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SLMA NEWS+

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Hypothyroidism: treating to improve the quality of life

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Suicide and self-harm: in the context of the COVID-19 pandemic

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Ending AIDS by 2030

Page 16-19

Looking back at '2022' and planning ahead

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1 Keep fit be active

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3 Check & control your blood sugar

4 Check & control your blood pressure

5 Take appropiate fluid intake

6 Don't smoke

7 Don't take over-the-counter pills regular basis

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* https://www.worldkidneyday.org/facts/take-care-of-your-kidneys/8-golden-rules/

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SLMA President

Prof. Samath D. Dharmaratne
MBBS (Colombo)
MSc (Community Medicine)
MD (Community Medicine)
President
Sri Lanka Medical Association

President's Message

Dear SLMA Members,

With a true sense of joy, fulfilment, gratitude and satisfaction, I take this opportunity to reflect on Sri Lanka Medical Association (SLMA) for the year 2022.

It was indeed a privilege and an honour to be the 128th President of the SLMA. I, together with our Council of 2022 took on the duty of maintaining the high standards expected of the SLMA.

I and the Council of the SLMA, started our tenure of office in the aftermath of the COVID-19 pandemic, with the effects of its devastating mortality and morbidity still in the air.

Then came the economic crisis, with its devastating effects on the health sector, the social disturbances with the breakdown of communal harmony, fuel shortage with long queues together with its associated travel restrictions, food shortages and their inevitable consequences and electricity shortages.

It was quite challenging with disagreements, even within our profession and the SLMA, on issues directly and indirectly affecting the SLMA, health sector and health care. The emotions were high; the reactions were unfathomable, and these affected every stratum of society, with a huge public outcry. An open discussion, based on facts and figures, national needs, and particularly the changing needs and expectations of our society, could not be addressed on a professional platform. I can state here without any hesitation that the wide mix of our own Council and members of SLMA Expert Committees, had diverse opinions for the reasons and for the solutions to the crisis affecting our Motherland. Numerous meetings, discussions, letters, inquiries, agreements, and disagreements were common. Respect to the views of the majority, considering Past Presidents' advice, and good will of the majority, brought some degree of sanity to the SLMA.

On a somewhat brighter note, let me take you on the journey of the SLMA during the past year.

I and the SLMA Council for 2022, took office on December 22, 2021, at the AGM with the theme, "Planetary health and global health security". This particular notion was chosen to reflect, remind and address the threats to humans on the planet earth. Even though not the first calamity in human history, COVID-19 left its legacy and consequences on human health. Therefore, that specific theme was selected as it was thought to be opportune for the situation.

Our tenure of office started on January 3rd with a religious ceremony at the SLMA, with the participation of clergy from all religions practised in Sri Lanka. This was followed during the ensuing year with seven orations, nine monthly clinical meetings and two regional clinical meetings, ten media briefings, fifteen seminars, lectures, and symposia. The 'Saturday Talk' was held every Saturday, from January 8th to December 17, 2022, without a break. SLMA published six media statements, addressed directly to policy makers on protecting the health of the citizens of Sri Lanka.

The SLMA established the 'SLMA Relief fund', to address the shortages of medicines and equipment in the health sector with a US Dollar account, the first of this nature ever.

The 135th Anniversary International Medical Congress 2022, the first with physical participation, after two years, was held from September 28th to October 1st at the BMICH. The congress was inaugurated on September 28, 2022, followed by the SLMA oration. The much-awaited Doctor's Concert was held in-person after a lapse of two years on the evening of October 1st at the BMICH.

The Foundation Sessions of the SLMA was held in November 2022.

The Medical Dance 2022 was a resounding and memorable event. Held after two years, our ability to bring the long-standing tradition of the Medical Dance to fruition so well, was remarkable. This was a huge team effort that was enjoyable and quite exceptional. It was held on December 16, 2022, at the Cinnamon Grand in Colombo.

The Law-Medical cricket match followed the dance at Colts on December 18th, 2022. Most unfortunately, we lost it by the narrowest of margins.

The SLMA was able to renovate and repair parts of the building and renewed the contracts with the colleges renting rooms in the SLMA. This made us generate much-needed additional income.

Just a reminder, I, and the Council of the SLMA lost valuable time due to various problems and issues facing the country during our tenure. Our achievements would have been even greater and more substantial if only we had the usual complement of a full year, uninterrupted by many an unavoidable occurrence over which we had very little control.

I conclude with the very best of my compliments and heartfelt wishes to all for the Christmas Season and the New Year 2023.

Professor Samath D. Dharmaratne
President - SLMA

Looking back at '2022' and planning ahead

At this time of the year, it is the usual practice to look back and reflect on the past year. By January this year, the COVID pandemic was coming under control, and there was hope that 2022 would be better than 2021. But we were disappointed as the economic and political crisis that followed turned out to be far worse than the effects of COVID.

With the unprecedented economic and political crisis, citizens' trust in the government collapsed and the people could no longer stay silent. Suffering from the scarcity of basic food items, fuel and medicines, people from all walks of life came out on the streets in protest with no overt involvement of the mainstream political parties. This was the start of the ARAGALAYA, a movement hitherto unprecedented in the country.

The ARAGALAYA resulted in the fall of a powerful President elected by a massive 69% of the people's vote less than two years earlier.

Instead of the 'complete system change,' the people demanded, the country received an interim President who had failed to get enough votes at the elections to win a seat in the current parliament. This was all in accordance with the country's constitution but quite contrary to the aspirations of the people.

The ARAGALAYA appears to have faded away, at least for the time being. Instead of the system change, we are now in a situation where even for a protest march, the people have to obtain written permission from the police. Professionals such as lawyers were with the people during and after the ARAGALAYA doing their best to protect basic human rights enshrined in the constitution.

The country is facing the worst healthcare crisis in its 74-year post-independence history, resulting in an increase in childhood malnutrition and severe shortages of essential medicines. It's extremely sad to see the rapid deterioration in our health indicators. Even as a low-middle income country, spending only 3.2% of our total budgetary expenditure, we had exceptional healthcare indicators on par with economically developed countries. In 2004 the BMJ had an issue on 'Health in South Asia'. One editorial by eminent international authors was titled - "Is there hope for South Asia? Yes, if we can replicate the models of Kerala and Sri Lanka" (BMJ 2004;328:777-8). Not even two decades later, in December 2022, the BMJ had an

editorial titled - 'Sri Lanka's health crisis - Urgent action is needed to maintain vital services.' (BMJ 2022;379:e073475). It's hard to believe that our health system has declined to such a pathetic state in less than two decades.

Nearly six million Sri Lankans- three in every ten households- are food insecure in the face of an 80% inflation rate for food. UNICEF estimates that over two million children in Sri Lanka require humanitarian assistance at present. Poor diets and missed meals increase the risk of non-communicable diseases through conditions such as hypertension and dyslipidaemia. The government has recognized food shortages as a key priority in its strategic planning. But when the facts are there for all to see and local and foreign sources report on drug shortages and malnutrition the Minister of Health denies these facts in the parliament.

During times of crisis like this, it is important to look back at what the SLMA has done so far as an apex organization of medical professionals. When the doctor who revealed the facts about childhood malnutrition months ago was suspended from his job, we as an organization were silent - not even a statement was issued. One of the key factors that resulted in medicine shortages was that the computer system that was supposed to monitor medicines from purchase to distribution was not working. The cost of the computer system was several hundreds of millions of rupees. Again we as an organization, did nothing.

As we look back at what happened and see what is likely to happen, what steps should the SLMA take? Shouldn't we take a more active role in voicing our opinion, or should we limit ourselves to just issuing statements with no follow up action? Shouldn't we take a step forward by organising public/ media conferences that discuss the true, current situation based on facts? Shouldn't we defend our members who are being penalised for voicing their professional opinion? Shouldn't we be thinking of peaceful protests even in the vicinity of our organisation? - It may be easy for us to obtain the Police permit.

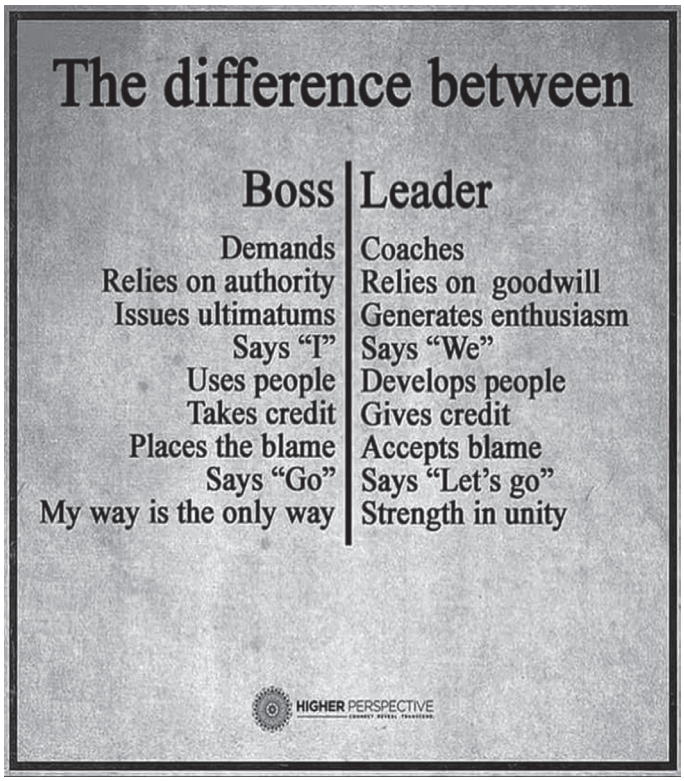
"Power concedes nothing without a demand. It never did and it never will" - Frederick Douglass.

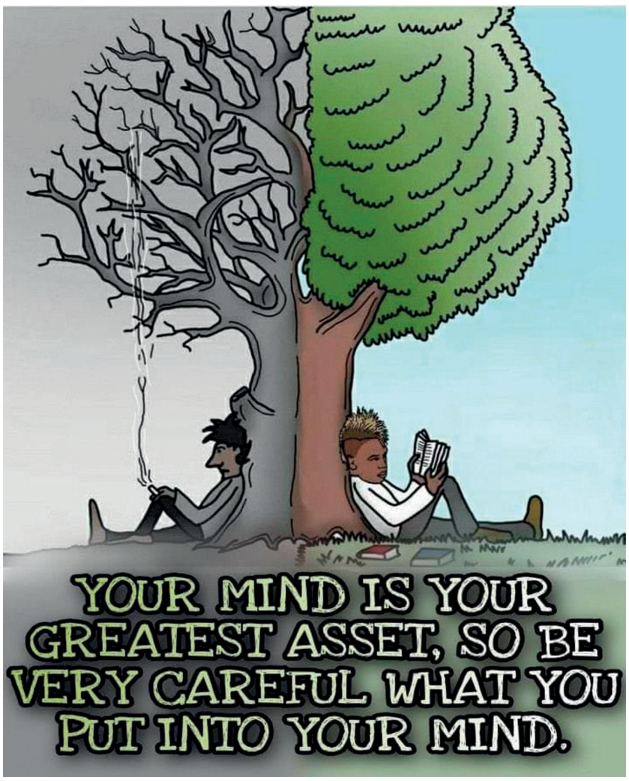
"Injustice anywhere is a threat to justice everywhere" - Martin Luther King Jr

Dr Kumara Mendis
Dr Sumithra Tissera

Co-Editors of the Newsletter

Disclaimer: This cover story reflects the considered opinions of the Co-Editors and may not necessarily be the views of the President, Council and the general membership of the Sri Lanka Medical Association (SLMA)





Activities in Brief
(16th November – 23rd December)

SLMA Saturday Talks

19th November

'Current Management & Update on Burns' by Dr Gayan Ekanayake, Consultant Plastic Surgeon, NHSL, Colombo.

