledge in biomedical sciences in the early years too should be acknowledged. More emphasis should be placed on finding meaningful ways to introduce and strengthen professionalism within teaching time and framework of biomedical sciences, so that professionalism becomes part and parcel of the main act. There may be ample, currently largely underutilized opportunities, for example, during dissections or practical sessions to introduce these aspects, without having to allocate additional teaching time. There are lessons to learn from the neighbourhood, for example, 'the silent mentor' concept in Singaporean and Malaysian medical schools, where students learn to respect and be grateful to the 'body donors' before they start dissections.

The selection process for the medical schools in Sri Lanka, a process which relies totally on academic merit, does not place any weight on accomplishments in humanities or soft skills. Hence, neither the medical teachers, nor the students have a clue about the baseline knowledge or experiences in professionalism the students bring in, and all inputs just start from scratch. In a society where pure academic merit is widely perceived as the only suitable criterion to judge a student's worthiness to enter medical school, and processes such as 'interviews' are seen as (and not baselessly so) as methods which can be easily manipulated, it is unlikely that A/L selection methodology will change in the near future. There is a period of at least 8-10 months between the point a student receives the required Z score, the admission ticket to medical school, and the actual induction as a preclinical student. This period of time is another currently wasted opportunity to hone soft skills of the students, and constructive use of this period will definitely pave the way to efficient usage of preclinical and clinical years to further develop professional skills.

How should professionalism be measured in medical undergraduates? There are many methods that are employed and the challenge is to make the assessments as objective as possible. In most developed countries the assessments start before entry to the medical schools, while in the school, by teachers, peers and patients. Whatever the methods used, they should be a tool to enhance and reward professional behaviour, detect those who have deficiencies in professionalism and decisively, strike-off the rare student who cannot meet the required standards and therefore not suitable to practice medicine.

It is perhaps time that our medical educators, medical anthropologists, sociologists etc. got together to study the ground situation further and develop culturally sensitive frameworks and teaching and evaluating methods that are suitable for us and our students to introduce and strengthen professional behaviour. At the same time, it is essential for all the medical undergraduates and graduates to be well aware of what is accepted as appropriate in global models, for our doctors will continue to travel and work across borders.



World Preeclampsia Day
May 22, 2017

Be Prepared for Preeclampsia*

Preeclampsia is a serious disease related to high blood pressure that can strike fast – "eclampsia" is the Greek word for lightning. It can happen to any pregnant woman during the second half of her pregnancy, or up to six weeks after delivery. Finding preeclampsia early is important for both mothers and their babies. If you're pregnant and experience symptoms or just don't feel right, contact your healthcare provider right away.

KNOW THE FACTS

- Affects **8-10%** of **pregnancies** worldwide
- Leading cause of **maternal and infant death** with **76,000** maternal and **500,000** infant deaths each year worldwide
- Common factor in **preterm delivery**, accounts for **20%** of all neonatal intensive care admissions
- Over **99%** of pregnancy-related deaths occur in **low-to-middle income** countries
- Results in **16%** of **maternal deaths** in low-to-middle income countries
- Accounts for **1/4** of **maternal deaths** in Latin America and **1/10** of **maternal deaths** in Africa and Asia

SYMPTOMS

- Severe headache that won't go away even with medication
- Swelling of the face and hands
- Weight gain of more than 5 pounds in one week
- Difficulty breathing, gasping, or panting
- Nausea after mid-pregnancy
- Changes in vision (spots, light flashes, or vision loss)
- Upper right belly pain

RISKS

For Mom
Seizures
Death

For Baby
Premature birth
Death

WHAT TO DO

- [x] Talk to your healthcare provider before or early in your pregnancy about your risk for preeclampsia
- [x] Attend all your prenatal appointments
- [x] Monitor your blood pressure and weight regularly, and contact your healthcare provider immediately if either becomes unexpectedly high
- [x] Know your family history, especially for pregnancy, high blood pressure, and heart disease
- [x] Eat right, exercise regularly, and maintain a healthy weight

*The term preeclampsia includes related hypertensive disorders of pregnancy, including eclampsia and HELLP syndrome.

