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CONTENTS

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President, Sri Lanka Medical Association

Social responsibility of doctors: Off-line and on-line

There are about 25,000 medical doctors in practice in Sri Lanka (0.1% of the population). Possibly due to stringent criteria of selection, it is unanimously accepted that those who are in this profession have higher intelligence than many of the general population. For the same reason, the general public, be it the elite crowd or those eating humble pie, have faith in the views expressed by the medical professionals even when they voice their view point about matters that they have no expertise on. Hence doctors should always have prudent social behaviour while on-duty and even when off-duty. Whether one likes or not, the society expects doctors to behave in a responsible manner at all times, be it on the road, at the super market or on social media.

Those doctors who think they can do anything they please when off duty and also have the abiding notion that other people should mind their own business, are terribly mistaken. All or most of us, sometime or other during our professional life have mentioned our profession to get a special favour done. Many use the 'doctor' pre-fix in places where it really does not matter, such as reserving a time to visit a salon or securing a table at a restaurant. The number of times you may have misused your doctors' car pass to get away from being fined by the police is just a simple example. On the other hand, one should also remember that whether related or unrelated, any illegal, or unsavoury deed committed by a doctor is reported by the media linking it to the medical profession.

Doctors who had self-discipline not to drink and drive while working abroad have no second thoughts about breaking the same rule while in Sri Lanka after returning. A research venture which analysed doctors whose names have been erased by the General Medical Council of the UK reported that 13% of cases were related to doctors' personal lives such as sexual issues, drink-driving offences, dishonesty and violence (mostly by non-white doctors). Rest consisted of working life issues such as dishonesty, inappropriate relations with patients or colleagues and clinical work issues. The medical ordinance has given powers to Sri Lanka Medical Council for suspending the licence to practice or erasing from the register.

Social media are powerful tools, influential enough to change the mind set and opinion of a great majority of people. Social media which are based on the principle of enabling user-generated content, allow everybody a voice, without needing prior approval and grants autonomy of anonymity and pseudonymity. Wrongdoers end up misusing all those aspects of freedom. There are examples from the recent past where social media has induced people to start riots or even affect the outcome of elections. Irresponsible social media behaviour is rampant in Sri Lankan society too. How many doctors share Facebook posts containing erroneous health facts without even reading the content? An incident of a doctor being suspended from practicing medicine in Switzerland for spreading wrong health facts related to COVID-19 is reported in an article in this issue of the newsletter. A Medical Board in USA suspended the licence to practice of a doctor who bragged while speaking in a political rally that neither he nor his staff ever bothered to wear masks when seeing patients at his clinic during the COVID-19 pandemic. Those events indicate that we have no defence for irresponsible behaviour in front of the society (actual or virtual). Some doctors abuse patients' rights when they post photographs of patients on social media breaching the privacy of another individual person. Abusing photos of kids or spouses of politicians is frequently seen on social media. How would one feel if someone posts a photo of one's kid without permission, to satisfy an ulterior motive of theirs? Some photos can go viral even without the owner of the photo or social media account knowing it and be abused by perverts. (There is a general circular (no 02/23/2006) on use of mobile phone with camera in hospitals issued by the Ministry of Health).

According to the Telecommunications Regulatory Authority statistics, Sri Lanka has 6.40 million social media users with Facebook accounting for 80% (in 2020) and 57% (in 2021). (Reduction is due to shift from Facebook to other social platforms). Restrictions imposed on social media are not popular decisions and have always bounced back on the ruling party. Besides, governments are mostly interested in blocking news items which are unfavourable to them rather than those harmful to society. Thus, we need to have some self –discipline within an ethical framework when using social media rather than relying on written laws or hiding behind freedom of speech and human rights shields to protect one's self after misbehaving. We, doctors are a minority with a disproportionately powerful voice to change the mind-set of the general public. Hence, we as a socially responsible category, need to use social media with sensitivity and responsibility for betterment of society. It is better to be cautious and responsible than having to regret later.

– 14th March 2021

Editor-in-Chief
Professor Hasini Banneheke,
Faculty of Medical Sciences,
University of Sri Jayewardenepura

President's Message

Dear colleagues,

I am extremely pleased that I was able to pen this message at a time where we are seeing some control of the COVID-19 infection that caused a devastating impact on the health of people, worldwide. As of recent, we are seeing a decreasing trend of new cases as well as deaths in Sri Lanka. However, we must not celebrate as every life is valuable for health care professionals working tirelessly to save lives in hospitals throughout the country and the presence of infection somewhere in the globe would remain the risk of appearance of new waves. The reasons for this regained control appear to be multifactorial including contact tracing, isolation, and adherence to public health measures. It is uncertain as to how much of an effect the mass vaccination have contributed to the reduction in cases, since the decreasing trend became apparent prior to the anticipated effects of vaccination.

On behalf of the council of the SLMA, I am thankful to the Government of Sri Lanka for providing vaccination to healthcare professionals with highest priority. According to scientific publications single dose of the Covishield vaccination provides 76% protection against COVID-19 for three months and the second dose increases the protection to 81%. As all health care professionals have now received vaccination, it is our primary responsibility to take care of non-COVID medical conditions who present for treatment to government hospitals, leaving no room for allegations. During the initial stages of the outbreak, there were numerous complaints against hospitals and doctors for not providing a reasonable service for non-COVID medical conditions.

The vaccination of health care professionals is relevant for future activities of the SLMA as well. While we were able to conduct few important in-person academic meetings in last few weeks, the Anniversary International Medical Congress of SLMA will be held as a conference with physical participation of delegates. Please check the SLMA e-Bulletin and the SLMA alerts that will update you on the various activities of the SLMA.

The academic committee of the SLMA has lined up an attractive academic programme representing both the clinical and public health specialities. Keeping with the theme "Professional Excellence towards Holistic health care", there will be symposia targeting doctors, nurses and allied health professionals. The conference is scheduled to be held from the 27th to 30th July, 2021 at the BMICH. Registrants will also have access to the conference material via "on-demand" facility for an additional 1 year without paying an extra fee. Healthcare professionals who plan to attend the conference will be able to revive and strengthen their friendships with their peers, while making use of the anniversary congress to update on the latest research and healthcare developments.

Thank you

"The academic committee of the SLMA has lined up an attractive academic programme representing both the clinical and public health specialities. Keeping with the theme "Professional Excellence towards Holistic health care", there will be symposia targeting doctors, nurses and allied health professionals. The conference is scheduled to be held from the 27th to 30th July, 2021 at the BMICH. Registrants will also have access to the conference material via "on-demand" facility for an additional 1 year without paying an extra fee.

Dr. Padma Gunaratne
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President,
Sri Lanka Medical Association

Activities in February and March 2021 at a Glance

15th February 2021

The first therapeutic update lecture for the year was done by Dr. Gunendrika Kasthururatne (Consultant in Rheumatology and Rehabilitation) on "Vasculitis". More than 80 persons viewed it on zoom and facebook live.

16th February 2021

A symposium on "Myasthenia Gravis & Congenital Myasthenia" was conducted as a case-based discussion. The resource persons included the following: Case presentations by Dr. Archana Niththiyaruban (Pediatric Registrar) and Hamspriya Vigneswarajah (Pediatric Registrar), Review of the topic by Dr. Vindya Subasinghe (Senior Registrar in Paediatric Clinical Genetics), MCQ/ Picture quiz moderated by Dr. YGT Priyawansha (Senior Registrar in Paediatric Clinical Genetics), Discussion by Dr. Clement Perera (Consultant Family Physician) and Dr. Anuruddha Padeniya (Consultant Paediatric Neurologist). About 50 persons attended online and around 10 physically.

17th February 2021

A symposium on "Ethics in COVID-19" was conducted by the Expert Committee on Ethics in Sri Lanka with more than 100 online participants and around 40 participating on site from both the medical fraternity and media personnel. Dr. Vinya Ariyaratne, Consultant Community Physician made a presentation on "Are we concerned about ethics in COVID-19?", followed by views presented by the following experts; Dr. Amal Harsha de Silva (Secretary to the State Ministry of Primary Health Services, Pandemics and COVID-19 Prevention, Dr. Razia Pendse (WHO Representative to Sri Lanka), Ms. Ritsu Naken(Country Representative, UNFPA), Dr. Deepa Gamage (Consultant Epidemiologist, Epidemiology Unit, Colombo) and Professor Athula Sumathipala (Keele University, UK). Presentations were followed by a discussion. A concept note was signed by all the resource persons was forwarded to the DGHS, MoH.

18th February 2021

The February Regional meeting was held as a hybrid meeting in collaboration with Chilaw Clinical Society. More than 80 participants gathered at two auditoriums of the Hospital and around 30 more joined online. The first half of the meeting was conducted by the resources persons from SLMA and the second half was by the resource persons from the BH Chilaw. Dr. Padma Gunaratne (Consultant Neurologist and SLMA President) spoke on Management of Acute Stroke, Dr. Kesara Ranatunga (Consultant Surgeon, TH Karapitiya) spoke on Bleeding per rectum; a clinical approach and Dr. Shehan Silva (Senior Lecturer in Medicine & Assistant Secretary SLMA) spoke on Multi-morbidity in older adults in the session before morning tea.

The second session had lectures by Dr. Chandrika Subasinghe (Consultant Endocrinologist, DGH Chilaw) on COVID-19 and Diabetes, Dr. Arjuna Ellapola (Consultant Psychiatrist, DGH Chilaw) on COVID -19 Mental Health, Dr. Rizny Sakkaff (Consultant ENT Surgeon, DGH Chilaw) on How to approach change in voice and Dr. K Vickneshwaran (Consultant Urologist, DGH Chilaw) on "Doctor, there is blood in my urine!"

20th February 2021

The first SLMA Saturday Talk was held on 20.02.2021. Dr. Padma Gunaratne, Consultant Neurologist and SLMA President, conducted a lecture on Acute Stroke: Case Based Discussion, for medical students, medical officers, GP and Registrars. It was attended by more than 350 participants. It was also live streamed via Facebook.

23rd February 2021

The clinical meeting for the month of February was held with the collaboration of Sri Lanka College of Paediatricians on "Cystic Fibrosis: No Longer a Disease of West". This included a case presentation by Dr. Srimali Wijesundara (Senior Registrar, Paediatric Pulmonology, LRH), a Review Lecture on Epidemiology, Clinical Spectrum and Principles of Management of Cystic Fibrosis by Dr. Channa de Silva (Consultant Pediatric Pulmonologist, LRH) and MCQ discussion by Dr. Thilini Muthukumarana (Senior Registrar, Paediatric Pulmonology, LRH).