26th November

'Long Case in Bronchial Asthma' by Dr Surantha Perera, Consultant Paedeatrician and Dr Channa de Silva, Consultant Paediatric Pulmonologist.

'Long Case in Nephrotic Syndrome' by Dr Surantha Perera, Consultant Paediatrician and Professor Randula Ranawaka, Consultant Paediatric Nephrologist.

10th December

'Approach to Kidney Disease' by Dr Dilushi Wijayaratne, Lecturer in Clinical Medicine, University of Colombo & Consultant Nephrologist, NHSL, Colombo.

2nd December

Expert Committee on Communicable Diseases of the SLMA in collaboration with the College of Sexual Health and HIV Medicine organized a symposium on 'Ending AIDS by 2030'.

The resource persons and the topics of discussion are given below;

'Current Situation of the HIV Epidemic' by Dr KAM Ariyarathne, Consultant Venereologist, NSACP, 'An Update on HIV' by Dr Geethani Samaraweera, Consultant Venereologist, NSACP & President, Sri Lanka College of Sexual Health and HIV Medicine, 'Diagnosis of HIV' by Dr. Jayanthi Elvitigala, Consultant Microbiologist, NSACP and 'Ending AIDS by 2030 in Sri Lanka' by Dr. Nimali Jayasooriya, Consultant Venereologist, NSACP. An interactive discussion followed the lectures.

5th December

The Expert Committee on Medical Education organized a webinar on 'Current Trends in Teaching Basic Sciences in Medical Education' and a Launch of the books authored by Professor Indika Karunathilake & Dr Sajith Edirisinghe, Senior Lecturer, Faculty of Medicine, University of Sri Jayawardenapura on 'Simplified Atlas of Neuro-anatomy & Anatomy Lower Limb - Study Companion for Medical Students'.

The resource persons were Professor Indika Karunathilake, Professor in Medical Education, Faculty of Medicine, University of Colombo, Professor Harsha Dissananyake, Professor & Consultant Radiologist, Faculty of Medical Sciences, University of Sri Jayawardeapura and Dr Sajith Edirisinghe, Senior Lecturer in Anatomy, Faculty of Medical Sciences, University of Sri Jayawardeapura.

9th December

The Expert committee on Non Communicable Disease (NCD) organized a webinar on the topic 'Safe Food before the TASTE for a Healthy Nation' with the collaboration of World Initiative for Soy in Human Health (WISHH/ASA) at the Shangri-LA Hotel, Colombo.

The welcome address was done by Mr Alan F Poock, Director Asia Divison for ASA's WISHH Programme and the Introduction to the workshop was done by Dr Renuka Jayatissa, Chairperson on SLMA NCD Subcommittee and Head, Department of Nutrition, MRI.

The other presentations were one by;

Dr Athula Mahagamage, In country Representative (SL), ASAs WISHH Programme on 'The WISHH Programme in Sri Lanka', Dr Haley Oliver, Director of the USAID Feed the Future Food Safety Innovation Lab/ Senior Research Fellow at the Krach Institute for Tech Diplomacy at Purdue on 'Introduction to the USAID Feed the Future Food Safety Innovation Lab - A Research Portfolio Overview', Dr Thilak Siriwardana, Director & Acting Deputy Director General, Environmental and Occupational Health & Food Safety, Ministry of Health on 'Import control of food in Sri Lanka and Food Safety assure system at Local Market', Dr Haley Oliver on 'Overview of Good Manufacturing Practices', Dr Bhanuja Wijetilaka Consultant Community Physician, Food administration unit, Ministry of Health on 'Implication of Aflatoxins and Prevention' and Dr. Haley Oliver on 'Clean then Sanitize - The Importance of Sanitation Programs in Food and Healthcare'.

A Question & Answer session followed the lecture. The Closing Remarks were given by Dr Renuka Jayatissa and the Vote of Thanks by Dr Sidath Wijesekara, Secretary, NCD Committee, SLMA.

13th December

A joint clinical meeting was organized with the collaboration of the College of Otorhinolaryngologists & Head and Neck Surgeons of Sri Lanka.

The resource persons and topics of discussion are given below;

'Managing a Patient With Vertigo: What Is New' by Dr. MTD Lakshan, Consultant ENT and Head & Neck Surgeon and 'Managing Acute Upper Airway Obstruction: Tracheostomy care' by Dr. Vasanthika Thuduvage, Consultant ENT and Head & Neck Surgeon.

20th December

Expert Committee on Communicable Diseases of the SLMA organized a symposium on 'Meningococcal infection in Sri Lanka: A newly emerging threat'.

'The Epidemiological Situation' by Dr. Sashimali Wickramasinghe, Consultant Epidemiologist, Epidemiology Unit, Ministry of Health, 'Clinical Presentation' by Professor Panduka Karunanayake, Department of clinical Medicine, Faculty of Medicine, University of Colombo and 'Laboratory Diagnosis and Update on Local Situation' by Dr. Lilani Karunanayake, Consultant Clinical Microbiologist and Head, Department of Bacteriology, Medical Research Institute, Colombo.

The Annual General Meeting 2022

The AGM of the SLMA was held on 23rd December 2022 at the NDW Lionel Memorial Auditorium with the participation of more than 50 members.

Professor Samath D Dharmaratne, President SLMA welcomed the members and gave a brief summary of activities done during the year. Professor Ishan de Zoysa, Honorary Secretary, SLMA presented a very detailed account of all activities undertaken in 2022. Professor Hasini Banneheke, Honorary Treasurer, SLMA presented the treasurers report and shared the audited accounts for the year.

Dr Vinya Ariyaratne was confirmed as the 129th President of the SLMA for the year 2022/23. He addressed the gathering and introduced 'Towards Humane Healthcare: Excellence, Equity, Community' as his theme for his year of Presidency.

Dr Sajith Edirisinghe was confirmed as the Honorary Secretary.

Doctors vs Lawyers Annual Cricket Encounter 2022

The 15th Annual Cricket Encounter between the SLMA Doctors and the Lawyers of the Bar Association of Sri Lanka (BASL) was held on 18th December 2022 at the Colts Cricket Grounds.

Although the doctor's team put up a fight the lawyers were victorius at the end. The Doctors team batting first scored 192 all out in 39.5 overs and the Lawyers scored 194 for 9 wickets in 37.5 overs.

The President of the BASL, Mr Saliya Peiris joined, Vice President of the SLMA, Dr Surantha Perera to award the winner's trophy to the captain of the Lawyers team.

Prof. Indika Karunthilake, Past President of the SLMA a member of the Doctors Cricket team himself, was also present throughout the match to cheer our team.

A six a side women's soft ball match followed the main cricket match. This was also won by the Lawyers.

However, the participation of doctors to see the match was very disappointing. As hosts, we should have been more considerate towards our guests, the lawyers, who were present in significant numbers.

SLMA Medical Dance 2022

Dr Pramilla Senanayake
Dr Christo Fernando
(Joint Social Secretaries)

The SLMA Medical Dance was held on 16th December 2022 at the Oak Room, Cinnamon Grand, Colombo after a two year lapse due to the COVID-19 Pandemic and the social restrictions imposed by the Government.

The council with all the members of the Dance Committee and the office staff worked very hard to organize this event looking in to every aspect of arrangements, logistics and the finer details to make this a very memorable event to all the attendees.

There were around 200 guests who had a really wonderful time dancing to the excellent and scintillating music provided by the Band 'Flame'. They set the tempo for the rest of the evening. The band and DJ Naushad took turns at short intervals to provide excellent and continuous music for dancing. The compere for the show was the inimitable Clifford Richards.

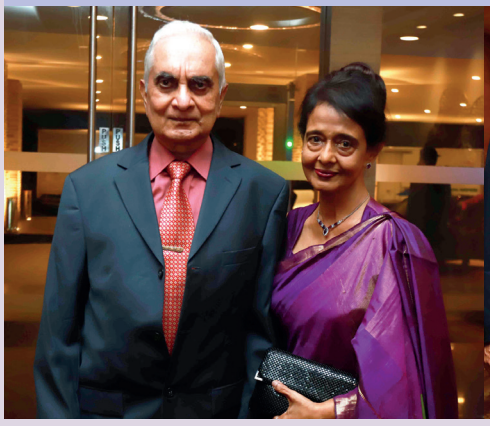
Two dances by 'With my Feet', trained by Naomi Rajaratnam kept the audience enthralled by their excellent dancing routines.

The excellent spread of the buffet was opened at 9.45 pm which was very much enjoyed by all present.

During the dinner, Seasonal Christmas Carols were presented by Dr Nilanka Anjalee Wickramasinghe ably backed and supported by members of the Faculty of Medicine, Colombo, Choir.

Many grand prizes were awarded to the winners of the table/ entrance ticket draw and jive/ baila contests during the event.

There was no doubt at all that everybody enjoyed the proceedings tremendously and had a rollicking time. The general opinion of all was that it was a night to remember and cherish. The curtain raiser to the SLMA activities for 2022.










Hypothyroidism: treating to improve the quality of life

Dr. Nethrani Pathirana

(MBBS, MD, Senior Registrar in Endocrinology, National Hospital of Sri Lanka)

Dr. Dulani Kottahachchi

(MBBS, MD, MRCP, Consultant Endocrinologist & Senior Lecturer, Faculty of Medicine, University of Kelaniya)

Thyroxine is an essential hormone affecting the development and metabolism of virtually all organ systems in the body. When deficient, it impairs the overall quality of life and leads to various medical issues. However, with improved awareness among clinicians and patients and increased screening, hypothyroidism is diagnosed more frequently before it gives rise to severe comorbidities. Following the correct diagnosis, with just a daily dose of thyroxine and regular TSH testing, we can do miracles to our patient's quality of life.

What are the causes of hypothyroidism?

Hypothyroidism can be primary, secondary, or very rarely tertiary. In primary hypothyroidism, the thyroid gland itself is diseased. In secondary and tertiary hypothyroidism, there is insufficient stimulation of the normal thyroid gland due to inadequate TSH secretion from the pituitary or inadequate TRH secretion from the hypothalamus, respectively1. Worldwide as well as in Sri Lanka, primary hypothyroidism is the most prevalent.

Sri Lanka, which is now considered an iodine-replete country (following the introduction of iodization of table salt), autoimmune thyroiditis, also known as Hashimoto thyroiditis, is the commonest cause of primary hypothyroidism, followed by iatrogenic, infiltrative, and drug-related causes. Congenital hypothyroidism, though rare, is an important cause.

