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Cover Story
Pharmaceutical supply in Sri Lanka: Can we do it better?

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SLMA President

Dr Vinya Ariyaratne
MD, MPH, MSc Com. Med. MD Com, Med., FCCPSL
Specialist in Community Medicine,
Past President of College of Community Physicians of Sri Lanka,
President of Sarvodaya Movement

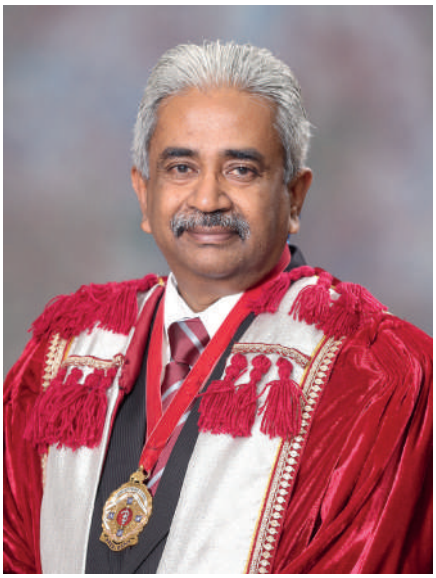
President's Message

Dear SLMA Members,

In this issue of the SLMA Newsletter, we focus on the grave problem of shortages of medicinal drugs in Sri Lanka. It is a problem that is having a significant impact on the health and well-being of our people. In the previous issue, we outlined the steps taken by the SLMA to address this conundrum which included the filing of a complaint at the Human Rights Commission of Sri Lanka (HRCSL). By now it is clear that the present crisis is not primarily the result of the economic crisis but that of serious mismanagement, including inefficiency, wastage and even possible corruption in the drug management cycle.

In this regard, the SLMA notes the landmark decision of providing interim relief by the Supreme Court of Sri Lanka on the 6th of April 2023 to suspend the importation of medicines from an unregistered foreign company, stating that serious doubts have arisen regarding the quality, safety, and efficacy of the products concerned. The Supreme Court also granted leave-to-proceed in a Fundamental Rights Petition filed by Transparency International Sri Lanka (TISL) in the public interest, which challenged, among other things, the non-compliance with procurement guidelines including emergency procurement process and the abuse of the process by the authorities.

At the recently held Induction Ceremony of the President of the Sri Lanka College of Medical Administrators (SLCMA), Justice Yasantha Kodagoda PC, Judge of the Supreme Court of Sri Lanka, who was attending the event as the



Chief Guest, made a strong appeal to the medical administrators to take up the issue of corruption and wastage as a priority area requiring their attention. He went on to say that *'I hope you will identify opportunities for corruption and wastage in within the health sector, and develop systems to eliminate such opportunities. I also hope that you will develop guidelines which can be adopted by the Ministry of Health, as administrative rules, so as to ensure objective decision-making while preventing decisions being taken for collateral corrupt purposes'.*

The message is clear. We as responsible professionals in the health sector need to act. Act now! As Justice Kodagoda emphasized, the policy of eliminating corruption and wastage and maintaining zero tolerance, cannot be sensitive or controversial, nor would it be politically or socially unacceptable or unpopular.

SLMA has taken this issue very seriously and will continue to advocate towards not only eliminating wastage and corruption in the health sector but also promoting rational prescribing and appropriate use of medicines. The Intercollegiate Committee of SLMA will play a crucial role in this regard and we urge the member Colleges and Societies to identify vulnerabilities for corruption and wastage in their respective disciplines and work with SLMA to urgently develop and implement a comprehensive plan to address the same. The SLMA also works on problems and issues related to Patient Safety and will organize sessions for doctors and other categories of healthcare staff, to update them on those matters.

During the previous month, SLMA took the lead to address some important public health issues that have surfaced which include reporting of suicides and the health impact of the prevailing extreme hot weather. Press briefings were held to educate the public on the precautions that need to be taken, which received wide publicity through the media.

As we are getting closer to the 136th Anniversary International Medical Congress of SLMA, scheduled for July this year, it is very encouraging to note the response received from the medical community in terms of a large number of abstracts/papers submitted for consideration. We request our members and others to register early for the Congress which will be based on the theme for this year *'Towards Humane healthcare; Excellence, Equity, Community'.*

Dr Vinya Ariyaratne
President SLMA.

Activities in Brief
(16th March 2023 - 15th April 2023)

SLMA Saturday Talks

18th March

'COVID and Afterwards: Impact on Suicide & Self Harm in Sri Lanka' by Professor Thilini Rajapakse, Professor in Psychiatry, University of Peradeniya

25th March

'Respiratory Infections in children: A Crash Course' by Ridma Jayarathna, Lecturer in Paediatrics, University of Sri Jayawardenapura

8th April

'Respiratory Trauma' by Dr Joel Arudchelvam, Senior Lecturer in Surgery, University of Colombo

15th April

'Critical Limb Ischemia: Getting the Basics Right' by Professor Ishani Rodrigo, Professor in Paediatrics, Sir John Kotalawela Defence University

Other Activities

17th March

The SLMA Expert Committee on Women's Health organized a symposium titled *'Empowering the Family in Critical Times'* to celebrate the International Women's Day 2023.

The topics of the lectures and the resource person are given below;

Dr Nisha Arunathilaka, Director of Research, Institute of Policy Studies on *'Economy at Home'*, Dr Enoka Wickramasinghe, Consultant Community Physician, Health Promotion Bureau on *'Prioritizing Needs over Wants for Better Health & Wellbeing'*, Dr Deepa Gunasekara, Senior Lecturer in Biochemistry, University of Kelaniya on *'Current Nutritional Issues in Sri Lanka'*, Dr Rajika Savanadasa, Medical Officer, Family health Bureau on *'A Nutritional Guide for the Whole Family during Times of Crises'*, Dr Pushpa Ranasinghe, Consultant Psychiatrist, Institute of Mental Health, Angoda on *'Stress, Anxiety and Violence at Home'* and Dr Vindya Wijayabandara, Consultant Psychiatrist, Provincial General Hospital, Ratnapura on *'Measures being Taken to Reduce Family Stress, Anxiety and Violence"*.

Professor Anurddhika Edirisinghe, Chairperson, Women's Health Committee, moderated the session.

20th March

A session of Expert Talks on *'Leptospirosis'* was held with the following participants; Dr Thushani Dabrera, Consultant Community Physician, Epidemiology Unit, Colombo on *'Epidemiology of Leptospirosis'*, Dr Wimalasiri Uluwattege, Consultant Physician, TH Karapitiya on *'Changing face of Leptospirosis'* and Dr Lilani Karunanayake, Consultant Microbiologist, MRI, Colombo on *'Role of the Laboratory in the Management of Leptospirosis'*.

21st March

A clinical meeting was held with the collaboration of the Sri Lanka College of Transfusion Physicians.

Dr Trilicia Withanawasam, Consultant Transfusion Physician, Sir John Kotalawela Defence University Hospital on *'Why we give BLOOD when we can do without it'*, Dr Nilantha Liyanage, Acting Consultant Transfusion Physician, National Hospital Kandy, on *'Transfusion related Adverse Events'* and a case presentation by Dr Nayanthara Silpage, Registrar in Transfusion Medicine, National Blood Centre,

Colombo, on 'Transfusion related Adverse Events'.

22nd March

A joint Regional Meeting was held by SLMA in collaboration with RDHS Office Batticaloa & Batticaloa Medical Association.

