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# SLMA NEWS+

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# CONTENT



## SLMA President

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

# President's Message

Dear SLMA Members,

The Sri Lanka Medical Association (SLMA) has been actively involved in discussing and educating its members, the public, and media on issue s related to the health sector crises such as manpower shortages, resource allocations, medical supply deficiencies, drug shortages and drug procurement problem as well as suggesting practical solutions to these issues.

Last year when several groups made complaints to the CID and to courts against the irregularities regarding procurement of essential drugs after cases of anaphylaxis and death due to poor quality of these drugs were reported, the SLMA also came out boldly in support of these allegations individually, as well as a group with other professional organizations and medical trade unions, pressurizing the government to take immediate action on this extremely important matter.

With all the pressure and evidence presented to the CID an investigation was initiated. The SLMA President 2023, President 2024 and all medical professionals who were present at the media briefing held, were interviewed at SLMA premises by the CID officials.

As was highlighted by me in my Presidential Address in 2024, the SLMA, together with all other professional organizations, will not stop now but will keep the pressure on the government to punish all those who were responsible for the dastardly act of the procurement of substandard medications and causing deaths of our patients due to this unforgivable act, till we see a satisfactory solution to the problem, together with measures being instituted to completely stop such things happening in the future.

All these were possible with the publicity given to this issue not only through the electronic media, but also the active role played by social media sites and activists who kept on pressurizing and sharing information with the public, police and the judiciary. They, together with the SLMA and other professional bodies played a pivotal role as *'whistle blowers'* in this situation.

The concern now is the newly gazetted Online Safety Act (OSA) which has clauses making it difficult for individuals or organizations to post or advertise activities that they feel are against the rule of law or the hallowed protection of its citizens, in this case the health-related issues in the country which may have very detrimental effects on the lives of the populace of our Motherland.

Although the Act has addressed issues pertaining to harassment of women and children including cybercrimes which are positive and laudable features of the act, it also includes prohibition on 'communicating a false statement' which poses a threat to national security, public health or public order, etc. The non-definition of what exactly would be considered a 'threat' is not at all clear. It could be left to the whimsical interpretations of the 'Online Safety Commission' consisting of five members appointed by the executive, who are entrusted with sole responsibility for deciding on what constitutes a 'prohibited statement' and making recommendations to internet service providers to remove such content and disabling access for those deemed offenders, thereby making it an even bigger threat to our much-valued freedom of expression.

Our concern would also include the safety of the SLMA in organising a media seminar to expose fraud and irregularities which could be deemed as a punishable offence under this draconian act. It also brings to light and even question the way in which we at the SLMA should address despicable acts related to health and healthcare of our citizens. The million-dollar question would be the way in which we could respond to various issues that may arise on health and healthcare from time to time.

These are questions that we at SLMA, and the other professional organisations as well as the trade unions in health, should discuss about and find solutions as soon as humanly possible to safeguard the health of the people, our profession, and the professionals.

As the President of SLMA, I, with our Council and our membership, will continue to advocate and pressurize the government at each juncture if and when irregularities are performed that endanger the lives of our people.

We will prevail, as so beautifully extolled by Bernice King, the renowned American Lawyer and the daughter of the venerated activist Martin Luther King Jr., *'Continue to speak out against all forms of injustice to yourselves and others, and you will set a mighty example for your children and for future generations.'*

Dr Ananda Wijewickrama
*President, SLMA*

# Activities in Brief
## (16th January 2024 – 15th February 2024)

## SLMA Saturday Talks

Dr Padma Gunaratne, Consultant Neurologist delivered the Saturday Talk on **21st January** on *'Neurological Evaluation of Lower Limb'*


## Media Activities

A press conference was organized by the SLMA Expert Committee on Non Communicable Disease (NCD) on *'Healthy Lifestyle: Are we doing enough? '*on **18th January.**

The resource persons were Dr.Jayanthimala Jayawardena, Consultant Cardiologist, Professor Chathuranga Ranasinghe, Professor of Exercise and Sports Medicine and Professor Ranil Jayawardena, Consultant Clinical Nutritionist.

Dr. Jayanthimala spoke about Primordial, Primary and Secondary risk factors for cardiac diseases and how to prevent non communicable diseases and improve and enhance healthy lifestyle. She also spoke about myths related to medication used to treat diabetes and hypertension.

Professor Ranil Jayawardena spoke about the value of a balanced diet and how important it is to have a variety of foods rich in different nutrients and also myths and scientifically proven facts regarding diets maintaining healthy weight. He also discussed the safety of using supplements and indications for its use, importance of consuming more protein in diet and also stressed on the importance of reducing the daily sugar intake.

Professor Chathuranga Ranasinghe discussed the importance of exercise in daily life and also clarified doubts about exercise and related matters. He highlighted the importance of being physically active daily for 30-60 minutes and to minimize sitting down and to enjoy friendly activities.



SLMA Expert Committee on Prevention of Road Traffic Crashes (PTRC) held a media conference on **30th January** on the topic *'Prevention of Road Traffic Crashes in Sri Lanka in 2024'.*



The resource persons were Dr Ruwan Thushara Matiwalage, Convener, Expert Committee on PRTC Mr Sujeewa Thennakoon, Assistant Commissioner DMT and Mr Dilantha Malagamuwa, Brand Ambassador, Safe Roads Initiative, Sri Lanka.

## Monthly Clinical Meetings

The January clinical meeting was held in collaboration with the Sri Lanka College of Paediatricians on **16th January 2024** on *'Some Intricacies of Measles'.*

Dr BJC Perera, Senior Consultant Paediatrician spoke on *'Measles in Sri Lanka: Clinical Manifestations & Personal Experience'* and Dr Asanga Rajapakshe, Consultant Paediatrician, Base Hospital Marawila spoke on *'Congenital Rubella, Measles & Mumps'.*

## Women's Cricket Carnival

The first ever Women's Six a Side Cricket Carnival organized by the Sports Forum Sri Lanka Medical Association with Doctors' Cricket Sri Lanka concluded successfully on **21st January** 2024 at the University of Colombo Grounds.

Women's cricket teams who participated, included nearly 100 lady doctors' professional and students from Ceylon College of Physicians, Sri Lanka College of Sexual Health, Sri Lanka, Lawyers, Ministry of Health Sri Lanka, District General Hospital, Nawalapitiya, National Institute for Mental Health, Doctors of Sirimavo Bandaranayaka Vidyalaya past pupils, Students of Faculty of Medicine University of Colombo & Students of Faculty of Medicine Sri Jayawardenapura.

The event was graced by the President of Sri Lanka Medical Association Dr Ananda Wijewickrama, Immediate Past President Dr Vinya Ariyaratne, council members of SLMA, officials of professional colleges, doctors, lawyers, other professionals, students and families. The media coverage was provided by Derana TV.

The day was filled with excitement, emotions, socializing, passion for cricket and some quality cricket displayed by the ladies where some matches ended with nail- biting finishes.

At the end, Ceylon College of Physicians emerged as champions with Faculty of Medicine Colombo as the 1st runner up and Ministry of Health as the 2nd runner up.




## Meetings on Invitation

Dr Ananda Wijewickrama, President SLMA attended a meeting on initiated by the GMOA on **24th January** which was attended also by the Association of Medical Specialists and Academic Colleges/ Associations.

Issues regarding the profession, professionals, challenges, probable solutions, guidelines, continuous medical education, and use of technological advancements to minimize health expenditure was discussed at the meeting.

Committees were formed to draw up action plans and to carry forward the proposals till implementation.