A few interesting drug-related causes of hypothyroidism require special mention. With the introduction of several immunomodulatory therapies in recent years, the use of immune checkpoint inhibitors has risen. A well-known complication of this group of drugs is hypophysitis leading to secondary hypothyroidism. Another noteworthy drug is amiodarone, used in treating arrhythmias, which can lead to hypothyroidism and hyperthyroidism. Lithium, commonly used as a mood stabilizer in bipolar affective disorder, also causes thyroid dysfunction1.

Who should be tested for hypothyroidism?

In the presence of symptoms

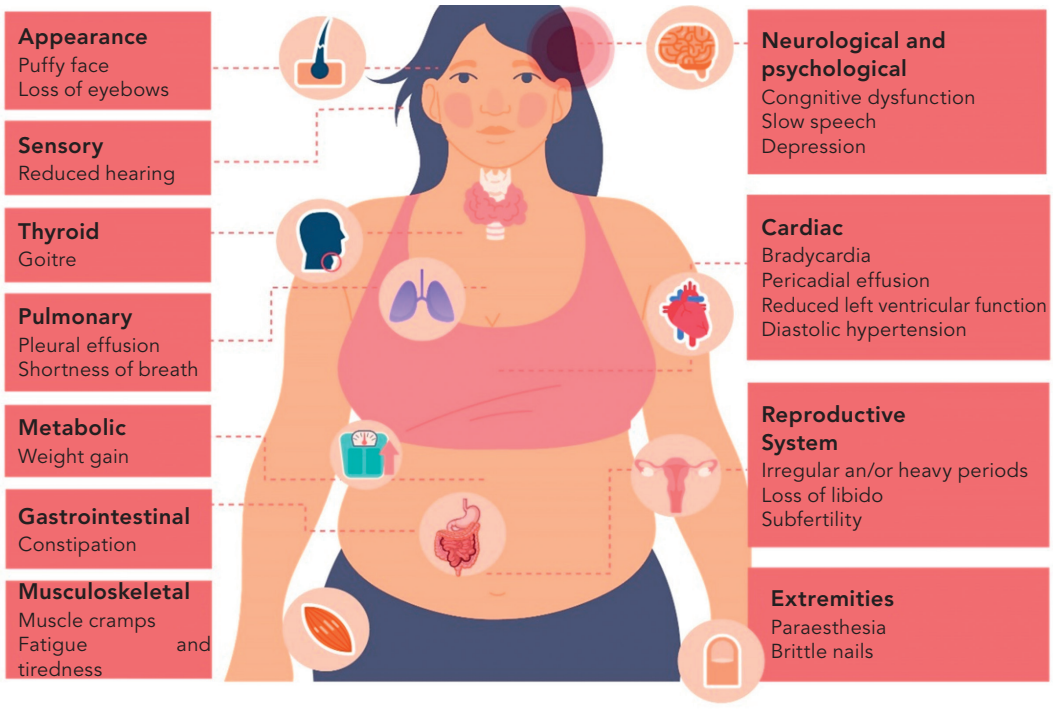
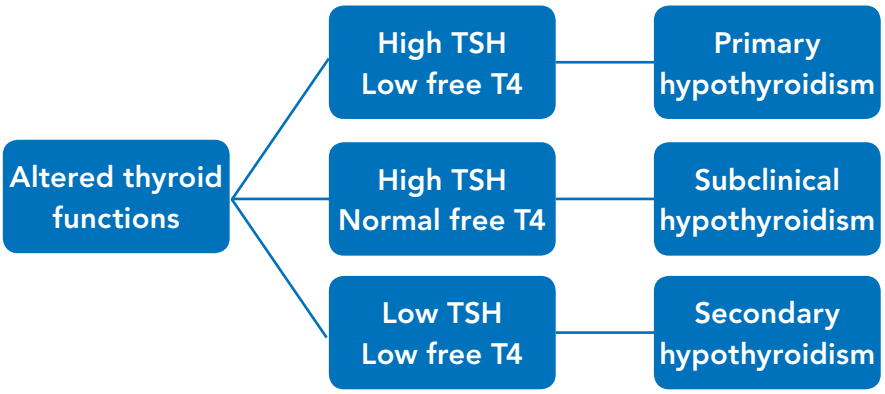


Figure 1: clinical features of hypothyroidism

suggestive of hypothyroidism (refer to figure 1), patients should undergo TSH and free T4 testing. Another essential but commonly neglected group is patients with hypercholesterolaemia with or without hypertriglyceridaemia, as both overt and subclinical thyroid dysfunction is common in this group of patients, and thyroxine treatment itself can improve their lipid profiles without the need for statins.

How do you diagnose hypothyroidism?

Diagnosis is based on thyroid function tests which should include TSH and free T4. Routine free T3 testing in suspected hypothyroidism is not indicated as it does not add any additional information in managing hypothyroidism. Depending on the TSH and free T4 levels, patients can be diagnosed with overt or subclinical hypothyroidism or rarely a patient may have a picture suggestive of secondary hypothyroidism.



What are the additional tests needed following the diagnosis of hypothyroidism?

Usually, when the diagnosis is primary hypothyroidism, no additional testing is needed before treatment.

But if the patient has a goitre or associated obstructive symptoms or any sinister symptoms to suggest an underlying malignancy such as rapid enlargement of the goitre, loss of weight or appetite, or hoarseness of voice, it is a definite indication for an ultrasound scan of the neck. Otherwise, a routine ultrasound neck is not indicated.

Thyroid autoantibody testing is also not routinely indicated. However, a diagnosis of an autoimmune aetiology using anti-thyroid peroxidase antibody levels may have implications for future management. For example, TPO antibody positivity in a young female may indicate her predisposition to developing other autoimmune conditions.

How do you treat hypothyroidism?

Treatment is with replacement of thyroxine (T4), with the therapeutic target being symptom relief, normalization of the thyroid functions, and preventing overtreatment.

When the diagnosis is primary hypothyroidism, a weight-adjusted dose of thyroxine with a maximum dose of 1.6mcg-1.8mcg/Kg of lean body mass can be prescribed with TSH monitoring. TSH normalization takes at least six weeks. Thus, repeating TSH earlier than 6 weeks is redundant. Once the patient achieves normal thyroid functions with a stable dose of thyroxine, annual testing with TSH alone is adequate for monitoring.

The diagnosis of secondary hypothyroidism warrants testing of other pituitary function testing coupled with pituitary imaging. Other pituitary hormones may need replacement in addition to thyroxine. In such patients, starting thyroxine for secondary hypothyroidism can precipitate an adrenal crisis if the patient also suffers from secondary adrenal insufficiency when concomitant hydrocortisone replacement is neglected. Thus, an endocrine referral is recommended when the diagnosis is secondary hypothyroidism.

What are the therapeutic implications of subclinical hypothyroidism?

Subclinical hypothyroidism (SCH) is a biochemical diagnosis. It requires two results, at least three months apart, which show elevated TSH and a normal free T4. Once the diagnosis is made, several factors require careful consideration before starting thyroxine treatment.

SCH can be transient while a patient is recovering from an acute non-thyroidal illness or following a transient thyroiditis episode. A more persistent form occurs commonly in the background of autoimmune thyroid disease. TPO antibody positivity in SCH predicts the development of overt hypothyroidism in the future, and these patients require routine follow-up.

An in-depth discussion on starting treatment in SCH is beyond the scope of this article. As a rule, younger patients with SCH benefit more from thyroxine treatment than the elderly, who are at risk of overtreatment-associated complications. As mentioned earlier, SCH is diagnosed biochemically, and the current practice does not use age-adjusted cut-off values for TSH or free T4 levels. But as for all things natural, there does not exist a single cut-off value for all, and as people age, their normal TSH levels also tend to rise. Hence treating mildly elevated TSH in an elderly person may not be justified as it may be the normal value for that patient.

The current recommendation suggests treatment if the patient is less than 70 years with symptoms suggestive of hypothyroidism and has TSH>10mu/L but with a lesser dose than in primary hypothyroidism. If the TSH is <10mu/L, starting treatment depends on the symptoms, patient's wishes, and comorbidities. But after six months of treatment, withholding thyroxine should be considered if there is no improvement of symptoms. In the elderly >70 years, treatment is not usually recommended. And care should always be taken not to overtreat as it can have deleterious effects on cardiovascular and bone health.

How to advise a patient on thyroxine treatment?

Thyroxine absorption is best on an empty stomach. So, patients are advised to take it on an empty stomach early morning with at least a 60-minute gap between the drug and breakfast or morning tea. Alternatively, it can be taken at night 3 hours after dinner2.

It is usually preferred that patients take the same brand of thyroxine as much as possible without switching between brands. Different brands, despite having bioequivalence, show a lack of therapeutic equivalence, which can lead to fluctuations in thyroid function when there is a change in the brand2.

It is not uncommon for patients on thyroxine to be on calcium supplements, especially if hypothyroidism results from total thyroidectomy. In such cases, the interval between calcium supplements and thyroxine should be at least 4 hours. It is the same for iron supplements as well2.

Hypothyroidism in special populations

Ischemic heart disease patients

They should be started at a lower dose of thyroxine with gradual dose titration by 12.5-25mcg per increment, as starting higher doses might worsen the underlying cardiac condition2.

Elderly patients (>65 years)

Starting with a lower-than-required dose of 12.5mcg-25mcg per day with gradual dose titration is recommended as it may require a lesser dose than the weight-based dose. If they have underlying cardiac conditions, it may worsen with initial high thyroxine doses2.

Pregnant patients

Pregnant hypothyroid patients are better cared for under endocrine follow-up. TSH targets are trimester specific (refer to table 1), and achieving these targets, especially during the first and second trimesters, is vital for fetal well-being and has been found to have far-reaching consequences on the development of the baby.

Thyroxine treatment should be optimized before conception to a target TSH of less than 2.5mIu/L. As soon as the patient is found to be pregnant, they are advised to take two additional thyroxine daily doses per week and to get TSH tested and optimized as quickly as possible. Within the first 20 weeks, they should do monthly TSH monitoring, and once past 20 weeks of gestation and if TSH is stable and within the trimester-specific range, less frequent monitoring can be arranged3. Once the baby is delivered, they can restart their pre-pregnancy daily dose.

Trimester	TSH target mIU/L
T1	0.1-2.0
T2	0.2-3.0
T3	0.3-3.0

Table 1: Trimester specific TSH values

Patients with thyroid cancer following thyroidectomy

Depending on the risk category of their thyroid cancer, these patients may require suppressive doses of thyroxine to keep TSH suppressed. Risk stratification in thyroid cancer is a dynamic process where the risk category may change with time and with surveillance (4). So accordingly, TSH targets also vary; thus, they are better looked after by the combined

care of the oncologist and the endocrinologist.

How to troubleshoot in a patient with high TSH despite a weight-based maximal dose of thyroxine?

It is not uncommon for patients to have elevated TSH while on thyroxine. It can occur in patients who are clinically hypothyroid or clinically euthyroid.

In hypothyroid patients, assessing their drug compliance take precedence. If compliance cannot be improved despite repeated counselling, it can be arranged for these patients to take their weekly dose of thyroxine at once under observation. If good adherence is confirmed, then changing the brand of thyroxine may work. If TSH normalization is still challenging to achieve, then absorption of thyroxine may be the issue requiring specialized investigations.