The theme for the regional meeting was *'Strengthening the peripheries: Reflections from the East'*

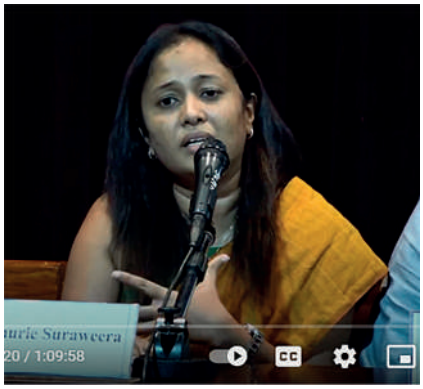
Ms Penny Jayawardena, Chairperson, Sri Sathya Sai Karuna Nilayam Foundation on *'Hope for the Little Heart - Introduction to the collaborative work'*, Dr Rajini Pandey, Head of the Department of Paediatric Cardiac Surgery, Sri Sathya Sai Sanjeewani Hospital, Raipur, India on *'Heart to Heart, The first ever Paediatric cardiac surgeries in Batticaloa: Experiences & Challenges'*, Dr S Vinothan, Consultant Cardiologist, TH Batticalao on *'From Vision to Reality: Cath Lab services in Batticaloa'*, Dr Vaithehi Rajeevan Francis, Consultant Microbiologist, TH Batticaloa on *'Anti-microbial Resistance: Are we capable to resist it?'*, Dr KT Sundaresan, Consultant Physician, TH Batticaloa, on *'Debunking fat & carb myths'* and Dr Dharshani Murugupillai, Medical Officer in Charge Provincial Health Training Centre, Eastern Province on *'Are we out of danger? Lessons learnt from population screening via PSSP Project in Batticaloa'.*

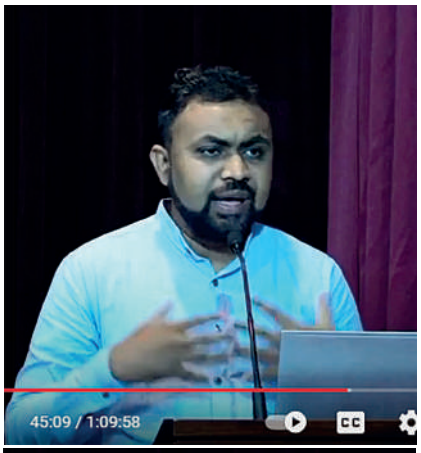
24th March

Two Guest Lectures were held at SLMA *on 'COVID 19: Controversies, Conspiracies and the Future'* by Professor Deepthi Jayasekara, Infectious Diseases Specialist, Los Angeles, USA and *'Management of Alzheimer's Disease: What's New?'* by Dr Ruvani Gunawardena, Medical Director & Consultant Neurologist, Centre for Brain & Neurocare, Affiliate John Hopkins University Hospital, Baltimore, USA

30th March

A media seminar on the topic *'Violence in Society: Impact on Mental Health'* was organized by the SLMA Media Committee. The resource persons were; Dr Chathurie Suraweera, Senior Lecturer in Psychiatry, University of Colombo, Professor Miyuru Chandradasa, Professor in Psychiatry, University of Kelaniya, Professor Mohamed Mahees, Professor in Sociology, University of Colombo and Mr Krishan Siriwardhana, Lecturer in Communication & Creative Art, University of Colombo





31th March

A joint symposium on '*Listeriosis: Another Epidemic on the Horizon*' was organized by the Sri Lanka College of Microbiologists and the SLMA

Dr JCP Rajendra, Consultant Physician, TH Ratnapura made a case presentation on '*Tragedy at the summit*', Dr Geetha Nanayakkara, Consultant Microbiologist, TH Ratnapura on '*Role of the Laboratory in Listeriosis*', Dr Thilanga Ruwanpathirana, Consultant Epidemiologist, Epidemiology Unit on '*Investigation process and the immediate preventive measures of the reported Listeriosis case*' and Dr Sujatha Pathirage, Consultant Microbiologist, MRI on '*Listeriosis as a food borne pathogen*'

31th March

A media seminar was organized by the Expert Committee on Prevention of Road Traffic crashes to make people aware on the possibility of increased road traffic accidents during the April New Year vacation and how to minimize / prevent them

The resource persons were Dr Surantha Perera, Dr Thushara Matiwalage, Dr Kapila Sooriyaarachchi, Mr Dilantha Malagamuwa and Mr Suneth Chithrananda

5th April

The SLMA Expert Committee on Medical Rehabilitation organized a virtual seminar on the topic '*Opportunities for All*' to raise awareness on issues faced by parents raising children with mental disabilities

The resource persons were; Dr Dilini Wipulagama, Consultant Community Paedeatrician, Dr KAD Punyadasa, Director, Special Education, NIE, Dr Pushpa de Silva, Consultant Psychiatrist, NIMH, Mr Priyantha Peiris, Vice President, Sri Lanka Para Olympics Committee and Mr Shamel de Andreo and His mother Ms. Lalani Perera

The session was moderated by Ms Wasanthi Nanayakkara, Senior Media Personnel, Derana Media Group

6th April

A discussion on '*Reducing RTA's during the festive season*' was held on Big Focus, TV Derana 24.

Dr Surantha Perera and Mr Dilantha Malagamuwa, participated on behalf of SLMA Expert Committee on Prevention of Road Traffic Crashes

7th April

Dr Vinya Ariyaratne President, SLMA attended a media discussion celebrating the World Health Day on TV1 '*Nagitimu Sri Lanka*' Programme.

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Pharmaceutical supply in Sri Lanka: Can we do it better?

Professor Priyadarshani Galappatthy
MBBS(Col),MD(Col),MRCP(UK),DipMedTox(Cardiff), FCCP,FRCP(Lond)
Chairperson, Medicinal Drugs Committe, SLMA,
Senior Professor and Chair Professor of Pharmacology
Faculty of Medicine, University of Colombo

Introduction

One of the main sectors that was seriously affected by the economic crisis in Sri Lanka, was the pharmaceutical sector. The World Health Organization (WHO) reported that Sri Lanka's economic crisis rapidly turned into a health crisis amid growing shortages of basic drugs and medical supplies (1). By January 2023, according to data from Medical Supplies Division (MSD) of the 383 essential medicines, 164 were reported to be out of stock in the MSD, although some stocks were available at the hospitals. Another 90 medicines were available in sufficient stocks only for one month, 38 medicines were sufficient only for 2-3 months and 18 medicines were available only for 3 months. Although the shortages were precipitated by the economic crisis, some aspects of the supply chain were noted to have lapses, which have contributed to these shortages. Identifying and rectifying these factors could lead to improvements of the pharmaceutical supply, preventing shortages in the future, while saving on expenditure on medical supplies. This analysis attempts to describe the role played by the major stakeholders and suggest some of the areas that could be improved in the supply of pharmaceuticals to the country.

Pharmaceutical market and expenditure on medicines in Sri Lanka

Medical and pharmaceutical expenditure of the country during 2020 was recorded at US$ 600 million (2). By 2022, the market was expected to reach a value of US$ 750 million, posting a five-year annual growth rate of 4.1%. Currently, 84.6% of pharmaceutical needs are imported and about 15 local manufacturing plants including SPMC provide the balance 15.4% of the requirement with an estimated value of Rs 18 billion annually. As per the World Bank data, Sri Lanka's total health expenditure (both public and private) as a share of Gross Domestic Product (GDP) was 4.08 % in 2019 (3). Comparison of expenditure, to the income group Sri Lanka belongs to, the lower-middle-income countries (LMIC), South Asian countries and other countries in the world in 2000 and 2019 is given in Table 1. The latest GDP in Sri Lanka, given for 2021 is 88.93 billion USD with a per capita GDP of 4,013.69 USD.

