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SLMA NEWS+

The Official E Magazine of The Sri Lanka Medical Association

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What do we need to know to offer medical treatment to a patient presenting with psychotic symptoms?

SCAN THIS CODE TO READ ONLINE

Sri Lanka Medical Association

Annual Child Art Creation 2024

When I grow up: What I'll be

Let's draw and send without delay
Sky's the limit for our paintings today

For ages from **Pre-school to Grade 10**
(Each grade is recognized as a category)
Colouring Medium: any medium
Paper Size: **A4 Paper**
Submissions should include:

1. Full name
2. Age
3. Grade
4. School
5. Home address
6. Parent name & contact number

Drawings need to be certified by Principal or Class Teacher of the child.
The drawing should not be copied from the internet or any other source.

One child can submit up to a **maximum of 2 drawings.**
All drawings need to be sent **ONLY** by post or hand delivered to
Sri Lanka Medical Association
No. 6, Wijerama Road, Colombo 07.

Deadline: 30th September 2024

For more information please contact SLMA offcie at
011-2693 324

ISSN : 1800 - 4016 (PRINTED) 2550 - 2778 (ONLINE)
"Wijerama House", No. 6, Wijerama Mawatha, Colombo 07,
Telephone: +94 112 693 324, Email: office@slma.lk

CONTENT

You won't be truly successful at work just by showing up. You have to outwork the competition and those around you.

President's Message

Dear SLMA Members,

Half the year is over, and we are now in July, just a month away from the 137th Anniversary International Medical Congress the most eagerly awaited activity of the annual calendar of events of the SLMA, which is keenly and enthusiastically being organized by the council and staff of the SLMA.

The congress which was first held to mark the 50th Anniversary of SLMA in 1937 during Dr Nicholas Attygalle Presidency has subsequently been held without a break annually even during the two world wars, COVID pandemic and financial/political instability in the country. It will be majestically organized by us this year too and, will be held from 16th to 18th August at the Hotel Galadari, Colombo.

SLMA has been organizing Pre-Congress Sessions since January this year and have concluded five such hands-on workshops up to the end of June on a variety of topics covering Paediatrics, Cardiology, Orthopaedics, Emergency Medicine (Trauma & POCUS), with the unreserved support of specialists in relevant fields, all of which attracted a full house for each of the events and was attended by the doctors very actively and with much appreciation.

The SLMA theme for the year as outlined by me in our previous newsletters; *'Ensuring equity in healthcare during challenging times'*, will be addressed within the main congress in different sessions organized during the 3 days.

The inauguration will be held in the morning of 16th August with the most awaited SLMA Oration.

Apart from the SLMA Oration there will also be 3 other orations, a Keynote Address, 12 symposia, 2 panel discussions, 8 plenaries, interactive workshop and a debate. The congress will conclude with the showcasing the cultural talents of our medical fraternity with the *'Doctors Concert'* to be held at the Main Auditorium, Faculty of Medicine, Colombo, at 7 pm on 18th August 2024.

The topics that will be covered within the congress will be on subjects useful from a day-to-day practice perspective such as diabetes, hypertension, thyroid disease, cardiology, Intensive care Unit practices, infection management and common respiratory diseases, as well as some other topics of general specific interest such as CT coronary angiograms, laser eye surgery, health hazards of vaping, skin whitening treatments, indiscriminating use of medicines, AI in routine practice, global medical education, sexual health and the LGBTIQ community. The detailed programme can be accessed on page 16 – 17 of this June 2024 newsletter.

The scientific congress is anticipated to bring together medical professionals from state and private sector, as well as the universities with undergraduate and postgraduate students, and medical officers, grade medical officers, specialists etc.

The sessions will give an academic portal for researchers to present and share original research, exchange views and ideas, update their knowledge and skills, explore the latest advancements in medicine and discuss strategies for improving patient care by interaction with local and foreign experts in the field of medicine.

I would like to invite each and every one of you to this year's medical congress which will provide you with unparalleled opportunities to expand your knowledge, network with peers, and contribute to the advancement of future healthcare of the country.

Please keep the dates free and also inform all your colleagues in Sri Lanka and abroad as the registration for the congress is already open.

For further details and online registration please visit our website (https://slma.lk/).

Looking forward to seeing you at our 137th Anniversary International Medical Congress.

Dr Ananda Wijewickrama
MBBS, MD, MRCP(UK), FCCP
Consultant Physician
National Institute of Infectious Diseases
President - SLMA

Activities in Brief
(16th May 2024 – 15th June 2024)

Saturday Talks

Following SLMA Saturday Talks were held.

18th May - *'Blood Transfusion Reactions A-Z'* by Dr Trilicia Withanawasam, Consultant in Transfusion Medicine & Senior Lecturer, Faculty of Medicine, Sir John Kotelawala Defence University.

1st June - *'Colorectal Carcinoma'* by Dr Wasantha Wijenayake, Consultant Surgeon & Senior Lecturer, Faculty of Medicine, Sir John Kotelawala Defence University.

Media Activities

Dr Ananda Wijewickrama, President and Dr Surantha Perera, President Elect, Dr Lucian Jayasuriya, Past President, & Dr Lahiru Koditiwakku, Honorary Secretary,conducted a media briefing on 19th May addressing the following key issues;

1. The importance of educating the young doctors on postgraduate training & post graduate courses available in Sri Lanka.
2. The dengue situation in the country, its prevention, the need for seeking medical advice early if fever persists and warning signs and care of patients at home..

A media seminar was organized in collaboration with the College of Community Physicians, Sri Lanka on 5th June on the topic *'Disease & injury prevention amidst adverse weather events'*.

The resource persons were Dr Ananda Wijewickrama, President, SLMA, Dr Shiromi Maduwage, President, College of Community Physicians, Sri Lanka. Dr Samitha Siritunnga, Consultant Community Physician, Directorate of NCD, MoH & Dr Thilanga Ruwanpathirana, Consultant Community Physician, Epidemiology Unit, MoH.

A media briefing was held on 12th June to discuss on Current health crises, shortage of medicines/ devices, dengue situation, diarrhoeal infection, migration of health professionals, availability of drugs, etc.

The resource persons were Dr Palitha Mahipala, Secretary, MoH, Dr Ananda Wijewickrama, President, SLMA, Dr Surantha Perera, President Elect, SLMA & Dr Lahiru Kodituwakku, Honorary Secretary, SLMA.

Monthly Clinical Meetings

The May clinical meeting was held in collaboration with the Sri Lanka College of Dermatologists on 28th May on *'An overview of Paraneoplastic Cutaneous Manifestation'*.

The resource persons were; Dr Dulani Liyanagama, Consultant Dermatologist, Dr Chiranjaya Ekanayaka,

Consultant Dermatologist, Dr Nithya Gunawardena, Senior Registrar & Dr Sachithra Samarakoon, Registrar in Dermatology. All resource persons were attached to the National Hospital, Kandy.

The first clinical meeting for June was held in collaboration with the College of Anaesthesiologists & Intensivists on 11th June on *'Driving sustainable practices in healthcare services: Paving the way for a greener future'*.

The resource persons were Dr Dilrukshi Perera, Consultant Anaesthetist, Sri Jayawardenapura General Hospital & Dr Anjali de Silva, Consultant Anaesthetist, Base Hospital, Panadura.

Career Guidance Seminar

The annual career guidance seminar organized by the SLMA Expert Committee on Health Management was held at the Dr NDW Lionel Memorial Auditorium SLMA on 19th May with the participation of many young doctors.

The speakers from many Colleges/ Associations delivered lectures on the relevant specialty and how and why one should choose that specific field of study;

Dr Himali Molligoda on *'Postgraduate training programmes'*, Dr Samitha Dassanayaka on *'Medicine & Sub specialities'*, Dr SMM Niyaz on *'Surgery & Sub Specialities'*, Dr Priyantha Weerasinghe on *'Venereology'*, Dr Chamila Jayasekara on *'Anaesthesiology'*, Dr Nuwangika Marcellin on *'Dermatology'*, Dr Janaki Karunasinghe on *'Obstetrics & Gynaecology'*, Professor Randula Ranawaka on *'Paedeatrics & Sub specialties'*, Dr Chaminda Weerabaddana on *'Health Informatics'*, Professor Vajira H.W. Dissanayake on *'Universities'*, Dr Upali Banagala on *'Private health Sector'*, Dr Sudath Dharmaratne on *'Ministry of Health – Cadre'*, Col. (Professor) Ayendra Balasuriya on *'Armed Services'*, Dr Kapila Jayaratne on *'Community Medicine'*, Dr Shirani Chandrasiri on *'Microbiology'*, Dr Prasad Pathirana on *'Ophthalmology'*, Dr Chamara Wijesinghe on *'Psychiatry'*, Dr Rukmali Rupasinghe on *'Otorhinolaryngology'*, Professor UCP Perera on *'Forensic Medicine'*, Dr Pradeep Ratnasekara on *'Medical Administration'*, Professor Sulochana Wijetunga on *'Pathology'*, Dr Shehan Waas on *'Radiology'* & Dr Dilini Baranage on *'Family Medicine/ General Practice'*.