24th February 2021

SLMA Webinar Series 2 on "COVID-19 in Sri Lanka: Perspective on the State-of-Play was held with the online participation of more than 125 participants. Three speakers made their presentations on the following topics; MOH initiatives and Activities by Dr. Hemantha Herath, Deputy Director General (Public Health Services), the Public and Community Health Outlook by Professor Samath Dharmaratne, Consultant Community Physician and President Elect SLMA (Faculty of Medicine, University of Peradeniya) and Viewpoints on the way forward by Dr. Razia Pendse, WHO Representative to Sri Lanka. This was conducted as an interactive activity which included a Q&A session after each presentation.

26th February 2021

The History of Medicine Lecture was upgraded to an oration after the demice of Deshabandu Dr. CG Uragoda on 28th March 2021. The first oration was delicered by Professor Ravindra Fernando (Senior Professor of Forensic Medicine, Sir John Kotelawala Defence University and Past President SLMA) on "History of Forensic Medicine in Sri Lanka".

2nd March 2021

The third media seminar on "Vaccines for COVID-19: Facts & Myths" organized by the SLMA Media committee was held as a panel discussion with Dr. Pramitha Mahanama, SLMA Council member, moderating the event. The panelists were; Drs. Ananda Wijewickrama (Consultant Physician, IDH), Dr. Deepa Gamage (Consultant Epidemiologist, Epidemiology Unit, Colombo) and Dr. Dhanushka Dassanayake (Consultant Immunologist, MRI). Apart from the questions asked by the moderator, the onsite and online participants also actively engaged in the discussion. There were more than 35 online participants including media personnel.

3rd March 2021

The International Birth Defects Day was commemorated at the SLMA with the participation of Hon. Dr. Sudarshani Fernandopulle (State Minister of Primary Health Services, Pandemics and COVID-19). The Colombo Declaration on Birth Defects Care and Prevention was handed to her by the co-chairs of the SLMA Expert Committee on Birth Defects. Dr. Padma Gunaratne (President SLMA) and Dr. Chitramalee de Silva (Director, Family Health Bureau) welcomed

the participants. Dr. Saraji Wijesekara (Secretary-SLMA expert committee in rehabilitation/Past president SLACDA) made a presentation on "inclusive society for individuals with Down syndrome". Prerecorded messages were given by Razia Pendse, WHO Representative, Sri Lanka, Dr. Salimah Walani, VP Global Programs - March of Dimes - USA and Dr. Neena Raina, Senior Advisor – Child and Adolescent Health – WHO SEARO. Hon. Dr. Sudarshani Fernandopulle shared the Role of the Government on Birth Defects prevention in Sri Lanka and the commitment by the MoH.

3rd March 2021

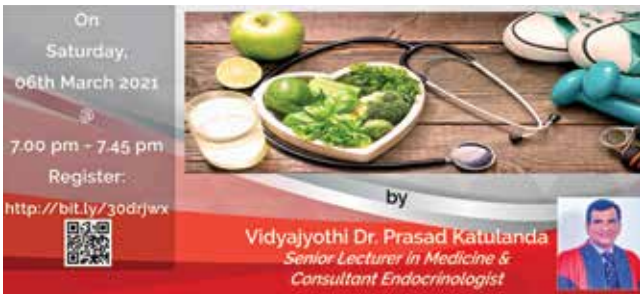
A Meeting between Health Ministry officials and SLMA representatives was convened by the Director General of Health Services (DGHS) Dr. Asela Gunawardena on the request of SLMA. It was attended by DGHS, Dr. PWCL Panapitiya (DDG Medical Services 1) and Dr.RMSK Rathnayake (DDG ET&R) and the representatives of SLMA, Dr. Padma Gunaratne (President), Dr. Ruvaiz Hanifa, Dr. Achala Balasuriya, Dr. Udayangani Ramdasa, Dr. Dilhar Samaraweera, Dr. Kalyani Guruge and Mr. Nandana Welage. The matters discussed at the meeting included burials of COVID-19 victims, vaccination of health staff at private medical centres and GP Practices, the SLMA representation at steering committees, stroke management, medical rehabilitation and improving geriatric care and palliative care services in Sri Lanka.

5th March 2021

The seventh edition of the SLMA Guidelines and Information on Vaccines was launched with the participation of selected invitees at the Dr. NDW Lionel Auditorium of the SLMA. Dr. Amal Harsha de Silva graced the occasion as the Guest of Honour and the representative of the Hon. Minister Dr. Sudarshani Fernandopulle, State Minister of Primary Healthcare, Epidemics and COVID-19 Prevention. Dr. Lucian Jayasuriya, Joint Editor welcomed the invitees and made a brief introduction of the book. Dr. Padma Gunaratne (President SLMA) spoke on behalf of SLMA and Dr. Hector Weerasinghe, Director - Medical, Regulatory & Government Affairs - GlaxoSmithKline Pharmaceuticals spoke on behalf of GSK Pharma. Dr. Amal Harsha de Silva, Guest of Honour addressed the gathering which was followed by a brief review of the book by Professor Guwani Liyanage, Consultant Paediatrician, Faculty of Medical Sciences, University of Sri Jayewardenepura. The handing over of copies of the book to dignitaries at the Head Table which included Prof. Indika Karunatilleke (Immediate Past President SLMA), Mr. Nimal Weerasinghe (brother of late Prof. Anura Weerasinghe), Dr. Hector Weerasinghe, Professor Guwani Liyanage and Mrs. Kumudini Hettiarchchi was done. The five joint editors and the twenty nine authors of chapters were also officially handed a copy of the book. Professor Jennifer Perera, Joint Editor and Past President of the SLMA, delivered the vote of thanks.It is available at www.slma.lk. All SLMA members can obtain ONE free copy from the SLMA office.

6th March 2021

The second SLMA Saturday Talk was held on 06.03.2021. It was on Diabetes Mellitus: Two Ends of the Spectrum" and was delivered by Vidyajothi Dr. Prasad Katulanda (Consultant Endocrinologist & Senior Lecturer in Medicine, University of Colombo). It was attended by more than 200 participants.



8th March 2021

A felicitation ceremony was organized by the SLMA to felicitate Dr. Razia Pendse, WHO Representative for Sri Lanka, to appreciate the distinguished services rendered by Dr. Pendse to the medical profession in the country. SLMA Council members and Past Presidents participated in this event. A citation was read and a felicitation plaque was handed over to her.

- Dr. Sumithra Tissera
Hony. Secretary of the SLMA

Vaccines for SARS-CoV2 - Will they end the COVID-19 pandemic?

Professor Neelika Malawige
Head, Department of Immunology and Molecular biology
Faculty of Medical Sciences, University of Sri Jayewardenepura

Infection due to SARS-CoV2 is thought to have originated in Wuhan, the capital city of the Hubei province in November 2019 (1). Since then it has spread to the rest of the world and is now found in 212 countries (2). Due to its spread in all continents the WHO declared it as a pandemic on the 11th of March 2020 (3). However, within a short period of 1 year there are several vaccines that have completed phase 3 trials and have been given emergency authorization by many regulatory bodies to be used in this pandemic situation. As these clinical trials were carried out over an unusually limited period of time, and the vaccines were made available for the general public in record time, there have been many myths and concerns regarding the safety and effectiveness of these vaccines.

Types of vaccines

The main aim of vaccination is to induce long lasting protection against infection with the SARS-CoV2 by inducing a robust virus specific neutralizing antibody (NAb) and T cell response. Analysis of SARS-CoV2 specific NAbs from infected individuals showed that the majority of such antibodies target the receptor binding domain (RBD) and prevent binding to the host cell receptor ACE2(4). Therefore, the majority of the vaccines under development and in use, only contain the spike protein of the SARS-CoV2, as this protein is the main target of NAbs. While messenger RNA vaccines (Pfizer and Moderna) deliver the RNA coding for this spike protein encapsulated in a lipid nano particle, the adenovirus vector vaccines (Oxford/Aztrazenaca, Sputnik V, Janssen and CanSino) deliver it through an adenovirus vector platform. Apart from the above vaccines there are many other inactivated vaccines (Sinovac, Sinopharm, Covaxin), DNA vaccines and protein subunit vaccines.

The adenovirus vector vaccines have been in clinical trials for various infectious diseases and cancers since 2005. The AD5 (one of the viral vectors used in the Sputnik V vaccine) was used in an HIV vaccine trial from 2005 to 2008 (5). However, as this vaccine did not show adequate efficacy, it was not approved (6). These vaccine platforms were also used in the Ebola vaccine trials from 2015 to 2018 (7). University of Oxford had been using the ChadOx1, a Chimpanzee adenovirus vector platform for a cancer vaccine against advanced prostate carcinoma since 2015 in clinical trials (8). The mRNA vaccines have also been undergoing clinical trials for many years as cancer vaccines (9). As these various very versatile vaccine platforms had already been developed and had been in clinical trials for many years, it was possible to use these vaccine platforms to develop vaccines for COVID-19 rapidly.

Vaccine safety and myths

Due to the rapidity with which the above vaccines were made available for the general public, despite careful evaluation by the WHO and many other stringent regulatory authorities, many have questioned their short term side effects and long-term safety. While most of these concerns are a natural, the anti-vaxxers have been carrying out a very carefully planned, extremely effective campaign against the COVID-19 vaccines (10) as they have been doing with many other vaccines such as the MMR. Stories regarding insertion of chips to track individuals, the vaccines can change one's DNA, that the vaccine is incorporated to the DNA and that they cause infertility and impotence were widely circulating in social media and some mainstream media. While the above stories are nothing but fiction, it is absolutely essential to ensure that the vaccines are safe, as vaccines are given to healthy individuals to prevent infection.

The immunization campaign in Sri Lanka is one of the best, if not the best in the world, with the highest coverage for all childhood infections. The public have the utmost trust in our vaccination campaign, and it is crucial that the authorities take adequate measures to ensure that public trust is not broken. While it is important to carry out extensive public education programs to dispel the myths, it is equally important to record and investigate all complaints after vaccination, even if they do not appear to be related. Certain adverse effects of the vaccine will only be evident after a large population has been immunized. For instance, vaccine associated poliomyelitis is a very rare, but serious side effect that usually occurs in immunocompromised individuals. Similarly, the thrombocytopenia and cerebral venous thrombosis that is report-

ed with the AstraZeneca vaccine should be thoroughly investigated and all vaccine related events properly monitored. A similar approach should be taken to investigate any vaccine associated adverse event, for all COVID-19 vaccines.