Table 1 Health expenditure as a percentage of Gross Domestic Product (GDP)

Total health expenditure (both public and private) as a share of Gross Domestic Product (GDP)	2000	2019
Sri Lanka	4.3	4.1
lower-middle-income countries (LMIC)	3.8	3.8
South Asian countries	3.7	3.1
All countries in the world	8.6	9.8
Sri Lanka's **public** health expenditure	2.3	1.5
Public health expenditure of LMIC	-	1.5
South Asia	-	1.0

Source : World bank, health expenditure as a percentage of GDP

Public sector health expenditure

Sri Lanka's **public** health expenditure amounts to 1.5% of GDP, and comparison to LMIC and South Asian countries is also given in Table 1. Public health expenditure is similar to the average public health expenditure of LMIC, while it is higher than the regional peers in South Asia (4). The total health expenditure in 2017 was around LKR 479 billion, and that of 2018 was around LKR 559 billion, respectively (5). In 2019, the Sri Lankan Government spent 23% of its healthcare budget, ie, LKR 54 billion of the total LKR 235 billion on medicines. Sri Lanka's total pharmaceutical expenditure covering both state and private sectors in 2022 was estimated to be LKR 163 billion per annum, and about LKR 58 billion for the state sector and LKR 105 billion for private sector. Capital investments made on the health sector for the same years were Sri Lankan rupees billion 44.3 and 40.2, respectively. Per capita health expenditure in 2017 was LKR 22,314 while in 2018 it was LKR 25,778 (5).

The annual budget estimate for importing medicines and surgical consumables is 300 million US dollars. As of January 2023, Sri Lanka was still facing a funding gap of 220 million US dollars to import essential medicines and supplies (1). Sri Lanka's government owed LKR 25.7 billion in arrears to foreign pharmaceutical suppliers. These figures indicate how the economic crisis affected the pharmaceutical supplies in the country as non-payment of bills resulted in delayed or non-supply of pharmaceuticals (6). In the 2021 budget, the supply of pharmaceuticals and consumables received LKR 60.7 billion. This is a comparative reduction by 29% relative to the 2020 revised budget allocations of LKR 85.8 billion.

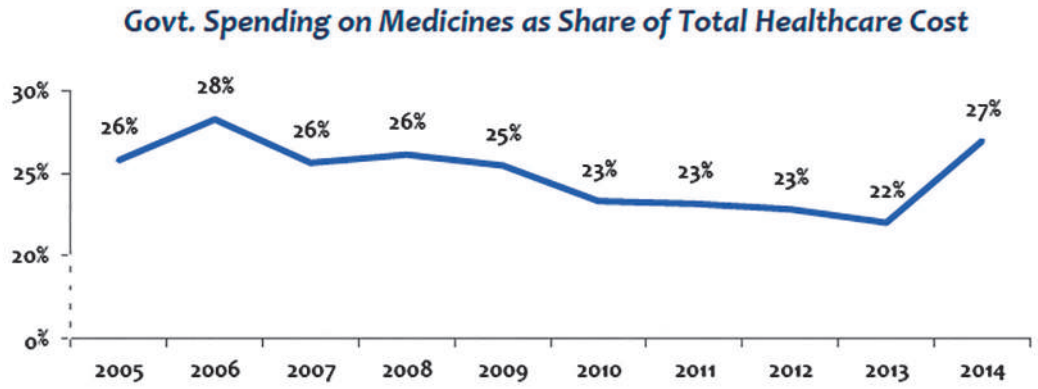

Figure 1 : Government Spending on Medicines as Share of Total Healthcare Cost (Reproduced from reference 6)

Health sector performance of Sri Lanka prior to the crisis

Sri Lanka significantly outperformed its peers on major health indicators, such as in reducing child and maternal mortality rates and in increasing life expectancy at birth (7). Sri Lanka's child and maternal mortality indicators are already lower than the relevant targets set under the sustainable Development Goals (SDGs) and are on par with those of developed countries. The national immunization program of Sri Lanka also has an excellent record, with low incidence of Expanded Program on Immunization (EPI) disease and more than 95% coverage for all EPI vaccines. There has also been considerable progress in eliminating several communicable diseases, including malaria, polio and filariasis.

Considering the availability and affordability of medicines, several studies conducted over the years report availability of selected essential medicines as high (>80%) or fairly high (50-80%) in both public and private sectors in Sri Lanka (8-9) according to WHO categorisation of availability of medicines. Most medicines were also affordable to the lowest income earners in the community (8-9). WHO emphasise that as a country that has performed consistently well on key health indicators with significant achievements well above the fellow countries in the income group, it is imperative to ensure progress is not rolled back (1).

Pharmaceutical supply process in government sector

The pharmaceutical supply to the state sector in Sri Lanka involves several stakeholders and interplay among them is crucial for an efficient supply system. The key stakeholders include the Medical Supplies Division (MSD), the National Medicines Regulatory Authority (NMRA), the State Pharmaceuticals Corporation (SPC) the local pharmaceuticals manufacturers, including State Pharmaceuticals Manufacturing Corporation (SPMC) and the pharmaceutical importers. The representatives of the professional medical colleges and associations serving many technical committees of the NMRA, MSD and SPC, who provide technical support to the supply chain at various points, the hospital administration both under the line ministry and provincial ministry as well as the government treasury under the finance ministry providing finances for purchasing, are also key stakeholders. During the crisis period the various donor agencies and other donors locally and globally continue to be important suppliers that needs consideration. All medicines imported for the state sector are procured through the SPC while the MSD and hospitals also procure some emergency supplies directly. The important role of these key players is described below with suggestions on how their role could be improved.

National Medicine Regulatory Authority

The regulatory body for pharmaceuticals in Sri Lanka is the National Medicines Regulatory Authority (NMRA). The NMRA Act of 2015 provides the legislative framework and is the legal authority to regulate and control the manufacture, importation, sale, storage and distribution of pharmaceuticals, nutraceuticals, and devices. The NMRA is the institution in which the Ministry of Health (MoH) has vested the authority to implement

the provisions of the Act, ensuring that pharmaceuticals and medical devices are made available to the public efficiently and effectively to meet the required standards of quality, and that they are within the existing legislative framework with respect to the production, marketing and dispensing of these items.

The main objective of the NMRA is to ensure that all pharmaceuticals available in Sri Lanka are safe, efficacious, and of acceptable quality. NMRA also has the responsibility of regulating medicines prices through price controls, regulation of clinical trials, monitoring of suspected adverse drug reactions, conducting quality checks on samples, recalling from the market on safety grounds and control of advertisements of medicinal drugs. There were 8,095 registered products at NMRA, including medicine, vaccines, and devices (10).

After careful evaluation of information submitted in a dossier, products are approved for registration by the Medicines Evaluation Committee (MEC) of the NMRA which meets monthly. The MEC comprises of representatives of all the major colleges, pharmacologists, Pharmacists and chaired by the Chairman NMRA or its Chief Executive officer (CEO).

Waiver of registration

All medicines that are made available to the public require registration except when a waiver of registration is granted in exceptional circumstances, as stated in the NMRA Act. Under section 109 of NMRA Act, the Authority may grant permission in special circumstances to import and supply a particular pharmaceutical product in specified quantities of a medicine without registration. The special circumstances include a medicine used to save a life, to control an outbreak of an infection or an epidemic or any other national emergency or for national security. The NMRA has also published guidelines on requirements to grant WOR, available on the NMRA website. However, it is noted from the list of medicines granted WOR, that requests for granting WOR have now become very common. Often WOR is granted when there are no registered suppliers for items required for government tenders of the MSD. Several applications are regularly received for WOR for government tenders due to either not having any registered suppliers or the registered suppliers not quoting for tenders due to many reasons, including non-payment for previous supplies due to the economic crisis. Often for medicines required in small quantities that are not profitable, companies are not interested in obtaining registration.