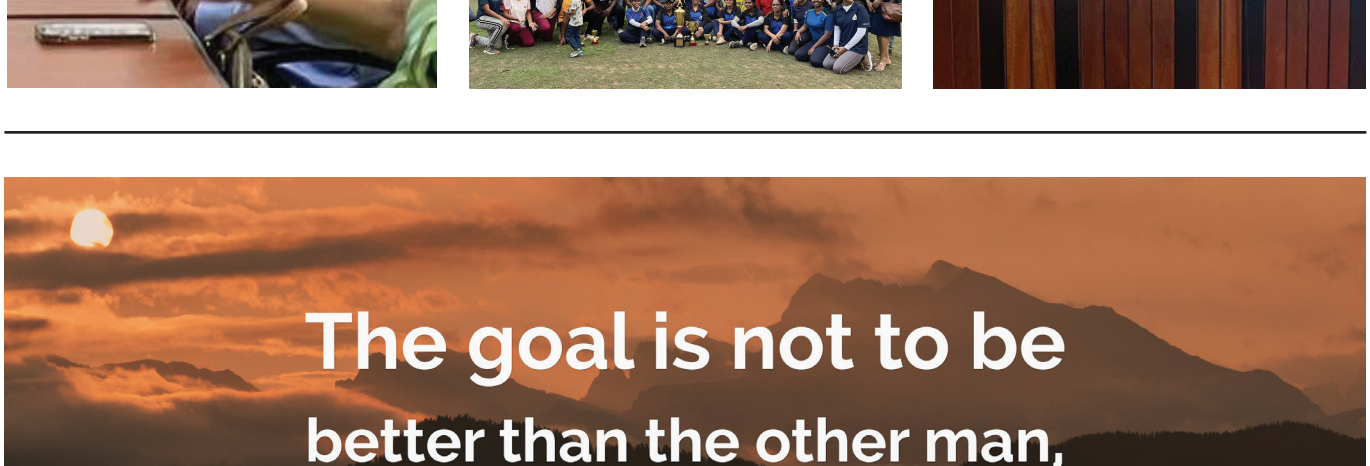
## Doctors' vs Lawyers Annual Cricket Encounter 2023

The 15th Annual cricket encounter between the SLMA Doctors and the Lawyers of the Bar Association of Sri Lanka (BASL) was held on **3rd February** at the BRC Grounds Colombo.

An unbeaten century by the skipper Dr Thaindu Kalinga helped the Doctors team defeat the lawyers by 5 wickets thus denying the lawyers a sixth consecutive win.

## Intercollegiate Committee Meeting

The first intercollegiate committee meeting for the year 2024 was held on **15th February** at the Dr NDW Lionel Memorial Auditorium with the participation of nearly forty professional colleges and associations.



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# Managing the systemic lupus erythematosus patient and shared care

**Dr SAF Kurukulasuriya**
*Senior Lecturer in Pharmacology and specialist in Rheumatology and Rehabilitation*
*University of Kelaniya*

Systemic lupus erythematosus (SLE) is often referred to as 'the disease with a thousand faces' due to complex multi-system organ involvement. It is a chronic inflammatory disease predominantly affecting the young female.[1]

Shared care is fast becoming the norm in managing many chronic diseases. [2] What exactly is shared care? It is defined as joint participation of primary care physicians and specialist care physicians in planned delivery of care for patients. How can it apply in managing SLE?

## DIAGNOSIS OF SLE

A staggering 46.5% of people with lupus are reported as getting a wrong diagnosis.[3] Unfortunately, the diagnostic delay of the disease is a median two years from onset of symptoms.

Diagnosis can be done by the primary care physician. When the disease is suspected, efforts should be taken for an early diagnosis.

Diagnosis of SLE is best based on the EULAR/ACR 2019 criteria.[4]

The criteria initially look for a positive anti-nuclear antibody (ANA) test performed by immunofluorescence. Once the ANA test is positive, the components under the clinical and immunology domains in the criteria should be considered in relation to the patient. The total score (maximum 51 and minimum 0) is considered, and this should be equal to or over 10 for the patient to be classified as having SLE. There is a requisite that at least one clinical criterion must be positive when calculating this total score. When a score of 10/51 is not reached in the patient, the presence of photosensitivity can be considered to arrive at a diagnosis of clinical SLE.

### Diagnostic challenges

Early stages of the disease, when only a limited number of clinical or immunological features may be present, poses a diagnostic challenge. Likewise antinuclear antibody (ANA)-negative cases or organ-dominant forms and rare disease presentations, which can nonetheless be severe and require expert opinion and prompt treatment can be challenging.

### Is there a possibility of an ANA negative patient being diagnosed with SLE?

In the presence of hypocomplementemia and/ or a positive antiphospholipid antibodies and a minimum score of 10 on the EULAR/ACR 2019 criteria which includes at least one clinical criterion, SLE can be diagnosed, even in a patient with a negative ANA test.

### Should the ANA test be repeated once positive when monitoring the patient?

Repeating of ANA testing once positive and frequent testing of serology in patients with steadily improving or inactive disease should be avoided.

### Which patients with SLE are more likely to develop severe disease?

Children diagnosed with SLE, male patients, patients with low complement levels, presence of positive anti-DNA or anti phospholipid antibodies, patients with high interferon (IFN) signature and patients with moderate to high activity indices are more likely to develop severe disease.

The above categories of patients should ideally be referred to centers where multidisciplinary care is available, returning to their physician once a therapeutic plan is in place.

## THE TREATMENT OF SLE

### What are the objectives in treating a SLE patient?

The objectives of treatment of SLE include, long-term patient survival, prevention of organ damage and optimisation of health-related quality of life

### Overarching principles

EULAR recommendations for the management of systemic lupus erythematosus: 2023 update includes :[4]

- SLE requires multidisciplinary care where other disciplines such as nephrologists and dermatologists are involved when needed. Treatment decisions should be individualized also taking into consideration patient preferences. Patient education about the disease, its prognosis and available treatment options should be discussed with the patient.In this era of economic constraints, it is important to take into

consideration the costs to patient and society.

- Once treatment is commenced it is important to assess disease activity of SLE at each clinic visit, with evaluation of organ damage at least annually. In measuring disease activity there are many scores to choose from. SLE Disease Activity Index (SLEDAI)/SLEDAI 2K is commonly used.[5] BILAG-2004 index is a comprehensive disease activity instrument for SLE but administrative burden and potential frequency of errors limits its use in routine practice.[6]A newly proposed SLE Disease Activity Score (SLE-DAS; accessible at http://sle-das.eu/) with more aspects of monitoring included, such as myositis, haemolytic anaemia, cardiopulmonary and gastrointestinal manifestations is also recommended by the EULAR recommendations.[4] Systemic Lupus International Collaborating Clinics/American College of Rheumatology (SLICC/ACR) Damage Index (SDI) score is recommended for annual assessment of organ damage due to the disease. [7]

- Regular screening for organ involvement (especially nephritis) is important. Vigilant monitoring for new organ involvement, mainly lupus nephritis (LN), especially during the first years of the disease is recommended.

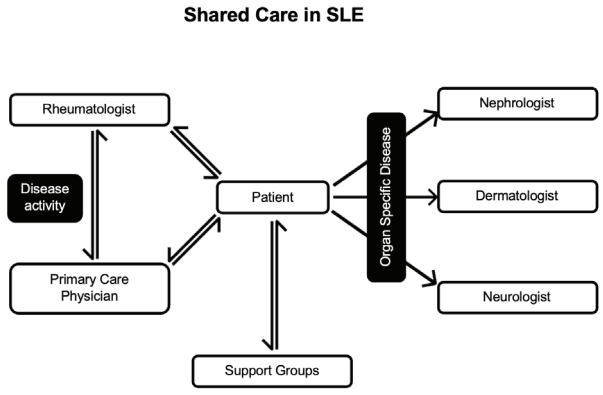
- Non-pharmacological interventions such as regular exercise in moderation, adhering to a healthy balanced diet and using sun protection are important to improve long-term outcomes. Cessation of smoking should be emphasized, as it is known to interfere with the efficacy of medications such as antimalarials and belimumab. The blood pressure, lipid levels and blood glucose levels should be optimized.

- Immunizations for the prevention of infections (herpes zoster virus, human papillomavirus, influenza, COVID-19 and pneumococcus), management of bone health, nephroprotection and cardiovascular risk, and screening for malignancies, should be done.

- Pharmacological therapy in the SLE patient should be guided by the patient comorbidities, severity of organ involvement, treatment-related side effects, patient preferences and of course accessibility to treatment. Prompt initiation of treatment aiming at remission (or low disease activity if this is not possible), and strict adherence to treatment are essential to prevent flares and organ damage. This would in turn improve prognosis and enhance quality of life.

**TREATMENT OF SLE DEPENDS ON WHETHER THE PATIENT HAS RENAL INVOLVEMENT.**

**Fig.1**




the disease is categorized as below:

**Mild disease:** presence of constitutional symptoms; mild arthritis; rash ≤9% body surface area; platelet count (PLTs) 50–100 × 109/L; SLEDAI≤6; BILAG C or ≤1 BILAG B manifestation.