Vaccines and variants

Although there are many different seasonal coronaviruses which cause upper respiratory tract infections, the coronavirus infections that result in significant morbidity and mortality have been due to the SARS-CoV1 (SARS), MERS and the SARS-CoV2. The majority of those infected with the SARS-CoV2 virus does not show any symptoms or only develop mild symptoms, whereas severe disease and death predominantly occurs in the older individuals and in those with comorbidities (11). For instance, although the overall case fatality rates for this infection is around 0.5-3%, case fatality rates of patients over 80 years of age is reported to be 14.8% and in those between the ages of 70 to 80 to be 8.8% (11). However, the SARS-CoV2 virus spread rapidly to every corner of the world, infecting, and killing millions (2.6 million deaths worldwide as of 17th March 2021). Therefore, the main aim of immunization was to prevent severe infection and death. In order to full fill this requirement, all the vaccine trials reported their efficacy with regard to reducing symptomatic infection and severe disease and were not designed to explore their efficacy against asymptomatic infection. However, as time progressed, different variants emerged with some being able to evade vaccine induced immunity.

The SARS-CoV2 is an RNA virus, and although it is a relatively stable virus, certain mutations have taken place with time. These have increased the transmissibility of the virus and may affect vaccine efficacy. While the majority of mutations that occur in the virus are insignificant, certain variants of concern have been reported that initially emerged in the UK (B.1.1.7), South America (B.1.351) and Brazil (P.1). Of these the B.1.351 and the P.1 SARS-CoV2 variants, have particular mutations in the spike protein, which have shown to affect vaccine efficacy and have a potential to cause re-infection in those who were naturally infected with the virus. There is a potential that new variants that escape natural immunity and vaccine induced immunity may emerge in the future. However, although these variants were shown to significantly evade vaccine induced immunity and cause mild or moderate infection, they were still shown to protect against severe disease and death. Therefore, these vaccines are fulfilling the expected requirements, which is to prevent severe illness and death. Fortunately, many of the vaccine platforms can be rapidly modified to be effective against the new variants.

Given that new variants are likely to emerge, that none of the vaccines will induce sterilizing immunity (completely prevent asymptomatic infection), it is questionable whether we can eradicate the SARS-CoV2 virus from the world. Therefore, once all the vulnerable individuals are immunized to prevent severe illness and death, we might need vaccines produced every year for this group of individuals, such as we see with the influenza vaccines. Although it is difficult to predict the future of COVID-19, it does seem like it is here to stay.

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Vaccine Safety, Efficacy and Hesitancy

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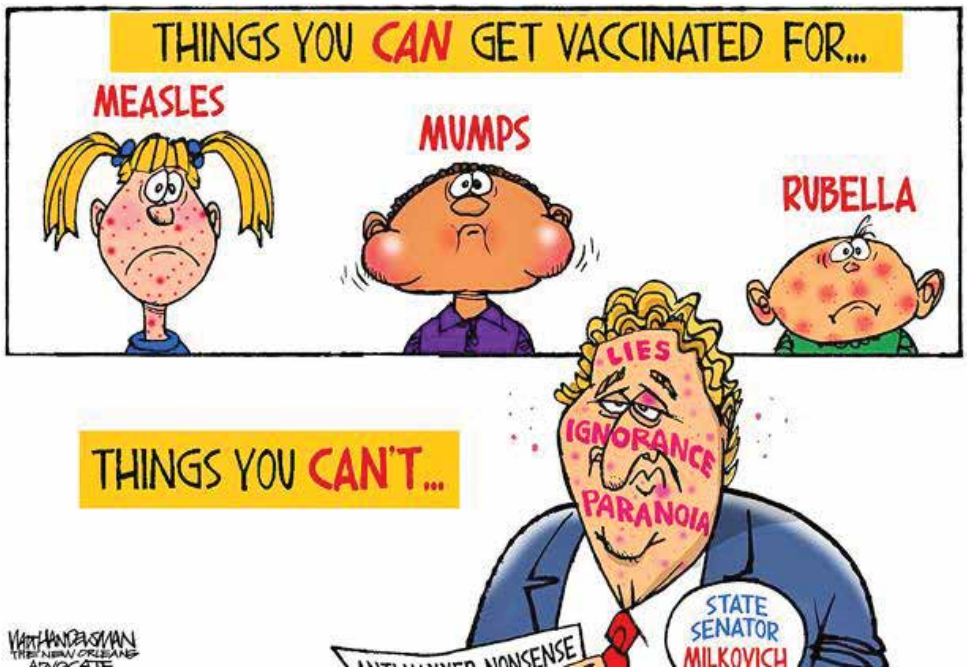


Vaccination is unquestionably the most successful health investment in the world. It saves 2-3 million lives every year.[1] Vaccination has been in existence in the world for nearly two centuries with eradicated diseases such as small pox and near elimination of many diseases such as polio, diphtheria, tetanus, and measles.

Globally, there is a dramatic decline of the incidence of many other vaccine preventable infectious diseases. Despite this incredible success story, universal vaccine acceptance is slowly slipping away due to issues related to vaccines and issues beyond vaccines such as anti-vaccine propaganda.

The two most debatable issues of vaccine administration are its safety and efficacy. There exist no vaccines or drugs without any adverse reactions. A drug administered to a patient for a disease could have some adverse reactions. However, the patient may still prefer to continue the drug, if it needs to be taken to cure his illness.

The perception is different when it comes to vaccines. Vaccines are always administered to normal healthy individuals.

Therefore, any trivial adverse reaction is considered significant. The expectations of the public to have a perfectly safe vaccine is understandable as it is given to healthy subjects, who might not get the disease (even if the vaccination was not given).

There is a global necessity to monitor all events following vaccination considering the sensitive nature of adverse events associated with vaccines.

Any medical event occurring after vaccination could be classified as an adverse event following immunization (AEFI) whether the event has any causal relationship to immunization or not.

Adverse events/reactions following immunization could range from mild to severe and from common to very rare.

They may occur as a result of the immunization, with a causal relationship between the event and immunization, or occur after the immunization by chance, or have a coincidental relationship between the event and immunization.

Adverse events following immunization could be classified as:

- Directly related to the vaccine
  - Product-related
  - Quality defect-related
  - Error-related
- Immunization anxiety-related reactions
- Coincidental event

Vaccine related adverse events

Common, mild vaccine reactions

A mild reaction is considered as a local symptom such as pain and/or swelling around the site of injection. Fairly common mild systemic symptoms include fever, headache, generalized body pain and lethargy.

Mild systemic reactions to vaccines usually occur few hours after vaccination and resolve spontaneously within few days without any specific treatment. The onset of mild reactions to injected live vaccines could take a week or more to occur but they also resolve spontaneously without any specific treatment

Rare, severe vaccine reactions

These reactions occur as immune system response to the vac-

cine. They include severe allergic reactions (anaphylaxis) to an ingredient in the vaccine, or as non-allergic manifestations such as haematological disturbances e.g. thrombocytopenia, febrile seizures, hypotonic hyporesponsive episodes (HHE), or prolonged inconsolable crying in infants.

Anaphylaxis could rarely be life threatening. Other severe reactions may or may not require treatment and rarely result in any long-term consequences.

Anxiety-related responses to vaccination

Any individual (especially children) could feel tensed or anxious when they need or receive a vaccine. This is particularly so when the vaccine is administered by injection.

Certain sensitive individuals feel so alarming and overwhelming leading to panic attacks, hyperventilation, breath holding attacks (in children), severe headaches, tingling sensations, fainting attacks and even convulsions. These symptoms are not specific to immunization as they could occur in many other anxiety-related situations. They will resolve by themselves once the state of anxiety passes away.

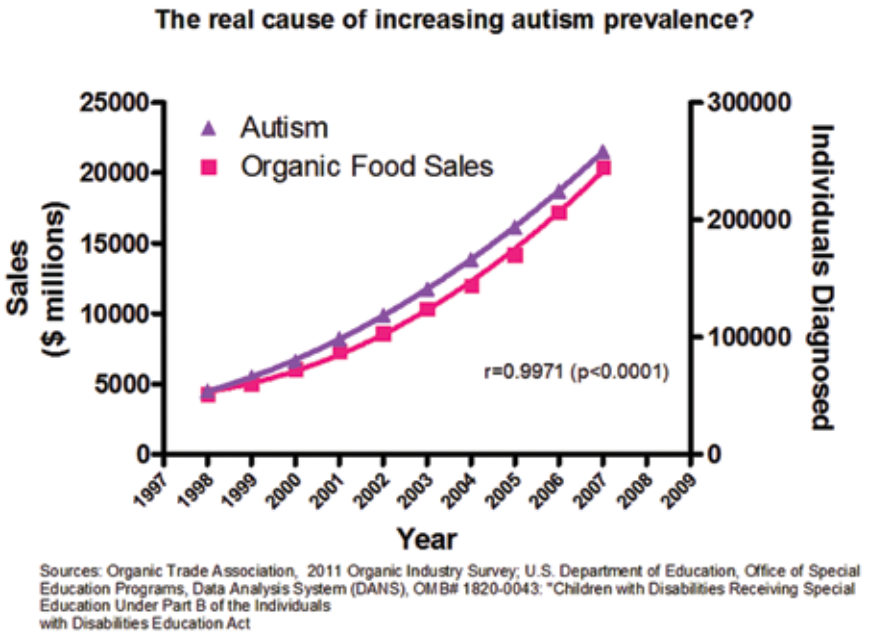
Coincidental events

These events are completely unrelated as they occur after immunization by chance. They are likely to have occurred even if the immunization had not been administered. A classic example is that of MMR vaccine and autism (a strong hindrance to measles vaccination programmes globally). Autism in children is diagnosed when they are around one year old.

The MMR vaccine is also directed around that age. Parents begin to notice abnormal behaviour of the child often happening after MMR vaccine.

It is a sheer chronological coincidence. There is obvious virtual correlation between administration of MMR and appearance of autistic symptoms. It is essential to understand that correlation is not causation.

Figure 1



Sources: Organic Trade Association, 2011 Organic Industry Survey; U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), OMB# 1820-0043: "Children with Disabilities Receiving Special Education Under Part B of the Individuals with Disabilities Education Act

Figure 1 is an illustration used to explain that correlation is not causation.[2] In this example, the incidence of autism increases in proportion to the same way as of increased consumption of organic food. However one must question whether consumption of organic food gives rise to autism.

Medical events occur throughout life. They are seen more frequently in children, or simply noticed and/or diagnosed more frequently when they are young. As large numbers of children are immunized at a time in their lives when congenital or developmental conditions are likely to be noticed, it is inevitable that one or more of these events will occur after an immunization.

This could create the appearance that illnesses or newly diagnosed conditions are related to immunization when they actually are unrelated.

