SLMA NEWS+

The eMagazine of the Sri Lanka Medical Association

Editorial

A Nexus Between Specialities for Holistic Care

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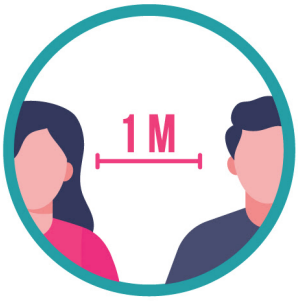
Please Adhere to the Following Simple Steps to Prevent COVID-19 in Your Workplace

Wear a mask.



Maintain distance of one meter with everyone.

Wash hands with soap and water or sanitize with a hand sanitizer.

Cover coughs and sneezes with the elbow

Do not allow any person having fever with or without respiratory symptoms to report for work.

Frequently disinfect commonly contacted surfaces by staff or customers.

Avoid exchange of equipment, utensils or any other items between workers. If exchanged disinfect them before and after exchanging.

Avoid sharing personal items between workers. If shared disinfect them before and after sharing.

Ensure good ventilation and use air-conditioning only if necessary.

If your duty involves close contact or touch customers, (Eg. Barber, Tailor) wear an eye shield or a goggle and sanitize hands immediately afterwards.

If your duty involves using instruments that touches customers (Eg. Measuring tape, Comb) disinfect them after use.

For details please refer to the "Operational guidelines on preparedness and response for covid-19 outbreak for work settings" published by the Ministry of Health. Visit health.gov.lk.

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health.gov.lk

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IN THIS ISSUE

Editorial
A Nexus Between Specialities for Holistic Care

Early medical practitioners were healers of all kinds of illnesses and groups of patients. They practiced herbalism, performed surgeries, treated infants, provided care for pregnant women and even engaged in the supernatural. Over time, as the knowledge and skill base expanded, specialisation became a self-evident necessity due to the common-sense perception that is it impossible for a single doctor to master it all. Specialisation allowed the in-depth study of a particular group of patients, illnesses or mastery of a precise skill sets; consequently, leading to further proliferation of medical knowledge.

To a certain degree, one could say that medical practitioners have long been specialised. According to Claudius Galen (c.130 AD - c.210 AD), the physician to the Roman emperor Marcus Aurelius, specialisation was common among Roman physicians. Medical specialisation appears to have existed even in the Hellenistic world. These informal socially recognised domains formed well before the formal specialised branches of medicine were established. In the 19th and the early 20th centuries, the rapid proliferation of medical knowledge catalysed the establishment of formal medical specialities. The term Internal Medicine rooted in the German term "Innere Medizin" was adopted only in the 1880s. Today, medicine is like an enormous Oak tree with countless branches; starting from the most basic and the obvious; internal medicine, surgery, paediatrics, psychiatry and obstetrics and gynaecology; branching off, over and over again into innumerable smaller offshoots, the sub-specialities, super-specialities and ultra-super-specialities.

Hence, the delivery of curative healthcare in modern day practice requires a connection between these different branches of medicine. There are doctors who are community centric; the general practitioners along with a few sub-specialities who have community-based practices such as community paediatrics. Then there are those who practice mainly in hospitals and other healthcare institutions. In a hospital setting, internists possess a broad perspective of medicine and master its complexity through a generalist approach. Those who are in sub-specialities and super-specialties engage in the exhaustive study of intricacies of their chosen domains. Therefore, in an ideal world, generalists would be the gate keepers of the specialists' access to practice medicine. In some developed countries, there is a well-established referral system, with specialist general practitioners being the primary care physicians who are tasked with assessing and managing patients' healthcare needs, whilst facilitating referrals to specialists when deemed necessary. Although such referral systems may increase waiting times and limit access to specialised care, they have been shown to be cost-effective and improve patient outcomes through optimising the utilisation of physician, hospital, and laboratory services.

This division of patient care is not without problems. Both under-referral and over-referral can be equally harmful. Under-referral can result in inadequate or inappropriate treatment, unmet healthcare needs and even litigation due to negligence. Over-referral may lead to repetitive testing or over-testing, dangerous polypharmacy and increased cost. Another inadvertent predicament of this system is the risk of fragmentation of care due to the lack of communication and collaboration. The ensuing confusion, frustration among patients and doctors, lack of continuity of care and missed opportunities for diagnosis and treatment will ultimately result in poor patient outcomes.

In Sri Lanka, the situation is even more chaotic because of the lack of a proper formalised referral system. It is compounded by the presence of two parallel but equally essential health sectors; the government-sponsored free state health sector and the fee-levying private health sector. Patients are able to consult a generalist or a specialist at any level, anywhere in the country based on their perceived requirement, and doctors are at liberty to manage patients on their own or refer to any specialist according to their own personal preferences. Although this decision to refer or not should be primarily based on what is best for the patient, it is may not the case in the current Sri Lankan context. A doctor's perception of one's own knowledge and skills as well as his or her judgement of the other's proficiency play a significant role. Moreover, an uglier certitude sometimes evident in the private sector is the aversion to refer because of the fear of "losing patients" to another. Some appear highly territorial and ill-disposed towards shared care. We have seen neurosurgeons prescribing disease modifying anti-rheumatic drugs, oncologists managing pulmonary fibrosis with antifibrotic agents, and internists managing complicated cases of inflammatory bowel disease; the list is endless. Irrespective of a doctor's expertise, whether gained by way of evidence or eminence-based practice, it is needless to say that this is far below the optimal standards of care and sometimes may even be unethical. If such practices are simply due to complacency, it is certainly immoral to rely on providence alone when a human life is at stake.

Evidently, a well-thought out, organised formal referral system is the key to overcoming these issues, albeit only a fantasy at the moment in our country. Therefore, as doctors, we will have to make do with what we have got and workout pragmatic solutions to our problems. Whether we openly acknowledge it or not, medicine has been made into a highly hierarchical field; within specialities seniority takes precedence; between specialities, some are construed superior to others. There is a constant clash of egos and ethos making shared care nearly impossible. The recent focus on promoting holistic care demands that we work in multi-disciplinary and multi-sectoral teams. Collaborating with multiple individuals who bring diverse yet complimentary knowledge and skills to a single platform to deliver optimal patient care requires mutual respect, understanding and good communication skills. Most of all for one has to be competent and self-assured in his or her own capabilities to be able to amicably iron-out differing opinions and seek assistance when required.

There are hardly any gospel truths in the practice of medicine; it is multifaceted and complex. A single case can be viewed through varying angles, with multiple plausible differentials and diverse potentially beneficial management options. As practitioners of medicine, our ultimate goal should be to provide the best care possible to our patients. Often a healthy mix of evidence, eminence and providence is required. In modern day practice, a single doctor alone may not possess all of the expertise required or be adequately equipped to optimally deliver the holistic care the patients deserve. If we are to achieve this ultimate goal, we must address the deficiencies in the country's health care system while inculcating the requisite attitudes and values conducive to providing such holistic care.

President's Message

Dear Members of the Sri Lanka Medical Association,

"Online CPD - The way forward"

The success of the recently concluded 133rd Anniversary International Medical Congress of the SLMA was an eye opener demonstrating the potential of technology in providing Continuous Professional Development (CPD) in Sri Lanka.

There are many reasons why we should embrace technology in providing CPD in the current context. There is a global information explosion with a rapid and exponential increase in published information. Knowledge is expanding faster than our ability to publish and disseminate it in the conventional mode. Further, the need to adapt to the New Normal has accelerated the move towards technology-based CPD delivery.

Providing CPD to the increasing numbers of doctors working in diverse settings in Sri Lanka is a challenge. There are many opportunities offered through online learning for CPD, driven by increasing access to the internet and increasing availability of IT facilities. Moreover, the evidence base for online learning for CPD is gaining strength.

There are many technologies currently being used in medical education including Simulation, E- learning/M-learning, Virtual Patients/Virtual communities, Virtual and Augmented Reality and Artificial Intelligence. Many of the features of these technologies can be implemented within Sri Lankan settings due to the availability of free open source software and programmes. The high IT literacy, high accessibility to the internet, high connectivity due to widespread usage of mobile phones and social media is notable. Online learning can provide medical education with many affordable options.