**Moderate disease:** moderate–severe arthritis ('RA-like'; rash 9%–18% BSA; PLTs 20–50×109/L; serositis; SLEDAI 7–12; ≥2 BILAG B manifestations).

**Severe disease:** major organ threatening disease (cerebritis, myelitis, pneumonitis, mesenteric vasculitis); thrombocytopenia with platelets<20×109/L; TTP-like disease or acute haemophagocytic syndrome; rash>18% BSA SLEDAI>12; ≥1 BILAG A manifestations

Irrespective of the severity of the illness all patients should be commenced on hydroxychloroquine, unless contraindicated, at a target dose of 5 mg/kg /day. This dose is individualized based on risk for flare and retinal toxicity.

Glucocorticoids, if needed, are dosed based on the type and severity of organ involvement and should be reduced to a maintenance dose of ≤5 mg/day (prednisone equivalent) and, when possible, withdrawn.

In patients with moderate-to-severe disease, according to the above categorization, pulses of intravenous methylprednisolone (125-1000 mg per day, for 1–3 days) can be considered.

In patients not responding to hydroxychloroquine alone or in combination with glucocorticoids or patients unable to reduce glucocorticoids below doses acceptable for chronic use, addition of immunomodulating agents (e.g.; methotrexate, azathioprine or mycophenolate) and/ or biological agents (e.g.; belimumab or anifrolumab) should be considered.

life -threatening or organ -threatening disease calls for considering of intravenous cyclophosphamide. If the patient is refractory to cyclophosphamide, rituximab can be considered.

**Treatment of skin disease of SLE**

Treatment of active skin disease should include topical agents (glucocorticoids, calcineurin inhibitors), antimalarials (hydroxychloroquine, chloroquine), and/or systemic glucocorticoids as needed, with anifrolumab, belimumab, methotrexate, or mycophenolate, considered as second-line therapy.

**Treatment of active neuropsychiatric disease in SLE**

Glucocorticoids and immunosuppressive agents for inflammatory manifestations and antiplatelets/ anticoagulants for atherothrombotic/antiphospholipid antibodies (aPL)-related manifestations should be considered.

**Treatment of haematological manifestations of SLE**

The haematological manifestations of the disease include autoimmune cytopenias, immune thrombocytopenia and haemolytic anaemia. In the treatment of acute severe autoimmune thrombocytopenia, high-dose glucocorticoids (including pulses of intravenous methylprednisolone), with or without intravenous immunoglobulin G, and/or rituximab, and/or high-dose intravenous cyclophosphamide, followed by maintenance therapy with rituximab, azathioprine, mycophenolate, or cyclosporine, should be considered.

**Treatment of lupus nephritis**

In the SLE patient, life-long risk for severe nephritis is approximately 20%. Screening for proteinuria and hematuria by urinalysis is recommended every three months in active SLE.[8]

With active SLE, C3 and C4 complement levels are usually low and anti-dsDNA autoantibody is positive. Serum creatinine level may be elevated or normal in the presence of proteinuria. Urinalysis shows the presence of proteinuria, microscopic hematuria, red blood cells, or red blood cell casts. The presence of protein in urine indicates glomerular damage. Proteinuria that exceeds 3.5 g per day is in the nephrotic range.[8]Renal biopsy is indicated in these patients. With the renal biopsy, the histologic form and stage of disease can be established which helps in determining prognosis and treatment.

Risk factors for end stage renal disease (ESRD) include male gender, hypertension, increased baseline creatinine, high histological activity and chronicity indices, and not being on maintenance immunosuppression.

The pharmacological management of patients include commencing on hydroxychloroquine, unless contraindicated, at a target dose of 5 mg/kg /day.

Patients with active proliferative lupus nephritis should receive low-dose intravenous cyclophosphamide or mycophenolate and glucocorticoids (pulses of intravenous methylprednisolone followed by lower oral doses); combination therapy with belimumab (either with cyclophosphamide or mycophenolate) or calcineurin inhibitors (especially voclosporin or tacrolimus, combined with mycophenolate) should be considered.

In patients at a high risk of renal failure (defined as reduced glomerular filtration rate, histological presence of cellular crescents or fibrinoid necrosis, or severe interstitial inflammation), high-dose intravenous cyclophosphamide in combination with pulse intravenous methylprednisolone should be considered.

Ace inhibitors or angiotensin receptor blockers and SGLT inhibitor should be added where possible.

Lupus nephritis associated with thrombotic antiphospholipid syndrome (APS) should be managed with long-term vitamin K antagonists after the first arterial or unprovoked venous thrombotic event; low-dose aspirin (less than100 mg/day) should be considered in patients with SLE without APS with high-risk aPL profile.

**Treat-to-target strategy**

By treating with a treat-to-target strategy where there is a strategy that defines a treatment target such as remission or low disease activity. Tight control is applied to reach this target. By this approach the severity and number of disease flares can be reduced. End organ damage will also be reduced.

**How is remission defined in SLE?**

In non-renal SLE

Remission is defined as SLEDAI=0, with HCQ, corticosteroids $\leq$ 5mg

Low disease activity is defined as SLEDAI $\leq 4$,with HCQ, corticosteroids $\leq$ 5mg, and Immunosuppressives or biologicals in stable, tolerated doses

In renal SLE

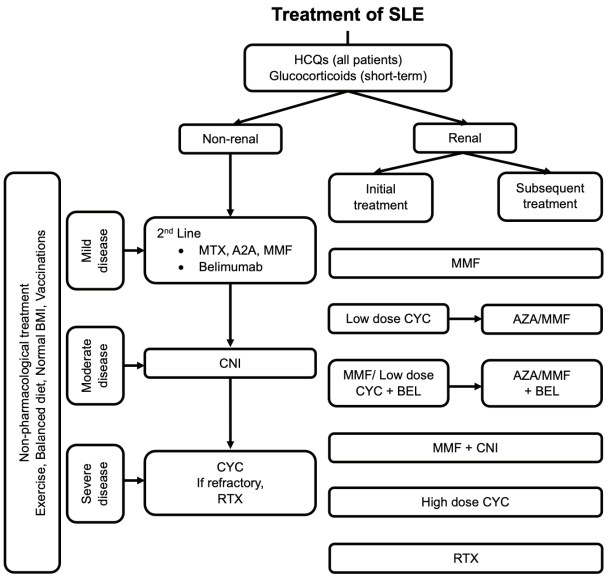
The targets of treatment are $\geq$25% reduction of urine protein at 3 months, $\geq$50% reduction at 6 months and daily urine protein to $< 0.7g/day.$

Tapering of treatment

In patients with SLE achieving sustained remission, gradual tapering of treatment should be considered, with glucocorticoids being the first medication to withdraw.

**What are the novel therapies that have been introduced?**

Biological drug, anifrolumab and Voclosporin, a novel calcineurin inhibitor (CNI) have been approved for patients with active LN.

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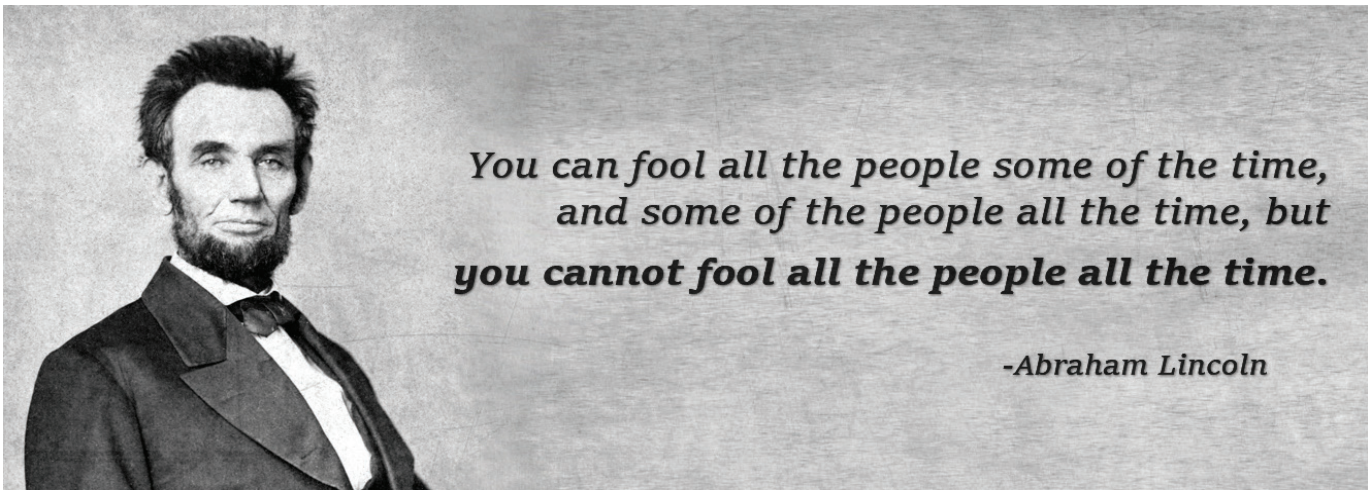