The sessions were chaired by Dr Ananda Wijewickrama, President SLMA, Dr Lucian Jayasuriya, Dr Sarath Samarage and Dr Ruvaiz Hanniffa.

Partnership Building

Dr Ananda Wijewickrama, President and Dr Lahiru Kodituwakku, Honorary Secretary met with Mr Chrisrian Skoog, Country Representative of UNICEF Sri Lanka, Dr Dhammikaa Rowel, Dr Nayani Dharmakeerthi & Dr Abner Daniel on 21st May at the UNICEF Sri Lanka office at Ried Avenue, Colombo 07.

The status of the school nutrition programme, food related promotions/ advertising/ legislation, vaping & E- cigarettes use among the adolescents and how a collaborative effort can mitigate these issues were discussed at the meeting.

A delegation led by Ms Helen O'Neill, MSF South Asia Representative, Dr Anuradha Saibaba, Director (Strategy & Planning) and Dr Harini Fernando (Global Health & Humanitarian Medicine Site Content Developer) from the MSF (Médecins Sans Frontières) South Asia office, met with Dr Ananda Wijewickrama, President & Dr Lahiru Kodituwakku, Honorary Secretary, SLMA in Colombo on 12 th June.

An international independent medical humanitarian organization, MSF/Doctors without Borders interacted with SLMA to explore the possibilities of future collaborative work in the field of health care in Sri Lanka.

The high-level delegation also included Dr Alaka Singh, WHO Country Representative to Sri Lanka.

Experts discussed and agreed on the way forward in addressing the drivers of CDoH and need for a scoping study to understand the entire landscape.

Advocacy work

A proposal jointly prepared by the SLMA Intercollegiate committee, GMOA & the AMS on *'Streamlining the ordering of lab investigations'* was presented to Dr Palitha Mahipala, Secretary Health, MoH on 22nd May.

The presentation of the final draft of the *'Charter to ensure the safety and well-being of patients in the South Asian region',* initiated last year, was presented to Chair of the Sectoral Committee on Health, Mayantha Dissanayake MP, by Chair of the Subcommittee appointed by the Sectoral Oversight Committee on Health, MP Upul Galappaththi MP, on 6th June at the Parliamentary complex. Dr Vinya Ariyaratne, Past President, SLMA was a member of the panel of experts of the subcommittee of the sectoral oversight committee on health who drafted this proposal and inputs were provided by members of the SLMA intercollegiate committee when it was discussed at a meeting held with the WHO expert who was involved in preparing the document.

Corporate Social Responsibility (CSR)

A blood donation campaign was organized by SLMA on 1st June at the Accident Service, NHSL in collaboration with the Central Blood Bank, Colombo.

Many staff members of the NHSL, SLMA, and the general public enthusiastically participated & also donated blood at the event.


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Sri Lanka Medical Association

IMPORTANT NOTICE

Call for applications for post of SLMA President Elect 2025

The SLMA elects a President-Elect at its Annual General Meeting every year in December to take over as President thereafter.

Applications are hereby invited for the post of President-Elect for 2025 from SLMA Life Members of over five (5) years duration, proposed and seconded by SLMA Life Members.

Application forms may be obtained from the SLMA Office during working hours.

The applications should reach the Honorary Secretary, SLMA on or before 11th October 2024.

Dr Lucian Jayasuriya
Past Presidents' Representative to the SLMA Council
13th June 2024

Sri Lanka Medical Association

WANTED

Dr V P de Zoysa MD (Lond.)
President, Ceylon Branch of the British Medical Association
1945/1946

Information about the above named is lacking in contemporary numbers of the Journal of the BMA (CB) as well as through internet searches. There is a photograph of him in the SLMA collection, but no other information regarding his early days or his presidency.

Any information about him will be gratefully received by me to complete the biographies of the Past Presidents of the BMA (CB), a work in progress.

Dr Malik Fernando
Past President
muhudubella@gmail.com

What do we need to know to offer medical treatment to a patient presenting with psychotic symptoms?

Dr L L Amila Isuru
MBBS, MD, MRCPsych
Head|Department of Psychiatry
Senior Lecturer in Psychiatry
Faculty of Medicine and Allied Sciences
Rajarata University of Sri Lanka.

Introduction

The concept of psychosis has evolved from the time it was coined in 1845 to the present day (1). Individuals with psychosis were labelled as prophets, witches, and devils before the 19th century. However, the identification of psychosis as a brain disorder led to the better understanding of patients with psychotic disorders resulting in more humane treatment, care and protection (2). Psychotic illnesses are one of the leading causes of disability worldwide (3). Psychosis presents a huge distress to those who are afflicted with the disease. In addition, there is an enormous impact on care caregivers, families, society, and the healthcare system.

A systematic review across the globe indicates that only 29% of patients with psychotic disorders receive formal mental health care (4). This highlights the fact that psychotic disorders are underdiagnosed and undertreated.

Understanding lived experience of psychotic phenomena.

The assessment of psychotic symptoms is clinical. Hence, the clinical skills of the doctor are of paramount importance as it should be able to differentiate between customary beliefs or perceptions from psychotic symptoms.

The patient experiencing the psychotic symptoms for the first time may be frightened, confused, feeling shattered and experiencing a lack of sense of belonging. Hence, communication skills, appropriate empathy, and behaviour observations are instrumental in performing an objective assessment by the clinician (5). Objective assessment of psychotic symptoms is mandatory for the correct diagnosis and management of the patient.

For example, if the patient is unduly suspicious, it is important to elicit the degree of conviction, evidence for and against, the ability to entertain alternative viewpoints, and that the belief is compatible with the patient's social, cultural, religious and educational background to identify above-mentioned suspiciousness is due to a persecutory delusion or not. Similarly, if the patient hears voices when no one is around, it is important to understand if the voices are coming from inner subjective space or outer objective space, whether people around also hear the same voice, and clarity of voice to report it as a hallucination. Furthermore, effective clinical care for individuals presenting with psychotic symptoms needs an understanding of the subjective experience and the meaning of psychotic symptoms as they are lived through.

Observation of patients' behaviours such as self-smiling, muttering to self, and neglected self-care may provide valuable information to support eliciting psychopathology.

Is it a psychosis or not: do your assessment right.

Sometimes, in certain circumstances, it is challenging to differentiate individual experiences in from psychotic symptoms. It is known that individuals find it difficult to trust people around them when they are under stress or perceived threat. Thus a person with low self-esteem may become jealous and suspect their spouses of having another relationship on inadequate ground. Also, individuals with paranoid personality disorder are suspicious and may misconstrue innocent gestures as threats. A correct interpretation and identification of this kind of presentation need careful evaluation to prevent medicalization of normal variations of individual and situational circumstances.

What is the underlying condition of psychotic symptoms?

A range of conditions can give rise to psychotic symptoms. Hence, it is vital to recognize and manage the underlying condition accordingly. Psychosis can occur in the context of a psychiatric disorder, medical illness or psychoactive substance use (Table 01).

Category	Examples
Psychiatric disorders	Schizophrenia, bipolar disorder, depression,dementia
Substance Use disorders	Cannabis, alcohol, Methamphetamine
Neurological disorders	Parkinson's disease, brain tumors, epilepsy
Auto-immune disorders	Systemic Lupus Erythromatosis (cerebral lupus)
Endocrine disorders	Hypothyroidism (Myxoedema), Cushing's syndrome, Addison's syndrome
Infections	HIV, syphilis, Acute Viral Encephalitis
Medication	Steroids, Anti-parkinsonism medications, Anti-cholinergic agents

Table 01 Physical conditions that can cause psychotic symptoms.

What causes psychosis?

Psychosis is caused by the complex interplay between neurobiological, psychological and environmental factors. Neuroscientists have identified increased levels of dopamine at the mesolimbic pathway in patients with psychotic disorders. The heritability of most psychotic disorders is reportedly high, indicating genes play a role in the causation. Another important risk factor is psychoactive substance use, which increases the risk of developing a psychotic disorder.