If the patient is euthyroid, then this TSH can be falsely high. For example, assay interferences can occur due to rheumatoid factor, heterophile antibodies, or biotin in multivitamin supplements, leading to falsely high TSH readings. Special assay interference testing can quickly solve the problem if there is such suspicion.

At a glance, hypothyroidism seems to be a disease with a simple solution of replacing thyroxine. But even then, there are patient subpopulations that will benefit from an expert opinion from an endocrinologist. Those subpopulations include patients with,

1. Difficult to interpret thyroid functions
2. Secondary hypothyroidism
3. Thyroid malignancy following surgery
4. Concomitant other autoimmune diseases or suspected Grave's disease
5. Higher thyroxine requirement than recommended doses for TSH normalization
6. Subfertility or pregnant females with hypothyroidism or subclinical hypothyroidism

Despite achieving clinical and biochemical euthyroid status, some patients still complain of persistent symptoms suggestive of hypothyroidism. They should be evaluated for other hypothyroidism-mimicking conditions like vitamin D deficiency, polymyalgia rheumatica, fibromyalgia, depression, etc. But most of our hypothyroid patients will have markedly improved quality of life with the correct dose of thyroxine, resolving their symptoms and leading to improved patient satisfaction, which is the goal of every clinician.

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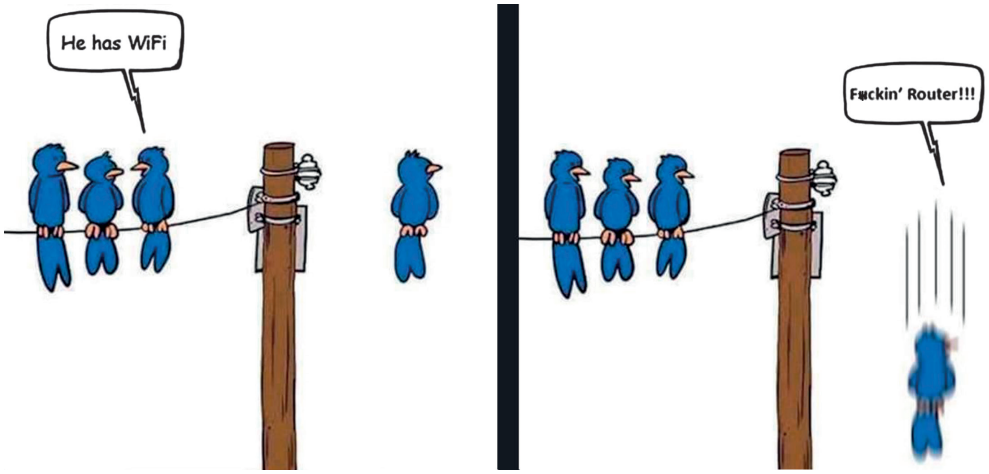

Suicide and self-harm - in the context of the COVID-19 pandemic

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COVID-19 and its aftermath have led to concerns worldwide, that the pandemic could be associated with an increase in rates of suicide and self-harm [1]. This is a very relevant concern for Sri Lanka too, especially given the past history of high rates of suicide in this country.

In 1995, Sri Lanka had the second highest rate of suicide in the world, with 47 suicides per 100,000 population [2]. In 1995, mostly young people died by ingesting lethal pesticides [3, 4]. In an attempt to curb the rates of suicide, national-level measures were taken to restrict access to toxic pesticides - i.e., 'means restriction.' These measures were indeed successful and were associated with a fall in national rates of suicide, after 1995 [2]. This fall in the rate of pesticide suicides was later accompanied by a gradual increase in the number of suicides due to hanging, but the overall number of suicides had declined. Since 2015 onwards, the most common method of suicide, among women and men in Sri Lanka, has been by hanging. Pesticide ingestion is currently the second most common method of suicide nationwide.

Together with the fall in rates of completed suicides, since the turn of the century, we have also seen an increase in the numbers of people getting admitted to hospitals for medical management of self-harm by self-poisoning - occurring in both urban and rural areas of the country [5]. Attempted self-harm by self-poisoning is seen more often in younger people, with a slight female preponderance, and the most commonly ingested substance is medicinal overdoses [6].

Despite concerns about the psychological impact of COVID-19, evidence regarding suicide rates in the *early part* of the pandemic has been reassuring. A systematic review published in April 2021 about suicide rates in upper and upper-middle-income countries, found that suicide rates remained unchanged during the early months of the pandemic [1]. Similarly, a systematic review of rates of suicide and self-harm in lower-middle-income countries (LMIC), conducted up to April 2021, found either a reduction or no change in suicide and self-harm behaviour [7]. However, the authors of this latter systematic review have highlighted that the evidence available from LMIC was limited, with very variable quality of data [7]. With regards to Sri Lanka, police data indicate that the total number of suicides in the country, for the years 2018-2020 have not shown an increase, and remained relatively stable. The rates of attempted self-harm in Sri Lanka during this period is less clear, but when we examined hospital admissions for medical management of attempted self-poisoning to Teaching Hospital Peradeniya during Jan 2019-Aug 2020, we observed a decline in admission rates for self-poisoning during this period [8]. This decline was mostly due to a reduction in the number of people presenting with ingestion of medicinal overdoses. Possible explanations are that the strict curfew-style lockdown limited access to medication for young people, or perhaps the fact that more people were in their homes, which entailed less chances for self-poisoning behaviour. An alternative explanation is that people who took overdoses were not brought to hospital due to transport difficulties during this time; however going against that theory is that when the strict periods of lockdown were lifted, there was no surge in admissions due to self-poisoning. The ban on alcohol sales nationwide, during the initial lockdown periods may have also played an indirect role.

So, despite fears, overall evidence indicates no increase in rates of suicide or self-harm, worldwide, and in Sri Lanka, during the *early part* of the COVID-19 pandemic. However, can we relax now?

Much of the world is now going through a period of economic downturn. Low-income countries and LMICs are particularly vulnerable, and Sri Lanka in particular has experienced significant economic and political upheavals as we emerge out of the shadow of the pandemic. These economic difficulties are likely to continue for a while at least. Suicide is a very complex, tragic outcome, and there is never one simple explanation - it is often associated with multiple factors; it is linked to a complicated interplay between acute distress, background environmental stressors, psychological vulnerability and psychiatric morbidity [9]. Unemployment and poverty are significant environmental factors that are well known to be associated with increased rates of suicide; as are psychiatric disorders such as depression and substance use disorders [10, 11].

We in Sri Lanka may face greater psychological stressors and risk of self-harm and suicide in the aftermath of the pandemic.

Given the possible forthcoming risks in the coming months and years, what could we do to try and mitigate the risks of self-harm and suicide in Sri Lanka, at least to some degree? Given the issue's complexity, there is no 'one size fits all' solution - we call for a range of multidisciplinary strategies, implemented parallelly at different levels, as the appropriate way forward [9, 12]. Useful strategies may include:

i. appropriate targeted support for vulnerable groups, such as the elderly and young people (For example, for the latter - increasing psychological awareness among young people, and linking them with alternative vocational training/ career opportunities),

ii. labour retraining, active labour market schemes, and appropriate economic relief packages,

iii. increased awareness among non-psychiatrist doctors about common mental health disorders and how to respond,

iv. prioritizing continued islandwide mental health services, and enabling access to the same,

v. responsible media reporting, to minimize glamorization of suicide and self-harm, and

vi. continued restriction to access of toxic pesticides [7, 12, 13].

This should be accompanied by real-time monitoring of rates of suicide and if possible self-harm, so that any shifts could be detected and responded to early. Prevention of suicide and self-harm in Sri Lanka cannot be done by the health sector alone. It requires collaboration between many different disciplines, should be guided by evidence, and be supported by advocacy and help at a national administrative and policy level.

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Ending AIDS by 2030

(A report from the Symposium organized by the Expert Committee on Communicable Diseases of the SLMA In collaboration with The College of Sexual Health and HIV Medicine)

Current situation of the HIV epidemic in Sri Lanka

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At the end of 2021, it was estimated that there were 38.4 people living with HIV, 1.5 million people were newly diagnosed with HIV and there were 0.7 million people died of AIDS. Worldwide, about 4000 people are newly infected every day.

In Sri Lanka, certain population groups contribute to new HIV infections according to the latest HIV estimations done for 2021. These include gay men and other men who have sex with men (34%), clients of sex workers (19%), female sex workers (5%), people who inject drugs (5%) and rest of the population (17%).

It is estimated that there are around 3,600 people living with HIV in Sri Lanka as of the end of 2021. Of these 82% have been diagnosed with HIV. However, less than 2,500 people with HIV were in clinical care as at the end of 2021. This indicates that around 30% of people living with HIV are not in our clinical services.

An increasing number of HIV cases have been reported to the National STD/AIDS Control Programme (NSACP) from the 4th quarter of 2021 up to the 3rd quarter of 2022. Approximately two (02) HIV cases have been reported every day during this period.

A higher rate of new HIV-infected people was reported from Colombo, Gampaha, Galle and Polonnaruwa

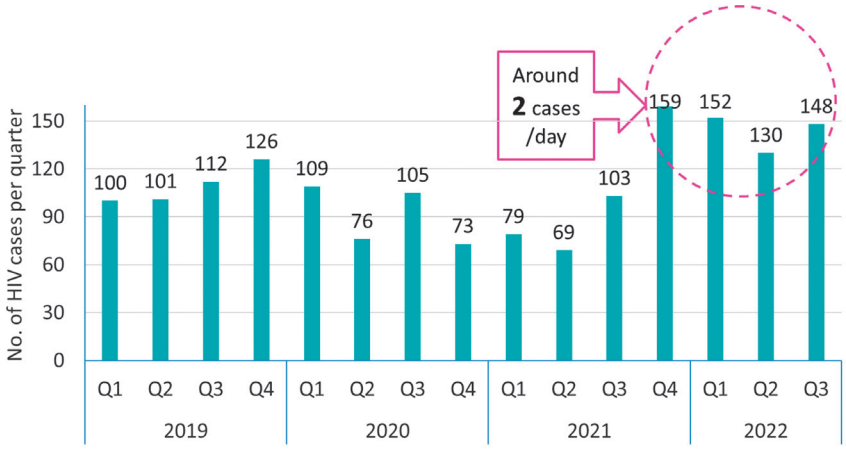

Figure 1: Quarterly reported People Living with HIV, 2019-2022 (3rd Q)

(2-4 cases per 100,000 population) in 2021.

Sri Lanka achieved the validation certificate of the World Health Organization for elimination of mother-to-child transmission of HIV and syphilis in 2019. Since 2018, no HIV cases have been reported due to mother-to-child transmission in Sri Lanka.

The world has committed itself to ending the AIDS epidemic by 2030 as given in the target 3.3.1 of the Sustainable Development Goals. Ending AIDS is defined as reducing new HIV infections and AIDS deaths by 90% compared to the baseline of 2010 values. To achieve this, a country has to achieve 95-95-95 targets by the year 2025. i.e., 95% of estimated people living with HIV should be diagnosed, 95% of them should be initiated on antiretroviral treatment and 95% of them should exhibit HIV viral suppression with treatment. Sri Lanka has achieved 82%, 81% and 85% respectively for these parameters as of the end of 2021.

To achieve the ending of AIDS goal, we need to reach hidden key populations and minimize stigma and discrimination which hinder access to HIV services.