Efficacy of vaccines

Just as much the safety of vaccines, there exist no vaccine which is 100% effective. Achievement of such success even if ideally exists needs multiple administration. Therefore it is still possible to contract the disease following any vaccine.

A stringent procedure called phase trials has to be followed to prove the efficacy of any new vaccine, before it is released to the global market. Phase trials are well controlled clinical trials including large number of volunteers. It is mandatory to do phase trials to find out the efficacy of a given vaccine.

What is efficacy?

A vaccine with an efficacy of 90% in a phase 3 trial, reflects that there is a 90% reduction in cases of disease in the vaccinated group compared to the non-intervened group. However, efficacy is measured in ideal conditions taking two similar groups.

It does not always translate to effectiveness when given in the reality therefore overestimating impact in practice.

Conditions under which a participant is taking a vaccine are carefully designed in clinical trials. Participants are often excluded if they are pregnant, have comorbidities or are taking medications.

Furthermore it is a representation of a subsection of the full age range of a population. For exam-

ple, not many COVID-19 vaccine trials have included young children, even though they may also need to receive the vaccine when one is ready. Adverse events are carefully monitored throughout the study.

How do we measure vaccine effectiveness?

When a vaccine is introduced to the population, factors such as medication, underlying chronic illnesses, age, pregnancy and other non-clinical factors (e.g. maintenance of cold chain) could reduce the effectiveness in preventing the disease in the community.

Once efficacy has been determined, measuring effectiveness is critical to ensure the community impact. Surveillance data is vital to understanding effectiveness, as is immunisation data i.e coverage in the community.

Effectiveness of a vaccine is measured in observational studies as participants are not randomly assigned to a treatment versus a placebo group.

In contrast case-control studies assess effectiveness by comparing the vaccination status of individuals who develop the disease (cases) with a group of individuals without the disease (controls) who are also representative of the population from which the cases arise. If the vaccine is effective, the cases are more likely to be the unvaccinated individuals.

Vaccines do not always need to have an exceptionally high effectiveness to be useful. As an example although the influenza vaccine is 40-60% effective, it saves thousands of lives every year. Similarly, a vaccine when administered to a subset of people in the community may have an indirect effect on others in the community.

Conjugated pneumococcal vaccine is given to children under 2 years of age. Many Cochrane data based studies had demonstrated that in almost all communities, there is almost 50-60% reduction in the incidence of pneumonia among the family members.

Especially among elderly persons who are at high risk of death when this vaccine is given to the directed population.[3] This indirect effectiveness is called herd immunity.

Therefore efficacy and effectiveness of a vaccine matters when assessing the actual impact of the vaccine on the disease in the community.

Vaccine hesitancy

Vaccine hesitancy refers to the delay in acceptance or refusal of vaccines despite availability of vaccination services.

Vaccine hesitancy is complex and context specific varying across time, place and vaccines. It includes factors such as complacency, convenience and confidence.[4]

Hesitancy sometimes occurs as a result of spread of news of an adverse reaction. It becomes time and place related. Similarly, a particular vaccine could be believed to be associated with an unwanted side effect which public considers quite seriously. The association between MMR vaccine and autism is a typical example.

The anti-vaccine movements scattered around the world are use modern media effectively in a manner of spreading vaccine hesitancy globally, getting filtered down to low income countries from the affluent.

They employ real life scenarios to derive public sympathy and attention. Jim Carey, a famous comedian gives interviews in social media with his stepson having autism after the MMR vaccine. They speak to the hearts of the people.

There is considerable and irreparable damage done by these anti-vaccine social media network.

Though Sri Lanka could boast of having a track record of one of the highest vaccine coverage in the world over last three decades, this track record would be at a risk as anti-vaccine feelings are already seeping into our society through social media.

We observe that many 'educated' parents are most vulnerable group to this media menace.

Vaccine hesitancy results from vaccine safety and efficacy issues. Many believe that vaccines have toxins which cause serious side effects.

They may also believe that they are not effective quoting persons who contract the disease despite vaccination.

Therefore vaccine safety, efficacy and effectiveness should be thoroughly understood by the medical community, so that they may be able to explain to the public clearly and confidently. This is the most important way to counteract anti-vaccine propaganda.

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Many roads, one destination: Parasitic infections through the One Health lens

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One Health defines the idea that the health of people is connected to the health of animals (both domestic and wildlife) and our shared environment (CDC). Although the basic concept of One Health is not new, this has received much attention and prominence in the recent times, recognizing that resolution of contemporary health issues created by the convergence of human, animal, and environmental domains requires multi-sectoral and trans-disciplinary expertise and collaborations.

Common One Health issues

There are some key issues dealt under One Health which aptly demonstrate the interconnectedness of human and animal health and their environment in relation to common parasitic infections which affects populations of different parts of the world (Fig. 1).

Emerging infectious diseases

An emerging infection is one that has appeared recently within a population or has existed but is increasing in incidence or geographic, host or vector range. When reported emerging infectious diseases are taken as a whole, parasitic infections comprise a small percentage. However, it is in the context of the latter part of the above definition that parasitic infections assume a greater importance. Further, according to a comprehensive literature review by Taylor et al on risk factors of disease emergence in humans (2), 75% of the reports were recognized as zoonoses, which are infections which are naturally transmissible from vertebrate animals to humans. Cryptosporidiosis, cysticercosis, toxoplasmosis, fascioliasis and chlonorchiasis constitute some important parasitic zoonoses to be considered from a One Health perspective while this can be extended to some other vector borne parasitic infections such as leishmaniasis, trypanosomiasis and babesiosis. Even though companion animals (eg: cats in toxoplasmosis) and farm animals (eg: pigs in cysticercosis) constitute the important reservoirs of many parasitic zoonoses, wildlife also comprises a noteworthy reservoir of pathogens with the possibility of spill over to domestic animals. A multitude of other factors such as changing demographics, global travel and transportation, industrialization, human migration and land use patterns (especially agricultural) impacting biodiversity are considered some of the core drivers in the increasing trend in emergence of new pathogens .

Antimicrobial Resistance

The development of antimicrobial resistance is a natural phenomenon primarily due to selective pressure as a result of an organism being exposed to antimicrobials, which however is hastened by factors such as the frequency of exposure. Use of antibiotics for mass medication and as growth promoters in food producing animals is considered a main contributor to emergence of antimicrobial resistance in bacteria harbored by animals, with the risk of subsequent genetic transfer of these characteristics to bacteria causing infections in humans. While antiparasitic drug resistance in animals has not been seen to affect the human health in the same manner, the effects may be reflected in production losses and availability of food of animal origin (FDA, USA). Thus, measures are now being put in place to promote sustainable use of approved antiparasitic drugs in livestock, especially in relation to use of anthelmintics.

Food safety and security

An estimated 600 million, almost 1 in 10 people in the world, fall ill after eating contaminated food, while diarrhoeal diseases are the most common resulting illnesses (WHO). The human –animal interface has changed over time due to many reasons, one of the main contributors being technological advances in livestock and poultry production leading to a global increase in production and consumption of these products (3). Changes in consumer preferences, promoted by healthy food habits, has also resulted in a substantial increase in fresh produce consumption in the recent years.

The sources of food borne parasitic infections differ widely. Some parasites, for example cestodes (tapeworms) such as Taenia saginata or Taenia solium, may infect people through consumption of undercooked beef or pork infected with the larval stage, respectively. Another example is undercooked fish containing the metacercarial stage of the fish-borne

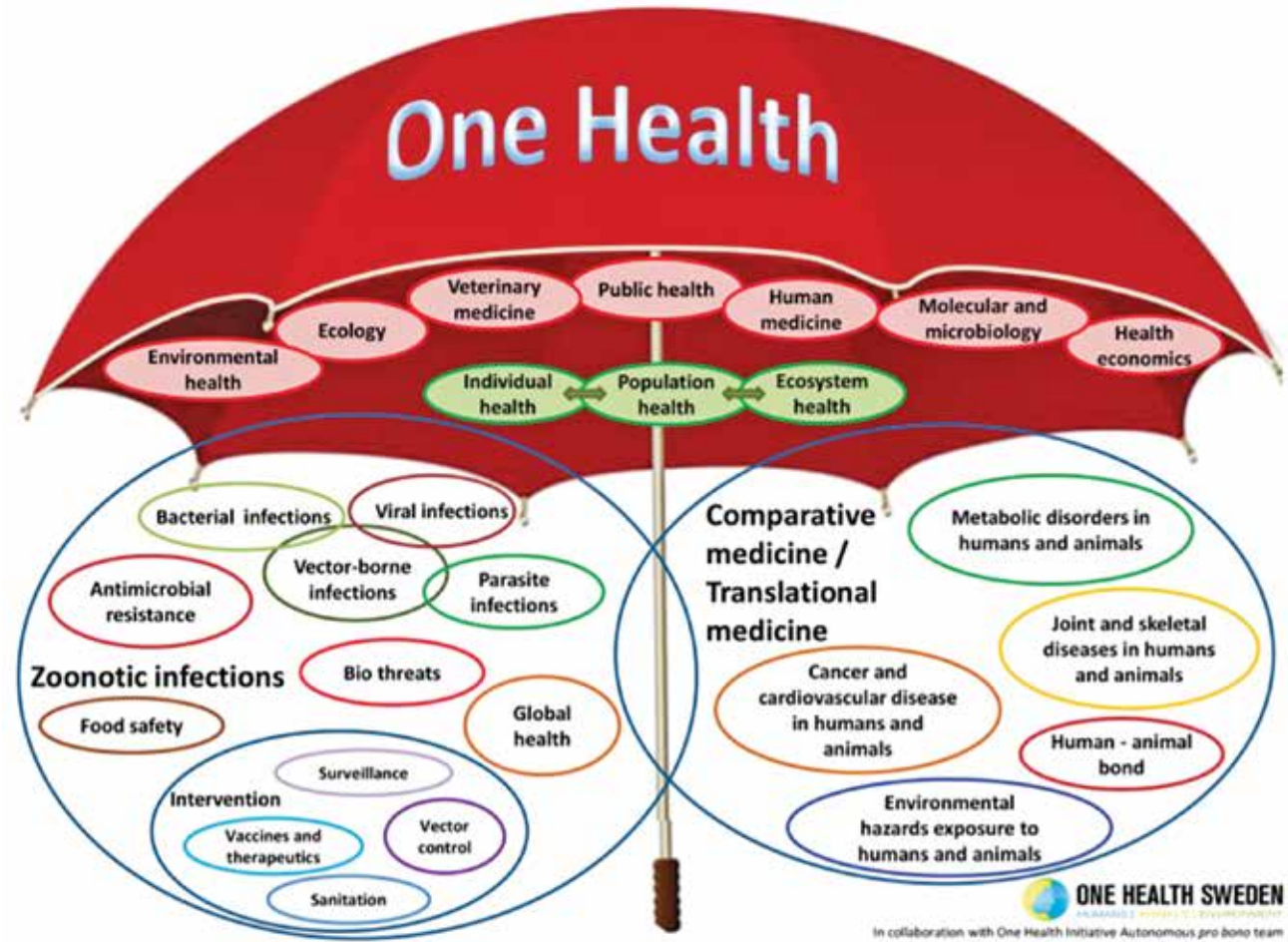

Fig. 1 The 'One Health Umbrella' developed by the networks 'One Health Sweden' and 'One Health Initiative' to illustrate the scope of the One Health concept (adapted from Gibbs et al 2014 (1)

trematode (fluke), Clonorchis sinensis causing infection in humans. Other parasites, such as Ascaris, Cryptosporidium, Entamoeba or Giardia, enter the food chain via faecal contamination of water or soil, primarily due to poor sanitary conditions in a community, and can contaminate fresh produce whereas toxoplasmosis can be acquired by ingesting different parasite stages either in undercooked meat, fresh food and water or infrequently in unpasteurized milk.