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# Medicine, Morals and Spirituality

**Dr Lalith Mendis**
*Director, Colombo Empathic Learning Centre.*
*Formerly, Lecturer in Charge*
*Dept of Pharmacology*
*Faculty of Medicine*
*University of Kelaniya*

It was Blaise Pascal, the French mathematician, physicist, inventor, philosopher, and Catholic writer, who said, *"the heart has its reasons which reason knows nothing of"*. A long historical tradition connects religion, medicine, and healthcare. Religious groups built the first hospitals in Western civilization during the fourth century for care of the sick who were unable to afford private medical care. For the next thousand years until the Reformation and to a lesser extent until the French Revolution, it was the religious establishment that built hospitals, provided medical training, and licensed physicians to practice medicine. Likewise, the profession of nursing emerged directly from religious orders that until the early 1900s staffed the majority of hospitals both in the United States and other Western countries. (1).

My consideration of Medicine and Religion will fall into two major categories.

Part 1 Clinical Health and Spiritual Solace

Part 2 Moral Decisions in Medicine

## Part 1 Clinical Health and Spiritual Solace

US Department of Health and Human Services divisions have been given a presidential mandate to encourage research on and remove the barriers from faith-based community organizations delivering mental health and substance abuse services (2). One study showed that people who have unresolved religious struggles have a worse mortality rate following discharge. Religious or existential turmoil, then, may impair recovery-underscoring the importance of physicians' identifying such patients and making appropriate referrals. (3). This points to a need for spiritual solace, at least in some patients. The renewal of the call to align religion and health, was accelerated by metal health needs & services for handling substance abuse. In both these fields, medicine alone had poor success and furthermore, faith based services showed promise in some studies. (4).

In a review by Mueller and colleagues of research explored the effects of religion on mental and physical health. In that review, religious beliefs and practices are thought to evoke health effects through psychosocial, behavioural, and physiological mechanisms that are known, understood, and accepted within the field of traditional science. The strength of this review is its comprehensive nature and its focus only on research studies that had findings explainable through scientifically rational pathways. (5) (6).

However, physicians are beginning to appreciate that the majority of their patients are religious and use religious beliefs to cope with sickness, that existential issues and spiritual struggles are common among patients, that religious beliefs influence the medical decisions that patients make, and, for all these reasons, religion might ultimately affect both psychological health and medical outcomes. Patients who have an optimistic belief system that gives life meaning and purpose in the setting of pain and suffering, those who have a large group of supportive friends committed to their welfare, and those who live healthier lifestyles and abuse their bodies less often with drugs, alcohol, and cigarettes, are bound to be healthier and recover more quickly from illness. Who could deny that such factors are relevant to the practice of medicine? (7)

Despite the many unknowns and the need for further research and greater understanding of these relationships, physicians can even now begin to address the spiritual needs of patients and yet avoid most of the dangers and pitfalls. The following recommendations are based on clinical experience and common sense, not systematic research. As Mueller and colleagues suggested, physicians can take a spiritual history, find out whether religious or spiritual beliefs are used to cope, are evoking religious struggles, are likely to influence medical decisions, or are responsible for other special needs that trained clergy may help with. A spiritual history should be taken in a way that does not endorse religion as either desirable or undesirable, but rather sends the message that religion and spirituality are an important area that may influence health for better or worse. (8). "Religious beliefs may have a powerful influence on the health of our patients, and we need to know about them". (7).

As well as moral responsibilities at the individual level, there are collective responsibilities in medicine. For example, the profession has a collective responsibility to ensure that the next generation of doctors is educated and that medical research occurs. (9).

## Part 2 Moral Decisions in Medicine

We may now consider other issues that are medical but need a holistic approach with moral, spiritual, or religious insight. Man may not be the measure of all things. Science may need metaphysical input on life-and-death matters.

SLMA made a commendable effort in bringing out the 'Health Charter' in 1996 and this author was a member of the committee that drafted the resolution.

THE SRI LANKA MEDICAL ASSOCIATION CALLS ON:

A. A. all health professionals, professional organisations and institutions involved in medical undergraduate and postgraduate training to improve professional and ethical standards and thereby give effect to the provisions of this DECLARATION;

B. B. the Government to provide the finance, human resources and infrastructure required for effecting such improvement, and to take appropriate action as called for in this DECLARATION;

C. C. the pharmaceutical industry to abide by the ethical standards as laid down in, Ethical Criteria for the Promotion of Medicinal Drugs and Devices in Sri Lanka (SLMA, 1996); (10)

**Life-and-Death Issues**

Human life has the very same value for all. Life has an Ultimate Author and an Owner. So., man cannot decide to terminate life based on exigencies.

Why should aged & weak people continue to live, when the resources they consume, especially hospital care, will be needed for the young, more economically productive people?

Why should mentally retarded people continue their miserable existence?

Why should others with debilitating illnesses live?

Why is suicide considered an indictable crime? Shouldn't one be able to decide, "I live or die?"

Why is infanticide wrong?

At which gestational age should abortion be legal?

Should abortion be wholly illegal, as it is in Sri Lanka? (11). Does the unborn have the right to life? Yes, the unborn has a right to live. Medical hazards of abortions are a well-kept secret. (12)

"And especially I will not aid a woman to procure abortion." The International Code of Medical Ethics has the following~ ". …I will maintain the utmost respect for human life from the time of conception;"

Medical risks of abortion must receive greater publicity. (14)

What about the preferential abortion of the girl child in some regions of the world? Some states of India had to bring in legislation to stop this deplorable state. (14)

Foetuses (abortuses) obtained by surrogate pregnancy and abortion are used for plastic surgery and for research. Isn't this cannibalism? (15)

**PECUNIARY AND SOCIO-ECONOMIC CONCERNS**

We should be in the forefront of a movement amongst doctors for a more socially concerned orientation towards our patients. This is an important ethical consideration that we ought to bring to bear on our guaranteed private practice. If a poor patient who can ill-afford the money, is compelled to offer the D.M.O. his private practice fee (P.P.fee!), because he will be better treated, then we are indeed economic oppressors who use our privileged profession, for which the country has paid, to fleece the sufferer. Even in consultation practice one needs to ask the question, "must I charge every patient I see? Is there any way to ease the burden on the poorer patient?

Why should the poor have equal access to health, when they are not earning for their health? How rich should I get, out of the misery of illness of my patients?

Prescribers should mind the safety, cost-effectiveness and rationality of effective prescribing. All should condemn the polypharmacy and unethical promotions that entice medical practitioners. There are laws in some countries. Prescribe the least number of drugs at the cheapest price. Antibiotics are available at Rs 30 cents per capsule and at Rs 300 a cap. Prescribe thee least costly, appropriate antibiotic, at the best and appropriate dosage, for the period required. Do not get taken in by the attractively designed documents with impressive clinical trials. Please remember that the pharmaceutical companies may have paid for the clinical trial with all the fringe benefits available to the researchers who may have fiddled the trial to achieve the desired end. Know your pharmacology better than the drug representative.

**Organ Trade**

Organ trade; the most extreme form of trafficking and forced organ harvesting, was found by the China Tribunal to be a crime against humanity. (9)

**Transgenderism and Pharmaceuticals**

Who decides that sex may not be strictly biological? Can a child choose his/her sex?

Homicide rates for transwomen, and in particular for transwomen of colour, account for a percentage of homicides far out of proportion to their numbers in the transgender population [8]

Many in the LGBTQI community rely on arguments that we refer to collectively as "born that way" arguments, namely, arguments for LGBTQI rights based on the idea that sexual orientation and gender identity are innate, immutable, and associated with choice. Two of the authors (TP and ES) have previously addressed the difficulties of using "born that way" arguments in relation to sexual orientation [10, 11].