Let's talk about a few examples of psychotic disorders.

1. Schizophrenia

   Schizophrenia is one of the most common severe mental disorders, with an incidence of 1%. It is among the top 25 leading causes of disability across the globe. Signs and symptoms include disturbances in perception, thinking, cognition, emotion and behaviours. The onset of the disorder usually begins before the age of 25 and persists throughout life, impacting the individual with the disorder, as well as families and societies overall.

   Antipsychotic medications are the mainstay of the treatment, and good compliance to medication improves the overall outcome of the disorder. Symptoms of schizophrenia can be fully understood by paying attention to all the symptom domains: positive (e.g., delusions, hallucinations, disorganization in the form of thinking), negative (e.g., loss of motivation, scanty speech), cognitive (impaired attention, verbal memory, and social cognition), affective (e.g., blunted emotional expression) and behavioral symptoms (behaviour appear purposeless or bizarre) (6). Evidence showed that a longer duration of untreated psychosis is associated with poorer outcomes in patients with schizophrenia (7). Hence, it is important to identify patients who exhibit symptoms of schizophrenia early and start treatment that will improve the overall outcome.

2. Delusional disorders

   The main feature of delusional disorder is one or more persistent delusions with a relatively intact personality and functional level. Persecutory and jealous types are commonly seen subtypes of delusional disorders. The diagnosis of delusional disorder can be challenging as they do not have easily noticeable abnormalities in their perception, emotions, cognitions and behaviour. Nevertheless, people with delusional disorder may display higher levels of psychological distress, a greater degree of pre-preoccupation and stronger conviction compared to people in the general population with beliefs that are similar in nature to the delusional belief (6).

   The major challenge of treating patients with delusional disorders is to engage them with the treatment as they lack insight into their illness. However, patients who willingly engage with the treatment show good outcomes.

3. Cannabis-induced psychosis.

   Cannabis use is known to cause psychotic illnesses, including schizophrenia. Research showed the incidence of psychosis increased in some countries, along with the rise of cannabis use among young individuals in these countries.

The risk of developing psychosis increases with an increased dose of cannabis use (8). Signs and symptoms of this condition are similar to other psychotic disorders; however, symptoms tend to improve following stopping cannabis use.

In addition, the physicians and other non psychiatric medical personnel treating patients should be alert to the possibility that some of their symptoms may have a psychiatric basis and refer them for appropriate treatment.

In summary, psychotic symptoms can occur in a range of psychiatric conditions and medical illnesses. Hence, giving deep thought to the condition resulting in psychosis is crucial to planning an individualized management strategy. All healthcare professionals working in mental health services need to understand the patient's lived experience of psychosis. It is important to ease the patient's distress and build a good therapeutic rapport, which helps to perform objective assessments and draw a sound management plan.

Reference:

1. Beer MD. Psychosis: A history of the concept. Comprehensive Psychiatry. 1996;37(4): 273–291. https://doi.org/10.1016/S0010-440X(96)90007-3.
2. George P, Jones N, Goldman H, Rosenblatt A. Cycles of reform in the history of psychosis treatment in the United States. SSM - Mental Health. 2023;3. https://doi.org/10.1016/j.ssmmh.2023.100205.
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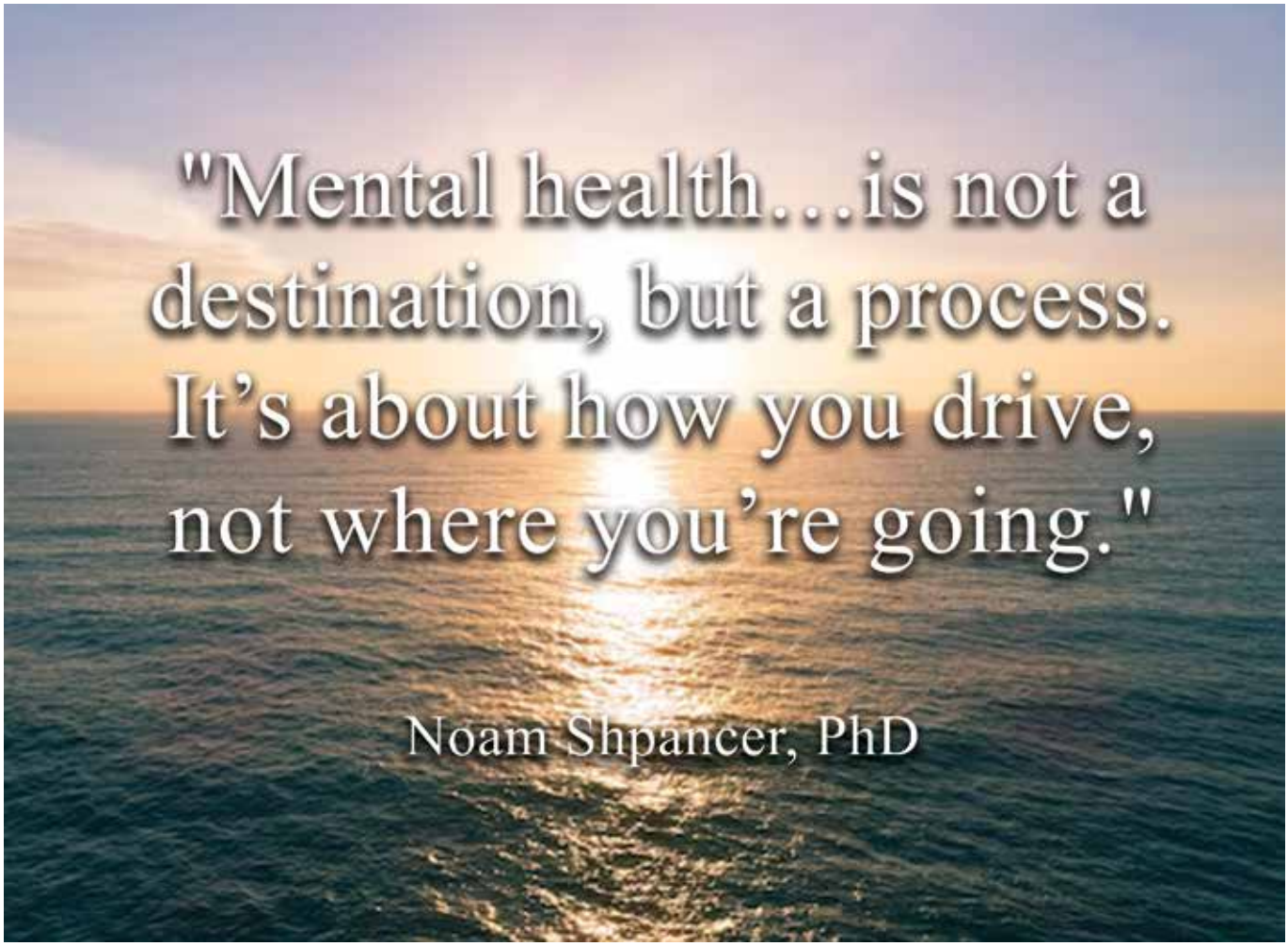
8. Andréasson S, Engström A, Allebeck P, Rydberg U. CANNABIS AND SCHIZOPHRENIA A Longitudinal Study of Swedish Conscripts. The Lancet. 1987;330(8574): 1483–1486. https://doi.org/10.1016/S0140-6736(87)92620-1.