Even though typically associated with certain countries or regions according to endemicity patterns, global trends have enabled foodborne parasites to emerge in different populations in new locations adding to challenges in disease control (4).

Vector borne diseases

Vector borne diseases, the impact of which is largely influenced by the worldwide distribution of blood-feeding arthropods (e.g. mosquitoes, ticks, fleas, phlebotomine sand flies, lice, and triatomine bugs), include several parasitic diseases with a high global impact such as malaria, leishmaniasis, onchocerciasis, lymphatic filariasis, Chagas disease, and African trypanosomiasis. While most of the above parasitic infections have been the focus of targeted control programmes with good results, several factors have contributed to the reemergence of these infections. One such key contributor is climate change which can lead to changes in vector bionomics affecting intrinsic incubation periods, longevity and breeding habitats. Other climate independent host behaviour such as deforestation for human habitation and farming can increase human vector contact as well as force previously zoophilic vectors to adapt to new feeding habits. Global travel and human migration have also introduced vectors to new habitats.

A range of vector borne diseases have small companion animals as reservoirs highlighting the interconnectedness of vector borne diseases and zoonoses. For instance, dogs are competent reservoirs of zoonotic leishmaniasis transmitted by sandflies and dirofilariasis transmitted by mosquitoes.

Environmental health/change

Increasing temperatures, changes to geographic patterns of rainfall, increasing climate variability, increasing frequency and severity of extreme weather events are all environmental factors which will drive various disease profiles (5). These effects can be observed in several vector borne parasitic diseases such as malaria, which is considered to

have spread to higher altitudes and more temperate areas due to increasing temperatures becoming more conducive for mosquito breeding while in endemic areas changing rainfall patterns result in more breeding habitats leading to increased transmission. Moreover, dynamics of pathogens and hosts which change in response to climate change can affect disease prevalence and transmission (6). Some regions in Africa and China have been identified as at high risk of increasing schistosomiasis due to increasing fresh water snail populations, which in turn has been related to water velocity, rainfall, and temperature. Similarly, in soil transmitted helminths such as hookworms, higher temperatures have been associated with faster maturation of eggs in the environment while increased precipitation would facilitate survival of larvae in the soil thereby increasing chances of human infection (7).

One Health in action

November 3, 2020, marked the fifth annual One Health Day, bringing the focus to concentrated global efforts to maximize One Health approaches. Many countries in the world have adopted these in their goals and action plans with regard to diseases of national relevance. The success stories of One Health approaches are often seen in the field of zoonotic infections indicating the application of disease control measures based on recognition of human-animal-environment relationships.

For instance, preventive measures of hydatid disease caused by the dog tapeworm Echinococcus granulosus include deworming of dogs with praziquantel at least 4 times per year and the vaccination of lambs, the intermediate host (WHO). Similar approaches of vaccination to prevent infection in natural intermediate hosts have been adopted to reduce impact of cysticercosis, a parasitic infection due to Taenia solium (pork tapeworm) (8).

Zoonotic visceral leishmaniasis is another parasitic infection with a complex interplay between the parasite, sandfly which is the vector and a small reservoir of a companion animal (dog) that is managed by treatment of human patients, the culling of seropositive infected dogs and the insecticidal treatment of human homes (9).

Developing a One Health workforce

For a medical practitioner, One Health offers the opportunity to work beyond the scope of traditional medical practice, forging interdisciplinary collaborations with veterinary, public health and environmental health professionals among many others. Emerging infectious diseases which stands to benefit immensely through a One Health approach requires clinicians, as those first in line to encounter these, to be trained and sensitized to look for "the unusual and unexpected" and include these in differential diagnostic considerations in everyday clinical practice. Introduction to One Health principles in the teaching of zoonotic diseases during infectious disease coursework early in medical school has been suggested as a preliminary step to incorporating One Health into medical education while keeping the focus on clinical relevance. Public health level applications may be more appreciated at postgraduate level or during continuing professional development which could be introduced through experiential short courses. Training of personnel in other related sectors including policy makers and educational programs targeting secondary school students are measures adopted by some other countries to maximize One Health approaches.

Surveillance with a shared sentinel approach where information is rapidly conveyed across different health sectors and disciplines is of essence for timely alerts of emerging infections while this should be complimented by up to date laboratory techniques for quick diagnosis and source identification. A comprehensive understanding of the life cycles of pathogens, transmission pathways,

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pathogen dynamics in natural habitats, better understanding of pathogen dynamics in host species and environment would be key to managing many of the issues mentioned above and should be part of the One Health research agenda.

With advances in digital health, crowdsourcing, where data obtained via mobile phones and online social networks are checked against expert assessment could alert authorities of possible emerging infections. Smartphone applications available to ground level public health personnel could be adopted for similar purposes in the local setting if the need arises, as a similar framework already exists for other selected public health monitoring activities.

In conclusion, the One Health concepts provide a heightened awareness of animal, and environmental sources and influences responsible for many human diseases and conditions, thus empowering us to take a more holistic, "upstream" approach and identify the most effective points for health promotion as well as disease intervention and prevention strategies.

Doctor's Expectations from His Patients

(Extracted from an E mail of an unknown author)

Please bring your old medical records but do not bring your opinion about your old doctor. I may not be any better than him/her.

Wait patiently for your turn to see me.

My phone is to be used only for an emergency.

Do not use your mobile phone in the consultation room. Keep it on the silent mode.

Just listen to me.

Come prepared with your complaints, ideally written down in point form.

Do understand that complications of the illness or adverse effects of drugs are often unexpected and do not blame me for those.

Do not praise me for "saving" you as it is my duty to treat you.

If you are not happy with my treatment please consult a colleague of mine without wasting your or my time.

Do not read the internet and try to diagnose or treat your illness. I do not try to repair my faulty computer with advice from the internet.

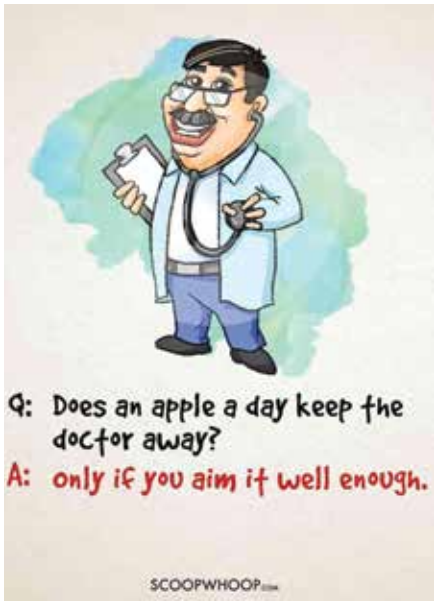
Do not suggest any investigations to be done on you, things that you have read or heard somewhere.

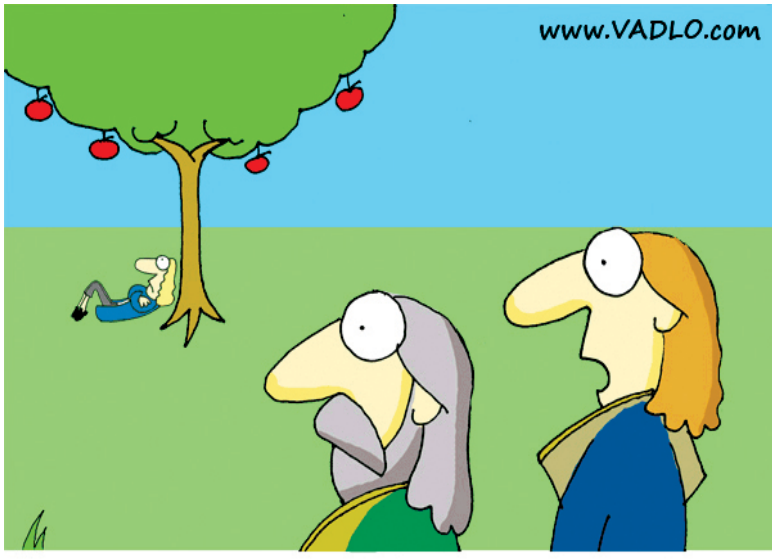
I am the doctor and you are my patient. Do not expect any special treatment because of your status etc. I treat all with respect.

If you like please wish me if you meet me at a social gathering, hotel, supermarket etc but do not try to discuss your health matters there also.

Do keep in mind that I am only a human being just like yourself.

– Extracted and presented by
Dr Sarath Gamini De Silva





"Reviewers have asked him to reproduce the experiment."

The SLMA Crest

The CMJ Cover (1951)

The CMJ Flyleaf (1951)

Saga of the crest of the Sri Lanka medical association

By Dr. Lakshman Ranasinghe
President SLMA (1984 – 1985)
& Joint Editor (1976 – 1987)

Abstract

The Sri Lanka Medical Association (SLMA) was established in December, 1887. An elegant crest has been its official emblem in the past 65 years. The narrative of the evolution of the SLMA Crest represents historical, functional, professional and social facets, aspirations, - plus the admirable vision of the pioneers and pathfinders of the medical profession in Sri Lanka.

"No great man lives in vain. The history of the world is but the biography of great men." Thomas Carlyle.