### Is paedophilia genetically determined?

The absurd discussion to justify paedophilia on genetic and other premises, tell us how far wrong thinking can be without a moral and spiritual compass. (16)

### Conclusion

If man is only brain, will AI take over all decision making and do much better than a human? Is human cloning a scientific issue or a religious issue?

I have raised issues that we need to discuss. I have tried to watch over a possible moral codex based on long cherished values. Future issues regarding AI in medical practice will need to be discussed at another time.

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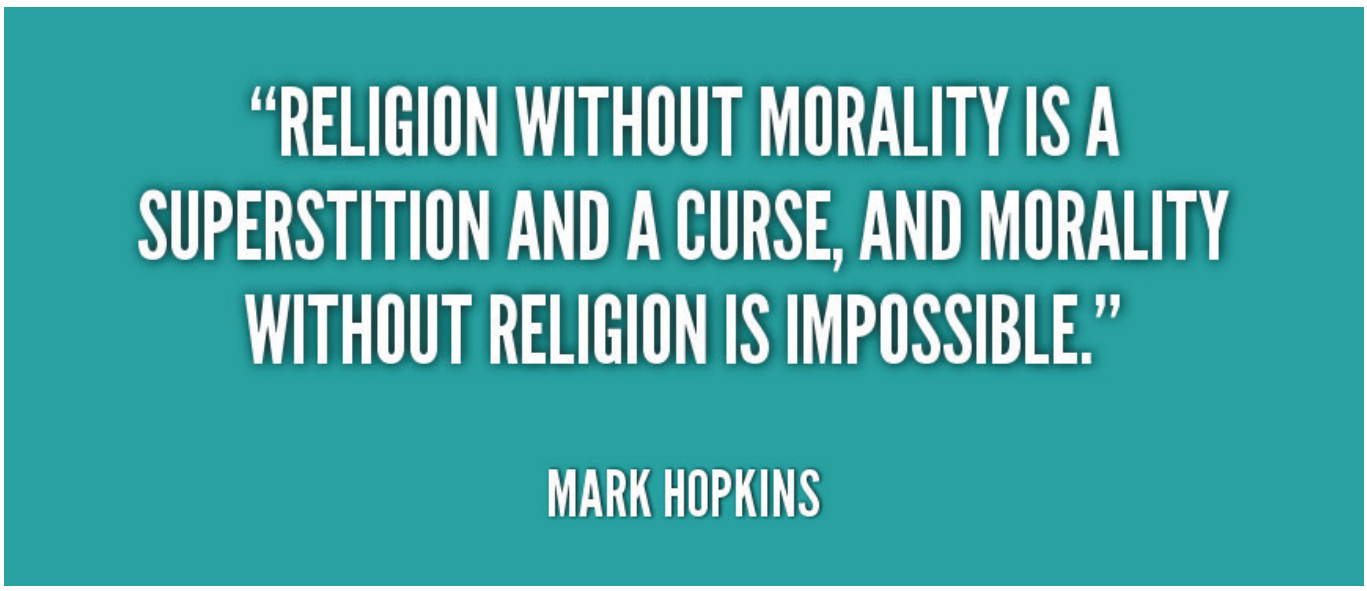


# The challenge for Sri Lanka Medical Association

**Dr Upul Wijayawardhana**
*Consultant Cardiologist*

At this unprecedented time of moral bankruptcy, on top of an enormous economic crisis, Sri Lanka Medical Association (SLMA) needs to face a huge challenge; that of re-establishing the honour of and the respect for the profession, which it had lost unfortunately. It is patently obvious that corruption which is eroding the Sri Lankan society has permeated all professions, my long-cherished profession being no exception. SLMA is the premier medical association in the country and the umbrella organisation that encompasses all medical men and women, whether they be specialists or general practitioners, government servants, employees of other organisations or independent practitioners. It is their collective voice and decisions taken by the SLMA are likely to be adhered to, by all. In a way, it is fortunate that the SLMA, which started life in 1887, as the Ceylon branch of the British Medical Association (BMA), severed connections with the BMA in 1956 as the BMA functions mostly as a trade union. Being a professional body with no trade union functions or affiliations, gives a distinct advantage to the SLMA.

I am confident that SLMA can face this challenge and I say so for two good reasons. First, this is not the first time the SLMA faced what seemed unsurmountable challenges but overcame difficulties by adapting and embracing change. Second reason is the induction of Dr Ananda Wijewickrama as its president. Though Ananda is saddled with another important responsibility as the chairman of the National Medicines Regulatory Authority and his time as President, SLMA is limited to a year, I am sure Ananda can, if anybody can! I say this with confidence as I can testify, not only to his many abilities but also to his honesty and integrity, having had a very close association with him for two years in Grantham Hospital, during his overseas postgraduate training in UK.

Perhaps, I have the dubious distinction of being the only president-elect of SLMA not to be inducted to that high office in 1989, as I left Sri Lanka in 1988 having chosen family over SLMA but am left with no guilt as I contributed my fair share for the advancement of SLMA. My close association with the SLMA began in 1974, during another period of great difficulty, perhaps, only marginally second to the present. In spite of the first JVP insurrection happening during my PG training in UK, I returned to my Motherland in January 1972 and was appointed Consultant Physician, Badulla Hospital. In spite of being a step down in the hierarchy, in June 1973 I accepted the post of Registrar to Dr N J Wallooppillai in the Cardiology Unit, GHC, to further my interest in Cardiology. In appreciation of my leadership in setting up a Postgraduate centre in Badulla Hospital, with the support of the Ceylon College of Physicians, Dr E H Mirando proposed my entry to the council of the SLMA.

The next year, 1975, I agreed to be Hony. Assistant Secretary without realising that the post carried the additional responsibility of being the business manager of the Ceylon Medical Journal (CMJ), the oldest surviving medical journal in Australasia which started life as "the Journal of the Ceylon Branch of the British Medical Association" in 1897. Except for a break from 1893 to 1904, it had been in continuous publication and was the only internationally recognised journal in Sri Lanka. However, there was a major problem; it was on the verge of collapse due to the vastly reduced revenue caused by the non-availability of advertisements due to restrictions imposed on pharmaceutical companies. To prevent closure, I proposed to the council that we have non-pharmaceutical advertisements which was carried through, not unanimously though! I rang round my patients and friends and was able to collect sufficient advertisements to tide over. For the first time, CMJ carried advertisements on Datsun cars etc. but ensured survival!

During my period as Asst. Secretary for three years and the Hony. Secretary for another three years, under the stewardship of six Presidents, we faced many more difficulties including dwindling finances. An American tour company, arranging tours for American doctors in India, approached me for similar tours in Sri Lanka. They were making use of the liberal tax laws in USA which allowed the cost of the entire holiday being tax-deductible if doctors took part in a scientific session. Having got council approval, I arranged an evening session of lectures for each group and am thankful to other members of SLMA for voluntary participation. Obviously, they each had to pay a registration fee which, if my memory serves right, was 100USD, which was a very large amount then, which helped SLMA's depleted coffers! I cannot recollect the total number of sessions we did but it pleased the travel company so much, I was invited to attend one of their sessions in Bombay. I insisted that the President too be invited and we were

their guests at the Taj Intercontinental in Bombay, just by the side of India Gate!

The other major problem we faced was dwindling attendances at the Annual Scientific Sessions and the falling numbers as well as the quality of papers presented. SLMA has been having these sessions since 1937 but this too seemed to be grinding to a halt. After a few brain-storming sessions with friends and fellow councillors, especially Dr Dennis Aloysius and Prof W A S De Silva, I presented three proposals to the council for energizing the Annual Academic Sessions:

1. Establishment of an oration titled SLMA oration and make it the most prestigious oration. It would be delivered at the inauguration of the sessions and for the lecturer to inaugurate the session, obviating the need for 'imported' chief guests.
2. Award of prizes for best presentations in different categories.
3. Instead of the prevailing practice of free attendance, charge a registration fee.

Though most council members supported the establishment of the SLMA oration, there were strong objections to the registration fee and doubts expressed about the feasibility of selection for awards. I offered to draw up the procedure of selection for awards and pointed out to the council that human nature being such, if one pays one will attend. With great difficulty, I persuaded the council to introduce the registration fee, on a trial basis. Though I cannot be sure of the year registration fee was introduced, maybe it was 1978, but am sure the first registration fee was Rs10. Contrary to the views of the majority of the council, but to my great relief, it was a tremendous success, all sessions being attended as never before!