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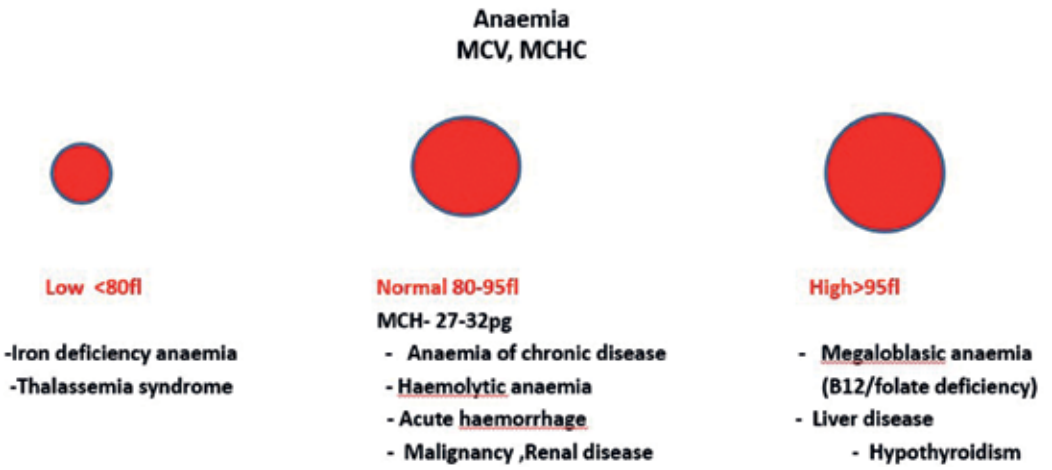
APPROACH TO ANAEMIA

Dr D Gunawardena
Consultant Haematologist/Senior Lecturer
University of Sri Jayawardenapura

Anaemia is defined as reduced haemoglobin for a given age and gender causing reduced oxygen carrying capacity which is insufficient to meet physiological needs. It is known to be the most common disorder globally (WHO database 1.6 billion people affected).



Anaemia will have effects on tissue perfusion giving rise to various symptoms. In pregnancy it could lead to pre-term labor, poor foetal growth, high risk of infection, high maternal and child mortality. Iron deficiency could give rise to problems in neurocognitive and mental development in children. Red cell indices is very helpful in the diagnosis of anaemia. Based on the red cell count (RCC), Mean Cell volume (MCV), Mean cell haemoglobin concentration (MCHC), a differential diagnosis for anaemia can be worked out at an early stage of investigation.

(1) A 70yr old man with dyspnoea and lethargy. On examination, he was pale and icteric. Following are his blood counts.

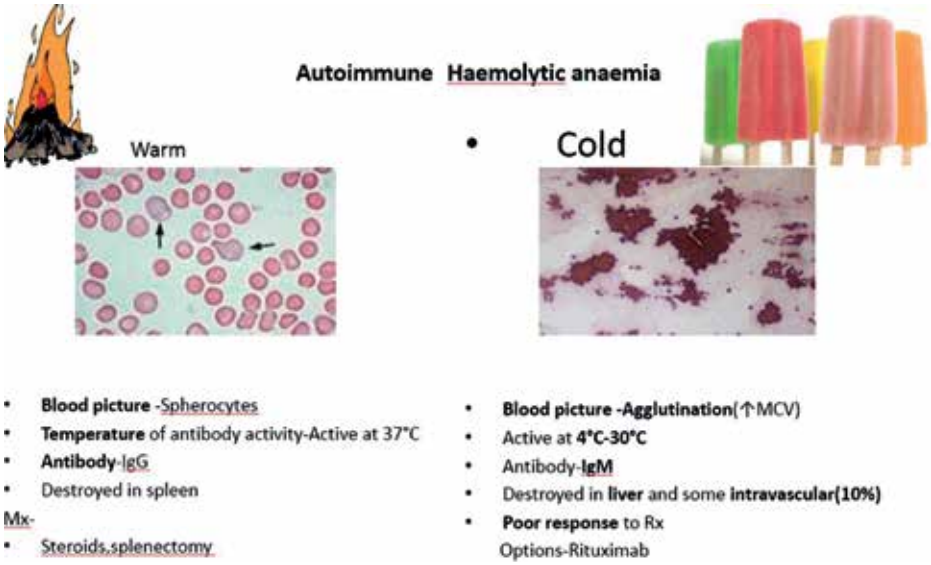
Red cell count- 1.2X1012/L

Hb-7g/dl, MCV- 150fl, MCH-56pg (27-32pg)