SRI LANKA MEDICAL ASSOCIATION
137th Anniversary International Medical Congress

'Ensuring Equity in Healthcare During Challenging Times'

Programme at a Glance 2024

				Day 1: Friday, 16th August 2024
09.00 am – 12.00 noon	Inauguration of the 137th Anniversary International Medical Congress			
09.30 am	Inauguration ceremony			
11. 15 am	SLMA oration			
12.00 pm	Lunch			
01.00 pm	**Keynote Address** *Food security challenges: Navigating through crises*			
01.30 pm	**Professor NDW Lionel Memorial Oration**			
Venue	**Hall A**	**Hall B**	**Hall C**	**VIP Room**
02.15 pm	**Plenary 1** *The scope of laser treatment in keeping the glasses away?*	**Plenary 2** *Indiscriminate use of medicines*	**Poster presentation**	**Guidance clinic for overseas placement of doctors**
02.45 pm	**Symposium 1** *Respiratory medicine*	**Symposium 2** *Commercial Determinants of Health (CDoH)*		
03.45 pm	**Plenary 3** *The ageing brain: Understanding and preventing cognitive decline*	**Symposium 3** *Rice fortification as a method of addressing the malnutrition crises*		
04.15 pm	**Plenary 4** *Fast-tracking antimalarial drug discovery*			
04.45 pm	Evening Tea & End of Day 1			

				Day 2: Saturday, 17th August 2024
08.30 am	Registration			
09.00 am	**Dr S Ramachandran Memorial Oration**			
Venue	**Hall A**	**Hall B**	**Hall C**	**VIP Room**
09.45 am	**Plenary 5** *Coronary artery disease assessment*	**Plenary 6** *Critical care: Don't forget the patient'*	**Poster presentation**	**Guidance clinic for overseas placement of doctors**
10.15 am	Morning Tea & Photographic Exhibition			
10.30 am	**Symposium 4** *Cardiology: A case-based discussion*	**Panel Discussion** *The health impact by media advertising of cosmetics, nutritional supplements & food targeting children*		
11.30 am	Debate *Are welfare policies a sustainable strategy for Sri Lanka?*			
12.30 pm	Lunch Break & Photography Exhibition			
01.30 pm	**Symposium 5** *Intricacies of managing diabetes*	**Symposium 6** *Comprehensive Sexuality Education (CSE): Advocating & exploring strategies for influencing policy & creating public awareness*		
02.30 pm	**Symposium 7** *Barriers to good hypertension control: Beyond medication*	**Free Paper Session**		
03.30 pm	**Interactive case-based discussion** *From coma to storm: Mastering thyroid disorders*			
04.00 pm	Evening Tea & End of Day 2			

REGISTRATION LINK

Venue
The Galadari Hotel
Colombo

Day One
16th August

Day Two
17th August

Day Three
18th August

SRI LANKA MEDICAL ASSOCIATION
137th Anniversary International Medical Congress
'Ensuring Equity in Healthcare During Challenging Times'

				Day 3: Sunday, 18th August 2024
08.30 am	Registration			
09.00 am	**Dr SC Paul Memorial Oration**			
Venue	**Hall A**	**Hall B**	**Hall C**	**VIP Room**
09.45 am	**Plenary 7** *Hippocrates' touch to algorithmic insight: AI for medical professionals*	**Symposium 8** *Enabling healthy food environment for school children & advocacy for implementation of the food marketing regulations*	**Poster presentation**	**Guidance clinic for overseas placement of doctors**
10.15 am	Morning Tea & Photography Exhibition			
10.30 am	**Plenary 8** *Addressing the concerns of the LGBTIQ persons and their families*	**Free paper session**		
11.00 am	**Symposium 9** *A fresh look at vaccines*			
12.00 pm	Lunch Break & Photography Exhibition			
01.00 pm	**Symposium 10** *Medical Humanities: 'Memento mori'*	**Free paper session**		
02.00 pm	***Workshop*** *Airway & renal support for the critically ill patient*	**Symposium 11** *Technology Enhanced Medical Education*		
03.00 pm		**Symposium 12** *Infectious Diseases: The new line of attack*		
04.00 pm	Closing Ceremony & Evening Tea			
07.00 pm	**Doctors' Concert** At Colombo Medical Faculty Main Auditorium			

REGISTRATION FEE

MEMBER			
CONSULTANTRS	**RS.10000**	**UNDERGRADUATE**	**RS.5000**
NON- CONSULTANT	**RS.8000**	**DAY REGISTRATION**	**RS.6000**
NON-MEMBER			
CONSULTANTRS	**RS.12000**	**SYMPOSIUM REGISTRATION**	**RS.2000**
NON- CONSULTANT	**RS.10000**	**FOREIGN DELEGATES**	**USD.150**

Sri Lanka Medical Association
137th Anniversary
International Medical Congress - 2024

Photography Competition

Catergories

1. Animals & Pants
2. Scenery (Landescapes/ Seascape, Etc.)
3. Health and Medicine (Activities or portraits promoting Public Health, Clinical Medicine, Medical Education and History of Medicine).
4. Mobile phone photos in any of the above 3 categories

Printed/ laminated photographs with accompanying digital copies and a completed application, and an entry fee of Rs. 500 should reach the SLMA Office on or before 4pm on 14.07.2024.

Selected first 100 photos will be displayed at the SLMA Sessions. Certificates and awards for the first 3 in each category, and participation certificates for all the photos selected for display will be awarded.

For any further clarification please contact SLMA (011-2693324) or e-mail to IT@slma.lk

DEADLINE EXTENDED

For Rules & Regulations & Application please visit:
https://slma.lk/medical-congress-2/

Functional Abdominal Pain Disorders in Children: Exploring Diagnosis, Management, and Implications

Dr S Krishnapradeep
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Senior Lecturer in Paediatrics, University of Peradeniya
Consultant Paediatrician, Teaching Hospital, Peradeniya

Chronic abdominal pain (CAP) is a not too uncommon disorder in children and adolescents worldwide. It is associated with a high psychosocial burden, poor functioning, missing school and low health-related quality of life[i]. Furthermore, CAP represents one of the most common reasons for consultations with paediatricians, and children with the condition show higher healthcare utilisation than children suffering from headaches or other bodily symptoms. Increased utilisation of health care not only poses an economic burden due to repeated diagnostic procedures and referral to higher-level medical services but may also negatively influence the prognosis of child pain[2]. Recurrent and chronic abdominal pain not only affects the child but also the parents and the other family members as well, in various ways.

Table 1.
Causes for recurrent and chronic abdominal pain in children[3]

System	Disorders
Gastrointestinal	Chronic constipation, Inflammatory bowel disease, Parasitic infection, Hepatitis, Gall bladder calculi, Chronic appendicitis, Dietary intolerance, Gastro-oesophageal reflux disease, Helicobacter pylori infection, Celiac disease, Peptic ulcer, Gastritis, Chronic pancreatitis, Functional dyspepsia, Aerophagia
Urinary tract	Urinary tract infection, Urinary calculi, Pelvi-ureteric junction obstruction
Gynaecological	Ovarian cyst, Endometriosis, Pelvic inflammatory disease
Miscellaneous	Abdominal epilepsy, Physical, emotional and sexual abuse

Although many organic causes give rise to recurrent abdominal pain in children, an organic cause is found in only 5-10% of children with recurrent abdominal pain. If so, what other conditions lead to recurrent or chronic abdominal pain in children? Growing evidence shows that the most common cause of recurrent abdominal pain in children is Functional Abdominal Pain Disorders (FAPDs). The FAPDs also known as Disorders of Gut-Brain Interaction (DGBI), refer to a common and perplexing condition characterised by chronic or recurrent abdominal discomfort or pain without any identifiable organic cause[4,5].

The Rome foundation is an organisation which has been involved in updating knowledge and proposing diagnostic criteria for many disorders of gut-brain interaction over the last 20 years. Based on the Rome IV criteria functional abdominal pain disorders are classified into 4 main subtypes[6].

Table 2

H2a	Functional dyspepsia
H2b	Irritable bowel syndrome
H2c	Abdominal migraine
H2d	Functional abdominal pain-not otherwise specified

The above subtypes can be diagnosed clinically using Rome IV criteria. The Rome IV criteria includes specific features with time duration to diagnose each of the above-mentioned conditions. This tool is very helpful for the clinicians but has its limitations.

Table 3
H2a. Diagnostic Criteria for Functional Dyspepsia(FD)[6]

Must include 1 or more of the following bothersome symptoms at least 4 days per month:

1.	Postprandial fullness
2.	Early satiation
3.	Epigastric pain or burning not associated with defecation
4.	After appropriate evaluation, the symptoms cannot be fully explained by another medical condition.

criteria fulfilled for at least 2 months before diagnosis.

Table 4

H2b. Diagnostic Criteria for Irritable Bowel Syndrome[6]

Must include all of the following:

1.	a.	Related to defecation
	b.	A change in the frequency of stool
	c.	A change in form (appearance) of stool
2.		In children with constipation, the pain does not resolve with resolution of the constipation (children in whom the pain resolves have functional constipation, not irritable bowel syndrome)
3.		After appropriate evaluation, the symptoms cannot be fully explained by another medical condition

Criteria fulfilled for at least 2 months before diagnosis.