Basics of HIV

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Human Immunodeficiency Virus (HIV) which belongs to the family of retroviridae and genus Lentivirus is the causative organism which leads to acquired Immune Deficiency Syndrome (AIDS). The virus was first discovered in 1983 and it has two subtypes HIV 1 and HIV 2.

The virus passes from one person to another through unprotected sex, sharing needles and from infected mother to her unborn child through a process of vertical transmission. The virus targets human cells with CD4 receptors, mainly T helper cells. Macrophages, dendritic cells and monocytes also get infected with the HIV virus.

Two to three weeks following exposure to HIV, the person may get flu-like symptoms such as fever, skin rash, lymphadenopathy, arthralgia and myalgia all of which are called seroconversion symptoms. Thereafter majority becomes asymptomatic for 8-10 years but a few may show generalized lymphadenopathy (WHO clinical stage 1). Although asymptomatic viral replication and destruction of CD4 cells continue during this period and they start to develop symptoms

gradually. The symptoms could be, mild to moderate weight loss, recurrent respiratory tract infections, herpes zoster, angular cheilitis, recurrent oral ulcerations, Popular pruritic eruptions (PPE), Seborrheic dermatitis or fungal nail infections (WHO clinical stage 2). With the further deterioration of immunity, they will start to develop more severe symptoms such as severe weight loss, chronic diarrhoea, persistent fever lasting for more than 1-month, persistent oral candidiasis, oral hairy leukoplakia, pulmonary tuberculosis, severe bacterial infections, and unexplained anaemia, neutropenia and/or chronic thrombocytopaenia.

Following severe immune deterioration patients will develop AIDS-defining illnesses such as pneumocystis jiroveci pneumonia, extra pulmonary tuberculosis, CNS infections such as cerebral toxoplasmosis, TB meningitis, malignancies such as invasive cervical cancer or cerebral lymphoma.

Depending on a variety of host and viral factors, the rate of progression of HIV to AIDS could vary from person to person. Prognosis of HIV infection has been revolutionized following the invention of antiretroviral therapy (ART). The current recommendation is to start ART to all individuals following confirmation of HIV infection irrespective of the CD4 count and is to start ART as early as possible (rapid initiation) even on the same day if CNS infections could be ruled out. There are 7 classes of antiretroviral medications available at the moment. Out of that 4 classes of drugs are available in Sri Lanka, namely, nucleoside reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), protease inhibitors (PIs) and integrase inhibitors (INSTIs). Each class targets a different step in the viral life cycle as the virus infects a CD4 T lymphocyte or other target cells. The use of these agents in clinical practice is largely dictated by their ease or complexity of use, side-effect profile, efficacy based on clinical evidence, practice guidelines, and clinician preference. The standard treatment consists of a combination of three active drugs (often called "highly active antiretroviral therapy" or HAART) that suppress HIV replication. The combination of drugs is used to increase potency and reduce the likelihood of the virus developing resistance.

ART reduces mortality and morbidity rates among HIV-infected people and improves their quality of life. The benefits of ART also include the prevention of HIV transmission by suppressing HIV replication in persons living with the virus. This benefit of ART is also defined as "undetectable equal untransmissible" or U=U. With the effective antiretroviral therapy with adequate viral suppression PLHIV could now live a normal life span and they could have children without passing the infection to their partners or to their children.

During the recent past there were several new developments in antiretroviral therapy which include approval of dual therapy and long-acting injectable ART for treatment of HIV patients. However, injectable ART is still not available in Sri Lanka.

Scientists are also trying to develop both preventative and therapeutic vaccines for HIV using non-neutralizing antibodies, neutralizing antibodies, viral vector vaccines, mRNA vaccines and through gene therapy. Several such vaccine trials are going on at the moment but up to date no vaccines have been proven to be effective.

Several trials are also going on looking for an HIV cure. There are 3 reported cases of "HIV cure" following bone marrow transplantation in leukemic patients but this approach is not suitable for routine clinical practice due to the high risks of bone marrow transplantation. However, there are several ongoing studies looking at achieving sustained viral remission without ART; "Functional cure" which give hope for the future.

Laboratory diagnosis

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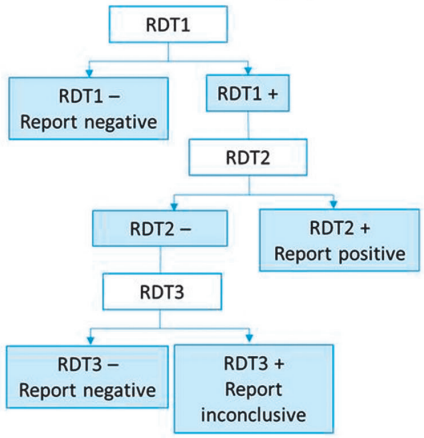
Guidelines on testing and diagnosis

There are many different guidelines on testing issued by world organizations as well as from several countries. These are usually based on HIV burden of the populations, testing selected to be used etc. Sri Lanka is always trying to be in line with WHO guide lines, but each and every country is supposed to have their own guidelines prepared nationally based on their own HIV burden. Accordingly, algorithms for testing are prepared nationally.

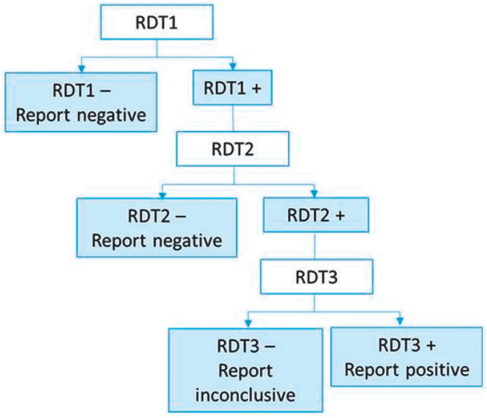
HIV diagnosis

- Providing correct HIV diagnoses, as quickly as possible, is critical to all HIV testing services and national programmes. To achieve accurate results, WHO recommends that countries use an HIV testing strategy/algorithm whereby a combination of rapid diagnostic tests (RDTs) and/or enzyme immunoassays (EIAs), used together, achieves at least a 99% positive predictive value (that is, less than one false positive per 100 people diagnosed with HIV).
- This requirement was the basis of previous WHO recommendations that, to maintain at least for ante natal mothers 99% positive predictive value, settings with a national HIV prevalence of 5% or more should use two consecutive reactive tests to make an HIV-positive diagnosis. However, for settings with a national HIV prevalence below 5%, to maintain at least a 99% positive predictive value, WHO recommended the use of three consecutive reactive tests to make an HIV-positive diagnosis.

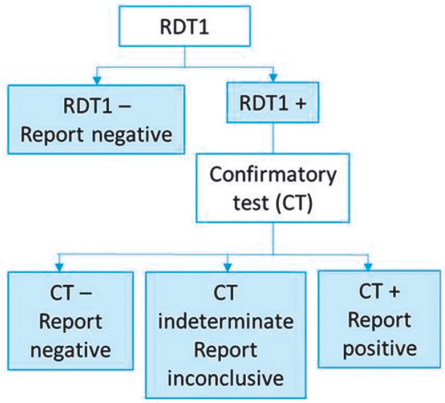
A/ Simulated algorithms – high prevalence settings



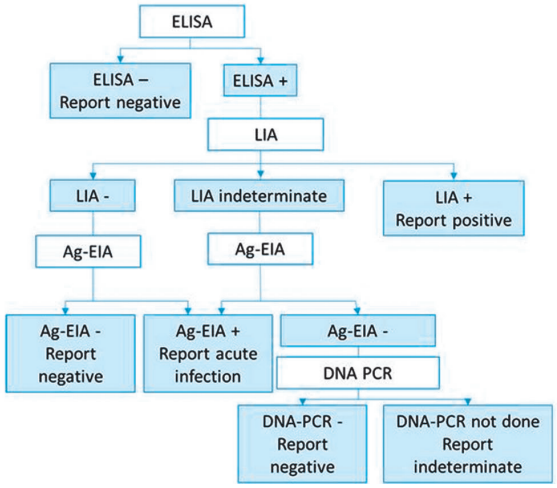
B/ Simulated algorithms – low prevalence settings



C/ Simulated algorithms – confirmatory test



D/ Reference testing



- For antenatal mothers, the WHO recommends the dual syphilis and HIV rapid tests (RDT) can be the first test for screening.

In 2019, in response to changing epidemiology, WHO recommended countries adopt a standard HIV testing strategy with three consecutive reactive tests for an HIV-positive diagnosis to ensure quality services as countries move towards achieving the UNAIDS 95-95-95 targets

HIV testing

HIV laboratory markers in blood are detected by HIV testing. The appearance of these markers vary with the stage of the disease.

HIV laboratory markers

(Figure 2)

Screening tests

EIA is commonly used as a screening assay for many infectious diseases, including HIV. These assays are used because they are highly sensitive and generally amenable to automation, facilitating high-volume testing.

HIV EIAs have become increasingly more sensitive and specific since HIV testing began in the early 1980s. This has shortened the 'window period', or the time from exposure to seroconversion, from up to 12 weeks or more in the early days of diagnostic testing to the current 'window period' of less than three weeks in most cases. Currently Sri Lanka uses Ag/ Ab combo tests (4th generation ELISA tests) for screening suspects.

Rapid tests (Point-of-Care or Near-Patient) are used in many countries for screening HIV. This facilitates on site testing and knowing results within a short period. The rapid tests are very useful to test difficult to reach populations and the key population groups who have to be tested periodically as there is high risk of contracting the disease.

There are self-tests introduced to screen for HIV specially for the groups who are not willing to come for a test by an institution. "Ora quick" is one such example which uses oral fluids to screen for HIV and it is easy to perform by self and is non-invasive.

Confirmation of HIV

HIV is never diagnosed using one test. A minimum of 3 tests of different types are used in combination to come to the conclusion of confirmation of the disease. Western blot test was used for confirmation in many algorithms since the commencement of testing for HIV. The Western blot is an immunoblot that allows for the characterization of antibodies to each viral protein. The test is labour-intensive and costly.

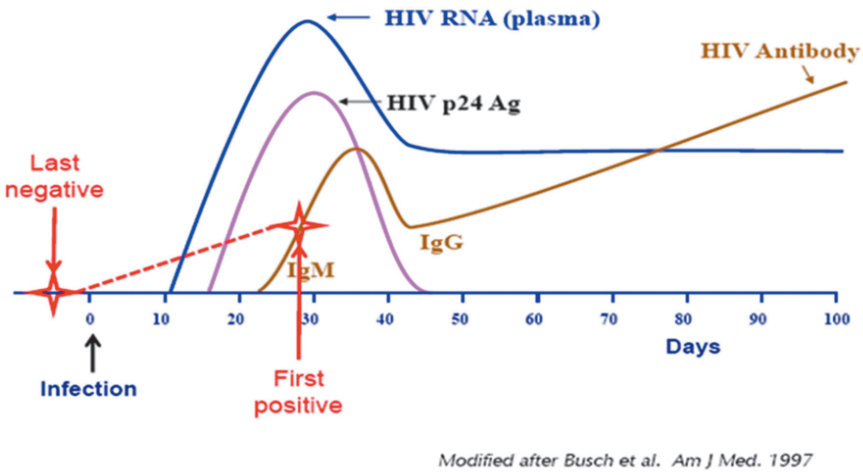


Figure 2

Currently WHO discourages the use of the test, mainly considering the time taken for diagnosis and encourage other modalities of confirming the disease which doesn't take a longer time to confirm the disease.