Access to information via the usage of repositories or digital libraries in medical education is on the rise. The SLMA has already pioneered several such initiatives and made these available in the following online platforms.
SLMA Web site: https://slma.lk/
SLMA CPD portal: https://slma.lk/cpd/
SLMA YouTube channel: https://www.youtube.com/user/SLMAonline
SLMA Facebook page; https://www.facebook.com/SLMAonline
SLMA Twitter: https://twitter.com/SLMAonline

Mobile learning (M-Learning) offers many exciting opportunities for CPD. M-learning refers to learning via a mobile device such as a tablet or smartphone. Such devices are ubiquitous among Sri Lankan doctors and offer an array of potential opportunities for CPD. The following Mobile application developed by SLMA for training of management is such an example.
App for training of COVID-19 Management: https://slma.lk/covid19-trainapp/home

Technology offers many opportunities to overcome future challenges in CPD. Ignoring technology by citing it as unaffordable is no longer an option. If you look in the right places, tomorrow's technology at an affordable price is already there.

Professor Indika Karunathilake
President, Sri Lanka Medical Association

133rd Anniversary International Virtual Medical congress of the Sri Lanka Medical Association

Dr. Nimani de Lanerolle, Assistant Secretary- SLMA

The 133rd Anniversary International Virtual Medical Congress of the Sri Lanka Medical Association, aptly themed "Professional Development for Quality Enhancement of Healthcare: Beyond the COVID-19 Pandemic", was held from the 24th to the 26th of July, 2020 at the Wijerama House, Colombo.

The Inauguration Ceremony and the SLMA Oration were held on 24th July 2020 and its live webcast was watched by over 500 viewers online. This was followed by a 2-day Congress with a stimulating academic programme along with the Professor NDW Lionel Memorial Oration and the Dr. S. C. Paul Memorial Oration. This year's Medical Congress culminated in the Doctors' Concert featuring scintillating performances by talented doctors and medical undergraduates.

Orations

The SLMA Oration

The SLMA Oration 2020 was delivered by Professor Sachith Mettananda, Professor in Paediatrics and Head of the Department of Paediatrics, Faculty of Medicine, University of Kelaniya and Consultant Paediatrician, Colombo North Teaching Hospital, Ragama. The oration was on "Improving the care for children with Thalassemia in Sri Lanka". Whilst discussing the findings of his own research on quality of life and psychological wellbeing of patients with Thalassemia in Sri Lanka, he examined advances in management and new research avenues pertaining to the topic.

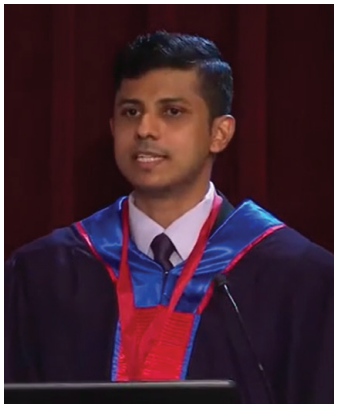
For the full presentation, please visit
https://www.youtube.com/watch?v=1rKjW_2AJ8c&list=PLZ8RoZIYEDV2lGhqJySOUlOJOfbq89Hib&index=3&t=0s

Professor NDW Lionel Memorial Oration

The Professor NDW Lionel Memorial Oration for 2020 was delivered by Dr. Kapila Jayaratne, Consultant Community Physician, National Programme Manager, Maternal and Child Morbidity and Mortality Surveillance, Family Health Bureau, Ministry of Health. The oration was titled "The challenge of the early arrivals: preterm births revisited". He discussed how to prevent maternal and infant morbidity and mortality translating his multi-country research findings into practice.

For the full presentation, please visit
https://www.youtube.com/watch?v=Idhgy-zF7Rk&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=2

Dr. SC Paul memorial oration



Dr. Miyuru Chandradasa, Consultant Child and Adolescent Psychiatrist, Colombo North Teaching Hospital in Ragama and Senior Lecturer, Department of Psychiatry, Faculty of Medicine, University of Kelaniya was the orator of the acclaimed Dr. S. C. Paul Memorial Oration. The oration was titled "Child mental health: Literacy, burden, cultural aspects and developing services for Sri Lanka!". The oration covered the various aspects of childhood and adolescent mental health while emphasising the need for considering cultural background and social learning when diagnosing and treating childhood mental health disorders.

For the full oration, please visit
https://www.youtube.com/watch?v=ycpXDSuv6po&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=8

Keynote address

The Keynote address of the Congress was delivered by Dr. T. Thirumoorthy, Adj. Professor at Duke NUS Medical School, Singapore, on 25th July, 2020. It was titled "Challenges in healthcare professionalism: vis-a-vis in healthcare delivery in the New Normal". In his lecture, he highlighted the lack of a consensus definition of professionalism, who qualifies as a Healthcare Professional and to whom this concept of Healthcare professionalism applied to as the main challenged we face today. He also stated that the eternal challenge to professionalism lies in the value system of societies and that professionals committed to altruistic healing and science are tasked with finding a proper balance from the commercialisation and politicisation of healthcare. He concluded by emphasising on the necessity of developing leadership modules in healthcare education.

For the full presentation, please visit
https://www.youtube.com/watch?v=8LD1VDsfhBI&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk

Guest Lectures

There were six guest lectures delivered by eminent members of the local and international faculty during the conference. The lectures delivered by international faculty included "Supporting primary care during COVID-19 pandemic" by Professor Michael Kidd, "The socio-political environment matters in a pandemic: Lessons from COVID-19" by Professor Bruce Maycock, "Gender equity and rights during emergencies" by Professor Liesl A. Nydegger, and "Nutrition for Infants During Emergencies" by Professor Colin Binns. The local speakers included Dr. Nayani Madarasinghe who delivered a lecture on "Maintaining your beauty in the 'New Normal'" and Dr. Lilani Rajapakshe who spoke on "COVID and sexual health".

The full presentations are available on
https://www.youtube.com/watch?v=ER4Dq3BjrxI&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=4
Guest Lecture 2: Environment and Communicable Diseases
https://www.youtube.com/watch?v=9-QgoDhHCxI&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=9
Guest Lecture 3: Looking Good in the "New World"
https://www.youtube.com/watch?v=De6PAk6oTms&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=6
Guest Lecture 4: COVID & Sexual Health
https://www.youtube.com/watch?v=i3DEZE51a4E&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=2&t=0s
Guest Lecture 5: Gender Equity & Rights during emergencies
https://www.youtube.com/watch?v=LFIWQCYOW1o
Guest Lecture 6: Effects on Nutrition during emergencies
https://www.youtube.com/watch?v=HTjaAtEP20k&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=3

Symposia

There were eight symposia that were presented over the span of just two days during the Congress. Each symposium consisted of a panel of speakers from both international and local faculties covering a range of timely topics. The symposia focused on areas such as the global and Sri Lankan response to the COVID-19 pandemic, the impact of the pandemic on other communicable and non-communicable diseases, emerging and remerging disease, rights-based approach to delivering comprehensive Sexual and Reproductive Health services in the new normal, and advances in delivery of health care.

For full presentations, please visit

Symposium 1: Response to the COVID-19 Pandemic: Lessons Learnt - Experiences from Sri Lanka, UK, USA & Singapore

https://www.youtube.com/watch?v=Hwj6yzcO7mQ&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=3

Symposium 2: Are we forgetting the other Communicable Diseases?

https://www.youtube.com/watch?v=Tl9ma0RigWM&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=10

Symposium 3: Challenges in the management of COVID-19

https://www.youtube.com/watch?v=4d_xSQrqs48&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=7

Symposium 4: Emerging & Re-emerging Infections

https://www.youtube.com/watch?v=0uUMQSP5qKM&list=PLZ8RoZIYEDV3SaSWVlb5o6I_DkNgkSUhk&index=11

Symposium 5: Panel Discussion on Rights-based approach to delivering comprehensive SRH services for All in the new normal

https://www.youtube.com/watch?v=NDrJkeeBZnM&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=3h

Symposium 6: Impact of COVID-19: Policy Implications Primary Healthcare, NCD & Migration

https://www.youtube.com/watch?v=YGngxYi_fxE&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=2

Symposium 7: Fast Forward to the "Future" Technology advances in Healthcare, Advances in delivery of Education, & New frontiers in Health Communication

https://www.youtube.com/watch?v=rP6F1py3uNI

Symposium 8: Psychosocial issues: During & After

https://www.youtube.com/watch?v=YkBs4WqhE5U&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=4

Plenaries

Two plenaries were conducted during the 133rd Medical Congress by two renowned internal speakers. The plenaries were based on current topics which are in vogue; the first focusing on the use of social media in continuous professional development by Dr. Lawrence Sherman and the second regarding the concepts of ethics and professionalism during the pandemic by Dr. Henrik Syse.