Table 5

H2c. Diagnostic Criteria for Abdominal Migraine[6]

Must include all of the following occurring at least twice:

1.		Paroxysmal episodes of intense, acute periumbilical, midline or diffuse abdominal pain lasting 1 hour or more (should be the most severe and distressing symptom)
2.		Episodes are separated by weeks to months.
3.		The pain is incapacitating and interferes with normal activities
4.		Stereotypical pattern and symptoms in the individual patient
5.		The pain is associated with 2 or more of the following:
	a.	Anorexia
	b.	Nausea
	c.	Vomiting
	d.	Headache
	e.	Photophobia
	f.	Pallor

Table 6

H2d. Diagnostic Criteria for Functional Abdominal Pain–NOS[6]

Must be fulfilled at least 4 times per month and include all of the following:

1.	Episodic or continuous abdominal pain that does not occur solely during physiologic events (eg, eating, menses)
2.	Insufficient criteria for irritable bowel syndrome, functional dyspepsia, or abdominal migraine
3.	After appropriate evaluation, the abdominal pain cannot be fully explained by another medical condition

criteria fulfilled for at least 2 months before diagnosis.

Epidemiology

The global prevalence of FAPDs is 13.5% [7] and in Sri Lanka the prevalence is 12.5% [8]. The studies done by Devanarayana *et al* concludes that, in Sri Lanka the prevalence varies in different parts of the island and Gampaha District shows the highest prevalence of 16.5%[8]. With increasing awareness among clinicians and with the help of the diagnostic criteria, FAPDs are diagnosed more commonly now.

Aetiopathogenesis

The aetiopathogeneis of functional abdominal pain disorders in children is incompletely understood. It is influenced by a multitude of factors encompassing biological, psychological, and environmental aspects.

A fundamental facet in the onset of FAPDs is central hypervigilance, where affected children demonstrate heightened awareness and sensitivity to abdominal sensations, intensifying their perception of pain stimuli. This heightened vigilance contributes to persistence of symptoms. Central sensitisation, another significant factor, involves amplifying pain signals within the central nervous system due to prolonged exposure to pain. This phenomenon leads to increased responsiveness to pain stimuli, exacerbating the severity and duration of abdominal pain experienced by children with FAPDs.

Additionally, disruptions in communication along the gut-brain axis further complicate the aetiology of FAPDs. Dysregulation in bidirectional signalling between the gastrointestinal tract and the central nervous system disturbs pain modulation mechanisms, exacerbating visceral hypersensitivity and pain perception.

Furthermore, visceral hypersensitivity, characterised by lowered pain thresholds within the gastrointestinal tract, contributes to the pathogenesis of FAPDs. Abnormal sensory processing in response to visceral stimuli results in heightened pain perception and discomfort in affected children.

Various sensitising medical events such as dysbiosis, early life usage of antibiotics, gastrointestinal inflammation, and altered gut motility, along with sensitising psychological events like early-life pain experiences, parenting dynamics, and instances of abuse, can serve as triggers for and contributors to the development of FAPDs[9].

Diagnosis

Diagnosing functional abdominal pain disorders in children necessitates a comprehensive approach that incorporates multiple elements. Initially, conducting a thorough patient history is crucial, focusing on details such as the type, location, severity, and duration of abdominal pain, as well as any factors that worsen or alleviate symptoms, and whether the pain occurs during sleep. Additionally, recognizing typical indicators suggestive of FAPDs in children, such as stereotypical symptoms and the presence of multiple somatic symptoms, is important. During the abdominal examination, assessing whether distraction can alleviate pain is key.

The Rome IV criteria serve as a valuable diagnostic tool, providing specific guidelines for different types of FAPDs to facilitate a positive diagnosis. The bottom line of the Rome criteria for FAPDs includes the following wording: "after appropriate evaluation, the abdominal pain cannot be fully explained by another medical condition". Hence it is the responsibility of the physician to decide what an 'appropriate evaluation.'

The history and examination should be focused to exclude any underlying major conditions. Consideration should be given to the presence of red flag symptoms and signs. Intermittent unexplained fever, weight loss, failure to thrive, recurrent vomiting, nocturnal diarrhoea, referred pain, dysphagia, pain disturbing the sleep, blood in the stools, jaundice and joint symptoms can point towards an underlying sinister problem.

Baseline investigations, including tests like complete blood count and C-reactive protein, help in ruling out organic causes, while specialised investigations such as stool studies or abdominal ultrasound may be warranted based on clinical suspicion. However, routine use of gastrointestinal endoscopy for diagnosis is discouraged due to its limited clinical value and potential to heighten anxiety if results are inconclusive. By integrating these approaches, clinicians can accurately diagnose FAPDs in children and implement effective strategies[9].

Management

Management of functional abdominal pain disorders in children poses a significant challenge, as pharmacological interventions alone often prove ineffective. While several treatments, such as behavioural therapy, have shown efficacy, their accessibility is limited due to a shortage of allied healthcare professionals specialising in pediatric gastroenterology. Compounding this issue is the fact that most randomised controlled trials (RCTs) evaluating drug therapies have been conducted in adult populations, with limited research focusing specifically on children. Furthermore, the RCTs conducted in children predominantly target irritable bowel syndrome (IBS), a subtype of FAPDs, thus limiting the generalizability of findings to broader FAPD populations. Additionally, children often exhibit different response patterns to treatments compared to adults, further complicating management strategies. Consequently, an integrated approach to management is necessary, which includes effective communication between healthcare providers and patients, dietary modifications tailored to individual needs, psychotherapy to address underlying psychological factors contributing to pain, and judicious use of pharmacotherapy when indicated. By employing a multifaceted approach that addresses the unique needs of pediatric patients with FAPDs, clinicians can optimise treatment outcomes and improve the quality of life for affected children.

Dietary modifications and supplements are essential for symptom relief and overall well-being in managing functional abdominal pain disorders. A balanced diet rich in fibre, fruits, vegetables, and whole grains, help to regulate bowel movements and prevent constipation while avoiding trigger foods like spicy foods, caffeine, fatty foods, and artificial sweeteners can reduce symptom severity. Some children may benefit from eliminating specific food groups like dairy or gluten, but this should be done under healthcare guidance to ensure proper nutrition. Probiotic supplements can also improve gut health and alleviate abdominal pain, but their effectiveness varies depending on the strain and dosage, necessitating consultation with a healthcare provider before use[10].

Pharmacological therapy for FAPDs include antispasmodics, antibiotics (if bacterial overgrowth is suspected), antidepressants (for pain modulation and mood), analgesics (for pain relief), and laxatives (for constipation). Tailored medication regimens aim to alleviate symptoms and improve quality of life in affected children[11]. Hence the management of FAPDs involves a multidisciplinary approach and will depend on the cooperation and compliance of the patient and the parents.

In summary, functional abdominal pain disorders (FAPDs) pose considerable difficulties for afflicted children and

their families, given the enduring nature of the ailment and its disruptive effects on everyday activities. Nonetheless, employing a holistic strategy that encompasses biological, psychological, and social aspects, such as providing reassurance, modifying diets, managing stress, and implementing therapeutic interventions, holds promise for mitigating symptoms and enhancing general welfare. The synergy between healthcare practitioners, caregivers, and young patients is essential in realizing positive results and elevating the overall standard of living for children grappling with FAPDs.

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A SALUTE TO OLD AGE

It is a stage that only the lucky ones get to reach,
Age is just a state of mind, keep being fun and free spirited.

Only worry about 'thinking old', it is a matter of feeling, but not of years,
Life is precious, and the 'old' motivate others to be the best.

Beauty exists at every age, it is not about youth and perfection,
It is about celebrating wisdom, strength, and love.

Beautiful young are products of nature,
Beautiful old people are works of art.

Live your life and forget your age,
Be grateful for old age.

Do not regret getting old,
It is a privilege denied to many.

Excerpted from an anonymous writer.
Presented by Dr B. J. C. Perera.

Sri Lankan Cultural Demons: An Impediment to Public Mental Health or the Overlooked Answer?

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Demons have always shaped the Sri Lankan folklore and culture. In particular, their relationship with traditional medicine has always been paradoxical at best. Sri Lankan allopathic doctors, while recognising the importance of traditional healers in culture, battle the blind faith that many communities have in traditional healers.

At the outset, that is perhaps the reason why demons, and demonological rituals, tend to present a negative outlook to the allopathic doctor. Given their history of scientific methods and reasoning based on modern psychology and neuro psychiatric conditions, this attitude is understandable. It is natural for the Western doctor to be annoyed with the patient and even the family members for a more positive attitude towards alternate practices, which may have led to a delayed presentation of a condition requiring early intervention and psychopharmacological intervention.