The number of awards has increased since and continues to this day. In fact, just before I left Sri Lanka, I set up a fund to award a cardiology prize but I was informed that it could not be named Wijayawardhana Cardiology Prize as I am not dead but it would be awarded as the cardiology prize set up by me but on the few occasions I attended the Anniversary Sessions, when it was awarded no such mention was made. I requested SLMA council to name it in memory of my parents, two years ago, but have had no response so far. It looks as if SLMA has grown so rapidly since our time and things have got unwieldly. Perhaps, they are waiting for my demise, to honour me properly!

The inaugural SLMA oration was delivered by the pioneer neurosurgeon Dr Shelton Cabraal in 1979 and I followed next year, detailing how I was able to set up the Permanent Pacing programme in Sri Lanka with the support of Dr N J Wallooppillai.

1982 was a significant year when my great friend Dr Dennis Aloysius was the President and I was handling public relations. Rupavahini has just started broadcasting and Mr M J Perera, Chairman of Rupavahini, requested me to do health education programmes. When I put this to the council there were objections, initially, but commonsense prevailed a couple of months later and I was able to conduct panel discussions on behalf of SLMA on Rupavahini's flagship programme "Neth Sera" produced by Mr Sanath Liyanage. Manufacturers of Panadol offered to sponsor a radio programme and I was able conduct "Sri Lanka Vaidya Handa", monthly, on SLBC. The reward I got was, one of my colleagues reporting me to Sri Lanka Medical Council that I was indulging in advertising! Fortunately, SLMC accepted my defence that I was doing these programmes on behalf of SLMA.

It was also in 1982, one of our beloved seniors, Prof N D W Lionel, much respected professor of pharmacology, died suddenly, very prematurely. The outpouring of the sympathy of the pharmaceutical trade, which was doing very well by then due to the liberal policies of the JRJ government, was channelled to build an auditorium, which we were badly in need of, in his name. The medical officer of Ceylon Tobacco, who was a council member, offered to get Ceylon Tobacco to fund the auditorium but that offer could not be accepted for obvious reasons!

I have gone in to details to show that we can come out of difficult times. I do hope the present council of the SLMA would take steps to re-establish the honour of the profession and that the SLMA would lead the way for other professions to follow, as unless corruption is reduced significantly Sri Lanka has no future.

Going by press reports and communications to the press, most dissatisfaction towards our profession seem to stem from irregularities in private practice, like overprescribing which is of great importance at this time of severe economic stress. Perhaps, SLMA can set up an expert committee to look in to this as well as other aspects. I am well aware that SLMA already has a number of committees but this should be very high-powered committee to produce a rapid response. If a voluntary code of practice is followed, public is likely to be reassured.

In fact, SLMA should go a step further. With the concurrence of private hospitals, guidelines could be drawn which could avoid many of the malpractices common at present. Irrespective of what the government does, which many do not care for in any case, SLMA accreditation may be the way forward and it is high time SLMA asserted authority.

# A Formula for Safe and Joyful Driving – The 3 Cs

**Professor Kolitha H Sellahewa**
*Senior Consultant Physician*

The scale of road traffic accidents is unprecedented and has resulted in many preventable deaths and disability. It is essential for all road users to adhere to the Highway Code and take responsibility to prevent road accidents. Poor standards in the mushrooming driving schools and corruption in the issue of driving licenses are major root causes that need to be addressed which are beyond our purview. In the interim the onus is ours to contribute positively to make driving safer and an enjoyable experience for all road users. This is achievable by adopting a defensive approach to driving rather than been aggressive and applying the **3 Cs** all the time when driving.

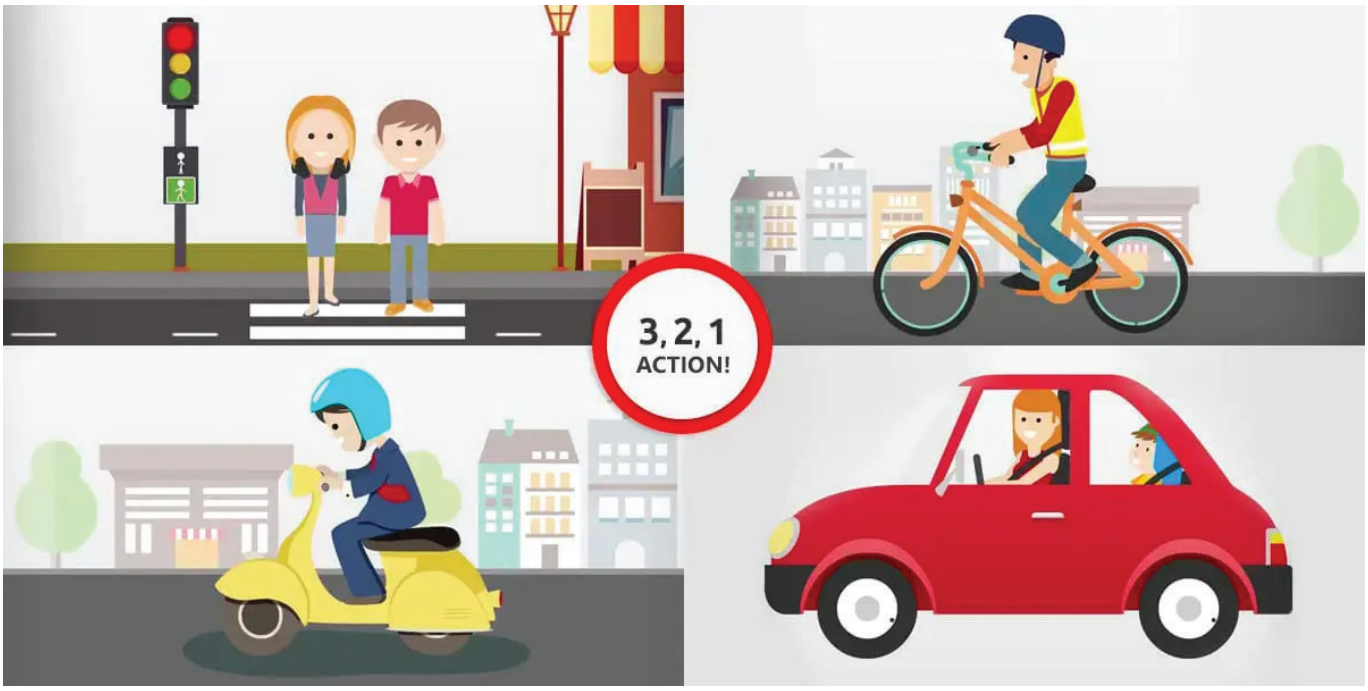
### 1st. C – Concentration

All drivers should take driving seriously. They should take the responsibility for their own safety and that of all other road users including cyclists and pedestrians apart from motorists of other vehicles. They should be acutely conscious of this need and *concentrate fully* on the job at hand *consistently* from the moment of starting the engine to the point of switching it off. Any lapse of concentration even for a split second at a critical moment could be the difference between life and death. Use of electronic devices should be strictly avoided at all times when driving. Your life or that of someone else is not hanging at the end of a mobile device for you to answer a call as a priority while driving. Let someone else answer it, you can always call back or if absolutely urgent pull over to the curb, press on the hazard warning of your vehicle and answer the call. There should be no lapses of concentration when driving, it should be full and sustained throughout the journey, however clear the road may be, and however competent and experienced you are because; unexpected circumstances conducive for an accident can occur at any time. If your concentration is sustained you will be able to react rapidly and appropriately to prevent an accident that would have occurred otherwise. Anticipation and prevention of accidents is the key for road safety and it is achievable primarily by good concentration.

### 2nd. C- Consideration

We all have some inherent selfishness to varying degrees tending to make us think and behave as if the road is all ours. However, a good driver will be acutely conscious that the road belongs to all alike and will respect and attend to others needs as well, throughout the journey. Consideration of the needs of others will make you slow down, stop, and park properly. This will contribute to mitigate traffic jams, ensure a smooth flow of traffic in congested roads and bring a smile to other road users. It will also bring a lot of happiness to yourself when reflecting on the good deed you have done. On a broader perspective such simple acts of consideration will serve to attenuate the stress of driving and road rage.