Introduction

As children of 5 yrs, every one of us clutched a hand of one or both parents, to enter the portals of the institution for our primary education. Soon enough, we realized that our new school had a crest which carried a motto that became symbolic of love, respect and allegiance to "Our School" (or "College" - as some would proudly have it). Allegiance would last our lives, - well into our respective careers and retirement. As time and affiliations moved on, this insignia of wholesome attachment came to be termed the logo, which combing form represented logotype, - defined as an emblem or trademark (of our institution, or company). All concepts of heralds, emblems, crests and logos evolved from the age of heraldry and chivalry.

Dr. K. P. Piyasena [1], writing on the significance of the logo of the College of General Practitioners of Sri Lanka, illustrated a representation of the caduceus, and painstakingly described its evolution and advent into the medical professional realm, as an emblem. A central twin - winged staff with 2 serpents spiraling upon it anticlockwise constituted this symbol [2] in early times. It evolved to be crowned by a dove facing right [1], and the entwining serpents held their crowned heads with protruding tongues protectively above the dove's head, - metaphorically implying: 'Be ye therefore wise as serpents and harmless as the dove'. Later, other animals, including in Sri Lanka, the lion which represented the Nation, were adapted, instead of the crown. Subsequently, the two snakes suggested association with eloquence, commerce, and intriguingly, trickery [1], and the wholesome concept was thought to have originated in Egypt [3]. The British Army Medical Corps interpreted the twin serpents as representing AESCULAPIUS (the Greek God of Health). In the modern context, commerce and trickery are seen as being closely associated with some trading establishments having logos and emblems. Eloquence and dedication, however, graduated into the Hippocratic Oath, although occasionally,

The President's Pendant

Past President's Pendant

in medical practice too, stains of commercial leaning and trickery do manifest, with hypocrisy. It has been surmised that the caduceus had its origin as early as the 3rd century, perhaps in association with heraldry. Its use as a symbol of the medical fraternity was established in the late 19th century [1]. The elimination of the serpent on the left of the central staff occurred subsequently (including in the SLMA Crest), and can be surmised (a personal hypothesis) as an exercise to minimize left - leaning tendencies and manifestations of aggression, commerce and trickery!

The caduceus is defined eloquently by Brewer [3], as having a Doric Greek evolution from the word karux to karukeion, meaning 'herald'. In mythology, it was carried by the herald of the gods, MERCURY, - who used it to give sleep to any person he chose. A white wand was later carried by Roman heralds when they went for peace.

The Sri Lanka Medical Association was inaugurated as the Ceylon Branch of the British Medical Association in December, 1887. Thereafter it evolved into The Ceylon Medical Association. After establishment of the Republic of Sri Lanka it took on the more appropriate appellation of Sri Lanka Medical Association (SLMA). Wisdom prevailed over emotion and nationalism when the SLMA decided that The Ceylon Medical Journal (established in August, 1887), - which was published as the Journal of The Ceylon Branch of the British Medical Association from 1904 to 1951(46 Volumes), shall change its name (back) to The Ceylon Medical Journal, - to enable (worldwide) indexing. Volume 1 of its New Series was published in 1952 when the President was the late Dr. E. M. Wijerama.

Noteworthy Events (antecedent to the birth of the Crest)

The national medical association did not have its own crest or logo before 1946 - 47. The late Dr. E. M. Wijerama, eminent physician and outstanding philanthropist, was elected President of the Ceylon Branch of the British Medical Association in 1947, - the Diamond Jubilee year of the association which, by then, was the most prestigious and represented organization of all registered LMS (Licentiate in Medicine and Surgery) and MBBS (Bachelor of Medicine and Surgery) doctors in the entire country. It seems reasonable to conclude that it was by no coincidence that the Journal, Vol. 43, 1 and 2 (1947) carried, on its cover and elsewhere, the official Crest, for the first time, - during the presidency of Dr. Wijerama, - having been the Editor 10 years earlier. As the 51st President he was a very, if not the most, senior physician of the General Hospital of Colombo, - which later qualified to be the largest hospital in the world, and was renamed The National Hospital. Illustrious personalities had also adorned the Chair of Office from the inception of the Association. Prior to 1910, - when Prof. Castellani, founder of the Medical Research Institute (MRI) in Colombo, who later became an illustrious and international medical professional celebrity, and, was knighted (as Sir Aldo) by King George the V1th of England while he was the Head of the London School of Tropical Medicine, - was elected President. Several distinguished doctors (including the founder, Sir William R. Kynsey) were also elected President; he and a few others, held the highest office more than once. Dr. Wijerama's elevation to presidency was more than tribute, because he had patiently toiled over many years for his Association and associates. He was endowed with organizing skills, and made a formidable number of literary contributions to the national medical journal [5], - most strikingly as its pro-active Editor for 3 years from 1937. In 1938 and 1939 he published 6 Numbers (issues) per year, - which record has not been achieved by any Editor of the Journal of the Ceylon Branch of the British Medical Association or the CMJ, - the maximum (prior to 1942) being 4 years. This record has not been surpassed in the entire history of the Journal.

Gestation of the Crest

Philosophical, social and medical concepts appear to have been

incorporated in the logo, which later necessitated only minor but relevant revision. For obscure reasons designing of a crest had not been looked into by the first 50 Presidents, even though they had taken timely action in most affairs of the medical association since 1887. Our view is that a motivated, dedicated, eagle - eyed and intensely focused personality realized, over a period of more than a decade before 1947, worked on the concept with anticipation, either by himself or in consultation and collaboration with senior colleagues, - to give our medical association its long - deprived but most impressive logo, as evident in the illustrations in this article. It cannot be just chance that carried the Crest to the cover of the Journal of the Ceylon Branch of the British Medical Association, in 1947, during its Diamond Jubilee. What baffles us is why the logo had not embellished the cover of the Journal when Dr.Wijerama was the Editor (1937 – 1939). It admits as reasonable to deduce that perfection, achievement and greatness need patience, endurance and time! [5]

Discription of the Crest of the SLMA

The SLMA Crest has been the harbinger of many crests of medical associations that were inaugurated in Sri Lanka in the last one third of the 20th century. Many smaller (specialist) associations have mushroomed and blossomed during the past 50 years.

A tusked elephant (tusker) crowns the SLMA Crest. The elephant is a symbol that has been displayed in both ancient and colonial coins minted in or for our country, and elsewhere. It adorns even the ornate monolithic granite moonstones at archeological and religious sites which constitute the point of entry into locations of Hindu and Buddhist temples, particularly buildings used for prayer and meditation. But the tusker alluded to herein evidently represents the Temple of the Tooth in Kandy because it carries, on its dorsal spine, the Casket that bears the sacred Tooth Relic of the Buddha, which has been carried in the internationally renowned annual procession around designated streets of Kandy, during the July - August Esala Festival that is conducted for several consecutive nights during many centuries past. When the British signed a treaty (The Kandyan Convention of 1815) to take over the administration of Ceylon (with the Kandyan Kingdom that prevailed until then), the treaty bore an undertaking that the colonial government would protect and assist the main religion of Ceylon, as had been for many centuries before. A personal view is that the crown of the Crest now represents the sacred tusker of the Dalada Maligava ('Temple of the Tooth'), reminiscent of the privilege mentioned above extended to all people of the country, including Buddhists. The space below the crown of the Crest, enclosed within a curvi – ovoid outline, "Sri Lanka" is inscribed, - replacing "Ceylon" (borne in the original crest displayed on the cover of the 1947 journal), introduced after Sri Lanka became a Republic. The space immediately below, within angular brackets, is "1987" – the year of establishment of the national medical association. In the first published crest (of 1947), 1887 is within an open - topped and bottom - lined boat - shaped bracket, which (personal view) represented the mundane journey, in the sea around Lanka, of the national medical association, - in an ocean of relentless time and unrelenting endeavour. Inferior to the above, a long curvi – oblong (outlined) space spans the crest, and carries the motto and dedication of a committed association, - three (of five) Pali words, which, together with the two (below), on the wings (within stylized flowing ribbons), - constitute the phrase: 'LANKADIPASSA KICCESU MA PAMAJJI'. Pronunciation of the underscored letters is: A as the long A of 'After', I as the E of 'Easter', and each C of CC in kichchesu as C of 'Church', - respectively.

Transliteration and Interpretation of the Pali Motto

The 1600 year old chronicle (written in Pali in the 5th century, and, translated into English by Wilhem Geiger of Germany in 1912, - the Mahavamsa [4] (the second 'm' of which is pronounced as the 'ng' of 'among'), stated: "before his demise, the Buddha addressed an attendant god thus: 'Sakra, my teachings will be established, to prevail, in Lanka. Therefore, I commend you to earnestly protect that Dvipa (the island) with spiritual fervour and committment'. The two - lined five - word phrase on the SLMA crest should thus be interpreted as: 'With regard to affairs concerning Lanka, do not dally (dawdle)'. This commendable motto thus represents the Vision and the Mission of the SLMA, - in accordance with timeless socio - cultural tradition.

It may be noted that the 'w' sound of English is replaced by that of 'v', in Pali and Sinhala.

Further Description of the Crest

Stylized ribbons decorate the dark (sometimes maroon) background of the logo, in the centre of which is a disc lined by 16 typically stylized lotus petals which represent the service which the profession provides, most of 16 hours of each day. The lotus is an ancient symbol of western and southern Asia, even proximal Eastern Asia, - particularly in Vedic, Hindu and Buddhist societies. This blossom flourishes in ponds, and the plant is embedded in mud, - but its blooming stem rises symbolically above the water and flourishes,

representing all life, humility, glory and success for all humankind. The large (white) lotus (Nelumbium speciosum), also called the Sacred Lotus, has 100 petals (the red too does), which, in our logo now represents (personal view) the 1st 100 successful years of service of the medical profession of Sri Lanka.

The white disc at the centre of the Crest bears the heraldic staff around which is the legendary serpent, dextro – spiraling upward on the staff, - which, significantly, is the right - hand representation of the 2 snakes which embellished the central staff of the caduceus. Finally, at the bottom, is SRI LANKA MEDICAL ASSOCIATION in English words completing the identity of the outstandingly humane medical organization, - the SLMA.

The gold Pendant of Office of the President of the SLMA

At all ceremonial events of the Associations, the pendant of office is worn by the President. The photo - gallery of Past Presidents in the Council Room of the headquarters of the SLMA at 6, Wijerama Mavata, displays and reveals that the earliest President to be (photographed and) 'framed' (!) with the Badge of Office was Dr. A. D. P. Wijegoonewardene (1963) and he was elected President of the Commonwealth Medical Association meeting held in 1984 at Galle Face Hotel in Colombo.