It is best to also recognize that modern medicine evolved from certain 'primitive' practices. Over 2000 years ago, the relatively new field of psychiatry from the West was portrayed in indigenous medicine and ayurveda as "insanity" (unmada) with different classifications.

As a South Asian country with a culture heavily influenced by Buddhist and Hindu teachings, Sri Lanka carries some unique characteristics in its demonological practices. The endemic Sanni demons, Kalu Kumaraya (Black Prince) and Mahasona may just carry many teachings worth the attention of the Sri Lankan western medicine practitioner.

Sri Lankan Culture and alternate medical practices

In ancient Sri Lanka prior to colonization, multiple forms of medicine were practiced. These include, Ayurveda, Siddha, Unani and most importantly, the Desheeya Chikitsa, which is the indigenous medicine of Sri Lanka (Kannangara, 2016). Ayurveda, the alternative medicine form most popular as of date, have described a biochemical basis for mental illness based on the imbalance of the 3 humours wind/air (vata), fire; sometimes referred to as bile (pitha) and water or phlegm (Kapa). The management would include herbal remedies with changes to food habits and behavioural patterns. The indigenous medical practices with similar roots to Ayurveda, would also describe the aetiology of illnesses by the 3 humours, and would sometimes be accompanied by religious or cultural rituals.

When it comes to mental health, cultural healing practices used today range from a simple chanted thread (pirith noola) or pendant (suraya) to vibrant rituals running from dusk to dawn.

Although demons are innumerable according to Sinhala belief, healing rituals are generally for four major demons, under whose primacy, all the other demons theoretically fall. These are the Riri Yakā (blood demon), Mahāsōna (great demon of the graveyard), Hūniyan Yakā (sorcery demon), and the Sanni Yakku.

Only a few demons and rituals are discussed in this article with drawings to provide a psycho cultural explanation.

The Sanni demons and their technical background

The Sanni demon concept is one of Buddhist origin and the story hailing from Visala, India as explicitly narrated by Obeyesekere in the book "Placating the Demons". The 18 sanni demons represent 18 illnesses, most which we know today, but are in different terms. Figure 1 is the Mask of Mahakola sanniya holding the 18 masks of the 18 sanni (illnesses). Each of these masks depict a unique symptomatology of the specific illness. One such description is shown in Table 1 as an extract from Bailey & De Silva (2006).

Figure 1. Mask of Mahakola sanniya encompassing the 18 Sanni masks for specific illnesses

Table 1 Sanni Classification of Disease (Bailey & De Silva, 2006)

Demon (*Sanniya*)	Literal translation	Associated conditions
Amukku	Vomiting bouts	Vomiting and stomach diseases
Abutha	Non-spirit related	Not spirit related insanity
Butha	Spirit related	Spirit related insanity
Bihiri	Deaf	Deafness
Deva	Divine	Epidemic diseases
Gedi	Lumps	Boils and skin diseases
Gini Jala	Great fire or flame	Malaria and high fevers
Golu	Dumb	Dumbness
Gulma	Worms (especially hookworm)	Parasitic worms and stomach diseases
Jala	Water or diarrhoea	Cholera and chills
Kana	Blind	Blindness
Kora	Lame	Lameness and paralysis
Maru	Death	Delirium and death
Naga	Snake (especially cobra)	Bad dreams about snakes
Pissu	Insanity	Temporary insanity
Pith	Bilious	Bilious diseases
Slesma	Phlegm	Phlegm and epilepsy
Vatha	Wind humour or	Flatulence and rheumatism

The deva sanni illnesses are the air-borne infectious diseases, (deiyange leda). These come with their own cultural practices of isolation, quarantine and notification (using khomba leaves), synonymous with the allopathic public health measures for air borne illnesses.

The sanni ritual is a vibrant event with dance, drums and a play. The dialogue is between the drummers or the chief (either referred to as adura/yakadura/shaman healer) and the actor wearing the sanni mask and acting to be the sanni demon with the symptoms of the illness. The dialogue which recites verses usually comes with a lot of humour and it revolves around the illness, and finally making the demon leave and demanding it to never return. The demon reluctantly takes this advice but promises never to return.

This has an understandable cognitive and behavioural component, which could form part of the healing process.

Exploring the more mental health related sanni, there are 3 identified by Bailey & De Silva (2016). These are Abhutha Sanniya referring to non-spirit related insanity, Bhutha sanniya referring to Spirit related insanity and Pissu sanniya being Temporary or acute insanity. In this article, we'll discuss one of them: "Abutha Sanniya".

Abhutha Sanniya is characterized by features like consumption of unsuitable unwholesome food, engaging in unsuitable conduct, excitement and anxiety, anger, sorrow, all leading to an increase of phlegm, lessening of bodily strength which leads to this baseless, false or unreal beliefs. This mask has been created to depict the characteristics of sleeplessness which causes absentmindedness: sweating, burning sensations and such like symptoms of illness (Figure 2) (Manoj, 2019).

This symptom categorization or classification is not synonymous with the modern-day Psychiatric illnesses of the DSM or ICD thus the performative nature of the sanni ritual gives the patient a sense of relief that their illness has been acknowledged.

Figure 2 Mask of Abhutha Sanniya

The Black Prince (Kalu Kumaraya)

Kalu Kumaraya (Figure 3), is described as a handsome, attractive, dark complexed male figure capable of seducing females until they are willingly killed by him. "The Sinhala demon of lust, possesses women with lustful intentions!" (Obeyesekere 2021)

Kalu Kumaraya is more commonly associated with young women who recently reached puberty. This can be explained by the changes in hormones around puberty giving rise to psychological changes including erotic thoughts. Kalu Kumaraya may appear when alone in the dark or in dreams

Figure 3 Portrayal of Kalu Kumaraya (Artwork: Papadamn)

The rituals performed are capable of releasing the inhibitions of the individual, to tap deep motivations, suppressed feelings and impulses (Obeyesekere 2021). Similar to dissociative states, the patient feels not responsible for their actions.

Mahasona

The story behind Mahasona is that it is the revived soul of a human giant known as Ritigala Jayasena, who was decapitated by Gotaimbara, a giant warrior of King Dutugemunu. In an open graveyard where his cadaver was disposed of, a deity has attempted to bring him to life by replacing his head with that of a bear (Figure 4). The end result of a distorted appearance has led to those seeing him falling ill. (Royal Asiatic Society, 1866)

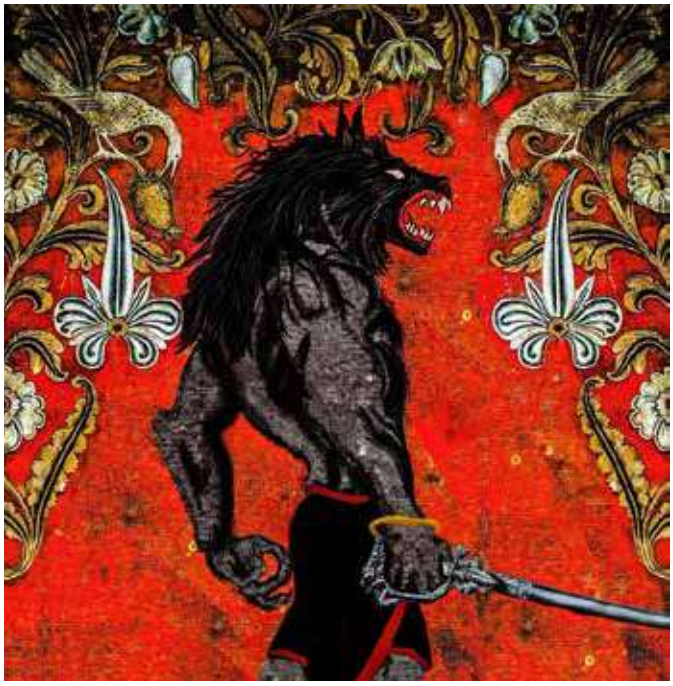

Figure 4 Portrayal of Mahasona

Mahasona is since the "Great Demon of the Graveyard" and is the chief of 30,000 demons. He is known as a powerful figure who punishes people with physical violence leaving the marks of his hands on the victim's back as kind of stigmata.

Certain literature broadly describes Mahasona to be responsible for conditions brought on by the humour Wind or 'Vata' (Kapferer, 1983) This is highly suggestive that possessions or hallucinations in line with Mahasona as a local folklore had not always been readily accepted as supernatural forces but rather, biochemical explanations had been thought of. For some Mahasona possession may be the chance to express the suppressed feelings of aggression through a dissociative state.

