SLMA NEWS+

The eMagazine of the Sri Lanka Medical Association

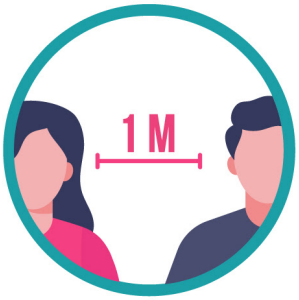
Editorial

Relativity of "Stupidity"

MAY 2020 | VOLUME 13 | ISSUE 5

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.

Design & Printed by NEO 0112 820 220

SLMA NEWS+

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ISSN : 1800 - 4016

Cover page photograph by Ashan K. Bopitiya

IN THIS ISSUE

Editorial

Relativity of "Stupidity"

Albert Einstein once said, "Two things are infinite: the universe and human stupidity; and I'm not sure about the universe". Today, some events which have caught media attention in the recent weeks sadly compel us to echo the same sentiments. Be it a "Trumping" claim of huge numbers of surgical masks being stolen from hospitals in New York or people taking to the streets protesting against social distancing directives or police insisting on lone drivers in their private vehicles wearing masks, all are "stupidity" exemplified in the eyes of the majority! If one is to draw examples closer to home, amidsts dedicated and selfless services rendered by many, we heard stories of doctors refusing to treat contacts of patient with COVID-19 who have been repeatedly tested negative or running out of a clinic because a patient with COVID-19 had been wheeled through it the previous day! However, "stupidity" is a relative term. It is relative to one's own discernment. Therefore, it is also subjective. What may seem "stupid" to one person may not appear so to another. Thus, is it fair to stamp any of the above as "stupid"?

Humans internalise, process and perceive information subjected to individual variations based on their past experiences, personal needs as well as priorities and their intellectual capabilities. These fashion our perceptions of true or apparent realities. Such disparities in perception may be even more pronounced in perplexing and taxing situations like the current COVID-19 pandemic. The risk perceived by one person may exceed that of another, and hence result in certain behaviours which are outside the norms expected, ergo "stupid". According to the Maslow's hierarchy of needs, safety needs come second only to the physiological needs of air, water, food, clothing and shelter. Human beings strive for safety above any psychological or self-actualization needs. Therefore, when faced with a threatening situation; true or apparent, fearful humans instinctively respond with the aim of self-preservation. Doctors are no exception; we are all human after all.

Yet, doctors are men and women of science, taught and trained to practice medicine based on evidence. When doctors appear to swerve from this evidence-based practice, it is often due to misconceptions or even plausible evidence being outclassed by fear and the compelling need to seek safety. We have seen doctors falter in emergency services and essential care due to preoccupation with safety and sometimes unreasonable fear. Disrupted routine out-patient services have also taken a toll, possibly increasing the morbidity and mortality of chronic non-communicable diseases. This collateral damage is palpable. Although it is to be expected amidst the information overload as well as rampant disinformation during this raging pandemic, we must explore all avenues possible to prevent such incidents. The lives of many depend on the actions of a few men and women in medicine; the end results of frequent internal negotiations of weighing one's own safety against another's.

The currently available evidence suggests that community spread of COVID-19 in Sri Lanka is very unlikely and the spread is confined to a few clusters. Therefore, doctors should be able to resume delivery of routine healthcare with appropriate risk assessment and triaging of patients along with the use of suitable personal protective equipment (PPE). At present, donning of PPEs has become a personal choice while doffing and disposal are unregulated. Most practices are not based on any local or international guidelines. Conversely, one may argue that it should indeed be a personal choice, based on the risk perceived by that individual. The need for physical and emotional safety outstrips any desire to conform to any guidance or regulation. However, should a patient ever be denied of care, when the risk to the doctor can be minimised to a reasonable degree and perhaps even be made negligible with precautionary measures? Again, we are all human, and every life is worth the same, and most definitely worth saving.