Above the tusker at the helm in this ornate badge of authority, in a decorative capped cage, the acronym "BMA" is inscribed (representing the parent body, the British Medical Association). Below the elephant "Ceylon" is carried. The year of inauguration "1887" appears below the central red disc bearing the staff and serpent, with "CEYLON MEDICAL ASSOCIATION" (introduced after its establishment) inscribed in circular style. "President" is carried in the scroll at the bottom. Foliage (3) and a flower (within four squares) represent the North, South, East and West of the country) and stand out in blue. Ribbons of ceramic - enamel (those at the top proclaiming the motto) and other designs surround the red central disc. At the periphery foliage adorn the pendant.

The Pendant of Past Presidents

This replica of the Crest, inscribed "PAST PRESIDENT" (at the bottom), and is worn during ceremonial processions and events which follow.

Our final tribute, in the context of the affairs of the SLMA, - especially the CMJ and the Crest is:

"Lives of great men all remind us
We must make our lives sublime
And, departing, leave behind us
Footprints in the sands of time"
– Henry Longfellow

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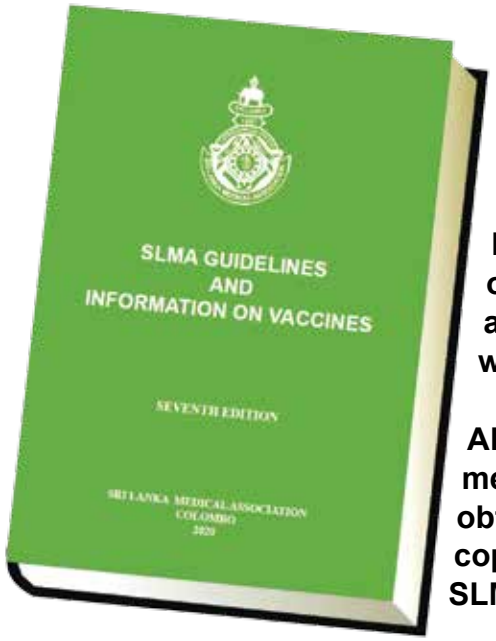

The 7th edition of the SLMA Guidelines and Information on Vaccines is available at www.slma.lk.

All SLMA members can obtain ONE free copy from the SLMA office.

It has been said that Jellyfish have survived for 650 million years, despite not having a brain.
It certainly gives hope to many people.

– From an e-mail sent by
Professor Sanath P. Lamabadusuriya
Extracted and presented by
Dr B. J. C. Perera

Sri Lanka Medical Association

134th Anniversary International Medical Congress

"Professional excellence towards holistic health care"

27 - 30 July 2021 at BMICH, Colombo

Symposia

Communicable diseases
Disaster Management
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Environment and Occupational Health
Nanotechnology
Maternal and Child Health services
Nursing
Nutrition
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Emergency medicine
Rehabilitation in trauma
Gender based issues
Psychiatry
Surgery
Adolescent health

Key note
COVID-19

Plenaries
Obstetrics and Gynaecology
Telemedicine
Non-communicable diseases

Pre-congress
Research and biostatistics
Stroke rehabiliation
Psychoactive substances
Balancing Professional and personal life

Post-congress
Anthroscopic cadaver workshop

Inter-provincial quiz on general knowledge
'for the first time among health care professionals in Sri Lanka'

Reduce the Delay in diagnosing imported Malaria

If a malaria patient is left untreated

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- Could lead to re-introduction of malaria in Sri Lanka

Malaria should be suspected in all fever patients with a travel history to a malaria endemic country …..!!

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A healthcare system accessible to all:

By Dr. Indika Weerasinghe
Consultant Orthopaedic Surgeon, Vavuniya District General Hospital.
Email : prasinwe@yahoo.com

Twenty-year-old Hashan from Kanadarawa, Medawachchiya was brought to the Accident Service of Vavuniya District General Hospital on the morning of 5thOctober 2020 following a fall from a coconut palm. He landed mostly on his back after falling from a height of 25 feet.

The Suwa-Seriya free ambulance arrived at the site in five minutes and brought him to the hospital. Fortunately, there was no damage to his spinal cord, which would have paralysed his legs. But he had an unstable fracture of his spine along with multiple other injuries.

His right leg was broken and the ankle dislocated. His left wrist was broken as well. This was a case of major trauma or poly-trauma, which needs multi-disciplinary care by several surgical specialities.

Despite multiple injuries, Hashan was conscious and alert as he has escaped head injury. Needless to say, his parents who were at the bedside, were devastated and in a state of shock.

Hashan himself did not realise the gravity of the injury until his X-rays and other imaging were explained to him that morning. All of his fractures needed surgery as soon as he was stable enough for anaesthesia.

Hashan's father had two questions for the orthopaedic team. 1) Is it possible to do all the surgeries in Vavuniya hospital? 2) How much is it going to cost him?

The answer to the first question was 'yes' and there was relief in his eyes upon hearing that.

Transferring Heshan to Jaffna Teaching Hospital or Anuradhapura Teaching Hospital would have meant that family members would have to travel longer distances back and forth to care for Hashan.

The answer to the second question was 'the entire treatment will not cost a cent'. Hashan's father looked skeptical hearing that as he understood that there will be multiple surgeries including one on the spine.

Two days later, after careful planning, Hashan had surgery to fix his spine. All implants and instruments were available in the hospital. Intra-operative X-ray machine was invaluable to complete the spinal surgery safely.

Simultaneously, his right leg and ankle were fixed. His left wrist was not operated on that day to limit surgical stress on his body. Three days later he had his left wrist operated with a plate and screws.

On post-operative day 2, he was brought upright with a brace and was able to bear weight onto his left leg. After an uneventful recovery in ward 9 of Vavuniya Hospital, Hashan was discharged 10 days later.

Hashan is just another patient out of many thousands of Sri Lankans who receive free healthcare on a yearly basis from government hospitals around the island.

His treatment was not groundbreaking, but what needs to be emphasized here is the cost the government bears through the Ministry of Health, to get people like Hashan back into the workforce after life changing trauma. It's easy to overlook the man-power, medicinal and equipment cost borne by the Ministry of Health to make Sri Lankan citizens like Hashan productive once again and contributing to the development of the country.

The three surgeries he had and the hospital stay of two weeks would have cost around two million rupees in a private hospital, which would have been much more than what Hashan's family would have been able to afford.

But thanks to free universal healthcare in Sri Lanka, Hashan is back home today without his father having to sell his house to pay hospital bills.

To appreciate the benefit of free healthcare in Sri Lanka, it is important to compare our healthcare model with other countries. India also has a universal healthcare system but the private sector healthcare is dominant.

Most health expenses are paid 'out of pocket' of patients and their families. Most people in rural areas do not have access to quality, affordable healthcare.

In the United Kingdom, the National Health Service (NHS) provides free healthcare to its people except for some charges associated with eye tests, dental care and prescriptions.

The NHS is funded by the significant contribution tax payers make to the government. (If the annual income of a person in England is between 50,000 to 150,000 pounds, 40% is deducted as tax).

It is that significant tax contribution that funds the National Health Service and its 'free' healthcare.

Healthcare costs in the United States are astronomically high. Medical bills are the number one cause of bankruptcy in United States. This is despite the United States spending 16.9% of its GDP

on health (2018). According to Bloomberg health efficiency index, Hong Kong ranks number one as the most efficient healthcare model in the world.

Hong Kong spends around 3% of its GDP on health and its citizens are provided with healthcare plans for a low cost. (not for zero cost). It is a mixed medical economy with 43 public hospitals and 12 private hospitals.

I feel it is in that context we have to look at our free healthcare model which is unique to Sri Lanka. Like in Hong Kong, private sector contribution prevents overburdening of government healthcare delivery.

But unlike in India, strong government sector healthcare delivery system reaches into rural areas like Kanadarawa, Medawachchiya where people like Hashan can get quality treatment at government hospitals absolutely free.

Editorial Comment:

"A nation's greatness is measured by how it treats its weakest members".

Mohandas Gandhi uttered these unforgettable words in a speech he delivered in 1931. The sensibility he spoke of then, is just as important, relevant and critical, today.

And unlike in the United States, health costs are not over the roof expensive.

It is true that from time to time, there are shortages of medicines and equipment in government hospitals in Sri Lanka.

But they are usually transient. Even for those shortages, there is a system to 'Local Purchase' these drugs and equipment by using funds allocated to the government hospital.

So, I think it is fair to say that as a developing economy, Sri Lanka is doing its best to look after the health of its people.

Therefore, it is the responsibility of all Sri Lankans to protect our universal free healthcare system and improve it further.

The medical profession and what are the limits of professional behaviour?

Today, a news item was about a doctor being suspended from the register and prevented from practising medicine in Switzerland. It illustrated an important point of the self-disciplinary nature of a profession and the limit of individual freedom and liberty on joining a profession.

The doctor had spoken out publicly against all protective measures for COVID-19, including the vaccine and said that there was no necessity for masks and other protective measures such as social distancing. It was not clear how long he had said this, but it was clearly established that he had said it publicly and repeatedly.

The Medical Council had then struck him off the register as unfit to practice as he propagated false health information.

In his defence, the doctor had said that as an ordinary citizen and an individual, he had the freedom of speech and could say what he wanted.

The Medical Council stated in return that by becoming a doctor (voluntarily), he had accepted the additional rules of the profession, which superseded his rights. An important part of these rules is providing science-based evidence when advising on health. Violating that principle meant that he had violated the rules of the profession and therefore could not remain a member of the profession.

What else can we draw from this incident?

What about smoking? (It is to the credit of the doctors in Sri Lanka that a vast majority does not smoke). However, what would be the situation of a doctor who smokes in public; what is the harm to the health of the individual and society? Yes, to his health (very few females smoke in Sri Lanka) and pollution and increase of passive smoking in others. However, he has not said smoking is safe – so no bad health messages/practices have been given. The doctor can defend himself with the proviso of freedom of individual choice.

Alcohol – again, a similar situation would arise, but there is debate about a safe limit of alcohol consumption and overstepping that is to be taken note of. The freedom of individual choice can be invoked in this situation when consumption is below a "safe" limit.

The acute effects of alcohol and damaging consequences also need to be considered. If a doctor causes an accident while "Driving under the Influence of Alcohol", there will the legal and other consequences from society. Should there be additional disciplinary action by the Sri Lanka Medical Council with a warning or suspension from practice?

"Doctor, discipline Thyself" and "The Profession, protect Society and Your Members"; duties that are at the core of our existence and which never end.