Reasons for the high uptake as well as the negatives of cultural healing

Sri Lanka is a country of good access to medical centers and internet in every corner, so why the uptake in traditional healers? One word: Stigma.

People prefer the "diagnosis" of a possession rather than of a mental illness. Sometimes, only when repetitive and continuous ritual practices fail, do they consider seeking allopathic mental health care for their family members displaying odd behaviours and strange beliefs. This significantly prolongs the duration of untreated psychoses. Behavioural problems in children such as speech delay, maybe attributed to cultural factors and diagnosis of autism spectrum disorders may get significantly delayed (Chandradasa and Kuruppuarachchi, 2017).

The word-of-mouth information about the side-effects of allopathic medications spread faster than the symptom control they bring about. This occurrence, combined with the more realistic explanations of mental illness control instead of the "cure" (nittawata suwaya) promised by cultural healers, make cultural healers more appealing first contact means for seeking help.

Sometimes, an additional self-stigma is observed among patients who have been labelled to be possessed. They would give up on the hope of having any control over self, or even putting an effort to "recover", due to this belief.

Figure 5 Mahasona healing ritual performed on a patient

What are the positives of Cultural healing? Where is the data?

Any Sri Lankan would have heard success stories of exorcism acts, and the tales would not be limited to Buddhists. The rituals performed would vary in length, intensity, healers involved and the specific ritual practices. A simple religious blessing or ritual may be the first choice if a child seems to fall mentally ill even among the literate and educated. Allopathic practitioners may be the second option.

Given the compelling psychological basis of some cultural healing practices one can question, are all these impede mental health? Despite the few possible explanations for the high uptake, there is no literature on the success rates of these practices, except for a few isolated case studies.

The questions that are yet to be answered are, including but not limited to, the numbers of the operating cultural healers, commonest healing practices include religious rituals or exorcism, demography of those seeking help and so on.

The symptoms that most of these patients show in the western medical practice would result in antipsychotics and hospital admission. In Sri Lanka, due to the safe space of demonology and cultural healers, the patients are able to act out on their culturally inappropriate thoughts in an accepted way, without the additional burden of navigating through guilt and shame for feelings of lustful or aggressive in nature.

The framework of isolation in Deva Sanni Illness would have benefited when we prepared for Covid in 2020. Had the printed notices been replaced by the bunch of leaves and had Covid been identified as a type of "Deiyange leda", Covid-19 pandemic would have been much less stigmatized and public health efforts for infection control could have been much more simplified.

The role of medical practitioners, with regards to traditional healing

In Sri Lanka, cultural healing journeys will always be accompanied by cultural practices and exploitation of the poor and underprivileged. Would the slightest knowledge of psychoses and the allopathic explanations in these healers help? Or a bridging course for cultural healers to obtain a basic understanding of mental illness may be the answer?

Discussion on training traditional healers to identify clear evidence of psychiatric illness and to refer patients to allopathic treatment early may be a starting point. How can we get them to approach Western medical treatment too? In fact, it begs us to think what could be the results if we tapped into the reach of media, teledramas, films etc?

Is it just to train and change the cultural healers?

From a medical practitioner's point of view, the need to standby our patient's best interest is the driving force for us to choose treatment accordingly. Keeping that in mind, it would be a more holistic approach if the medical practitioner is more accepting of a patient's rights to choose traditional healers. This would benefit doctors, as patients would be more forthcoming with their histories, as they will not feel judged or shamed. This would include adopting the community engagement approach of traditional healers.

Finally, food for thought?

Have we underestimated the teachings from the land bearing the ruins of the first hospital in the world?

How common is Kalu Kumaraya and Mahasona possession or hallucination? Is it common enough in the South to be named a culture bound illness or belief, or should it be characterised as a mental illness? One of the reasons we hear of its commonality is because a lot of clients find that spaces that traditional healers build conveniently allow people to act out exactly how they want to, validating that their "bad" behaviour is not due to them, but rather a supernatural being. This also helps them feel less guilty about not being "normal"

When the same client consults a cultural healer and then secures allopathic treatment for mental health, it sometimes makes one wonder as to whether psychosis is over diagnosed?

The demons have given us many questions to answer… Maybe they just needed to be heard… or acknowledged rather, I'm not implying a demonic auditory hallucination!!!

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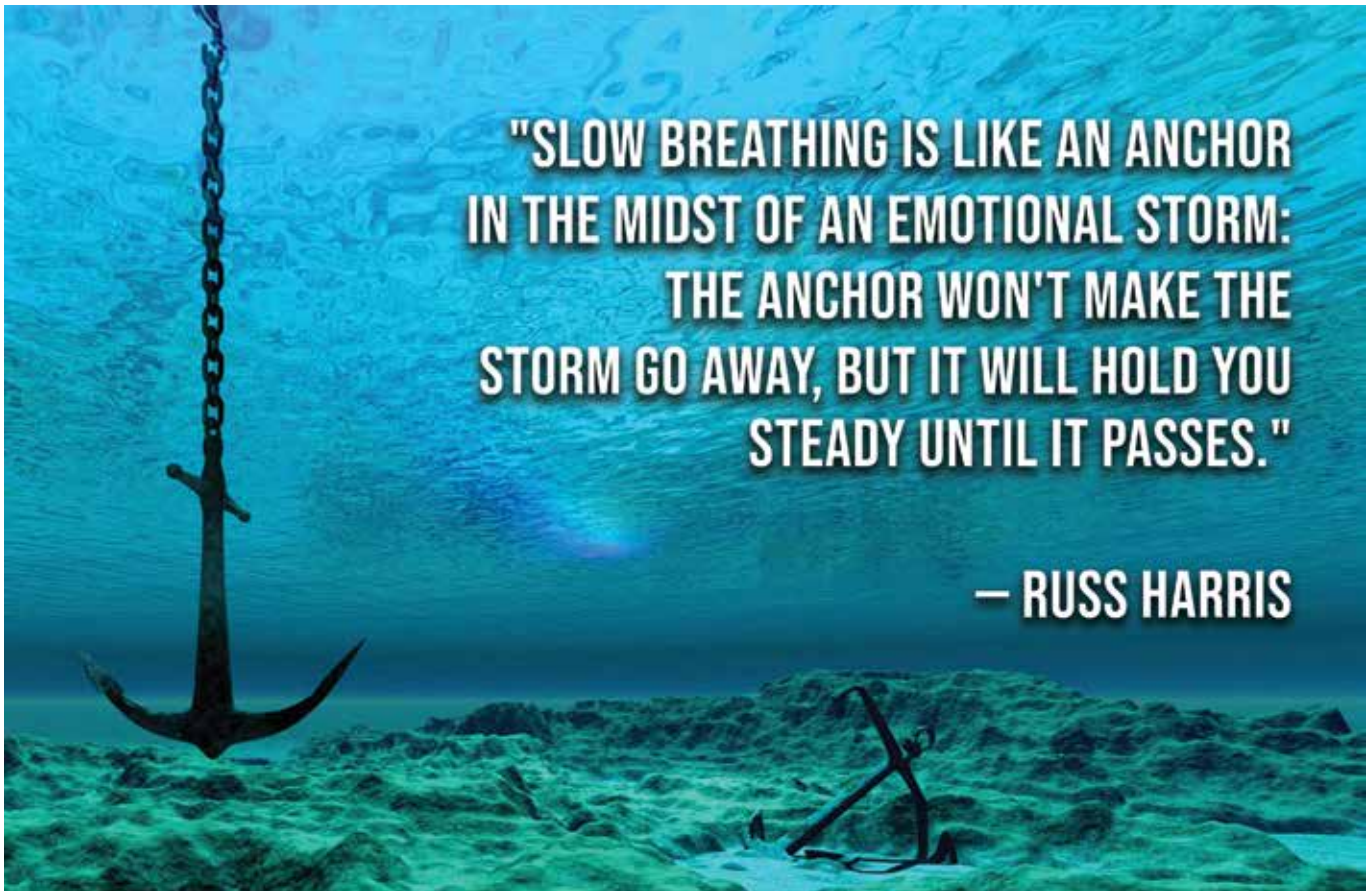

Sri Lanka Medical Association

Call for Applications
Deshabandu Dr C G Uragoda Oration on the History of Medicine 2025

This oration was established as a lecture in the year 2012, the 127th anniversary year of the Sri Lanka Medical Association (SLMA), to commemorate establishment of the SLMA by a meeting attended by a group of doctors at the Colonial Medical Library in Colombo on 26 February 1887 to discuss the formation of the Ceylon Branch of the British Medical Association, which later became the Sri Lanka Medical Association.