The full videos are available on

Plenary 1: Role of Social Media in Continuous Professional Development of Doctors

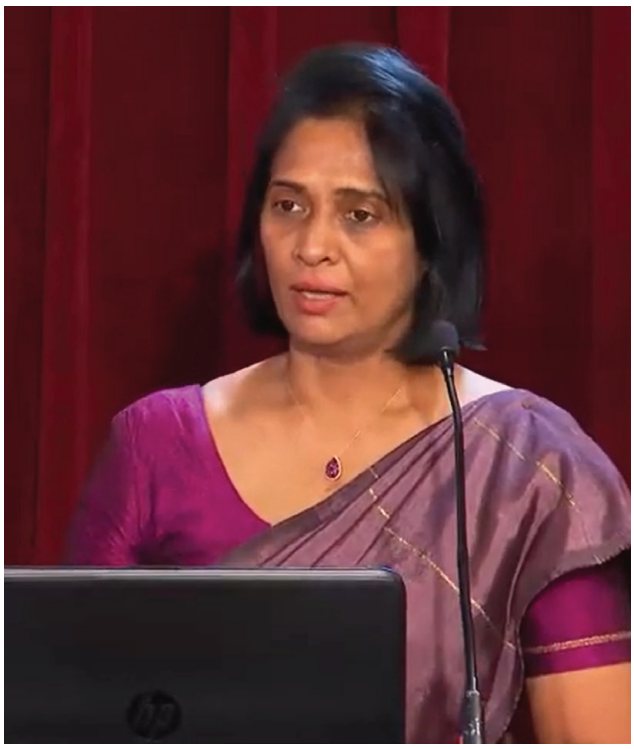
https://www.youtube.com/watch?v=YEBc5Wpd98s&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=1

Plenary 2: Promoting Ethics & Professionalism during COVID-19 pandemic

https://www.youtube.com/watch?v=QjICCx-grFQ&list=PLZ8RoZIYEDV0sB8B8oZe-88s0GLIL5KlQ&index=2

Educational programme for the general public

In addition to the main academic programme, this year the congress consisted of a 2-day educational programme dedicated to the general public. At a time when access to healthcare is restricted due to a raging pandemic, these sessions which were webcast live were well received by the public. These discussions were carried out by specialists from different fields focusing on topics ranging from childhood illnesses to injuries to sexual health to problems of the elderly.



Research presentations

A total of 54 oral presentations and 104 poster presentations were show-cased at the 133rd Anniversary Medical Congress of the SLMA. The poster presentations were held prior to the main congress and the oral presentations were scheduled during the span of the main congress. These research presentations have been recorded and made available in video format online to assist further dissemination of research findings in Sri Lanka.

The triumphant completion of this congress was due to the combined efforts of a team of individuals lead by the President Prof. Indika Karunathilake and Secretary Dr. Sumithra Tissera of the Sri Lanka Medical Association. The concept of a virtual congress, though new and unexplored, and though borne as a result of a worldwide pandemic, is one that maybe carried forward into the future, because as stated by John F. Kennedy "Change is the law of life and those who look only to the past or present are certain to miss the future".

The Doctors' Concert 2020: An evening to remember

Dr. Sankha Randenikumara, Council Member/Coordinator - Doctors' Concert 2020

The Doctors' Concert is an evening that has become a tradition; an evening the doctors lay down their stethoscopes and come upon a stage to shine; a tradition we felt must continue even in a challenging time like this!

Marking an exciting end to the 133rd Anniversary International Virtual Medical Congress, the Doctors' Concert in the 'new normal' was staged on the 26th of July 2020 at the New Postgraduate Institute of Medicine (PGIM) Auditorium, Colombo 8.

The Doctors' Concert was held this year in keeping with the health guidelines to prevent the spread of COVID-19. Hence though the audience present physically was limited, the event was streamed live on YouTube and Facebook, taking these performances to a wider audience in the comfort of their homes.

The performers were accompanied as usual by our amazing band, which included Mr. Ray Gomes as the lead guitarist, Mr. Upali Fernando on rhythm guitar, Mr. Manoj Ramanayake on keyboard, Dr. Mathisha de Silva and Dr. Christo Fernando on drums. As the compere for the evening Dr. Nimani de Lanerolle graced the stage.

The event contained an enchanting assortment of performances visiting the golden oldies, the magical 80's, contemporary pop/rock, and an unforgettable 'Vaada Baila' as a special treat.

The curtains were raised to welcome the medical students representing the new generation of the family of medicine. It is noteworthy to mention that groups of medicos representing three faculties performed for the first time in the concert's history. A beautiful a cappella arrangement of popular Sinhala pop songs was performed by a group from the Faculty of Medicine, Colombo opened the evening and it was followed by an enchanting medley of songs performed by a group of students from Faculty of Medicine, Kelaniya. Health education disguised as an upbeat baila was the concept behind 'Corona Vaada Baila', which was created by a group of students from Faculty of Medical Sciences, University of Sri Jayewardenepura. The lively performance not only entertained the crowd, but also managed to take the message regarding the importance of hygienic practices in the times of a pandemic across to the audience.

Several golden oldies were performed on stage, a beautiful ode to evening, 'Shantha Me Re Yame', was sung by Dr. B. J. C. Perera accompanied by his daughter Manisha, followed by 'Lo Ada Ninde' a lively performance by Professors Jennifer and Joe Perera.

That talent may have a genetic componenet was proved by the performances by Dil and Desh Dissanayake backed by their parents singing 'Soothe', one of their own compositions, Dr. Yamuna Rajapakse and children visiting 'The Magical 80's', and of course Dr. Anula Wijesundere flanked by her two adorable granddaughters, singing *'Nil Ahas Thale'.*

Four enchanting solos; a potpourri of Sinhala and English songs were brought to the stage by Dr. Kushlani Jayatilleke, singing 'Mini Mini Poda Wesse', Nishalee Weeraratne singing 'One call away', Dr. Sanjeewani Rupasinghe singing one of her own songs 'Laaba Sonduriyak Noweya', and Dr. Nilanka Munasinghe singing 'Shallow', from the movie 'A Star is Born' in her dulcet voice.

Professor Shaman Rajindrajith performed a magical flute solo accompanied by Drs Kolitha Lelwala and Sisira Dissanayake. A beautiful rendition of the classic love song 'Nim Him Sewwa' by Maestro Amaradeva was recomposed as a duet by Dr. Nirodha Jayawickrema and myself, which featured Dr. Indeewara Muthuarachchi, who accompanied on the violin.

The tradition continued as the Council of the Sri Lanka Medical Association got up on stage to perform 'Indunil Gangulel', a patriotic song in perfect harmony, following which the stage was handed over to our talented band who ended the evening with a bang through a medley of songs by Clarence and Santana, gradually building up the tempo to a baila session which brought the audience to tap their toes and dance the night away, while maintaining social distancing. The concert was a novel and mesmerizing experience to both audiences, present in the PGIM Auditorium and watching from their homes!

I would like to extend my heartfelt gratitude to the President and the Secretary of the SLMA for the continuous support offered in the organizing process in this unprecedented time. I would like to extend a special 'thank you' to Dr. Christo Fernando on behalf of the SLMA council for his unending support through the years to make the Doctors' Concert a much anticipated event in the SLMA calendar and for his guidance to make this event a success this year. I also thank the Social Secretaries of the SLMA for their encouragement during the planning process.

We hope to return next year, bigger and better in what is hopefully a COVID free world.

SLMA Health Innovation Awards – 2020

"Health Innovations for Tomorrow"

Dr. Sashika Sandaruwanie, Convenor - Health, Innovation, Research and Practice Committee, SLMA

The Health, Innovation, Research, and Practice Committee of the Sri Lanka Medical Association (SLMA) organized SLMA Innovation Awards - 2020 under the theme of "Health Innovations for tomorrow", a milestone event of the SLMA. Applicants were requested to submit abstracts describing their health innovations along with a video clip under 5 categories; namely Schools, General Public, Universities, other Institutions, and Medical Doctors.

These abstracts and video clips were evaluated by an external and internal panel of evaluators comprising of experts in relevant medical and non-medical fields. The enthusiasm for innovation among university students was evident in the high quality of the projects submitted by them. Gold, Silver and Bronze Medals were awarded for the best innovations in each category. The Awards Ceromony of the Health Innovation Awards - 2020 was held on 25th July 2020 at the Lionel Memorial Auditorium of SLMA.