The list of products submitted for WOR at each MEC meeting on the NMRA website gives information on whether the request was granted or, if not, reasons for not granting approval. The reasons for not granting WOR include the availability of registered suppliers, the price quoted being too high, requesting doctor not giving justification for the request, MSD having sufficient stocks etc. Over time, it is noted that purchasing medicines through WOR has become a regular phenomenon rather than an exceptional event, and this could jeopardise the quality of pharmaceuticals supplied to the country. A detailed analysis of reasons for submissions for waiver of registration and rectifying the reasons for any identified unjustified requests need to be addressed urgently, to minimise the purchases to the MSD through the WOR pathway.

As WOR become more common, recently, there were several issues raised regarding granting approval for WOR for a large number of medicines, without the approval of members of MEC by the administration of the NMRA. There were reports of political interference in the registration process by granting WOR to several pharmaceuticals without adherence to guidelines, which led to several professional organisations, including the SLMA, complaining about this matter to relevant Authorities, informing the public, and even seeking legal action. Strictly implementing the available guidelines for WOR, insisting that all applicants submit all the required documents and taking steps to further revise the guidelines appropriately, to limit the applications for WOR is urgently required, to ensure quality and safety of pharmaceuticals supplied through the Ministry of Health.

While so many applications are submitted for WOR, it is also noted that for some commonly used medicines such as atorvastatin, metformin, and losartan, which are the 3 most commonly prescribed medicines in the country, there are over 50 registered products. Some medicines for which there was a large number of registered products have also been submitted for importing through the WOR pathway. There are many products registered such as gabapentin, and sildenafil, which are noted to be prescribed irrationally and abused by patients, through self-medication. Therefore, while there are no registered products for some needed medicines, there is a surplus of registered products for some other medicines, which becomes a burden for the short-staffed NMRA. Prioritising and expediting the registration process of essential medicines, which has a lower number of registered products and increasing the NMRA staff by obtaining special permission during the time of state sector recruitment ban, could be done to improve the NMRA functioning for a more efficient registration process.

The MSD could also add another requirement to the tender conditions to the existing 36 conditions, requesting any supplier not registered with the NMRA to apply for WOR to the NMRA at the point of applying for

the tender, submitting all the required documents given in the WOR guidelines. This will require all applicants who are not registered to apply for WOR, instead of the only one selected for the tender and would allow time for the NMRA to review the applications while the tender process is progressing. The NMRA should also include a clause to say that any supplier who applies for a government tender should submit the product for the normal registration process afterwards, and those who fail to do so should not be awarded subsequent government tenders to supply the product without registration.

(Part 2 of the Article will be published in the May Issue)

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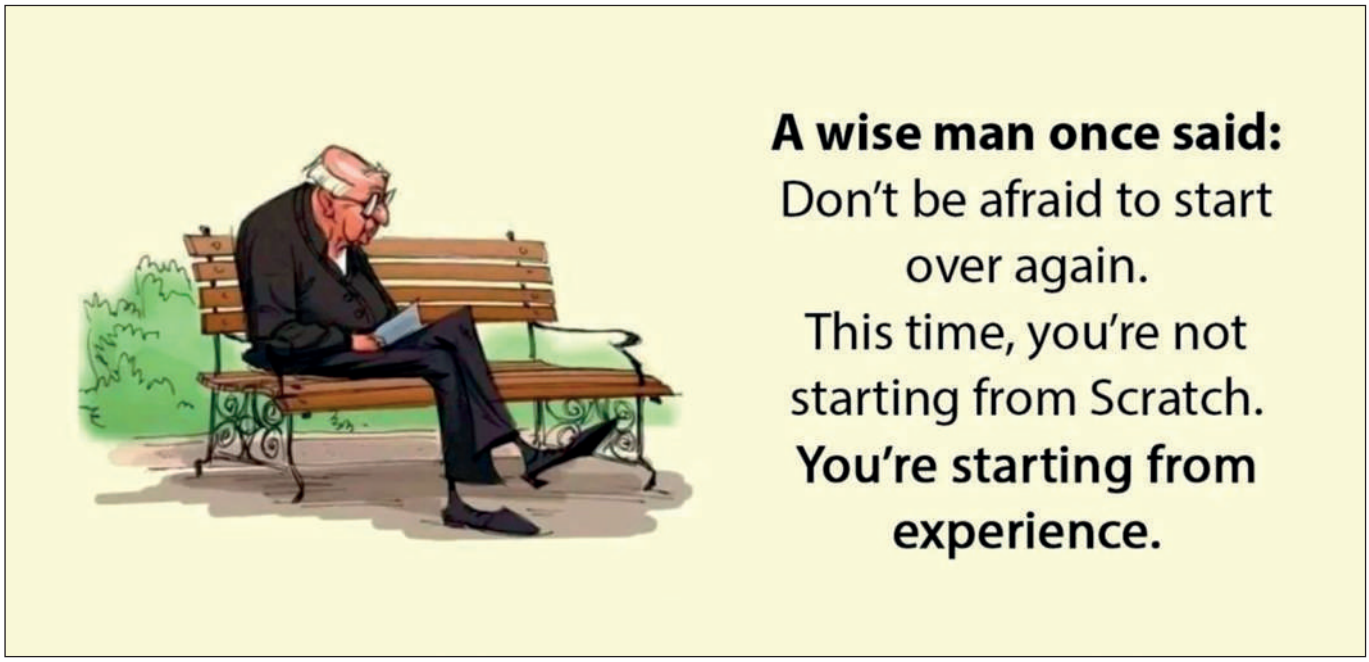

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Diagnostic laparoscopy was introduced over 100 years ago. It gained wide acceptance in the 1960s, with the development of improved visibility due to advances in fiberoptic technology. Initially, it was used mainly by gynecologists to diagnose pelvic disease and to perform simple procedures, such as tubal ligations. During the 1980s the video camera was introduced and was used in combination with the laparoscope (1). As a result, it became possible to perform therapeutic procedures with the use of diathermy after inflating the abdomen with 2-3 L of carbon dioxide to create a space for visualization. Carbon dioxide is used because it is non-toxic, very soluble, and less likely to cause air embolism. Laparoscopic surgeries also require a strong light source, video processor and high-quality video screens. To obtain working space in the abdomen a pressure-triggered gas insufflator with gas-tight trocars is required. The trocars allow smooth passage of specially designed instruments of different diameters. Laparoscopic procedures are technically more demanding for the surgeon, because of the loss of sensation and high demand of eye-hand coordination for safe use of the intraabdominal instruments. It requires excellent team work and the whole team needs to be familiar with the setting and the equipment.

Laparoscopic surgery (LS) had its initial impact on the management of patients with symptomatic gallstones, acute appendicitis and intraabdominal adhesions. With the development of better energy sources and vessel sealing devises surgical laparoscopy has expanded in the past few decades to include all abdominal surgical procedures. The advantages of laparoscopic surgery include less post-operative pain, shorter hospital stay, early return to normal activity and smaller surgical scars.

As the indications for LS have broadened the number of contraindications has reduced drastically. At present the only contraindications are haemo-dynamic instability and uncontrolled coagulopathy. However, as conversion to open surgery may be required during the procedure it is mandatory to obtain consent for conversion at the time of obtaining consent for LS.