A common example is: you observe a motorist driving in the opposite direction who has stopped and is waiting for traffic to clear on your side to turn across and enter a side road. If your anticipation and observation is sharp, you only have to slow down momentarily and signal for him to cut across without even stopping your vehicle. On the other hand you could stop for a few seconds and allow him to pass across. Yet another option is for you to accelerate fast if there are no vehicles closely behind you so that he is given sufficient time to cross before the next vehicle comes to that point of obstruction. The precise option of your reaction to enable a motorist in the opposite direction to cut across your side of the road, namely; stop, slowdown or accelerate will be determined by the quality of your own mind and intuitive judgment. It stems essentially from a rapid mental analysis of the distance between your vehicle and his, as well as the vehicle behind yours, the congestion behind you (*as judged from the rear view mirror*) and the speed of your vehicle. Whatever the modality, the thought to allow him to turn across is a reflection of consideration cultured among good drivers. In this particular example it will bring relief not only to the driver of the turning vehicle but also to so many others whose flow has been blocked by just one driver. The building up of stress, anger, sound pollution by tooting of horns, and the consequent enhancement of the anxiety, impatience, and restless of the driver waiting to turn, can all be prevented by a simple gesture of kindness on your part if you had cultivated this quality of consideration. Such a gesture with enormous benefits to others would not have cost you anything, nor would it have contributed a significant loss of time to your own journey even if you were running late for an event. The happiness you would have experienced by one such act of consideration is profound and you will be searching for more opportunities to do so. Besides, your act of consideration will motivate in an imperceptible way




the one who benefitted who will do the same for others having learnt and benefitted from your act. Additionally the karmic benefits of your wholesome deed will benefit you as well, as invariably total strangers will stop their own vehicles for you to move on when you encounter a similar situation.

This is only one example. ***Consideration*** *at all times and recognizing the needs of others* while driving, parking, opening a car door, approaching traffic lights, pedestrian crossings, etc. will go a long way in preventing accidents, easing congestion, and reducing stress. The beneficial impact of a single act of consideration is not confined to one road user who derived the direct benefit but will have ramifications of far reaching benefits to many including you.

**3rd. C-Courtesy**

Courteous drivers will make it a point to acknowledge a good gesture done by other road users. This may be in assisting to park, reverse, and facilitate to overtake a slow vehicle by giving room when overtaking is safe and signaling to do so. A smile, waving the hand or a gentle toot of the horn are ways of acknowledgement selected as appropriate to the situation and deemed safe.

Such simple gestures serve to attenuate impatience, irritability, anger, and rash risky maneuvers apart from bringing immense happiness to you and others.

Additionally, it will serve to soften your own heart and nurture within you the divine qualities of *Mettha* (compassion), *Karuna* (kindness), *Muditha* (altruistic joy) and *Upekka* (equaminity). Consider driving as an opportunity given to you to practice courtesy consistently, and in the process develop these divine qualities without devoting any additional time or place to do so. The road is the place for those who have a positive outlook to do good for oneself and others.

In conclusion it is an earnest request for all road users to apply the **3Cs** while driving. Do it ***consistently and mindfully.*** Practice will make it habitual and you will be able to do so with effortless ease all the time. In doing so you will contribute positively to prevent road accidents, traffic jams, stress and will bring a lot of happiness to others apart from savoring the overwhelming joy yourself, which would make the day a better one for you and others.

So remember and apply mindfully all the time when driving, the **3-Cs: Concentration, Consideration, and Courtesy.**

**Kill your Speed, Not Others**

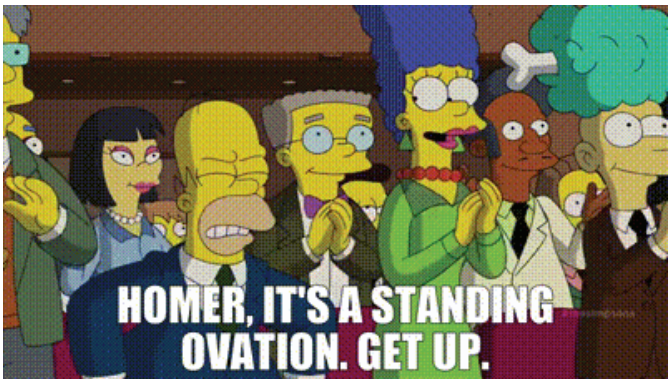
# A standing ovation: Is it an anathema to Sri Lankan audiences?

**Dr B. J. C. Perera**
*Specialist Consultant Paediatrician and Senior Fellow, Postgraduate Institute of Medicine of the University of Colombo.*

Anywhere else on this planet, away of course from this Pearl of the Indian Ocean, an audience is more than happy to show their superlative appreciation and gratitude for something fabulous and deserving, with a standing ovation. Sometimes it goes on for such a long time that it virtually becomes a performance in itself. Only an exceptional and extraordinary presentation or achievement is acknowledged by a standing ovation as it is something that is ever so singular and the ovation is reserved for the very best of the best. Quite often, what starts off as enthusiastic applause ends up as a crescendo of untouchable grandeur accompanied by a standing ovation with the entire audience on their feet, standing up in unison.

As an example, a unique and novel combination of gently and harmoniously descending scales over a scrupulously held chord near the end of a musical performance will very often lead to the fuelling of huge cheering and a standing ovation. Quite recently, when Roger Federer the great tennis player was felicitated following his retirement from the sport, there was an ecstatic standing ovation when he arrived. Even after several physical acknowledgements on his part, the standing ovation continued without any sign of dwindling, abating, or stopping for many a minute. Her Royal Highness Duchess of Cambridge and Princess of Wales who was standing next to Federer and applauding, had to gently coax him to sit down for the ecstatic ovation to die down. That standing ovation reflected the regard the tennis followers had for all that Roger Federer had achieved on tennis courts in many countries, as well as his iconic demeanour on a tennis court even in the face of fierce competition. It was an act of intense appreciation for a mortal not like anyone else.

However, all this is well and good but it is not to be in this emerald isle of Sri Lanka. An audience that is seated will only get up either to go to the washroom, to the sales outlets to get some food and drink or at the end of the entire event. They would stay seated, come rain or sunshine, as if their backsides were glued to the seats. A performer in a theatre, a stage or a playing field could present the most impossible performance; one of glittering splendour, and a Sri Lankan audience will provide rapturous applause but whatever happens, they will generally never stand up and give a standing ovation in unity and harmony. Occasionally when one or two or




three or even a few have stood up, others do not join the process, leaving the very few standing ones to appear as rather conspicuous misfits, or at worst, fools of a type.

On closer analysis, one does wonder why this is so. Is it because our people tend to think that nothing is so very special as to deserve a standing ovation? Is it because of a kind of *'I syndrome'* as there is a feeling that *'I am the greatest and no one can be greater'* in the minds of many people? Is it because there is a kind of cultural and behavioural barrier to our people providing a standing ovation to something that richly deserves it? Or is it that our people just cannot be bothered? As to the exact reason, your guess is as good as mine. One cannot believe that it is due to ignorance, as a standing ovation is seen regularly at many an event over the electronic and print media. It is there to see, the world over, even at the drop of a hat.

We do come across exceptional events and achievements in medicine in our resplendent isle. From time to time we see phenomenal research endeavours, ground-breaking efforts being presented as orations or even oral platform presentations of sheer artistic beauty. Some of these have even transcended barriers that would have stopped even lesser mortals in their tracks. Some of these are of such exquisite quality that they lift the presentations even onto a celestial level. They epitomise the saying *"A thing of beauty is a joy forever"*.

Perhaps it is time that we started this business of standing ovations in our medical circles. Of course, it is not at all necessary or even remotely desirable, to dole out a standing ovation to every Tom, Dick and Harriet who even talk of rather mundane things. It is not something that is to be presented to someone purely on the strength of a person's *"eminence"*. It has to be meticulously and ever so carefully reserved for something that is extraordinary, and extremely special; one of unquestionable brilliance and dazzling academic acumen or for a paradigm-changing achievement.

# SRI LANKA MEDICAL ASSOCIATIONCALL FOR ORATIONS

## Applications are called for the following Orations to be delivered atthe 137th Anniversary International Medical Congress 2024

### SLMA Oration

The SLMA Oration is the most prestigious Oration of the Association. Instituted in 1979, it recognizes outstanding achievement in research. It is delivered at the Inaugural Ceremony of the Annual Scientific Congress.