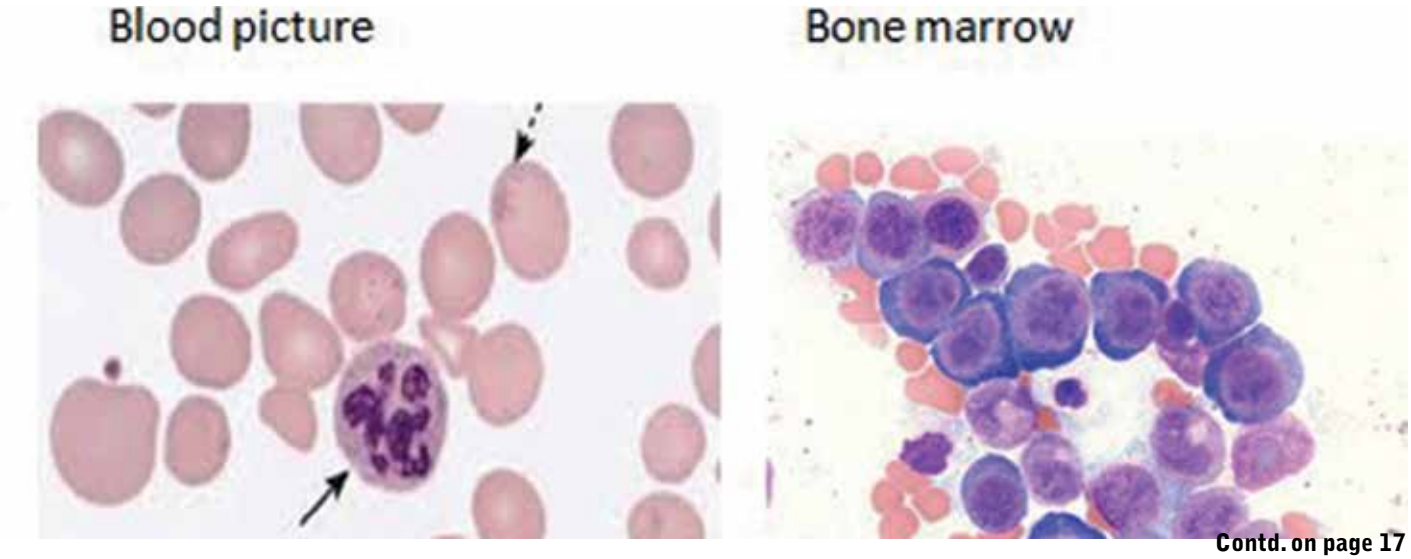
WBC- 10X109/L with normal differential count.
Platelet count- 230X109/L

Reticulocyte count-10%

1. What is your diagnosis/ DD?
2. How will you confirm the diagnosis?



(2) A 56yr old man with severe anaemia and skin rash. Examination findings are normal. Blood picture and bone marrow are given.