The confirmation of the disease in early infants is different to adult diagnosis. The babies born to HIV mothers should be diagnosed for HIV with HIV DNA PCR test instead of using the serological tests due to the placental transfer of antibodies.

Monitoring of HIV patients

Quantitative RNA PCR, commonly known as HIV viral load test is used to monitor HIV-positive individuals before or during antiretroviral therapy. It is used to help determine the patient's response to therapy. Quantitative PCR should not be used as a diagnostic test for HIV because false positives and false negatives can occur in these circumstances.

HIV Drug resistance

Genotyping is used to monitor the development or presence of drug resistance in people living with HIV (PLHIV) before or during therapy.

It assists physicians in their choice of antiretroviral drug combinations for the patient Currently the test is being established in National Reference Laboratory of NSACP.

Ending AIDS by 2030 in Sri Lanka

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National STD/AIDS Control Programme

The phrase "end of HIV/AIDS" does not refer to the eradication of HIV. In 2015, the United Nations' (UN) Sustainable Development Goal (SDG) 3 established that by 2030, the world would "end the epidemics of AIDS, tuberculosis and malaria." As part of the SDG strategy, UNAIDS and partners developed the "Fast Track Response Strategy" in 2016 and they have defined ending AIDS as, 90% reduction in HIV incidence and mortality by the year 2030 compared to baseline year of 2010. In this regard, challenging goal would probably be optimal implementation of existing treatment and prevention modalities.

Ending AIDS will be achieved by reducing new HIV infections and by reducing AIDS related deaths.

Early diagnosis is the key to start antiretroviral treatment (ART). Early initiation of ART will maintain higher CD4 cell counts, prevent further damage to the immune system, and decrease the risk for HIV-related and non-HIV-related health problems. Significantly it improves the health of an individual and reduce the person's risk of developing AIDS and AIDS related deaths.

HIV can be diagnosed through facility-based, community-based and home-based testing approaches. The available HIV testing methods are standard blood drawing method, HIV antigen antibody rapid testing and oral-fluid based HIV self-testing. All these testing approaches are available in Sri Lanka. HIV testing services provided by National STD/AIDS Control programme in collaboration with community based and through Non-Governmental organizations.

Peer led intervention programmes and hybrid intensive case finding models are key population intervention programmes operating in 15 districts island-wide. Peer led intervention programmes involve members of key population groups to influence and support members to maintain healthy sexual behaviours, change risky sexual behaviours, modify norms in ways conducive to healthier lifestyles and promote HIV testing. Social Network Strategy (SNS) is another approach to test key population groups. This approach is through the same social network who know, trust, and can exert influence on each other who share similar HIV risk behaviors and motivate a person to accept HIV testing. Index testing approach is an intensified case finding model functional in Sri Lanka to find new HIV cases.

Currently there are new preventive options available in Sri Lanka to reduce the risk of acquiring or transmitting HIV. ART for prevention, Pre-Exposure prophylaxis, Post exposure prophylaxis, using condoms, lubricants and treating for Sexually Transmitted Diseases will effectively reduce the risk of HIV transmission.

Ending AIDS in Sri Lanka in 2030 is a possible task with diagnosing all people with HIV as early as possible, treat all people with HIV effectively to reach sustained viral suppression, prevent new transmission by preventive measures and respond quickly to potential HIV outbreaks.

Professionalism and Politics

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Introduction

In the recent past there was much concern regarding the educational standards and performance of the politicians in Sri Lanka. It has been revealed that a significant number of the parliamentarians have not passed even the GCE ordinary level examination. Further, there are allegations that some are directly or indirectly involved with the underworld, drug dealers, murderers and other criminal offenders, and some have been ground guilty in courts. In this context, there was a tendency for only a few professionals to get involved in politics through some organizations, other than the mainstream political parties. Few were able to enter the parliament while few others received appointments to posts in government or corporate sector mainly through political patronage. Even in developed countries there were instances of professionals entering politics and acquiring higher posts in the legislative bodies. 'Non-partisan politics' became popular in the recent past.

Professionalism

Professionalism can be defined as the skills, competence, and conduct displayed by an individual of a certain profession. Professionalism encompasses a variety of dimensions. Those dimensions are

1. Competence (abilities matching the requirements of the role, and producing results that exceed expectations) and up-to-date Knowledge,
2. Conscientiousness (excellence, reliability, high standards/ quality of care, visionary, and accountability),
3. Integrity (ethical, being honest, genuine, beliefs and behaviors and following regulations),
4. Respect other people by taking their needs into account, and by helping to uphold their rights.
5. Emotional Intelligence (stay professional even under pressure, a clear awareness of other people's feelings, active listening, empathy)
6. Appropriateness in different situations, and Confidence (Trustworthy, motivates people, leadership).

There is a link between ethics and professionalism and it comprises two distinct but overlapping domains. Ethics refers to the guidelines on standards or practice in a specific context whereas professionalism refers to the specific traits that are expected of a professional. Professionalism is about social relationships that determine an individual's position within society; financial relationships that potentially influence motivations and behaviours, and inter-professional relationships that determine how a person interacts with colleagues. Therefore, an imperative feature of professionalism is that it is outward-looking, having nothing to do with the self-serving interests of a person and everything to do with protecting the members of the public.[1]

Politics

Politics can be defined in different ways: as the exercise of power, the science or art of government, the making of collective decisions, the allocation of scarce resources, the practice of deception and manipulation, and the authoritative allocation of values. Aristotle declared that 'man is by nature a political animal'. It is only within a political community that human beings can live the 'good life'. From this viewpoint, then politics is concerned with creating a 'just society' or ensuring 'social justice'.[2] In a realistic way, politics can be defined as the struggle for power that is universal in time and space.[3] Aspiration for power through whatever means is a reality in politics at international, national or institutional level. Further, politics is also seen as a means of resolving conflict by compromise, conciliation, and negotiation, rather than through power. Politics is associated with 'policy'.

Politics is practiced not only in parliaments or legislative bodies but also in other government and semi-government institutions including universities and in all social contexts. Therefore, politics is engaged in not only by political party members, but also by civil servants, and government officials. Often politics is treated merely as

the equivalent of party politics and the activities of politicians. Not only the political ideology but also politicians' behavior and decisions affect the lives and well-being of citizens. Politicians are at the top of the hierarchy which determines the functionality of every other sector: economy, fiscal policy, tax policy, education, health, etc. Different political players will have different types of responsibilities, depending on the specific powers they have. Politicians are often seen as power-seeking hypocrites who conceal personal ambition. This reflects the liberal perception of politics where the individuals are self-interested and therefore, political power is corrupting. The politicians who are 'in power' exploit their position for personal advantage at the expense of others.

Political systems

Today, the major types of political systems are capitalism and socialism. Capitalism is an economic and social system that safeguards the private ownership of property, production, and assets with minimal government intervention. A capitalist market economy creates an unequal opportunity for the people and therefore the majority of wealth is concentrated in a fewer number of social groups leading to unsustainable economic inequality which can lead to social injustice. The relationship between capitalism and liberalism makes them mutually supportive. The key principles of liberalism are individualism, freedom, and safeguarding of civic rights. Neoliberalism stresses privatization and private enterprises, and free trade. Neoliberalism believes that greater economic freedom leads to greater economic and social progress for individuals. Disadvantages of neoliberalism are an increase in inequality in the income and the provision of essential social services. In addition, it can lead to exploitation, and may even criminalize poverty.

Socialism is an economic and political system that advocates collective or governmental ownership for the administration, production, and distribution of goods and services, and equal sharing of the different elements of production and exchange of resources among the people. The disadvantage of socialism is the lack of competitiveness for production.

Democracy

The theory and the practice of democracy have undergone profound changes over the years from the time of the ancient Greeks. In the 18th century, it turns to representative democracy which would require a set of political institutions. European countries adopted versions of the British parliamentary system. Few countries adopted a version of the American presidential system. Liberal democracy is decision-making while remaining within a constitutional framework that guarantees the rule of law, independence of judiciary, and minority rights. Direct democracy is a popular method in Europe and involves referendums, recall elections, and citizens' initiatives with some consensual elements. Deliberative democracy is grounded in the values and concerns of the public so that their voice is not necessarily the voice of the politicians.[4] It bridges the gap between politicians and the public that characterizes much of politics. This can be done by citizens' assemblies, which are a uniquely powerful tool for increasing participation in decision-making. Therefore, features of ideal democracy are the right to form and participate in independent political organizations, free, fair, and elections at regular intervals, and effective participation in policy-making without fear of any repercussion.

Social justice

Social justice is a collective concept that is more related to socialism and democracy. It is a political and philosophical movement that refers to a fair and equitable distribution of resources, opportunities, and privileges in society. It also emphasizes equity instead of equality, social diversity, community participation for decision-making, and safeguarding human rights, not only civil and political rights but social and economic rights as well.

Professionalization of politics

The professions emerged in a recognizable form in the mid-nineteenth century. The professionalization of politics has two different aspects. In one politics becomes an occupation, allowances were transformed into salaries, with the introduction of pension schemes. The line of demarcation between occupation and profession is blurred. Therefore, others refer to the distinct group of occupations with special qualities setting them apart from others like health professionals. Individually, politicians give up prior occupations and move into politics. For example, professionals in law, medicine, or academics may move into politics. These newly installed politicians have little experience of anything other than their own discipline. It is unlikely that their performance is better for representing the electorate or community than the others. Further, the rule of government has become increasingly technical, especially in highly complex areas such as the economic management

of a country. Politicians should have competencies with special skills, experience, and expertise to understand and control complex and interdependent social issues. Professional politicians should know how politics work and hence have the ability to get things done quickly and efficiently. Even though professional self-regulation is not adequate for politics. For example, Research Ethics Review Committee (ERC) has standardized operating procedures for conducting its activities. When the members of ERC do not have the required knowledge and skills in research methods or bioethics or both, one couldn't expect the desired outcomes from an ERC. Even though there are adequate knowledge and skills for being members of ERC, the president and/or secretary's unethical behavior, for example working with conflicts of interest, would affect the professional performance of an ERC.