### Dr S C Paul Memorial Oration

The S. C. Paul Oration is the oldest Oration of the Association. Instituted in 1966, it is delivered in memory of Dr S C Paul, an outstanding surgeon. It is delivered on the second day of the Annual Scientific Congress.

### Dr S Ramachandran Memorial Oration

It is delivered during the Annual Scientific Congress of the SLMA.

### Prof N W D Lionel Memorial Oration

It is delivered during the Annual Scientific Congress of the SLMA.

### Murugesar Sinnetamby Memorial Oration

Instituted in 1968, this Oration is delivered in memory of Dr Murugesar Sinnetamby, an outstanding obstetrician and gynaecologist.

### Sir Nicholas Attygalle Memorial Oration

Instituted in 1975, this Oration is delivered in memory of Sir Nicholas Attygalle, an outstanding Obstetrician and Gynaecologist, the first Ceylonese Vice Chancellor of the University of Ceylon, and President of the Senate. It is delivered on the Second day of the Foundation Sessions of the Association.

### Sir Marcus Fernando Memorial Oration

Institute in 1969, this Oration is delivered in memory of Sri Marcus Fernando, an outstanding physician and the first Sinhala member of the Legislative Council.

### Guidelines for Submission

**The following documents should be submitted to the Sri Lanka Medical Association as hard copies**

1. The Oration should be written in full, and the script of the Oration should be submitted. The IMRADformat is suggested unless the content requires otherwise.
    a) A substantial part of the Oration should be based on original research.
    b) Orations based on work published in peer-reviewed journals will be given priority.
    c) For all research involving human or animal subjects, provide details of 'Ethical Clearance' in the methods section. Randomized Control Trials should have been registered in a WHO-recognized Clinical Trial Registry and the details of the same should be mentioned.
    d) The Oration should be typed using Times New Roman, size 12, double line spacing. Harvard orVancouver's system of referencing can be used.
    e) ***Seven (07) copies of the script should be submitted. Of the seven (07) copies, one (01) copy should be with the name of the author and six (6) copies should be without the name of the author.***

f) Each copy should be accompanied by a ***brief resume of the salient points on one sheet of paper (A4 size)*** indicating the contribution made to advances in knowledge on the subject. Further particulars may be obtained from the SLMA office.

2. The cover letter addressed to the Honorary Secretary, SLMA, should consist of

   a) The name of the Oration/Orations for which the manuscript should be considered.

   b) The Murugesar Sinnetamby Memorial Oration should preferably be on a topic on Obstetrics & Gynaecology.

   c) an explanation of why the applicant believes that the work is of sufficient merit to deserve an Oration

3. A separate sheet stating the list of the original papers/ publications on which the Oration is based (if applicable)

4. Conference presentations (both oral and poster) of the applicant cited in the Oration (if applicable).

5. A separate document with the following should accompany the submission.

   a) The impact of the research in terms of advancing scientific knowledge, quality of clinical care and improvement of service delivery.

   b) In the case of multi-author research and publications, the applicant should inform the other authors of their presentation and provide details of the contribution to the design, data collection, analysis and writing of the manuscript by the applicant.

   c) A declaration by the applicant that the other authors of the presented research have no objections to the submission of the Oration.

   d) The applicant should declare if all or part of the work included in the manuscript has already been presented as an Oration.

   e) Declaration of financial and other conflicts of interests.

***Your submission should be directed to the SLMA office addressed to the Honorary Secretary, 'Wijerama House', No.6, Wijerama Mawatha, Colombo-07).***

**All authors submitting orations should be LIFE MEMBERS OF THE SLMA (If you are not a member at present, please become a life member before forwarding your submission).**

**Closing date for the orations: 30th April 2024**

**(The closing date will not be extended)**

**Dr Lahiru Kodithuwakku**
**Honorary Secretary**
**Sri Lanka Medical Association**

**For further details, please contact:**

The Sri Lanka Medical Association, 'Wijerama House', No.6, Wijerama Mawatha, Colombo-07.

Tel: 011-2693324, Email: office@slma.lk

# SRI LANKA MEDICAL ASSOCIATION
# CALL FOR ABSTRACTS

**The Sri Lanka Medical Association invites you to submit abstracts for the 137th Anniversary International Medical Congress – 2024** ***(16th August – 18th August at Galadari Hotel, Colombo).***

***The deadline to submit abstracts is 30th April, 2024 23:59 Sri Lankan Time.***
All abstracts should be submitted via **https://www.slma.lk/abstract**

- Hard copy submissions to the SLMA office will not be accepted.
- One author will be permitted to submit a **maximum of three (03) abstracts**.
- **All authors of abstracts** should be members of the SLMA, if they are eligible for membership (doctors & medical students).
- All research studies should have obtained ethics approval. All clinical trials should be registered with a Clinical Trials Registry. Authors should provide the letter of approval from an accepted Ethics Review Committee (ERC) for research studies and registration number for clinical trials, upon request.
- The SLMA considers plagiarism as serious professional misconduct. All abstracts are screened for plagiarism and when identified, the abstract and any other abstracts submitted by the same author will be rejected.
- The SLMA reserves the right to edit the contents of abstracts to improve the quality of the presentation.

## INSTRUCTIONS FOR ABSTRACT SUBMISSION

### Guidelines

- The title of the paper should be concise and the SLMA reserves right to modify the title if necessary.
- The forwarded abstract should be in *Microsoft Word format*. The File name should be the *Title of the Abstract.*
- The document must consist of 2 pages; a cover page and the abstract.
- The cover page must contain the following
  - » Title of the abstract
  - » **Authors:** The author(s) name(s) should be in the format of last name followed by initial(s). Please DO NOT use prefixes such as Mr/Dr/Prof.
    - – The presenting author must be underlined. A superscript number should be placed after each name to refer to the respective affiliations. (eg.:- Perera AB[1], Silva CD[2])
    - – **Affiliations:** must be listed below the authors without their designations BUT only their place of work/ attachment
  - » Subject category: Please select the relevant submission category (Eg: Dermatology, Family Medicine…etc) from the list below and mention this on top corner of the cover page.

| | |
|---|---|
| Anesthesiology | Miscellaneous |
| Cardiology | Nephrology |
| Community Medicine | Neurology |
| Dermatology | Nutrition |
| Emergency & Critical Care | Obstetrics and Gynaecology |
| Endocrinology | Oncology |
| Family Medicine | Ophthalmology |
| Forensic Medicine | Paediatrics and Neonatology |
| Gastroenterology | Pathology |
| General Medicine | Pharmacology |
| Genetics | Psychiatry |
| Geriatric Medicine | Radiology |
| Health Informatics | Rehabilitation Medicine |
| Health Systems Research | Respiratory Medicine |
| Haematology | Rheumatology |
| Infectious Diseases | Sports and Exercise Medicine |
| Medical Administration | Surgery |
| Medical Education | |

- The second page must contain the following
  - » **Title: Bold sentence case.**
  - » **Body of the abstract:** Structured with the following subheadings:
    Introduction and Objectives,
    Method
    Results
    Conclusions
  - » **Font:** Times New Roman
  - » **Font size:** 12, single line spacing
  - » The body of the abstract MUST NOT exceed 250 words
  - » Please DO NOT include the names of the authors, institutions or any tables/graphs/figures or references within THE body of the abstract.

## 1. Important notices:

- Please note that NO amendments to the submitted abstracts (including the authors list) would be entertained after closing of submission.
- Abstracts not conforming to the above instructions will be rejected.
- A panel of reviewers will review abstracts anonymously and the decision of the Scientific Committee will be final. Successful applicants will be notified via email by slmaconf2024@gmail.com
- The presenting author is required to register for the sessions upon acceptance of the abstract.
- Please provide a name of a second presenting author (in case of a situation where the original presenting author is unable to attend).
- Failure to make a presentation (oral or poster) once participation is confirmed will be considered an episode of academic/scientific misconduct and the authors will be liable for punitive action.

Please provide the e-mail address and the mobile number of the corresponding author when submitting the abstract.

Please note that all submissions should be made electronically through the online Abstract Portal. More details will be uploaded on the SLMA conference website in due course (http://slma.lk/scientific-congress ).

**Dr Lahiru Kodithuwakku**
Honorary Secretary
Sri Lanka Medical Association

**For further details please contact:**
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No.6, Wijerama Mawatha, Colombo-07
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