Emeritus Professor
K. Weerasuriya
Department of Pharmacology,
Faculty of Medicine
University of Colombo.
5th March 2021

A Eulogy on the First Death Anniversary of Dr. C G Uragoda

Deshabandu Dr. Chrisopher Gunapala Uragoda MBBS (Ceylon), MD (Ceylon), Honorary D.Sc. (Colombo), FRCP (Edinburgh), FRCP (Glasgow), FCCP, FFOM, FNASSL, Honorary FCGP(SL) was a Physician, an acclaimed expert on occupational respiratory disorders, a renowned author, an unmatched folklorist, a celebrated historian and a dedicated ecologist.

Dr. Uragoda was born on 22 September 1928 in Hikkaduwa to Francis University and Lena (Weerasinghe) University and was educated at Richmond College, Mahinda College, Ananda College and at the Faculty of Medicine, University of Colombo qualifying with Bachelor of Medicine, Bachelor of Surgery (1953) and Doctor of Medicine (1963).

He trained in the UK becoming a Fellow of the Royal College of Physicians of Glasgow and Edinburgh. He was the Physician at the Chest Clinic, Kandy from 1962 to 1973, Physician-in-charge of the Central Chest Clinic, Colombo from 1973 to 1988 and Physician Chest Hospital, Welisera from 1988 until his retirement. He worked as a consultant at the Tameside General Hospital, Lancashire, England from 1977 to 1978.

He was a member of the WHO Expert Panel on Tuberculosis and Respiratory Diseases. He was a Fellow of the Faculty of Occupational Medicine of the Royal College of Physicians, London (FFOM), Fellow of the Ceylon College of Physicians, Fellow of the American College of Chest Physicians (FCCP), Fellow of the National Academy of Sciences of Sri Lanka (FNASSL), and Honorary Fellow of the College of General Practitioners of Sri Lanka (Hon FCGP).

Dr. Uragoda was known for his work in Occupational Lung Diseases caused by the dust of chilli, tea, kapok, cinnamon, coir, ilmenite, and activated carbon. He is known for his paper showing for the first time that skipjack was rich in histamine and that isoniazid prevents its destruction, thus increasing skipjack poisoning in patients being treated for tuberculosis.

In addition to books on medicine, he wrote on Wildlife Conservation in Sri Lanka. He was the Joint Editor of the Ceylon Medical Journal and later Editor Emeritus of the same journal, the Journal of the Ceylon College of Physicians and the Journal of the National Academy of Sciences.

Dr. Uragoda co-edited the Sesquicentennial (150th anniversary) Commemorative Volume of the Royal Asiatic Society of Sri Lanka 1845– 1995. He also wrote Traditions of Sri Lanka: A Selection with a Scientific Background, which explores scientific explanations for Sri Lankan traditional beliefs and customs and a volume compiling works of authors from Sri Lanka between 1795 and 1948.

Dr. Uragoda was the President of the Royal Asiatic Society of Sri Lanka from 1987 to 1991, the Ceylon College of Physicians in 1981/82 and the Sri Lanka Medical Association in 1983/84.

Dr. Uragoda has received awards for research, which include the Guinness Award of the Commonwealth Science Council and the Guinness Trust, London in 1980, for his work on occupational lung disease in Sri Lanka, the Peter Pillai Award for his work towards promoting social justice in Sri Lanka in 1981, President's Award of the Natural Resources, Energy and Science Authority of Sri Lanka in 1996,

and the Sarvodaya Award in 1999.

The Royal Asiatic Society of Sri Lanka awarded him the Society's Medal for 1993. In 1992 the University of Colombo conferred on Dr. Uragoda the Degree of D.Sc (Honoris Causa). Dr. Uragoda was awarded the National Titular Honour of Deshabandu by the Executive President of the Democratic Socialist Republic of Sri Lanka in 2005.

He is the joint author of 'Bibliography of Medical Publications Relating to Sri Lanka 1811-1976' and 'A bibliography on Health in Sri Lanka 1977-1980'. He is best known for his book 'A history of medicine in Sri Lanka - from the earliest times to 1948' which was first published by the Sri Lanka Medical Association in 1987, the Centenary Year of the association.

In 2012, in the Quasquicentennial (125th anniversary) year of the Association, the History of Medicine Lecture was established by the Sri Lanka Medical Association (SLMA) to mark the meeting attended by a group of doctors at the Colonial Medical Library in Colombo on 26 February 1887 to discuss the formation of the Ceylon Branch of the British Medical Association, which later became the Sri Lanka Medical Association. In this same year that institution elected Dr. Uragoda as a Honorary Life Member of the Sri Lanka Medical Association, in recognition of his distinguished services to the association and the field of Medicine.

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

Professor Vajira Dissanayake
Past President-SLMA
Dr.Sumithra Tissera
Hony Secretary of the SLMA

Mysterious language-swapping after brain injuries

In April 2010, a teenager in Croatia woke up from a 24-hour coma, much to her family's relief. Then a strange thing happened. That 13-year-old girl had lost her ability to speak in her native Croatian language.

While she was still able to understand the language, she could only respond in very fluent German, a language she had only just begun learning in school. She needed a translator to communicate with her family.

In 2013 an Australian man woke up from a coma following a car crash, speaking perfect Mandarin Chinese. In 2016, a teenager from Atlanta, USA, woke up from a coma speaking fluent Spanish and had a lot of trouble speaking in his native English.

In another case reported from the UK, a Czech racing car driver regained consciousness after a crash and was speaking only in English, with a British accent. This effect was temporary however, and he regained the use of his native Czech language later.

Doctors and scientists cannot fully explain these events. Such manifestations are quite infrequent and are rather difficult to study. Scientists presume that it is important that all of the examples listed here had some knowledge of their new language but it is not known why this phenomenon can affect some people so drastically. Waking from a coma speaking a foreign language is just one of many mysterious things that happen without a proper explanation.

Language is best described as a form of symbolic expression of thought. The thoughts are the same and different languages express them through different sounds and written symbols. It has been suggested that the centre that stores the ability to speak in the native tongue is stored in the left side of the brain while the ability to speak in a second language comes predominantly from the right side.

However, if a second, third or fourth language is mastered in early childhood, it will be stored in the same place as the first language but languages learned later on will be stored elsewhere. There is also some deterioration of the ability to learn new languages with advancing age. After about 18 years of age, there is a precipitous decline in the ability to learn a new language.

Yet for all that, there are numerous examples of people who pick up a language later in life. Our ability to learn a new vocabulary later in life appears to remain constant, but most of us will not be able to master grammar like a native speaker or probably sound like one either.

However, none of these explain these above listed bizarre occurrences. Doctors and scientists remain quite perplexed by them.

Material extracted from *https://www.ba-bamail.com/video.aspx?emailid=38738*

– Sent by Dr B. J. C. Perera

Remembering "Wallops": The Father of Cardiology in Sri Lanka

By Dr Upul Wijayawardhana

The pioneering Cardiologist Dr Narendradas Jayaratnam Wallooppillai, affectionately referred to as "Wallops" by his friends, who succumbed to heart failure on 6th January 2011, surely deserves the title 'The Father of Cardiology in Sri Lanka' because it was during his tenure that Cardiology came to its own as a speciality. However, he was not the first to head the Cardiology Unit of the General hospital, Colombo. That distinction goes to Dr Ivor Obeysekara who, in spite of fighting against all odds to establish a dedicated Cardiology Unit, took early retirement and left for Australia. Dr Obeysrekara's tenure was short, not having sufficient time to develop the speciality, and to establish a "Cardiology Unit " it was merely functioning as a Cardiology ward during his time.

Dr Wallooppillai was born on 6th June 1925, to the wealthy and influential Velupillai family which settled in Balangoda thanks to the hospitality of the Ratwatte family; the ancestors of Mrs Sirimavo Ratwatte Dias Bandaranaike. It is said that when he was admitted to St. Thomas' College, Mount Lavinia, the warden, Canon De Saram, changed the spelling of his name from Velupillai to Wallooppillai as he thought it was more user friendly. He graduated from the Faculty of Medicine, University of Ceylon in 1951 and proceeded to The UK soon after. He obtained MRCP (London) and MRCP Cardiology (Edinburgh), while undergoing training in Cardiology in Manchester.

On his return he was appointed Consultant Physician, General Hospital, Jaffna. Subsequently he was appointed the first Physician-in-charge of the Cardiac Investigation Unit (CIU) in General Hospital, Colombo which was set up around the same time as the Cardiology Unit. Dr Mahinda Weerasena was appointed the Consultant Cardiac Radiologist to this Unit, and Dr Thistle Jayawardena, Consultant Anaesthetist, who was instrumental in setting up the Surgical Intensive Care Unit (the first intensive care unit in the country), joined later.

I was fortunate to know Dr Wallooppillai from June 1968, when I became his Registrar, and owe my entire training in Cardiology to him. Dr Wallooppillai was a great teacher, very inspirational one at that, as well as an efficient organiser. He shaped the career of many, including myself, who practice/d Cardiology not only in Sri Lanka but around the world. In 1972, Dr Wallooppillai was appointed Cardiologist. In 1975 Coronary Care Unit, the first medical intensive care unit in the country, opened and progress was relentless. He gave me a free hand, as well as all the support, to develop the permanent pacing programme. The seeds that were sown blossomed out, Cardiology being one of the most advanced specialities in the country today.

Dr Wallooppillai taught me not only Cardiology but also how to fight for principles. His wife, Yoges, who pre-deceased him, showered kindness. They had no children but brought up Yoges' sister's daughter, Mala, till she passed 'O' levels at Ladies College and returned to her family living in London.

What was most impressive to me about Wallops was his absolute honesty and integrity. He was held in high esteem and held many high positions. He was the President of the Ceylon College of Physicians, President of the Sri Lanka Heart Association for many years and the President of the Orchid Circle. His hobby was growing orchids and his garden was filled with wonderful, rare blooms. However, most remarkable was his time as the President of the Sri Lanka Medical Association in 1980 when I served him as the Honorary Secretary. I have served many Presidents as Assistant Secretary and Secretary of the SLMA but no one equals Wallops. The monthly council meetings were a pleasure to attend. There was no straying from the points under discussion and the meetings were crisp, concise and always finished on time.

Though shy by nature avoiding large gatherings and a man of few words, paradoxically, he was a trade union leader too! He was the President of the Association of Medical Specialists for many years and demonstrated to other trade unionists that justice for members could be extracted without confrontation and trade union action like strikes, by using the art of diplomacy which he excelled in.

After leaving Sri Lanka, he made trips back home, seeing private patients in Healthcare Laboratories. It was sad to see him gradually developing heart failure following a silent heart attack. The day before his death Mala rang me to get my address as 'appa' had sent me a note. When I received it, after his death, I realised it was his Goodbye message.

If there an afterlife, Wallops is one colossus I would love to meet again. Till then Sir, pleasant memories of a great life of service to rich and poor alike!

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