The following were the Gold Medal Winners;

Schools: Automated Water Tap and door Controlling System by B.N.V.P. Fernando

General Public: Automated Guided Vehicle for Covid-19 Hospital by M.V. Dissanayake, A.S. Thennakoon, M.P. Ilangakoon, R. Pathirana & S. Amarasinghe

Universities: Public Addressing Drone for COVID 19 by R. Munasinghe, C.K. Pirunthan & S. Jayamanna

Medical Doctors: Osshca kvd-20 - A semi-automated, mobile chest physiotherapy & prolong cardiopulmonary resuscitation machine which can be operated by a single person from a mobile application by T.A.O.I. Somaratna, K.M. Samarasinghe, H.A.D. Chanaka, A.A.V. Niroshan, S.V. Liyanwalage, C.M. Mathangaweera, M.M. Jayewardene & E.A.S.T. Edirisinghe

On behalf of the SLMA, I thank Professor Kumara Mendis, the Chairperson of the Health, Innovation, Research and Practice Committee and Dr. Duminda Ariyarathne, Dr. Thilina Wanigasinghe, Dr. Sankha Randenikumara and Dr. Pamod Amarakoon, members of the Health, Innovation, Research and Practice Committee for their support throughout the process to make this event successful. The SLMA is committed to encouraging all innovators by making the Innovation Awards an annual event.

The videoclips of the winners' presentations will be published in the SLMA YouTube channel soon.

What was the role of the SLMA in ensuring COVID-19 free election process for the General Election 2020?

Professor Indika Karunathilake, President - SLMA

The Sri Lanka Medical Association (SLMA) worked in close collaboration and supported National Election Commission of Sri Lanka in conducting the General Election 2020 in accordance with COVID-19 prevention guidelines. It was a momentous achievement of the Election Commission to be able to conduct a national election when many countries in the world are forced to reinforce lockdown restriction due to the raging pandemic. We consider it a privilege as the national medical association to be a part of this operation as an independent technical contributor.

The process that was witnessed at all polling stations in the country was planned and designed through a series of meetings and consultations. On 05th June 2020, representatives of the SLMA were invited by Mr. Mahinda Deshapriya, Chairman, Elections Commission for a meeting to discuss the preventive health measures that should be implemented to prevent the spread of COVID-19 during the General Elections 2020.

This first meeting was attended by Professor Indika Karunathilake, President SLMA, Professor Manuj Weerasinghe, Vice President SLMA, Dr. Chandana Atapattu, Council Member SLMA and Assistant Registrar, Sri Lanka Medical Council, Dr. Ananda Wijewikrama, President Ceylon College of Physician and Senior Consultant Physician at National Infectious Diseases and Dr. Shirani Chandrasiri, President Sri Lanka College of Microbiologist and Consultant Microbiologist Colombo South Teaching Hospital.

Objectives of this meeting were to minimize the risk of novel coronavirus transmission during the election campaign, minimize the risk of novel coronavirus transmission during the processes and procedures of conducting the election and conducting a fair, transparent and equitable election process adapting to the "new normal" This first meeting was followed by a series of meetings till the election was successfully concluded, each meeting lasting several hours and sometimes going past midnight

What were the areas in which the SLMA has provided technical

During the process of rescheduling election, we were invited several times to discuss the epidemiological pattern of the diseases and the possibility of holding the election. We were able to provide detailed information and our position on this issue as an independent group. Our stance was that, the election can be held with adequate precautions during the controlled phase of the epidemic. The election process provided it is conducted with the necessary precautions will not increase the risk of COVID-19 transmission.

Refining and operationalization of health guidelines

Our inputs were helpful in refining the guidelines provided by the Ministry of Health on conducting a COVID-19 free election. Further, we contributed immensely to operationalize the guidelines throughout election process at ground level. We had many discussions with the officials involved in the election process and the knowledge and experience of officers at the Election Commission were of great help.

How the COVID-free voting process was planned?

We participated at the mock polls from the Ambalangoda and the counting rehearsals. We observed the process carefully to refine the guidelines further and added new processes to make the polling stations COVID free. The process was further refined during subsequent mock sessions.

The specifications derived from these mock polls and rehearsals included details on times of reporting to duty, handwashing and use of hand sanitizers, other preventive measures to be practiced by election officials and voters, security measures, physical distancing while voting, identification of voters, use of non-touch techniques in handling documents and decontamination of frequently touched surfaces.

What was the contribution of SLMA towards training election officers and educating the public on the new process?

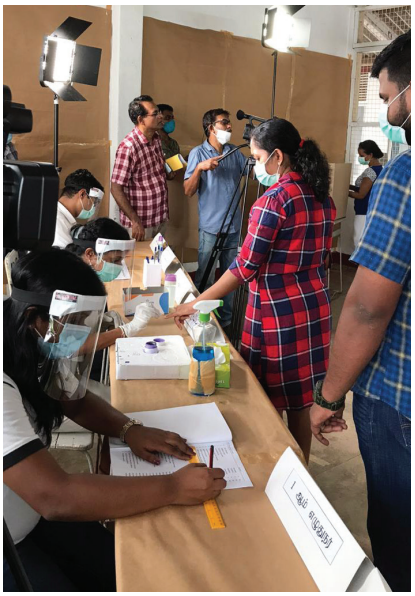
We were able to produce a detailed video to demonstrate the actual process which would take place at a polling station. This helped to train the officers participating the election and educate the general public. This video was telecasted in all mass media and social media.

The challenge of operationalization of guidelines for voting for those under quarantine

One of the key concerns was enabling voters still under institutional and home quarantine to vote at polling stations. We discussed this issue in detail during the numerous meetings we had with the Election Commission. We proposed several options and plans to ensure their voting rights are preserved whilst safeguarding the safety of the public. We also actively contributed to implement these plans during the voting process on the day of the election.

What was the role of the SLMA during the election?

Our team played a central role in managing the health desk at the National Operation Room at the Election Commission. We proposed a plan for health screening at counting centers and it was established with the collaboration of regional health directors and of the Medical Officers of Health in those areas. We provided assistance in resolving and managing the health concerns and COVID-19 related issues and complains during the day of election. We inspected several polling booths and health screening centers at counting centers to ensure that guidelines were being adhered to..



Our observations on the election process

We are confident in stating that the election process was conducted adhering to the expected health recommendations. It was possible mainly due to the resilience of the Election Commission and all the officers at all levels. Further, the enthusiasm of the officers at the Election Commission to share their wide experience is a rarely seen feature in the public service. This was one of the key factors which helped successful implementation of health guidelines during the election.

We would also like to highlight few observations that may be helpful in the future. Commencing counting of votes the next day improved the efficiency of the officers, reduced the stress and helped implement the health guidelines successfully. Implementation of health guidelines during the election imparted confidence in the process and it would be beneficial to establish a health advisory committee at the onset to make recommendation and overseas the matters related to health. Including health guidelines in a summarized form in the manuals of all the election officers would also help improve their knowledge and adherence to these guidelines in the future.

Life-giving blood: How your blood bank can serve you

Dr. Lawanya Wijesekara, Act. Consultant Transfusion Physician, Regional Blood Centre - Ampara

We in Sri Lanka are bestowed with the luxury of free health. From outpatient care for mild ailments to state of the art major surgeries, Lankans have the privilege of enjoying the benefits of free health. In this vast spectrum of health services, blood and blood product transfusion has become an integral part of providing optimum health care to our patients. This is where National Blood Transfusion Service comes into the lime light.

National Blood Transfusion service (NBTS) has come a long way since its humble beginnings almost five decades back. Today it is the sole supplier of blood and blood products to all the state sector hospitals as well as the majority of private sector hospitals. It is a centrally coordinated blood bank network, where the National Blood Centre in Narahenpita acts as the headquarters. NBTS provides its' services via a cluster system. There are 25 cluster centres, each led by Consultant Transfusion Physicians, which manages a total of 105 hospital blood banks. Special tertiary care centres like National Hospital of Sri Lanka, Lady Ridgeway Hospital, Colombo South Teaching Hospital, Castle Street Hospital for women and Colombo North Teaching Hospital are manned by Consultant Transfusion Physicians for more specialised care.

A hospital qualifies to have their own blood bank when it belongs to the category of a Base Hospital. Hospital Blood banks are managed by, Medical officers and nursing officers who have e had a minimum of one-moths training on blood banking at the National Blood Centre. All the other staff, including the Medical Laboratory Technologists, Public Health Inspectors and Junior staff members are also trained at the National Blood Centre on the blood banking processes as each of them has a unique role in handling the vein to vein chain of blood donation to transfusion.