Laparoscopic Cholecystectomy

This is one of the most commonly performed laparoscopic surgeries. It is considered the gold standard treatment for symptomatic gall stones. It can be performed in the presence of complications of gall stones ie acute cholecystitis, mucocele and empyema. When it was introduced in the late 1980's it was associated with a higher incidence of bile duct and vascular injuries. However, with improved fiberoptics and better training of surgeons the incidence of these injuries has reduced to levels which are comparable with open surgery. Conversion rates from laparoscopic to open cholecystectomy have also reduced significantly over the years. It is possible to perform per-operative cholangiography during laparoscopic cholecystectomy to delineate the anatomy of the biliary tree in difficult cases and to identify common bile duct (CBD) stones. Although the preferred method of managing CBD stones is therapeutic Endoscopic Retrograde Cholangiography (ERC), these stones can also be extracted by laparoscopic CBD exploration, which could be done either through the cystic duct or by directly opening into the CBD. In such cases the CBD could be closed over a T tube or a biliary stent. Laparoscopic cholecystectomy can be performed as a day case procedure and it has resulted in much shorter hospital stay, smaller scars and early return to work and to other normal activities.

Laparoscopic Appendicectomy

Appendectomy is the standard treatment for acute appendicitis and it is one of the most commonly performed abdominal surgeries. Laparoscopic appendicectomy (LA) was first performed by Kurt Semm in 1983, and it was initially thought that the procedure did not result in much patient benefit as open appendicectomy could be performed through a small muscle spitting incision. However, numerous studies have shown that LA was associated with shorter operation time, less intraoperative blood loss, quicker recovery of gastrointestinal function, shorter period of hospitalization and a lower incidence of surgical site infection (2).

Laparoscopic Colorectal Surgery

Colorectal surgery is most commonly performed for colorectal cancer but also for complicated diverticular disease, inflammatory bowel disease, familial adenomatous polyposis and rectal prolapse. The

procedures performed for these conditions include hemicolectomy, sigmoid colectomy, anterior resection, abdomino-perineal resection, total proctocolectomy and rectopexy. All these procedures are laparoscopically feasible. Although laparoscopic surgery takes longer it gives better short-term results including reduced blood loss, earlier return of bowel function and early mobilization. Laparoscopic colorectal cancer surgery gives comparable oncological resection margins and lymph node clearance compared to open surgery with comparable disease-free survival (3). More recently, robotic surgery has gained popularity in colorectal surgery due to its ambidextrous capability, 3-dimensional view, and tremor elimination (4).

Laparoscopic rectopexy for rectal prolapse results in lesser postoperative pain, lesser hospital stay, and better patient satisfaction than open rectopexy.

Laparoscopic Fundoplication

Laparoscopic fundoplication is the standard surgical treatment for GERD. It is highly effective in curing GERD with a 80% success rate at 20-year follow-up. Many randomized studies and meta-analyses have shown that laparoscopic fundoplication is superior to open surgery. The Nissen fundoplication, consisting of a total (360°) wrap, is the most commonly performed antireflux operation. To reduce postoperative dysphagia and gas bloating, partial fundoplications are also used, including the posterior (Toupet) fundoplication, and the anterior (Dor) fundoplication. Currently, there is consensus to advise laparoscopic fundoplication in PPI-responsive GERD for those patients who develop untoward side-effects or complications from PPI therapy. PPI resistance is the real challenge in GERD. There is also consensus that carefully selected GERD patients refractory to PPI therapy are eligible for laparoscopic fundoplication, provided that objective evidence of reflux as the cause of ongoing symptoms has been obtained. For this purpose, impedance-pH monitoring is regarded as the diagnostic gold standard (6).

Laparoscopic cardiomyotomy for achalasia

Laparoscopic cardiomyotomy is one of the most commonly performed procedure for the treatment of achalasia. Good to excellent symptom improvement occurs in over 80% of patients with a low operative mortality. It is considerably superior to injection of botulinum toxin and balloon dilatation. However, per-oral endoscopic cardiomyotomy has shown to give comparable relief of dysphagia. The most significant early complication of myotomy is perforation of the esophageal mucosa especially in patients who have undergone previous balloon dilatation. When suspected, it is mandatory to rule out a perforation intraoperatively by endoscopic inspection and insufflation and repair any mucosal defect (6).

Laparoscopic Bariatric and Metabolic Surgery

Bariatric and metabolic surgery was not popular prior to the advent of laparoscopy because of large wounds and wound related complications such as seroma formation, deep wound infections and incisional hernias which were difficult to treat in morbidly obese patients. Laparoscopy has revolutionized these surgical procedures mainly due to the fact that wound related complications have been minimized. Mortality was found to be lower for laparoscopic bariatric procedures compared to open surgery .

At present, all bariatric restrictive and malabsorptive procedures including sleeve gastrectomy, gastric bypass and duodenal switch are performed laparoscopically and open surgery for morbid obesity has become obsolete. The number of bariatric procedures has also increased exponentially in recent years due to laparoscopy (7).

Laparoscopic Splenectomy

Laparoscopic splenectomy has been established as a safe and feasible minimally invasive procedure. It can be used in almost all cases of splenectomy, with better results than open splenectomy in terms of intraoperative and postoperative complications. However, there are some situations, such as splenic trauma, in which the role of laparoscopy is not widely accepted. Hand Assisted Laparoscopic Surgery (HALS) is useful in the resection of larger spleens.

Laparoscopic liver Resections

Laparoscopic resections for benign liver tumours, hepato-cellular carcinoma and liver metastasis in colorectal have been shown to be superior to open surgery. However, these advanced procedures have a long learning curve as they require much surgical expertise.

Laparoscopic procedures of doubtful benefit

Studies have shown that there is no difference in short-term mortality between laparoscopic and open oesophagectomy or gastrectomy. The safety and efficacy of laparoscopic pancreatico-duodenectomy is also questionable with some clinical trials showing a higher 90-day mortality compared to open surgery. These difficult laparoscopic procedures can only be performed safely by experienced surgeons in large volume centers.

Complications of Laparoscopic Surgery

Most of the complications unique to laparoscopic surgery ie vascular and visceral injuries occur during

access to the peritoneal cavity. Other specific procedure related complications are similar to those encountered in open surgery. Opinion is divided as to the safest entry technique, and clinical practice is variable. In general, gynaecologists commonly use a closed method of entry and other surgical specialties routinely use an open methods of entry (8). Vascular injuries to the aorta, inferior vena cava iliac arteries and veins as well as visceral injuries to the large and small bowel have been reported in laparoscopic surgery.

Newer Developments

During the past two decades, minimally invasive surgery has continued to evolve to minimise operative invasiveness and to improve post-operative cosmetic results. Single incision laparoscopic surgery has been shown to be effective in complex procedures such as colorectal surgery and splenectomy.

Robotic surgery is considered to be one of the greatest advances in minimal access surgery recent years. Robotic surgical systems were developed in part to solve several constraints of laparoscopic surgery and offer technical advantages. It provides a 3-dimensional view of the operating field and greater flexibility of movement and eliminates the tremor of the surgeon during complex maneuvers. There is a substantial body of evidence that demonstrates its superiority over laparoscopic surgery in the treatment of rectal cancer and prostate cancer

In recent years the use of intravenous Indocyanine Green has been shown to be a safe and practical tool to identify anatomical structures, to verify devascularization of tissues and to identify safe resection margins in oncological surgeries.

In conclusion, laparoscopic surgery has many surgical applications in current surgical practice. In most cases laparoscopic procedures are beneficial compared to open surgery, However, surgical laparoscopy requires expensive equipment and greater surgical expertise. In general, advanced laparoscopic procedures take longer to perform than corresponding open procedures. Therefore, laparoscopic and open surgical procedures should be tailored to the individual patient considering the costs and benefits.