Politics in Sri Lanka

Sri Lanka adopted a capitalistic liberal/neoliberal system in the 1980s. A free and fair election is an important first step towards maintaining the democracy of a country. In Sri Lanka, elections were postponed on several occasions over the years. We have experienced numerous acts of election-related violence, intimidation, and stealing or buying voters' cards during the months-long election campaigns. Distribution of food, money, or other gifts prior to an election is another form of violating democracy. Further, there are reports that highlight an "unparalleled misuse of state resources and media" for election propaganda by the ruling parties. Sometimes the state media were openly asking people to vote for the ruling party. The behavior of the police and other security forces was not in an impartial manner during the election time. The method of conducting an election whether it is based on an electoral system or a proportional system has also an impact on professionalism. Past political experience is that the majority of election promises are not honoured. Every public institution including politicians, legal officers, and bureaucrats in Sri Lanka are considered as corrupt. Every regime that comes into power, takes it as a license to rob the country. Sri Lanka occupies the 102nd least corrupt nation out of 180 countries. The "Corruption Perceptions Index" for the public sector showed 63 points (out of 100) in Sri Lanka for 2021.[5] Sri Lanka is 88th in the overall Prosperity Index rankings in 2021 and performs most strongly in health (40th) but is weakest in safety and security (130th).[6]

Good governance

There is no consensus on the definition of good governance. Good governance strongly relates to the political, economic, and social development of a country. Good governance encompasses several interrelated areas. For ensuring civil and political rights, it is crucial to reforms and development of legislative frameworks for strengthening democracy, and reforms in the legal framework to establish rule of law in society. An independent system of judiciary, its impartial nature, and the incorruptible police force are key elements to ensure rule of law. Good governance reforms democratic institutions and create avenues for the public to participate in policy making and establish formal mechanisms for the inclusion of civil societies and local communities in decision-making processes, and receiving feedback on issues of importance to them. This may enhance mechanisms of accountability and transparency to ensure that services are accessible and acceptable to all. Further, this initiative may create establishing anti-corruption commissions to shape anti-corruption measures, and mechanisms of information sharing on various government policies and monitor the implementation of policies including the use of public funds. Full respect of human rights involves not only the ensuring of civil and political rights but also embracing cultural, economic, and social rights as well. That includes the right to health, adequate housing, sufficient food, and quality education. Social justice and equity are key to good governance.

Professional politician

To be a politician, there is no requirement as far as educational qualifications are concerned. In developed countries, most successful politicians at the national level hold at least a minimum of a bachelor's degree. Common areas of study for politicians include political science, economics, public/business administration, international relations, or another related field such as law, agriculture, health, etc. Moving to politics from diverse categories of professionals does not imply the professionalization of politics. Being a member of a profession or professional association or having a certificate of practice for a profession does not imply that the person practices professionalism. For being a professional politician, a person needs part-time or full-time, formal or informal experience in politics for years, other than the required competencies, and demonstrates professional behavior. Professional self-regulation itself is not enough for good governance if the political system/type is not conducive to social justice. From the foregoing it is clear that representative

democracy alone is not a guarantee of good governance. Deliberative democracy empowers citizens and therefore is a basis for social justice. Professionalism, democracy, social justice, and good governance are intertwined. A politician needs a correct vision, ideology, suitable political system/type, and commitment for the people, to practice professionalism in politics.

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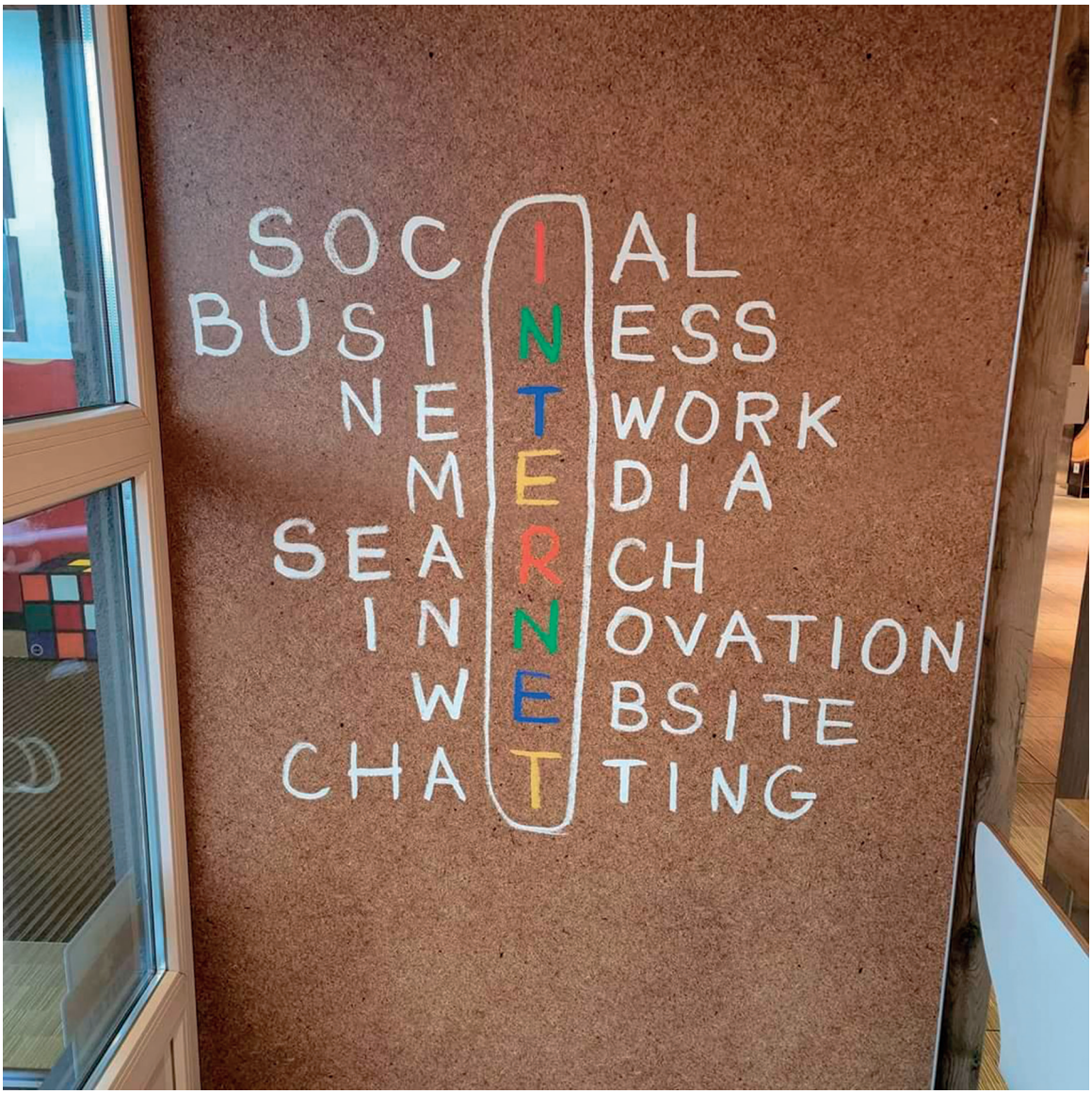

Doctor in the Society; A Sri Lankan Perspective

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Plenary lecture delivered at the Colombo Medical Congress, 24th Nov 2022

We in Sri Lanka are going through perhaps the most difficult period in our lifetime, a crisis of unimaginable proportions. More relevant to the topic, the role of every member of the society, specially the professionals, is being questioned and re-examined, either to apportion blame or to find ways out of the dire situation.

During this presentation wherever I appear to find fault with the activities of the medical profession, it is purely to ensure that we do our best to reorient ourselves to maintain the respect the society still has for the noble profession. The activities, or rather inactivity, of the medical professionals have a direct impact on society.

A doctor has been treated as a demigod. Such was the respect with which the doctor has been held in society throughout history. However, while the doctor may be venerated by the individual relieved of an ailment and by the family, the reality is that the society at large often sees the doctor as yet another member serving and benefitting from a corrupt system. The doctors' shortcomings and mistakes are highlighted while their achievements in maintaining services without adequate resources are downplayed mostly.

There is hardly a secret in day to day life a patient will not divulge to the doctor, if we are prepared to spend time listening. That is important as many of the complaints a patient presents with have a social background contributing in a big way. For that interaction to be fruitful, the doctor has to maintain the best demeanor in all aspects to instill confidence in the patient. Unfortunately the general impression among the public is that the doctors do not spend enough time to listen to patients during a hasty consultation.

The doctors of yesteryear belonged to a different generation and a different mould, where citizens were nurtured from early days in a value centered society, and as such worked in a more respectable way as public servants. Thus it is not reasonable to expect present day doctors nurtured and working in a corrupt environment to behave very differently from the rest of the society. However, due to the very nature of our work in close contact with the people to relieve their suffering, they quite rightly expect us to be above board all the time.

Society is ever ready to treat doctors with respect. That is why wherever we go, we are treated with a difference. We are always encouraged by others to break queues; we are often let off lightly by the police after committing traffic offenses and the like. The doctor's badge on our cars makes a big difference where it matters. No wonder, this badge is abused by those not entitled to use that, as well as by doctors themselves. It is a new phenomenon to see doctors appearing in public places in their blue scrubs meant to be worn only in clinical settings. Demanding respect is not the way to go about.

Fallout of the Pandemic

The COVID pandemic has made the medical profession admirably manage the unprecedented crisis.. This has changed the very outlook of medical practice world over. How the medical services in the resource poor country of ours rose to the occasion and managed as well as or even better than the richer countries is being admired even by the WHO. Free on call services provided by volunteer doctors in the SLMA-Mobitel 247 Doc on Call service was a new experience, much appreciated by the people.

We have now learned to live with COVID. However it is unfortunate that continued hiding behind masks has further distanced the caregiver doctor from the patient. Reported reluctance of many doctors in out patient clinics to get close to the patient for fear of catching infection, despite themselves being vaccinated and using other protective measures, and writing prescriptions without ever touching the patient, is beyond comprehension and cannot be justified.

The pandemic has exposed many undesirable facets in the administration of healthcare services in the country. As was happening over the years the doctors in various specialities served in committees to advise the administrators in planning the response. And, as often happens, it was disheartening to see how such advice was ignored by the decision makers leading to chaos in many instances. This crisis has exposed corruption and fraud plaguing the health service, as

much as the rest of the affairs of the country, over many years. It is unimaginable and shameful how unscrupulous politicians, administrators, private healthcare providers, businessmen and even some doctors themselves, allegedly exploited human misery to line their own pockets. As a consequence we are now faced with almost insurmountable problems in maintaining even basic healthcare services in a bankrupt country, including the shortage of drugs and other resources nearly paralyzing the services.

A country hitherto boasting of an exemplary free health service admired world over, is now on the verge of seeing avoidable deaths and disease due to many deficiencies in the healthcare services.

Role of the Medical Profession in Preventing Irregularities

Could the medical profession have done more in the past to avoid the current difficulties in the making for many years? We knew all along that there was alleged corruption in procuring drugs and equipment. There was evidence of gross political interference in the functions of the drug regulatory authority. It was well known that there was mismanagement in the distribution of manpower. The hospitals in bigger cities were overstaffed while the health services in the periphery suffered from shortage of doctors, other personnel and material.

The doctors demanded and received increased salaries with overtime payments, which we know were often on fraudulent claims. No College of specialists advised their members not to endorse such claims without checking properly. The trade unions of doctors on the other hand indulged only in looking after the interests of their members, just like any other union in non professional occupations, turning a blind eye to many of their own shortcomings and fraudulent activities, at the expense of deterioration of services. This is despite the fact that a professional, by definition, unlike others just doing a paid job, is expected to work towards the improvement of the standards of the profession as well.

At present there is callous disregard for the fundamental rights of people to express their opinion peacefully. Such suppression of dissent has health implications as well. Alleged overuse of outdated tear gas, physical assault of unarmed protesters, manhandling of men and women, uncivilised treatment of prisoners are all instances where there should be an outcry from the medical profession, at least as far as the health implications are concerned. Apart from a recently formed grouping of a few medical professionals for system change, there is hardly a whisper, apart from issuing lengthy statements with no follow up action, from older well established organizations of doctors. Recently, when a doctor was interdicted for speaking aloud on impending childhood malnutrition, not even the Colleges of Paediatricians or Community Medicine have come to his defense.