There are several strata of Hospital blood banks which are designed to provide a better service island-wide. For example, Amapara Regional Blood Centre, situated within the Ampara District General Hospital, is a cluster centre with a Consultant Transfusion Physician. They do blood collection, testing for transfusion transmitted infections and do therapeutic aphaeretic procedures. There are 7 hospital blood banks in the Ampara district which are managed by the Regional blood centre consultant.

A hospital blood bank is involved in the blood collection from the donors, either by in-house donation, where the altruistic non remunerated donors walk into the hospital blood bank to donate blood or apheresis platelets or in mobile blood donation campaigns organised by the people of the area. Each bag of collected blood is tested for five transfusion transmitted infections, namely HIV I & II, Hepatitis B, Hepatitis C, Syphilis and Malaria. This testing is done at blood banks which have the facilities to do testing. All the blood collected by the NBTS undergoes these mandatory testing, irrespective of the place of collection.

The services the clinicians can get from your hospital blood bank

1.Collecting, Testing and Provision of Blood and Blood Components

2.Routine Blood Bank Laboratory testing
- a.Grouping & Cross matching
- b.DAT (Direct Coombs test)
- c.IAT (Indirect Coombs test)

3.Supplying Blood components

4.Rotational Thrombo Elaso Metry (ROTEM) testing and ROTEM guided component therapy

5.Therapeutic Procedures
- a.Therapeutic Plasma Exchange
- b.Platelet Rich Plasma preparation
- c.Red cell exchange

6.Immunohaematological tests - Done in liaison with Immunohaematology Reference Laboratory, Narahenpita

7.HLA testing - done in liaison with National HLA Laboratory
- a.For solid organ transplants
- b.Stem cell transplants
- c.Platelet refractoriness
- d.Prior to starting some anti-retroviral medicine
- e.In some autoimmune conditions

Blood and Blood Components available at our blood banks (Figure 1)

- **Red cell products**
  - ·Red cells concentrate (RCC)
  - ·Leuco-reduced / Leuco-depleted red cells (LRRC/ LDRC)
  - ·Washed red cells (WRC)
- **Platelets**
  - ·Random donor (RDP)
  - ·Apheresis Platelets/ Single Donor Platelets (AP-Plt/ SDP)
  - ·Platelets suspended in Platelets Additive Solution (Plt in PAS)
  - ·HLA matched Platelets
- **Buffy coat**
- **Plasma products**
  - ·Fresh frozen plasma (FFP)
  - ·Cryoprecipitate (Cryo)
  - ·Cryo supernatant plasma (CSP)
- **Irradiated cellular products (IR-RCC/ IR-Plt)**

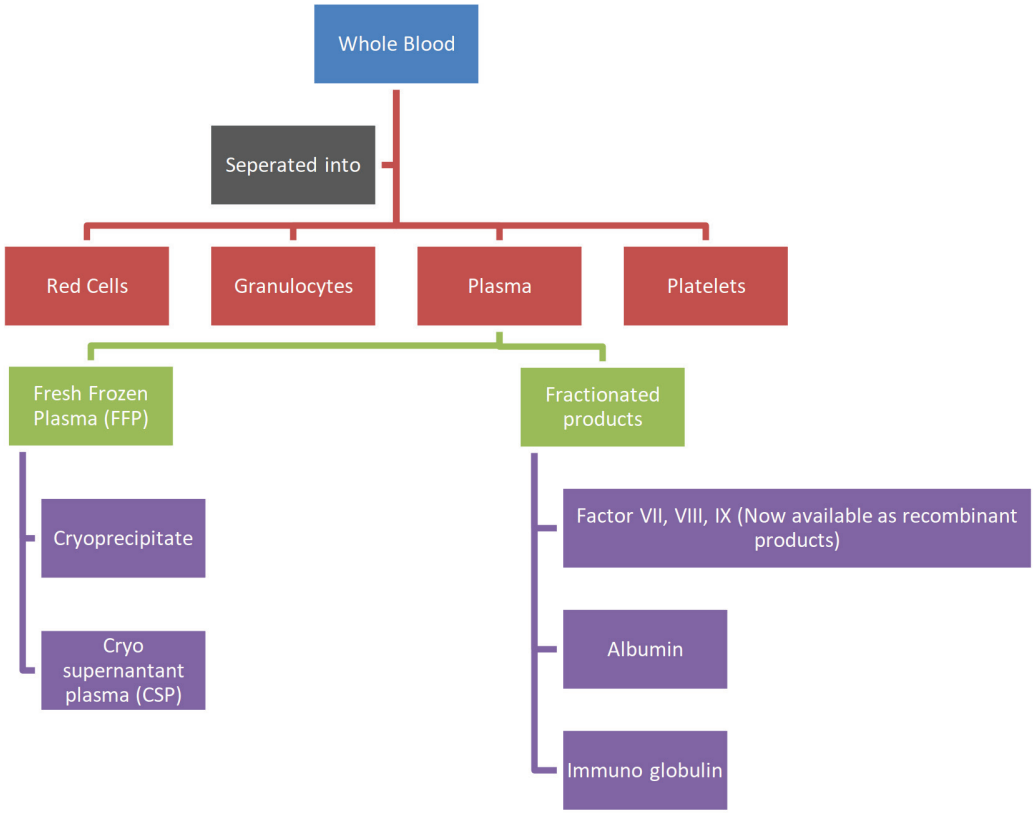


Figure 1: Blood and Blood Components available at our blood banks

WHEN TO REQUEST BLOOD (RCC)

·Acute blood loss
·Transfusion dependent anaemia
·Symptomatic anaemia - cause being investigated
·Threshold of ≤ 7 g/dl, target Hb 7-9 g/dl
·specific co-morbidities or acute illness

There is a Special Request Form to request blood. All the fields in it must be filled and signed by the requesting medical officer and sample collection should be signed by the nursing officer.

BLOOD COMPONENT TRANSFUSION

There are several blood products that can be used in a variety of conditions and the most common indications are mentioned in the request form. The component requests form is the same for Platelets, FFP, Cryoprecipitate and CSP. If there is a previous grouping record/ report from the hospital blood bank there is no need to send samples. If not, you need to send an EDTA sample.
Buffy coat. Which basically is white blood cells, is a component made on demand as its shelf-life is 24 hours. It is transfused for very special indications and its use is declining globally. If it is needed, it should be discussed with the CTP and should be requested in the blood cross match request form. Buffy coat need to be cross matched with patients' blood, and all buffy coats should be irradiated.

It is mandatory to monitor the patient during and after the transfusion and report to the blood bank if there is any reaction due to transfusion. Further, the patients' responses to transfusion should be assessed clinically and with pre and post Hb/ Platelets/ PT/INR levels to decide on further transfusions.
Depending on the patients' clinical condition and any reactions he/she may have to transfusions, blood and component type maybe changed to Leuco-reduced, Plasma-reduced, Washed, Apheretic, Phenotypically matched, HLA matched or Irradiated product, after consultation with the Consultant Transfusion Physician.

SPECIAL PRODUCTS

- **Irradiated (IR) cellular products**
  Cellular products (red cells, platelets and buffy coat) should be irradiated prior to transfusion for some disease conditions.
  Eg:- Hodgkins Lymphoma, Patients on Purine analogues, etc
  his is done to prevent the occurrence of the rare but fatal side effect of Transfusion Associated Graft vs Host Disease (TAGvHD). Irradiation facility is only available at the Blood Bank of National Cancer Institute Maharagama and if your patient needs IR products, it is mandatory to inform the CTP/ or the blood bank

- **Plasma reduced Platelets**
  This is a product with reduced shelf life and it is prepared on request. Once prepared should be transfused within 6 hours. The decision to transfuse plasma reduced platelets should be taken after discussion with the CTP

- **Apheresis platelets**
  Platelets collected by the aphaeretic method have the advantage of lesser donor exposure to a recipient. This is because one Adult Therapeutic Dose (ATD) is derived from a single donor. The decision to give aphaeretic platelets to a recipient should be taken after discussion with the CTP as this is a very costly procedure done only at selected centers.

- **Human Leucocyte Antigen (HLA) matched platelets**
  Platelets matched with patients Human Leucocyte Antigen is prescribed for patients who have developed platelet refractoriness to normal platelets transfusions. Decision to give HLA matched platelets to a patient is arrived after several investigations done at National Blood Centre, Narahenpita. Since it takes time to find specific donors, which matches the patient's HLA type, it will take some time to provide HLA matched platelets to a patient.

  If your patient needs HLA matched products, please inform and discuss with the blood bank regarding its logistics.