The lecture was renamed the Dr. C. G. Uragoda Lecture on the History of Medicine in the year 2017 to honour the lasting contribution made by Dr. C. G. Uragoda to document, "The History of Medicine in Sri Lanka". In 2020, on the demise of Dr. C. G. Uragoda, the Council of the SLMA decided to elevate the lecture to that of an Oration and also add his national titular honour Deshabandu to the title of the Oration.

This oration is delivered on the 26th February of each year.

Applications are called for the Deshabandu Dr. C. G. Uragoda Oration to be delivered on 26 February 2025. Applicants should submit a short abstract of the proposed lecture (no more than 500 words, font size 12 in Times New Roman and margins set at 1 inch right round) and a brief curriculum vita (no more than 3 pages).

The orator should have been considerably associated with and contributed to the field of medicine in his/her chosen topic.

The SLMA will give presently to application in areas of medicine that have not been covered in previous orations. A list of past orations can be found on the SLMA website – http://www.slma.lk. Applicants should bear in mind that they must make themselves available to deliver the oration on 26 February 2025 at the SLMA Auditorium (if selected) as the oration is delivered to mark the founding of the SLMA.

Applications should be submitted to the Honorary Secretary, SLMA, on or before 31st October 2024.

Enhanced patient communication in medicine: The vital distinction between hearing and listening

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In the perpetual but somewhat perplexing realm of healthcare, effective communication between healthcare providers and patients as well as the relatives and loved ones of our patients is paramount for delivering high-quality care and fostering positive patient outcomes. Central to this communication process are two verbs: "hear" and "listen". However, while these two verbs are often used interchangeably, they denote distinct processes. These have significant implications for patient-centred care. We must probe into the distinctions of these verbs and their critical roles in patient-provider interactions to complete the embroidery of useful communication. Such phenomena should be intricately woven into the tapestry of rapport with our patients and their family members. This is ever so important as it could form the unshakeable foundation on which mutually satisfactory communication portals are established between patients and healthcare providers. It generally is the vital force that promotes human-human interaction which is at the epicentre of optimal healthcare.

Understanding the crucial separation between hearing and listening is crucial to formulating satisfactory principles of communication. Hearing refers to the physiological process of perceiving sound waves through the auditory system; a kind of afferent input of thoughts and information. It is a passive, involuntary action that occurs without conscious effort. In contrast, listening actively totally transcends mere auditory perception. It involves dynamically paying attention to, interpreting, and comprehending the meaning behind the sounds or words being heard. Listening requires intentionality, focus, and empathy, to facilitate true understanding of the speaker's message and the ever so vital context of the words that are spoken. The curious paradox of hearing but not listening carefully is most unfortunately seen more often than not, even in medical consultations. Colloquially referred to as falling on deaf ears, such a phenomenon would destroy the all-important intellectual relationship with the patient.

The vital importance of listening in the context of healthcare is that listening holds profound significance for patient-centred care. When healthcare providers actively listen to their patients, they demonstrate respect, empathy, and genuine interest in understanding the patient's concerns, preferences, and experiences. Active listening fosters trust, strengthens the patient-provider relationship, and enables shared decision-making, thereby and ultimately enhancing patient satisfaction and compliance with and adherence to the planned details of management of the illness.

Despite its undoubted importance, effective listening can be impeded by various barriers in healthcare settings. Time constraints, heavy workloads, and systemic pressures may undermine the providers' ability to allocate sufficient time and attention to listening to patients. Additionally, language barriers, cultural differences, and emotional distress on the part of either the patient or the provider can hinder meaningful communication and hamper active listening.

Given the critical role of listening in patient-centred care, healthcare providers should actively cultivate and refine their listening skills by resorting to strategies that could enhance them. This would often need active efforts on the part of the healthcare personnel to develop it into a fine art. This can be achieved through training programmes, workshops, and ongoing continuous professional development initiatives focused on communication and empathetic listening. Techniques such as reflective listening, paraphrasing, and non-verbal cues such as body language, facilitate deeper understanding and rapport with patients. Out of all these vital attributes, paraphrasing; a graphic form of communication whereby one reiterates in different words what someone says, holds pride of place as it very clearly demonstrates to the patient that the healthcare provider has been intently listening to what the patient was saying. Furthermore, creating a supportive organizational culture that prioritizes effective communication and allocates adequate time for patient interactions is essential for fostering a conducive environment for listening.

While listening takes precedence in patient-centred communication, hearing too remains a rather indispensable and adjuvant component of a composite healthcare encounter. It plays a complementary and crucial role in the entire process of communication. Adequate and enhanced hearing abilities enable healthcare providers to detect connected but subtle cues, such as changes in a patient's breathing patterns, eye contact avoidance, or changes in vocal tone, which may convey valuable diagnostic information. Moreover, for patients with hearing impairments or those with communication disorders, healthcare providers must adapt their communication strategies to ensure an effective exchange of information and promote inclusivity in care delivery. It is indeed a really fine art to be able to communicate with some of the people who are disadvantaged by their inability to hear or process what they hear.

It must even be reiterated that in the perpetually dynamic scenery of healthcare, effective communication forms the bedrock of patient-centred care. Pivotal to this communication is the crucial form of understanding the separation between hearing and listening. While hearing represents the passive reception of sound, careful and dedicated listening embodies active engagement, understanding, and empathy. By honing their listening skills and recognizing the value of both hearing and listening in patient interactions, healthcare providers can cultivate more meaningful relationships with their patients, promote shared decision-making, and ultimately, improve clinical outcomes. It is always most valuable and ever so important to listen carefully to what one is hearing through the special sense of the auditory apparatus. It may sometimes mean a lot more than what is received through the afferent acoustic pathway and the patients would absolutely adore healthcare personnel for their commitment and dedication towards their vocation.

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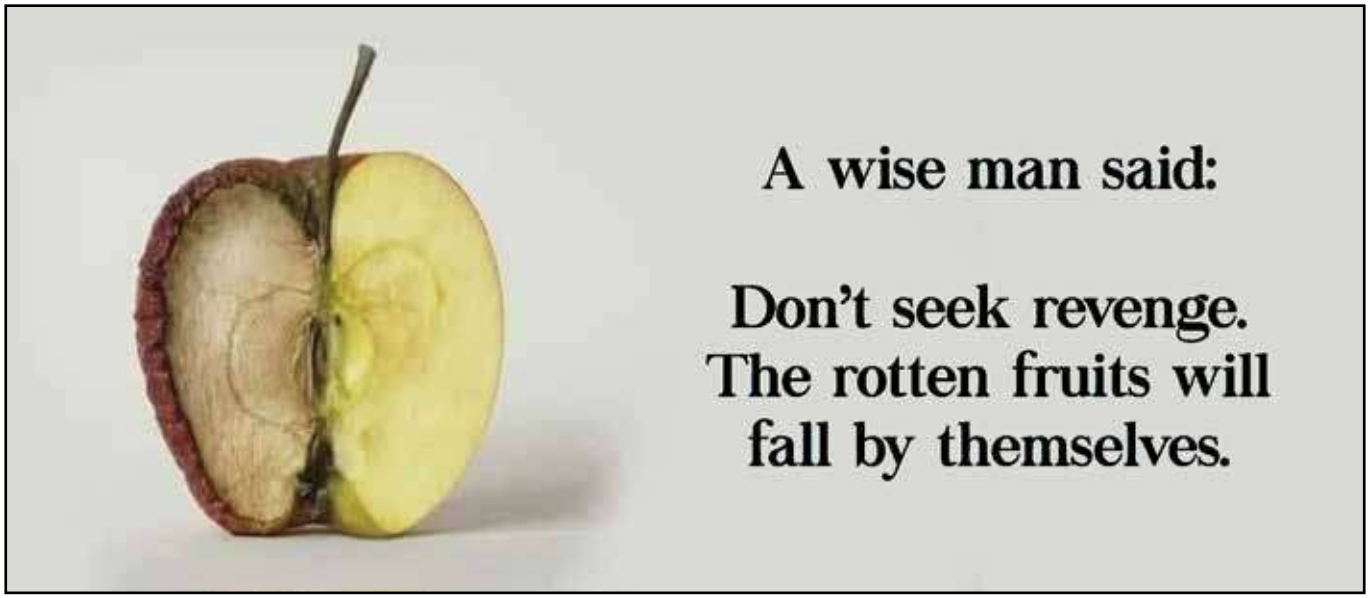

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