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Lesson in Neurology: Localizing the lesion in weakness

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A simple task such as holding a cup involves first an intention to do it, and then translating that into precise, coordinated movements of groups of muscles to achieve the desired action. This is carried out by the motor pathway system in the nervous system. Motor system in addition is capable of using the same pathways to allow us to carry out more complex tasks like running, dancing and cycling which need much precision. Higher-level motor control involves the pre motor and supplementary motor cortices interacting with the basal ganglia and the cerebellum. The motor plan devised by these circuits is transmitted down the corticospinal pathways to stimulate the relevant motor peripheral nerves that activate the muscles involved in that movement.

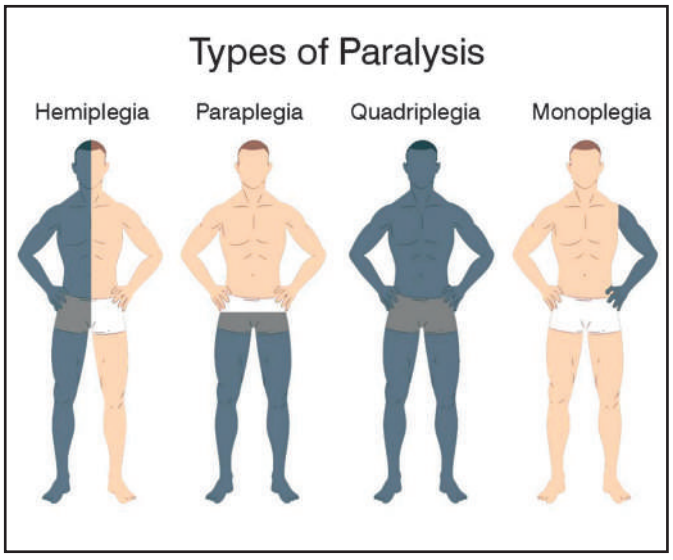
The motor system can be divided into the pyramidal system and the extrapyramidal system. The pyramidal system consists of the corticospinal tracts that start in the cerebral hemispheres, brainstem, and spinal cord. The extrapyramidal system includes the basal ganglia and cerebellum which serve to initiate, pattern, and coordinate movements. Lesions in the pyramidal system produce weakness, lesions in the cerebellum produce impaired coordination of movements causing ataxia and dysmetria and lesions in the basal ganglia can alter muscle tone causing rigidity and increase or decrease of movements.

The pyramidal system has two main components. They are upper motor neurons in the central nervous system and lower motor neurons in the peripheral nervous system. The upper motor neurons begin in the precentral gyrus of the frontal lobe and travel in the corticospinal tracts through the subcortical white matter and anterior brainstem, decussating in the lower medulla and descend in the contralateral pyramidal tracts in the spinal cord. The axons synapse with the lower motor neurons in the anterior horn of the spinal cord. Axons of the lower motor neurons travel through ventral roots into peripheral nerves and end at the neuromuscular junction. Any lesion occurring in the motor pathway will result in weakness.

The severity and the pattern of weakness will depend on the location and extent of the lesion. Hemiparesis is a term used for partial weakness of one side of body and hemiplegia refers to complete paralysis. Determining the **distribution of weakness, associated examination findings** (reflexes, muscle bulk and tone, fasciculations) and **additional non motor findings** (abnormal cognition, sensation, sphincter function) and time course of symptoms and signs help in formulating the differential diagnosis of the cause.

Distribution of Weakness

Localization of the lesion in the motor pathway causing weakness is dependent on the distribution of the weakness. Weakness that involves one side of the body (hemiparesis) is caused by a lesion in the opposite side cerebral hemisphere, brainstem, or same side spinal cord.



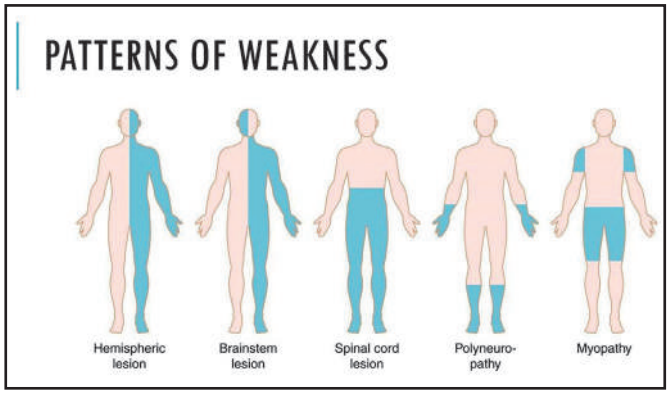
When there is facial weakness with a cortical lesion the facial weakness will be upper motor neuron type and on the same side, but if the facial weakness is of lower motor neuron type with limb weakness on the opposite side, the lesion will be in the brainstem Pons. This is because the facial nucleus is in the pons and the pyramidal motor tracts crosses below the pons in the lower medulla.

Weakness on one side arm and leg with face spared will be due to lesions in the motor pathway at the level of lower medulla or in the cervical spinal cord. Small lesions (lacunar infarcts) in the internal capsule can also

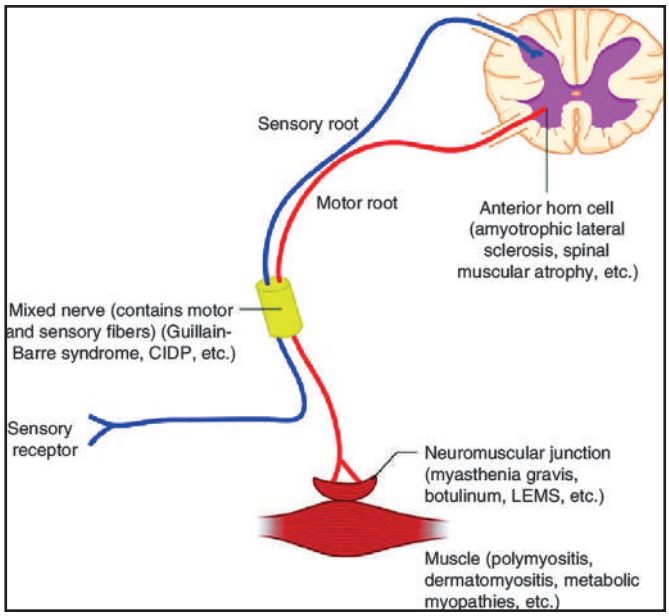
produce a similar pattern.

Weakness affecting the extensors more than the flexors in the upper limb and flexors more affected than the extensors in the lower limb suggest an upper motor neuron lesion in the hemispheres. Weakness affecting one limb only (monoparesis) can be due to a small lesion in the motor cortex, a lesion in the spinal cord or an extensive plexus lesion. Weakness affecting part of a limb can be due to a lesion at the level of nerve roots, nerves, or muscles. Bilateral symmetric weakness suggests a lesion at the level of the spinal cord, peripheral nerves, or muscles. Bilateral proximal weakness in the arms and legs is suggestive of a myopathy. Bilateral distal weakness is usually due to peripheral neuropathy commonly.

Patterns of Weakness



Peripheral nervous system lesion sites



Characteristics of weakness and accompanying signs

Weakness without any sensory changes and with normal reflexes suggest a problem at the level of neuromuscular junction or muscle.

Hyperreflexia, increased tone, Babinski sign are suggestive of a lesion in the central nervous system but these signs may be absent in the acute stage if the weakness is of sudden onset.

Areflexia, flaccidity, fasciculations and muscle atrophy are seen in lesions of the peripheral nervous system.

Motor neuron disease causes motor weakness and wasting without any sensory impairment and may have in addition UMN signs.

Myasthenia gravis results in weakness that affects limbs, trunk, cranial nerves except the pupils and a characteristic feature being fatiguability of the affected muscles.

Exercise induced weakness, pain and cramps are a feature of metabolic myopathies.