- **Leuco reduced/depleted red cells**
  These are red cells that have a lesser number of white blood cells. This is usually achieved by the change of whole blood collection and preparation method. Filtration is also used to get a lesser residual WBC count in the red cell concentrate. It has the advantage of less side-effects following transfusion and is recommended especially for transfusion-dependent patients and patients who have had recurrent transfusion reactions.

- **Phenotypically Matched RCC**
  Red cells have a large number of antigens on their surface than the commonly known ABO and Rh antigens. Some patients, especially patients who are transfusion dependent and those who have had repeated transfusions develop allo-antibodies against these minor red cell antigens. In such an instance the patients' blood samples should be sent to National Immunohaematology lab at Narahenpita to discern the type of allo-antibody that has developed. Once the antibody type is identified, if it's a clinically significant allo-antibody that can cause transfusion reactions and / or haemolytic disease of the newborn, red cells that lack the corresponding antigen is selected for that patient. This selected blood units are called phenotypically matched blood, and most of the time, they should be sent from the National Immunohaematology lab at Narahenpita.

GOOD PRACTICE POINTS AND MISTAKES TO BE AVOIDED

- Blood & FFP - Complete transfusion within 4hours
- Platelet & Cryo - Transfuse as soon as possible
- Blood not used but kept in cool box - Return to blood bank within 30 min
- Do not store blood products - In domestic refrigerators
- Don't warm blood - Unless you use a blood warmer

- If there is a reaction during or after transfusion please report to the blood bank with the relevant form and samples

- Please make sure that the patient is suitable to receive blood/ components
  - Presence of IV access
  - Fluid status of the patient
  - Body temperature
  - Informed Consent for transfusions, where applicable

SAFE TRANSFUSION PRACTICES

Transfusion of blood and blood components is a supportive therapy required to correct haematological deficiencies until the primary disease is dealt with. It has its own inherent risks that can even be fatal. Hence the appropriate use is the prudent choice in the interest of the patient as well as the clinician. The transfusion of safe blood products to treat a condition leading to significant morbidity or mortality that cannot be prevented or managed effectively by other means warrants a blood product transfusion and reduces the potential risks of blood transfusion.

Risks of blood transfusions

1. Risk of transfusion transmitted infections (TTI) is proportionate to number of units transfused
2. Alloimmunisation
3. Transfusion reactions
4. Haemolytic transfusion reactions
5. Transfusion Related Acute lung Injury (TRALI)
6. Febrile transfusion reactions
7. immunological refractoriness
8. Immunomodulation
9. Psychological fear
10. Cost of maintaining the blood chain

NEW VENTURES OF THE NATIONAL BLOOD TRANSFUSION SERVICE

1. Frozen red cell project
2. Sri Lanka Stem cell donor registry (SLSCDR)
3. Stem cell (autologous and allogenic) harvest
4. Cord blood banking
5. Nucleic acid amplification testing for transfusion transmitted infections

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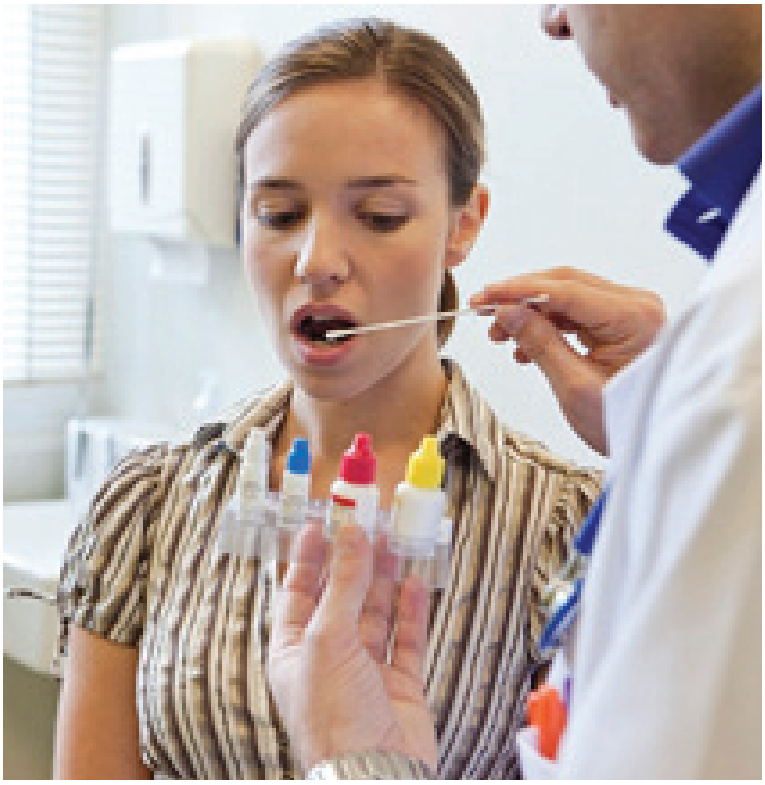
COVID-19: The new saliva test promises to be cheaper and faster

Dr. B. J. C. Perera, Senior Consultant Paediatrician

Extensive and rapid result oriented testing to detect coronavirus infections is a vital key during the on-going pandemic. Detecting an infection early would help to contain the spread of the virus and help save lives. Many countries around the world have been exasperated over testing shortages and delays for a considerable time.

A new saliva-based test for COVID-19 could offer a fast and inexpensive solution to millions of people. This new laboratory diagnostic test has been developed by researchers at the Yale School of Public Health in the USA. In a paper published on 04th August 2020 in the preprint server medRxiv, a team from Yale documented the new tool called 'SalivaDirect'. Another team, comprising many of the same researchers, had earlier this year detailed that saliva could be collected in any sterile container and that it remained mostly stable, without the need for special tubes or preservatives.



Until now, detecting the novel coronavirus SARS-CoV-2 involved the reverse transcription-polymerase chain reaction test. This "RT-PCR" test is conducted by collecting a sample from the back of a person's nose or mouth. While effective, the nasopharyngeal swabbing is unpleasant and the test is not cheap. There is also a limit to the amount of COVID-19 testing that can be done through this method.

This is where the new SalivaDirect test could be a real game-changer as it promises to be faster, less expensive and more flexible. With saliva being quick and easy to collect, this test could indeed be a significant advance in COVID-19 diagnostics. Up to now, the results have shown that SalivaDirect is highly sensitive and produces similar results as nasopharyngeal swabbing. Now, further tests are being conducted to see if the method can be successful as a test for asymptomatic individuals, too. Compared to nasopharyngeal swabs, researchers found a "high agreement" of more than 94 per cent in detecting true positives between the two methods.

> *"Up to now, the results have shown that SalivaDirect is highly sensitive and produces similar results as nasopharyngeal swabbing."*

The SalivaDirect test does not require a special swab or collection device. It can also be used with reagents from various vendors. The researchers had simplified the test so that it only costs a couple of dollars. The cost per sample could be as low as $1.29 to a high of $4.37, with the addition of a saliva collection aid.

A key step in the traditional COVID-19 testing includes extracting the virus's RNA after the sample is collected

before it can be detected by sensitive PCR-based methods. SalivaDirect removes the extraction step and replaces it with something very simple. An enzyme is added and the mixture is heated up. This process removes the most expensive step which is the most time consuming one which requires the most skill as well. The new test can run approximately 90 samples in fewer than three hours and has the potential to scale higher in bigger laboratories having automation. What is even more encouraging is that Yale is offering SalivaDirect's protocol open source. This means that researchers around the world can take and modify the method for use in their own labs depending on the resources they have.

"SalivaDirect removes the extraction step and replaces it with something very simple. An enzyme is added and the mixture is heated up. This process removes the most expensive step which is the most time consuming one which requires the most skill as well"

Moreover, the saliva-based test is safer, too. In the traditional method, when the swab is inserted into the back of the throat, it often leads to a cough or a sneeze. Thus, there is always a risk of the discharge of droplets from the person carrying the virus. With SalivaDirect, that risk is minimized as only the saliva will be collected. It can be further reduced if the sample is self-collected under the supervision of a healthcare professional. Thus far, the only condition with SalivaDirect is that the sample collected should be clear liquid saliva. This effectively means that the technique may not be suitable for hospitalized COVID-19 patients because their saliva samples may contain blood or mucus that can affect the final reading. Barring this, SalivaDirect does seem to be a good, low-cost, and effective method for rapid detection of COVID-19.