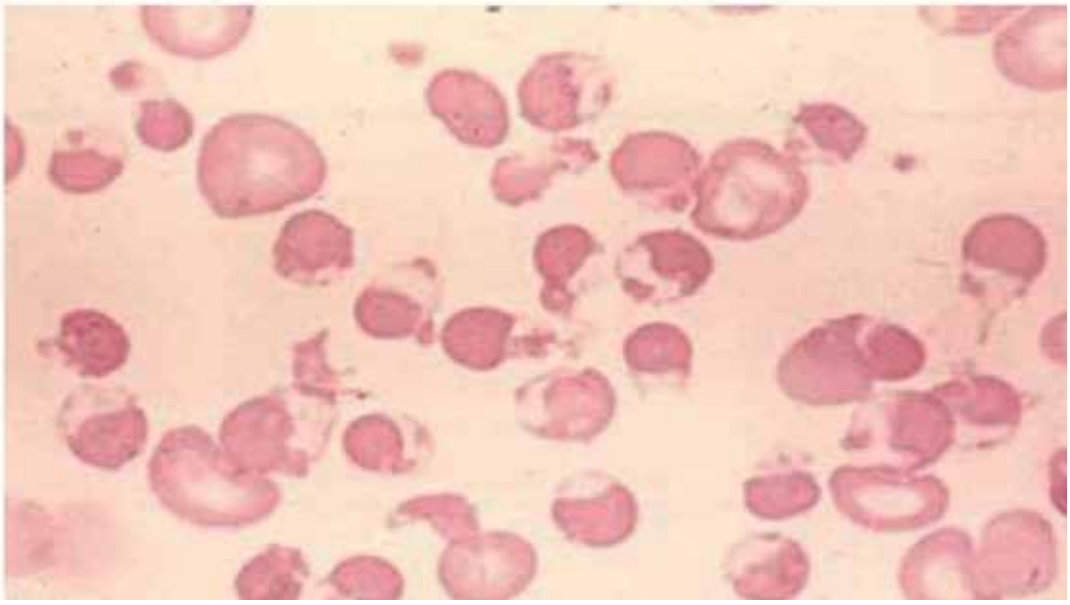


Contd. on page 17

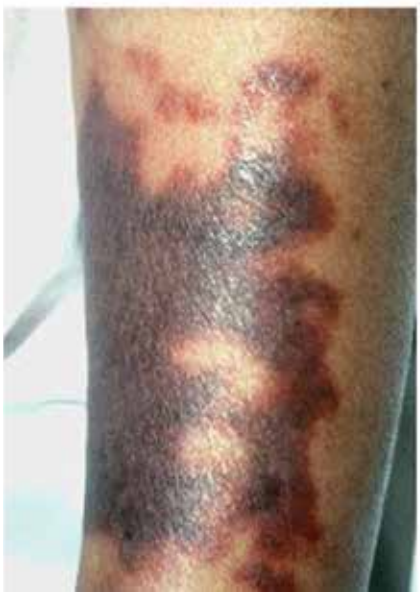
Contd. from page 16

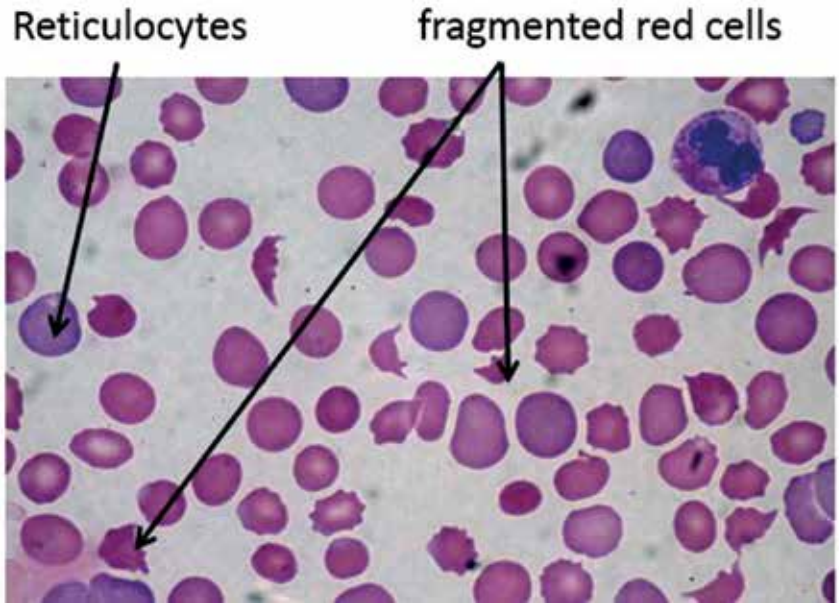
APPROACH TO ANAEMIA...

(3) A 34-year old man presented with fever, loin pain and passing dark-coloured urine. A peripheral blood film is shown.



(4) A 50yr old male with high fever for 6 days with pneumonia. What is your diagnosis?





Answers-

1.Cold autoimmune haemolytic anaemia – Very low RCC, high MCV and MCH, is a result of analyser counting agglutinated red cells as single cells.

2.Megaloblastic anaemia - Oval macrocytes , hypersegmented neutrophils in the blood film and megaloblasts in bone marrow

3.Urine sample shows haemoglobinuria with 'bite' and 'blister' cells in the blood picture which indicates intra vascular haemolysis that occurs in oxidant stress in patients with G6PD deficiency

4.Disseminated Intravascular coagulation. clinical presentation of bleeding with the blood picture findings. Confirm with very high values of D-Dimer level.