Additional nonmotor symptoms and signs

Higher function deficits such as aphasia, hemianopia and hemineglect suggest a hemispheric lesion. Cranial nerve signs associated with contralateral motor deficits of limbs suggest brain stem lesions. Bowel and bladder dysfunction points to a spinal cord or cauda equina lesion.

Generalized Weakness

Acute generalized weakness though uncommon, represents a life-threatening problem from respiratory muscle paralysis and requires prompt attention. Generalized weakness indicates involvement of upper and lower limbs, the trunk and cranial muscles. Guillain Barre syndrome is the most common disorder of acute generalized weakness. Acute porphyria, Organophosphate poisoning, hypokalaemia, snake bite and myasthenia gravis are some other conditions that should be considered in the differential diagnosis.

An Icon is no more

Emeritus Professor of Paediatrics
Priyani Elizabeth Soysa
By
Dr B. J. C. Perera
Specialist Consultant Paediatrician

That fantastic lady, an intensely reputed *persona grata* of eminence, as well as a teacher of immense repute, one who lit up the field of paediatric healthcare over an entire lifetime, Emeritus Professor of Paediatrics, Deshamanya Priyani Elizabeth Soysa MBBS(Cey), DCH(Eng), MD(Cey), DSc (Ruhuna) *Honoris causa*, FRCP(Edin), FRCP(Lond), FRCPCH(UK), FCCP(SL), FSLCPaed, and Fellow of the National Academy of Sciences of Sri Lanka, most peacefully bid *adieu* to this mortal world on Good Friday the 7th of April 2023.

The 97 years that she had spent on this planet earth, where she served our Motherland to her last breath, is one of seminal significance for the services she provided in caring for children. As a student and a mentee of hers, I am deeply saddened and heartbroken by her demise and am quite sure that many others in the medical profession, as well as those members of the general public who have come under her captivating influence, would share those very same sentiments. She will always be remembered as an unmatched change-maker in the paediatric scenario.

How does one start and where does one end in recounting the details of the lifetime of a person who lived a kind of life that defies even rational exposition? Needless to say, young Priyani Elizabeth De Mel had excelled as the brightest of stars at her alma mater, Princess of Wales College in Moratuwa. Then her meteoric sojourn as a student in the Colombo Faculty of Medicine culminating in First Class Honours in the Final MBBS Examination was the forerunner to a dedicated career that saw her go higher and higher in her academic pursuits. An acclaimed clinician and a researcher of repute, she functioned as a paediatrician in various parts of the country including Jaffna and then became the first woman in Sri Lanka to be appointed to a Professorial Chair. That occurrence came about when she succeeded her guru and mentor, Professor C. C. de Silva, as the Professor of Paediatrics in the Faculty of Medicine, University of Ceylon and subsequently the University of Colombo. She held that exalted position as the Chair Professor of Paediatrics for 25 years before retiring in 1991. We share nostalgic memories of this fantastic personality, who in addition to all her sublime qualities, was also a most capable administrator and a policy maker; one who had a vision that she pursued through a resolute pathway of unbridled commitment.

Professor Priyani Soysa is well-known and supremely recognised for many a battle that she fought, very often in a single-handed dedication towards the welfare of little children in our country. When she assumed duties as the Chair Professor of Paediatrics, the subject of healthcare of children was just a part of Adult Medicine in the Faculty of Medicine. Professor Soysa managed to convert paediatrics into a subject in its own right that was tested in the Final MBBS Examination.

Professor Soysa had an abiding interest in childhood nutrition. Long before the current scientific evidence regarding the crucial importance of nutrition in the physical and mental well-being of children emerged, she fought a valiant skirmish to ensure proper nutrition for children. Malnutrition was rampant in the country at the time she assumed the high office of the Chair of Paediatrics. Professor Soysa became an unwavering advocate of exclusive breastfeeding of all babies for the first six months of life. In that endeavour, she fought a lone but heroic battle against the might of the infant formula food manufacturers. Artificial cow milk-based formula foods were the fashion of the Western world and it was no mean task to fight against the Western manufacturers of these infant foods. Professor Soysa declared all-out war on them and their overt and even subtle efforts at jeopardising the exclusive breastfeeding initiatives. She worked ever so hard to change the mindset of Sri Lankan mothers from bottle feeding to breastfeeding. This was such a great achievement as at that time breastfeeding was not considered to be 'fashionable or trendy.'

As the undisputed champion of exclusive breastfeeding, Professor Soysa played a major role in securing maternity leave for working mothers and that effort tipped the balance against the infant milk food industry, truly and

most decisively. The fact that today we have an over 90 per cent rate of exclusive breastfeeding in the first six months of life is the eternal testimony to her work as the undisputed winner of that initiative. Her work in that respect has shown a pivotal influence, not only in Sri Lanka but globally as well.

Among the very many endeavours that she was involved in paediatric care in Sri Lanka, yet another one that stands above most, is her dedication and commitment towards the eradication of polio from our land. Polio was a killer and those children who survived after contracting the disease were left maimed for life with paralysis of limbs. The author of this article has seen three epidemics of the disease in his medical student days and in the early part of his career. Professor Priyani Soysa was at the forefront of the vaccination initiative of the Ministry of Health to prevent children from contracting the disease. The golden testament to all the efforts at preventing the disease is the fact that the last virologically confirmed case of polio in Sri Lanka occurred as far back as 1993, 30 years ago.

Professor Priyani Soysa is a Past President of the Sri Lanka Paediatric Association (now known as the Sri Lanka College of Paediatricians), the Sri Lanka Medical Association and the Sri Lanka Association for the Advancement of Science. As a gesture of genuine appreciation, the Sri Lanka Medical Association, the oldest medical organisation in Asia and Australasia, awarded her the Honorary Life Membership during its 125th Anniversary celebrations in 2012. In grateful recognition of her services to the country, the government of Sri Lanka bestowed on her the coveted national honour of Deshamanya in a glittering investiture ceremony at Nelum Pokuna Theatre in 2017, attended and presided over by the Executive President of Sri Lanka.

In addition to being a splendid academic, Professor Soysa was a marvellous family person, devoted to her husband, the reputed ENT Surgeon Deshabandu Dr Ananda Soysa, who predeceased her in 2019. They have four daughters, Dharini, Chandini, Keshini and Thilina, to whom Madam Priyani was an exemplary mother. Those who have had the privilege to be at a meal in the Soysa household would vouch for the abilities of Professor Priyani Soysa as an accomplished chef as well. It is no easy task to combine all these superlative qualities with a most successful academic life but Madam Soysa just took it in her stride.

The medical paediatric fraternity of Sri Lanka owes her a lot. Many of us have learnt the basics of paediatrics from her. But then, what we learnt from her goes even further than that. In a personal anecdote, I know for sure how she responded to a problem that myself and my allocated working partner had with a family that was assigned to us for the Social Paediatrics appointment when we were doing the Professorial Paediatric appointment in our final year in the Faculty of Medicine. That family was so poor that they lived a frugal hand-to-mouth existence. We noticed that they did not have a toilet. When the good professor was grilling us during discussions that involved the entire group of medical students, I was forced to tell the professor that the lack of a toilet was the least of their problems when they did not know where the next meal was coming from. I put my hand up and told her told her "*Madam, if we go and talk to them about latrines, they would chase us out as it is the least of their problems.*" The good professor did not say anything and most pensive in her thoughts. We found out later that she had used her own personal funds to build a toilet for that family. She had done it without telling anybody and without any fanfare. It just went to show that beneath her professorial strict façade, there was a very kind heart that was capable of exhibiting the wonderful quality of empathy.