The US Food and Drug Administration (FDA) has now given Emergency Use Authorization to SalivaDirect. The low-cost and non-invasive procedure requires minimal processing and retains much of the accuracy of traditional nasopharyngeal swabs. FDA Commissioner Stephen Hahn says in a press release announcing the emergency use authorization, "Providing this type of flexibility for processing saliva samples to test for COVID-19 infection is ground-breaking in terms of efficiency and avoiding shortages of crucial test components like reagents",.

"The low-cost and non-invasive procedure requires minimal processing and retains much of the accuracy of traditional nasopharyngeal swabs"

SalivaDirect has already been used voluntarily by several teams of professional basketball players. People such as coaches, staff, and players from both the National Basketball Association (NBA) and the National Basketball Players Association (NBPA) began voluntarily using the test in June, and their participation was central in gaining FDA Emergency Use Authorization.

Ethics and professionalism in modern day medicine

Dr. Chamara Ratnayake,Consultant Cardiologist

Albert Einstein once said, "only morality in our actions can give beauty and dignity to life". The distinction between right and wrong, good and bad, will always be challenging and debatable; perspective matters. However, in the field of medicine, a code of ethics is bestowed upon us as we graduate with the great responsibility of healing human beings. Unfortunately, this responsibility has also led to some individuals to gain a false sense of entitlement, leading to conflicts and misunderstandings with patients, colleagues and society at large. This essay will focus on my own personal views on this matter.

The doctor-patient relationship: A bond that should not be broken

As we graduate from medical school, the final words that are announced to us prior to embarking on our journey in medicine is usually "primum non nocere" (first, do no harm). Medical ethics, we are told is built on four pillars: autonomy, beneficence, non-maleficence and justice. We are groomed for years to follow these principles, primarily to safeguard patients and of course the profession. However, I feel, simply following these "rules" leads to a one-dimensional way of thinking, and in modern day practice it may lead to misunderstandings.

An important aspect that is currently being ignored in most instances is effective communication between the doctor and the patient. In Sri Lanka, this may be due to many reasons; but mostly due to high patient volume in many centres with a limited time allocated per patient in government hospitals. The daily sight of long patient queues at clinics for a 2-minute consultation with the doctor to receive their list of medicines gives a despondent feeling. Some patients resort to private sector consultations to relieve themselves of this tiring experience. Unfortunately, it is not uncommon to hear that even in the private sector, where patients spend hard earned money to meet a doctor, hardly any time is spent explaining the condition and exploring management options. This leads to dejection and frustration, with rants on social media being a common occurrence nowadays. Medical practitioners used to be considered among the most respected and trusted professionals in society, however in modern times this honour seems to be diminishing, and the fault is ours alone.

Sri Lanka's exemplary state healthcare system is based on a free for all, no-one is turned away, platform. However, due to the constant overspill of patients and long waiting lists for procedures, private sector hospitals have flourished over the years. This too has led to a debate on hospital charges and professional fees, where on occasion patients feel they have been robbed. This unpleasant experience could easily be circumvented if patients do feel that there has been value for the money spent: pleasant conversation, time given for questions and clear plan in place for follow-up. No one will find fault in a doctor charging a fee for their time and hard years spent in medical school if the outcome is pleasant.

"This unpleasant experience could easily be circumvented if patients do feel that there has been value for the money spent: pleasant conversation, time given for questions and clear plan in place for follow-up. No one will find fault in a doctor charging a fee for their *time and hard years spent in medical school if the outcome is pleasant."*

In Sri Lanka, doctors are privileged in many ways. Upon graduating from medical school or sitting for qualifying exams as an overseas graduate, the state absorbs all doctors into the Ministry of Health, the state healthcare system. Those who wish to pursue postgraduate studies are allowed to do so as well. A career is always guaranteed. Only a minority relinquish this security and seek jobs in state universities as academics or join the private sector. This is far different from the situation in many other countries where fresh medical graduates search for jobs and sit for interviews, undergo periodic appraisals and renew employment contracts based on performance. In addition to the job security relished by doctors in Sri Lanka, all doctors irrespective of whether they are in the state health sector or working in a state university are allowed to engage in private practice. What is expected though, for this privilege enjoyed, is dedication to their duties within the stipulated government working hours. It is unfortunate though that not too uncommonly, certain individuals engage in unethical private practice for personal financial gains during these "holy hours". Those who do engage in such practices will only be answerable to their own conscience at some point in their lives.

It amuses me to see that current postgraduate trainees have mandatory workshops on ethics and professionalism and how best to practice medicine. I am a believer that professionalism is an art, a product of nature more than nurture, deeply inherent and cannot be simply taught. It is the ultimate expression of a set of

internalised characteristics at one's workplace. However, given the current context, it does seem apparent that it is a lost art that needs revival, which I hope will not be artificial but genuine. It pains me to hear stories of certain doctors, shouting vulgarities at and degrading patients and other staff members or dismissing patient's concerns with a "holier than though" attitude. Setting aside one's ego and accepting humility to achieve holistic care is the need of the hour.

"I am a believer that professionalism is an art, a product of nature more than nurture, deeply inherent and cannot be simply taught. "

The doctor-doctor relationship: Friend or foe?

We are often taught that the best outcomes in patient management will be achieved with a multidisciplinary team approach. This entails a group of doctors and other healthcare professionals coming together and outlining the best method of tackling a problem. Teamwork is essential and mutual trust is a must! The reality though is, that on certain occasions, concrete decisions are hard to make as a clash of egos takes precedence.

"Teamwork is essential and mutual trust is a must! "

Mark Twain once said, "Such is professional jealousy, that a scientist will never show kindness for a theory which he did not start himself". As I entered the realms of "consultanthood" I was advised on many things, but what struck me most were the endless reminders of how "cut-throat" the atmosphere will be and "to survive in this world you need to grow a thick skin, fast". At first, I was amused by the very thought; what threat could a junior consultant be for others to feel so intimidated? However, with time I came to the unpleasant realisation that the early warnings were indeed correct. Stories of bad-mouthing and denigration trickled back to me. I was then advised on not treading on "seniors" paths and not to "jump the gun" as far as private practice is concerned. I kept questioning myself, am I doing something wrong? Am I intruding into others territory or am I just being myself and inadvertently attracting attention? After careful reflection, I realised it was the latter. Further introspection and input from family and friends led me to believe that the term "professional jealousy" is indeed real. But why so? Why should one be jealous of a colleague's success? If they are embarking on an independent path with no interference with others, why should it bother anyone else? Are humans born with a natural inferiority complex and a desire for grandiosity that peaks its head out at the sight of a colleague's achievements? These are indeed distressing thoughts. What should one to do when jealousy turns to animosity? Turn a blind eye and carry on or fight fire with fire? Someone once said "Before you speak, let your words go through three gates: Is it true? Is it necessary? Is it kind?". Taking the high road is tough, but the view is majestic. Is it ethically acceptable to unfairly vilify a fellow doctor for one's own personal gain? If I have one piece of advice to my junior colleagues who will be entering the battle ahead, it would be this: practice medicine with kindness and with the best interests of the patient always at heart. What comes after is beyond your control. Never fear if you have not evaded from the basic ethical principles that were inculcated in the early years.

If I have one piece of advice to my junior colleagues who will be entering the battle ahead, it would be this: practice medicine with kindness and with the best interests of the patient always at heart. What comes after is beyond your control.

The doctor and social responsibility: where do we draw the line?

A recent article which was published and later retracted in the Journal of Vascular Surgery titled "Prevalence of unprofessional social media content among young vascular surgeons" attracted media attention for its biased conclusions on the attire, opinions and behaviour of young doctors during their private times. A debate arose about the appropriateness of social media content of doctors and if it would influence patient confidence in seeking treatment. What interested me mainly was the boundaries of the doctor: patient relationship. To be judged outside the hospital during our private life is certainly not a comfortable feeling. However, the responsibility of protecting the nobleness of the profession is also in our hands. This debate would never have occurred 20 years ago, when social media was a non-entity. However current trends do point to a paradigm shift. I believe doctors do have every right to enjoy life away from the hospital, in whatever way they deem appropriate, however posting such activities on social media will always attract judgement from others. It is our own conscience that would dictate whether it was appropriate or unprofessional.