Contd. on page 18

Contd. from page 17

APPROACH TO ANAEMIA...

MCQs on bleeding and thrombosis

Dr. Chitranga Kariyawasam
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Department of Haematology
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Post Graduate Training Center

MCQ 1

A 3-year-old boy is admitted with sudden onset of bruising, generalized petechial rash and a history of intermittent epistaxis for 2 days. Ten days before admission the child was treated for an upper respiratory tract infection. Physical examination was unremarkable.

The hemoglobin level was 10 g/dL, total WBC and differential count normal and platelet count 2 x 109/L. Which one of the following management options is not appropriate in this particular case?

a) oral prednisone2- 4 mg/kg/day

b) IV anti-D 75 µg/kg

c)IVIG 1 gram/kg x 1? 2

d) close observation in hospital

MCQ 2

A 25-year-old pregnant woman with a past history of immune thrombocytopenic purpura (ITP) treated successfully with splenectomy is due to deliver vaginally in 2 weeks. Her platelet count is normal. Advise about the type of delivery and immediate post-natal care of her baby. Her obstetrician states that there is no other obstetric contraindication to a vaginal delivery. The correct advice is:

a) Obtain a scalp vein blood sample for platelet count determination at the time of delivery and deliver the baby by C-section if the fetal platelet count is < 50 x 109/L

b) Proceed to an elective C-section

c) Perform in-utero percutaneous umbilical vessel blood sampling before delivery with measurement of the fetal platelet count and advise delivery by C-section if the platelet count is < 50 x 109/L

d) Advise a controlled vaginal delivery with measurement of the infant's platelet count shortly after delivery.

MCQ 3

A 32-year-old obese woman diagnosed with the presence of antiphospholipid antibodies in her 1st pregnancy. No previous thrombotic event or pregnancy losses.

What is her ideal management?

a). She does not need to be treated with anticoagulation during her pregnancy or delivery

b). She requires anticoagulation for a period of 10 days post-partum if no other risk factors

c). She requires to be on anticoagulation throughout the pregnancy and 6/52 post-partum

d). If associated with another risk factor she needs to be commenced on prophylaxis anticoagulation at 28/52 POA and for 10 dayspost-partum.

MCQ 4

A 28-year-old woman with a POA 10/52, diagnosed with antithrombin deficiency, no thrombotic event in the past, was on OCP. Her father died of a pulmonary embolism.

a). She is not considered at risk for developing thrombosis

b). She requires anticoagulation throughout her antenatal, natal and postnatal period up to 6/52

c). She does not require anticoagulation during her pregnancy or delivery

d). She requires anticoagulation from the 28/52 of POA till 10 days postpartum

Answers-

1. (b) The history of epistaxis and a low hemoglobin level exclude intravenous anti-D as a first-choice option because of the obligatory fall in hemoglobin that will be induced by this therapy.

2. (d) The current recommendation for management of a pregnant woman with ITP is conservative. It is important to recognize that women with a history of ITP treated successfully with splenectomy may have circulating platelet auto- antibodies and deliver infants with neonatal ITP and clinically significant thrombocytopenia.

3. (b) The presence of antiphospholipid antibodies alone does not make her at risk for thrombotic events during pregnancy. However, the risk is minimal and therefore does not require anticoagulation throughout the antenatal, natal and post-natal period. But as she has a further risk factor, being obese, she needs to have prophylactic anticoagulation for the 10 days' post-partum only.

4. (b) Patients with Antithrombin deficiency (AT 111), is at high risk for developing thrombosis during pregnancy. Therefore, even though she has had no previous thrombotic events she needs to be on high prophylaxis throughout her pregnancy, which includes the antenatal, natal and post-natal periods.

Anything to Say?

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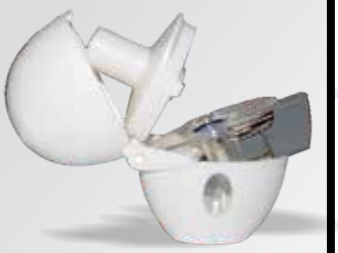

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