One could write reams about our guru Professor Priyani Soysa. However, even then, we would not be able to get through all that we want to say. Her daughters and the members of the immediate families are sure to feel the intense pain of losing a loved one who was definitely like no other. We hasten to proclaim that their loss is our loss as well.

No doubt a company of angels would have escorted her to her divine heavenly abode on the 7th of April 2023. On the 10th of April 2023, we saw her for the last time when we took part in the final rites for her mortal remains. We were tremendously honoured and greatly privileged to join her on her last journey on earth, even in pouring rain, which probably was the lamentations of the heavens on the demise of a great person.

Dear Madam Priyani Elizabeth Soysa, you will stay in our hearts forever, till we meet again, perhaps at some time in the future.

Once a thing of grandeur; but now in the doldrums of an appalling abyss of gloom

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The National Health Service (NHS) of the United Kingdom was the proudest and the most fantastic facility that all citizens of that country were intensely delighted to have, even just under 50 years ago. That is first-hand information from this author who had the privilege of working over there as a postgraduate doctor during his mandatory training period as a practising NHS doctor before being appointed as a Specialist Consultant in Sri Lanka.

In those halcyon days, our leanings towards the NHS as well as our connections with it made it virtually imperative that we got the final polishing of our vocation in the UK. All of us who trained over there learnt many things in that alien environment including the invaluable commitment to put the patient first in all our dealings. There was hardly any waiting time for all emergencies that were brought in to be attended to and referrals to consultants were promptly dealt with, within a maximum of one week. As a Registrar in General Medicine, this author has dealt with all emergencies within a matter of minutes. All referrals of admitted patients to another unit were dealt with inside of a couple of hours. The NHS functioned like a well-oiled machine performing at its best at all times, day and night. The axiom of the NHS was never to allow a patient to perish without a fight.

In a normal course of progression, one would expect even a very fine healthcare institution such as the NHS, to get even better with time. However, what has happened is exactly the opposite. In an article titled ***Satisfaction in NHS has now dropped to the lowest level ever recorded thanks to long waiting times and widespread staff shortages,*** published on 29th March 2023, Hanna Geissler, the Health Editor of the Daily Express Newspaper laments that shockingly long waiting times and widespread staff shortages have led to the public losing faith in the NHS, a statement based on a damning report titled British Social Attitudes Survey. Satisfaction in the National Health Service of Great Britain has now dropped to the lowest level ever recorded, thanks to the massive backlog in treatment caused by the COVID-19 pandemic. It was indeed a double whammy of shortages of staff and a pandemic causing unparalleled misery.

Although the public still overwhelmingly supports the NHS's founding principles, including the provision of completely free healthcare at the point of delivery to all British citizens, just 29 per cent of the respondents in the survey said they were now satisfied with it. The crisis in the NHS means 7.2 million people were waiting for further assessment and treatment in January 2023, with 3 million of them having to wait for over 4 to 5 months. The battle to try and reduce the backlog has been hampered by low staffing levels with around 137,000 unfilled posts across the NHS and more recently by industrial action by several grades of healthcare professionals. The latest findings for 2022 have been published by the think tanks; The Nuffield Trust and The King's Fund. Co-author Dan Wellings, a senior fellow at The King's Fund, said the results should ring "*loud and continuous alarm bells in the corridors of power*". He added: "*It is easy to become desensitised to the relentless flow of bad news about struggling health services, but we cannot underestimate the significance of today's unprecedented results. In 2010, satisfaction with the NHS stood at a record high of 70 per cent. Yet, satisfaction has now plummeted to its lowest-ever level, at just 29 per cent. People are struggling to get the healthcare they need, particularly in an emergency, which is borne out by the extraordinary spike in dissatisfaction with Accident and Emergency Services.*" He concluded by saying "*It is still the thing that makes us proudest to be British but these results are very clear – it is not working for large numbers of people right now.*" To compound matters further, there has been industrial action being brought about by junior doctors from time to time, which has completely ruined the ability of the struggling NHS to provide the necessary services.

What is not working right now is a National Health Service in the UK that is under-staffed, and overworked, with disgruntled workers, as well as healthcare staff, being made to work under very difficult conditions. Dissatisfaction in a winter of discontent has led to many echelons of healthcare workers, especially the doctors and nurses leaving the country in droves to seek greener

pastures abroad. This is compounded further by the failure of the NHS to attract young people into healthcare services, including the medical profession. Some highly specialised portals like newborn medical services known as neonatology have been made to feel the pinch even more than other healthcare providing services.

The fundamental problem is not shortages of medicines, nor is it a telling lack of infrastructure. It is a dreadful dearth of human resources across all strata of the NHS. Those who still work in the NHS are dissatisfied with their poor pay and difficult working conditions. Many areas of the healthcare provision services are terribly understaffed, stretched to the maximum and also made to work under the most trying conditions. The average waiting time to be attended to in emergency services in hospitals could be as long as 4 to 6 hours. Even ambulances that have brought in severely ill patients are made to wait in line at the Emergency Services to get the patients attended to. There are documented instances of patients losing their lives while waiting to be attended to at the Out-Patient facilities and Emergency Services. The referral services where medical specialist attention is required and requested are left in the lurch with consultation appointments being given sometimes at several months long periods. Routine surgical operation services have very long waiting lists. All these are such drastic changes from the situation that prevailed half a century earlier. It is indeed quite a bleak scenario at present.

Now then…, let us look at the situation in our resplendent little isle. Of course, it is common knowledge that our health services too have had some significant and even drastic problems. Shortages of essential drugs, healthcare personnel resorting to trade union action, and staff shortages created by a significant exodus of healthcare workers; mainly doctors seeking greener pastures abroad, have been the bane of the National Health Service of Sri Lanka. In addition to all these woes, the patients were made to suffer for a couple of days when healthcare staff resorted to strike action. Although it is a service free of charge at the point of delivery in government healthcare institutions. out-of-pocket expenses for patients went through the roof due to the non-availability of quite a few drugs.

Yet for all that, even with a multiplicity of problems in our system, our scenario is nowhere even near as bad as it is in the UK at present. Even during all these trying times in Sri Lanka, emergencies were attended to without delay, even when healthcare staff were on strike. Staff were exempted from resorting to strike action in maternity hospitals, children's hospitals and those units and hospitals providing cancer care. Referrals to consultants were attended to within a very short time. Specialized care was also available in the private sector for those who could afford it. All in all, ill patients were not left to die without the staff fighting tooth and nail in providing the best possible care for the sake of their patients.

True enough, the Sri Lankan National Health Service has had its fair share of problems. The newly implemented draconian tax structure has imposed unbearable hardships on healthcare personnel. They have been made to protest and even resort to trade union actions. Loads of them are going abroad for greener pastures as the grass always looks greener on the other side. However, the general populace of our country also has short memories. They will not remember for very long the number of times healthcare personnel have gone even beyond the legendary extra mile for their patients. They will not remember how the healthcare personnel put their collective shoulder to the wheel to deal with the miserable COVID-19 pandemic, not so long ago at that.

Let us face the current situation with some gratitude and resilience as the provision of healthcare services in Sri Lanka at present is far better than that provided by the NHS in the UK. Most unfortunately, judging by all reports, that is the inevitable conclusion arrived at by this author who was trained to be a Specialist Consultant in the very same UK National Health Service, in what now looks like aeons ago.

(This was initially published in The Island Newspaper on 06th April 2023)

EUROPEAN HEAVEN AND HELL

European Heaven is where:

All the cops are British,
All the wine is French,
All the cars are German,
All the lovers are Italian,
The weather is Greek,
And everything is organized by the Swiss.

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All the wine is German,
All the cars are Greek,
All the lovers are Swiss,
The weather is British,
And everything is organized by the Italians.

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