Social responsibility of doctors in the modern era does go beyond the simple act of practicing medicine for the greater good of society. With the advent of social media platforms, health education has gained prominence and has far reaching consequences. We still do live in a society where for most patients, doctors' words are taken as gospel truth. The COVID-19 pandemic especially has

given examples of the good, the bad and the ugly of how information and misinformation is embraced by the public. The debate on the effectiveness of Hydroxychloroquine was given political mileage in the USA. Dexamethasone was introduced as an effective medication to increase survival in critically ill patients. However, there was misinformation of its use as a method of prevention of COVID-19. Similarly, other medical conditions will also be affected by the vast amount of data available online. "Google doctor" is a term that is commonly used for those who use the internet to come to diagnoses and find cures for common symptoms and signs. Hence, it is the responsibility of modern-day doctors to accept this current trend and attempt to respond positively to the patients who are seeking answers to questions which we may not have heard 20 years ago.

Hence, it is the responsibility of modern-day doctors to accept this current trend and attempt to respond positively to the patients who are seeking answers to questions which we may not have heard 20 years ago.

Concluding remarks

Practicing medicine is a privilege that not many can achieve. However, with this privilege comes many challenges as well as tremendous responsibilities. For some it will mould them to become better human beings. For others, it would lead to a life of envy and hardship. The path one takes is determined by a combination of what nature has given plus what is learnt. No two people would be alike. The ethical principles that are meant to guide us are not written in stone. We should each find our own path, where we will do justice to patients, colleagues, society and most importantly....ourselves.

A Message from the Editor-in-Chief

SLMA NEWS+ is the official e-magazine of the Sri Lanka Medical Association. We invite all SLMA members to contribute to SLMA NEWS+ with articles, letters, poems, cartoons, quizzes, medically relevant photographs, drawings or any material you wish to share with the other members. We also welcome your views on the content published in SLMA NEWS+.

Please send them by e-mail to office@slma.lk or by post to Editor-in-chief SLMA NEWS+, Sri Lanka Medical Association, No. 6, Wijerama Mawatha, Colombo 7.

Dr. Chiranthi K. Liyanage

IMPORTANT NOTICE

Any member of the SLMA who considers himself/herself suitable to guide the SLMA in the year 2022 as President is kindly requested to contact the SLMA Office to obtain the application for President Elect 2021. The applications should reach the honorary secretary on or before 30th September 2020.

Calling applications for Sri Lanka Medical Association (SLMA) awards for Excellence in Media Communication 2020

The above awards are presented to journalists (professional / freelance) & medical professionals in recognition of their work published in print (feature articles) or broadcasted on television (documentaries) on any Medical or Environmental topic in all three languages (Sinhala/ Tamil or English) to educate the general public during the period of 01st July 2019 to 30th June 2020.

Closing Date for application submission: 30th September 2020

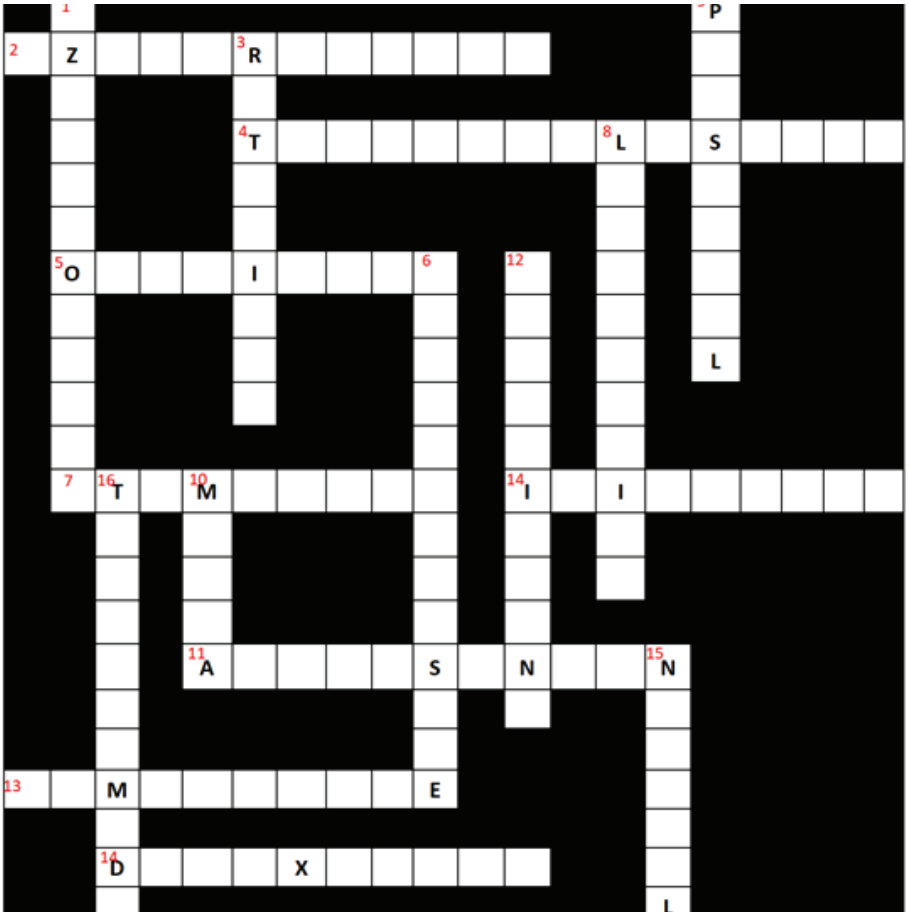
For application details contact:

Ms. Nirmala Alahakoon on 011 2693324 or through the link

https://bit.ly/2Q9OZgb

MEDICAL CROSSWORD : Know Your Medicines

By Dr. Chiranthi K Liyanage



ACROSS

2 Binds to the 50S subunit of bacterial ribosomes and inhibits protein synthesis
4 A thrombolytic agent
5 A recombinant humanized IgG1 monoclonal antibody
7 Used in rapid sequence intubation (RSI)
11Blocks endothelin receptors on vascular endothelium and smooth muscles
13 Used in the treatment of subarachnoid haemorrhage
14 A serotonin-norepinephrine reuptake inhibitor (SNRI)
17 An Azole antifungal

DOWN

1 Chronic immunosuppression with this drug is known to cause malignancies
3 A monoclonal antibody (mAb) that targets the CD20 antigen
6 A super potent topical steroid
8 An anti-epileptic
9 Irreversibly blocks the P2Y12 component of ADP receptors on the platelet
10 Given for prevention of cyclophosphamide-induced haemorrhagic cystitis
12 An acetylcholinesterase Inhibitor
15 A nonselective beta-adrenergic blocker

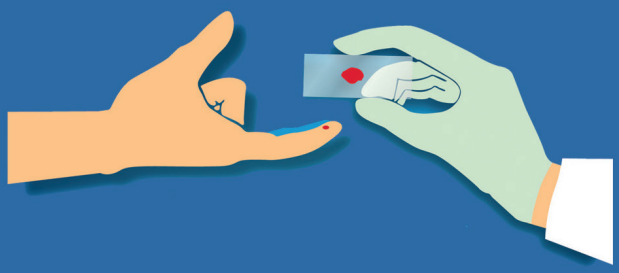
Answers

ACROSS

2 Azithromycin
4 Tenecteplase
5 Omalizumab
7 Etomidate
11 Ambrisentan
13 Nimodipine
14 Duloxetine
17 Imidazole

DOWN

1 Azathioprine
3 Rituximab
6 Betamethasone
8 Lamotrigine
9 Prasugrel
10 Mesna
12 Neostigmine
15 Nadolol
16 Thalidomide



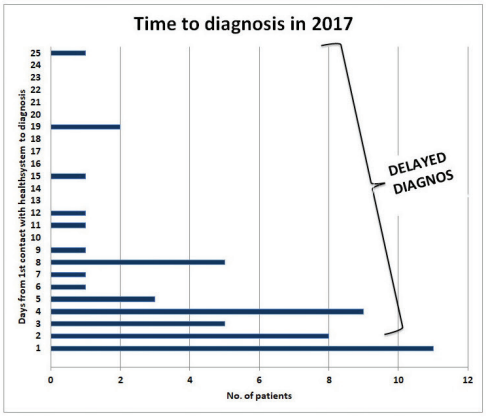
Reduce the Delay in diagnosing imported Malaria

Every single day that a malaria patient is left untreated,

* **His/her chances of survival decreases, &**

* **He/she can transmit the disease to others & re-introduce malaria to Sri Lanka**

Therefore malaria should be diagnosed within 24 hours of onset of fever



Your role:

For all fever patients, always check **travel history** at first interview. If patient has travelled to a malaria endemic country recently, **test for malaria.**

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Tell: 011 2 588 408/ 011 2 368 173/ 011 2 368 174
Email : antimalariacampaignsl@gmail.com

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