Role of the Professional Colleges

To what extent have the various medical associations and professional colleges acted to keep these irregularities in check? Guided by the decades old constitutions they confine themselves to purely academic activity. I was surprised and dismayed just a few weeks ago when the oldest college of medical specialists in the country unanimously decided to remain strictly within the objectives of their constitution drafted over 50 years ago, when the issues affecting the community and the doctors were very different, confining themselves purely to academic activity. They decided it was too risky for their reputation to get involved in the current political turmoil in the country, and to avoid it like plague.

The medical associations and Colleges should note that if they just watched passively in silence as the social fabric collapsed around them, they may not be left with any room to manoeuver or enough members to work with, as the younger doctors leave the country in droves looking for greener pastures to live and work in peace. It is pertinent to note here that almost all post graduate trainees who passed the MD medicine examination recently prefer to specialize in general internal medicine rather than in hitherto popular fields like cardiology or endocrinology, as it is much easier to find jobs abroad that way. I understand that services in anaesthesia and psychiatry will have the greatest negative impact due to the brain drain. The Colleges by confining themselves to academic activity, may be just training doctors at tax payers' expense for service abroad!

However, let me note with appreciation and congratulate the multitude of Colleges and Associations for their resilience in continuing the academic programmes at a very challenging time. At the same time, they have garnered support from a wide range of well wishers and obtained donations of drugs and other material for hospitals that are in short supply during the crisis.

It is high time that the colleges amended their constitutions, to include as an objective, an

advocacy role in non academic matters dealing with social welfare and governance which could have a serious impact on healthcare services in the long term. They could appoint subcommittees to constantly monitor such aspects in the community and formulate appropriate action. The SLMA has done just that now. The intercollegiate committee initiated by the SLMA for the purpose of COVID control could be a basis for coordinating this non academic activity.

If we were proactive in the past, we could have prevented to some extent the calamity befalling the society at present. We knew that the most powerful trade union of doctors, much respected in the years gone by, was getting too involved in mundane politics. They indulged in giving expert advise on non medical affairs as well, bringing disaster, among other areas, to the agriculture sector in the country and hunger and poverty to the farming community and the public at large. As a result, the medical profession is now being looked upon by the people as one of the main architects of the current dismal situation.

The senior doctors in various associations and colleges, knowing the obvious repercussions, did not seek a discussion or some other form of intervention with the medical trade union leaders to advise them to review their course of action. We had no say, or rather were reluctant to have anything to do with, in the affairs of these powerful trade unions of mainly non specialist medical officers whose services and cooperation were essential for specialists to function.

Similarly we should have known all along that irregularities in areas like drug procurement will create many future shortages affecting our services. We could have taken a strong stand to prevent or minimize them by at least exposing the same to the public. Non-medical unions in the health service shouted hoarse about the irregularities but were conveniently ignored by those in authority. Doctors, with perhaps greater influence on decision makers, could have had a greater impact if they resorted to similar forceful action. But we considered ourselves to be too respectable to get involved in such so-called dirty affairs.

It is considered more beneficial to keep company with powerful politicians many of us associate with and avoid discussing political matters with them. It is an open secret that many senior doctors were close associates of errant politicians in power. Our word would have carried more weight if we cared to address the various issues leading the country to the present dismal state. We could have easily arranged discussions with political and administrative authorities to convey our displeasure at the way things were being done. We waited until it was quite late and much damage was done to educate the public about the fallacy of the Dhammika Peniya in curing COVID. It was the same in controversial issues like the forced cremation of Muslim bodies dying of COVID and alleged large scale sterilization procedures by a doctor. No specialist or the College in the relevant field came out openly without delay to educate the public on the issues. We watched passively as so much of false rhetoric by politicians, the clergy and even medical men, kept the issue inflamed.

I wrote several newspaper articles on these issues. I was warned by my colleagues not to court trouble and to write under a pseudonym, which advice I ignored without any hesitation. I was somewhat ridiculed by union members when I wrote an open letter at an early stage to the medical trade union leader already referred to, asking him to review his problematic behaviour and change course. Such activity by influential organizations of doctors would have achieved positive results where I as a mere individual acting alone may have failed.

We are silent observers when so much harmful unproven medications are promoted over electronic media about non communicable diseases like diabetes. I admit that while having immense faith in the rational scientific basis of allopathic medicine, we have to be quite smart and diplomatic in practising our art and keeping afloat in a sea of native medicine.

It appears that our profession that can greatly influence the affairs in the country, is paralysed by an overwhelming desire to avoid unnecessary trouble and by the fear of victimization by politicians thus allowing the latter to do as they like and ruin the country. Preventive interference cannot be misinterpreted or summarily discarded as unnecessary involvement in politics. After all politics involves governance of the people and that certainly overlaps our field of work in a big way.

While complaining about the poor educational standards of our parliamentarians, a situation beyond our control, how can the professionals keep quiet allowing them a free hand in matters of cardinal importance?

Private Sector

There is no doubt private practice by doctors has become a necessary evil. It has reduced a tremendous burden on the free health service. But we have to bear in mind that many patients prefer

private services not because they can afford it, but because of the delays, lack of basic comforts in the wards and attitudinal problems seen among government health workers. This in turn is due mostly to overcrowding and shortages of materials, and cannot be blamed entirely on the personnel involved.

However it is sad to note that very similar undesirable conditions have now pervaded the private sector as well.

The lack of a properly regulated general practice with a system of referral to specialists has made a mess in the private sector. As a result everyone with a headache goes to a neurosurgeon and every young man with a chest pain of obviously musculoskeletal origin goes to a cardiologist. But then, it is the responsibility of the consulted specialist to see that unnecessary investigations like CT scans or other expensive tests are avoided and that they are referred to the appropriate consultant or a GP for follow up. I know of a patient with bronchial asthma in an outstation town who traveled a long distance to be followed up for nearly two years by a cardiac surgeon as the ignorant patient went to him for "papuwe amaruwa". This has to be sheer irresponsibility, and not greed for money, as the specialists concerned are already overloaded with work in their own field, and are financially well rewarded.

Many doctors including specialists do not follow the basic guidelines in writing a simple prescription. I am not going to deal at length with the well known allegation against doctors in government service working in the private sector during hospital working hours, not spending enough time for a consultation or the exorbitant charges for their services. Society looks upon the doctors in poor light as a result.

I doubt whether any Association or College of doctors ever engaged their members in a discussion on these aspects. As far as I am aware, none of their academic conferences have symposia on the public perception of the way we practice our profession. It is up to the doctors themselves to address these issues and rectify the shortcomings without waiting for the authorities to regulate through legislation.

The doctors have a social responsibility to see that the private sector does not exploit the hapless patients. As I keep saying repeatedly, this is the only business or service where the "salesman", namely the doctor, decides what the "customer", that is the patient, should buy. Hence there is a tremendous moral obligation on the doctor to see that the patients' misery is not exploited for personal gain. This has to be kept in mind every time we order an investigation or prescribe a drug. Practicing medicine in the midst of an unprecedented economic crisis in a bankrupt country is an art the doctors have to master pretty fast. It is high time that the SLMA and other Colleges and Associations turned their attention on this aspect as a matter of urgency.

At present many justifiably believe that the doctors work hand in glove with the private sector service providers and the pharmaceutical industry for personal gain at the expense of the patient. It should prick our conscience if these third parties are exploiting our patients who primarily come to us for relief. We as a group can have much influence in getting the private healthcare service providers to be more reasonable and people friendly in pricing their services.

Funding by the Pharmaceutical Industry

How our various academic activities, like the annual Conferences, are lavishly funded entirely by the pharmaceutical industry is well known. Presidents and councils of various Colleges more or less demand drug companies for sponsorship. Year end account balance sheets allow the office bearers to boast of profits made almost entirely by extracting funds from the pharmaceutical companies.

We pretend not to know that every rupee the drug companies spend on all these activities is added to the price patients pay for their drugs. It is sheer hypocrisy when we appear to speak for the patients rights by complaining about the exorbitant prices of medicine.

Being so extravagant in our activities is inconsistent with the difficult times we are in. I have been arguing for a drastic reduction of the costs thus incurred. Using cheaper venues rather than five star hotels, making do with boxed meals where necessary at one third the cost of buffets are some of the practical solutions we can employ. For quite sometime now, many developed countries as well as neighbouring India have imposed drastic restrictions on the unholy alliance between doctors and the pharmaceutical industry.

Let's make 2023 the year we start to minimize our dependence on funds from pharmaceutical companies for our academic activities and set an example to the community on how to thrive in the midst of an economic and humanitarian crisis. This I understand will be a difficult task to deviate from the culture we are used to over the years. As a council member I am personally hoping to continue my agitation to achieve this in the SLMA next year. I sincerely hope other colleges and

associations too will work along these lines without any further delay.

Sri Lanka Medical Council

Our regulatory mechanisms too have been less than effective in maintaining standards that the society expects from the medical profession. The General Medical Council in the UK acts like an independent court of law in its regulatory function. In contrast, the Sri Lanka Medical Council, still working on an archaic medical ordinance, is restricted in its ability to do a proper regulatory function to maintain discipline among doctors. Many amendments to rectify its shortcomings, broadbase its composition and expand its scope proposed over the years by the Council itself, but needing approval by the parliament, have been ignored by the politicians concerned. It is sad to note that some leading members of the medical profession too have connived with the politicians to undermine the authority of the SLMC. As a result the SLMC is concerned mainly with the registration of doctors while moving at a snail's pace in maintaining their discipline thereafter.

Our standing in society would be enhanced if we appear to stand with the people assisting them in their struggle for survival. We have more to do than just treating the victims after the damage is done. As much as we give prominence to preventive medicine, we have an important role to play in working against social injustice perpetrated by the rulers. People quite rightly believe that with the respect we command from all sectors, our positive actions on their behalf are likely to be more productive than the general public demonstrating vociferously on the streets.

As an example, we can see how the police are more careful in dealing with demonstrations and protests by lawyers and other professionals. Of late the legal profession has come out in a big way in defence of the people, though up to now they too have been silent bystanders while the laws were being applied unequally and grossly abused depending on the power and influence of individuals concerned.

Looking to the Future

Until we rethink our strategies and change course, people look upon doctors and other professionals as a privileged bunch looking after their own interests only and thriving at their expense.

There is little use in continuously boasting and congratulating ourselves for praiseworthy achievements so far in curative and preventive aspects of medicine despite limited resources. Those achievements are brought to nothing by the traitorous activities of unscrupulous politicians and their henchmen, which we have ignored so far. Rather than extolling the virtues and many good qualities still preserved in the medical profession, that is why I devoted this presentation mostly to highlight the shortcomings and the reluctance of our professional organisations in preventing or rectifying them. Thus we have failed our countrymen in many areas where we could have been proactive to prevent social maladies the Sri Lankans are suffering from now.

The medical profession should look inwards and effect a radical system change before we could influence the outside world. It is high time, though rather belatedly, to rethink our future role outside the sphere of academic activity, as an influential group of professionals, whom the society can look upon as their saviours rather than as a part of the problem.

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