Circumventing relative "stupidity" during the current pandemic would require transparent communication and disclosure of facts between authorities and medical professionals. As doctors, we should also be vigilant of disinformation and habitually rely on official sources of information. Differing opinions are to be anticipated as this is a novel virus forcing us to adapt to a New Normal. No one has fought this battle before. Open discussions clarifying issues and ironing out opinions may promote best practices. Empathy, tolerance and morality are indispensable virtues to avoid friction and conflicts among ourselves in dealing with the public.

Albert Einstein's principle of relativity holds true only in inertial frames. However, neither human interactions nor the human mind is ever inertial; they are in a constant state of flux. Human perceptions and resultant behaviours are always relative. Hence, the best remedy for relative "stupidity" is perhaps simply soap, water and common sense.

President's Message

Dear Members of the Sri Lanka Medical Association,

COVID-19 has inflicted an unexpected and unprecedented degree of uncertainty on humanity and on the global economy. As the pandemic is slowly brought under control, experts predict that life would not be the same as in the pre-COVID era. The 'new normal' has become a buzzword.

Sri Lanka's COVID-19 response is characterized by a strong focus on the preventive approach and contact tracing, together with rational utilization of available resources. The success of this approach when applied within the Sri Lankan context is evident in the current situation analysis. With only 40 cases per million population and a case fatality rate of 0.8 %, key Sri Lankan statistics are much lower than the global averages.

The Sri Lankan approach has not been vastly different from the recommendations and prescribed measures practiced globally. However, a key difference has been in the timing of those measures and the intensity with which they were applied.

There have been several queries related to the sufficiency of the testing carried out in Sri Lanka. In contrast to the aggressive testing approach, Sri Lanka followed a unique strategy of 'Trace, Test, Treat'. In this approach, priority was given for contact tracing and isolation. A policy of preemptive quarantine and isolation of contacts even before they were tested has reduced the margin of error. Sri Lanka's policy of rational and methodical use of testing has been effective. From an average of 5% at the beginning of March, the test positivity rate has dropped to 2.62% by the time of writing.

Most of the current active cases are either asymptomatic or mildly symptomatic. Even after 14 weeks since the detection of the first patient, most cases can still be traced to an identifiable origin. However, we cannot be rest assured that the risk no longer exists. Analysis of the global situation shows that many countries which apparently curbed the spread are now experiencing a rapid resurgence in patient numbers.

Fully curtailing COVID-19 is doubtless going to be a long-term battle. A definitive treatment or vaccine is unlikely to be available in the near future. New behavioral patterns should be learnt and adopted in order to survive in the new world. Adhering to physical distancing, practicing hand hygiene, adhering to cough etiquette and other general hygienic practices are vital for survival and should be inculcated in to behavior as second nature.

The opening of a country following lockdown should be a gradual and stepwise process. Commencement of routine activities should be done after giving due consideration to economic impact. It is next vital to identify sectors where staff could be deployed in minimum numbers. Facilities for hand hygiene and physical distancing should be established prior to opening and the involvement of local public health authorities in inspection of these facilities is imperative.

The months ahead are critical as the Sri Lankan community seeks to establish a balance between adapting to the new normal while minimizing the spread of COVID-19. It should be acknowledged that some of the infection control measures will have long standing effects on social practices as well as the economy. However, a number of positive changes and trends have emerged which need to be recognized, valued and supported in order to maintain a sustainable change.

Professor Indika Karunathilake
President, Sri Lanka Medical Association

International Webinar on COVID-19
"Breaking the transmission chain through community empowerment"

Dr. Nimani de Lanerolle,
Assistant Secretary, SLMA

The Asia Pacific Academic Consortium of Public Health (APACPH) international webinar on COVID-19 in collaboration with the Sri Lanka Medical Association (SLMA) titled "Breaking the transmission chain through community empowerment" took place on the 30th of April 2020. This was the first international virtual conference of its kind conducted by these two esteemed medical associations.

The resource persons consisted of leading experts in the fields of public health, medicine, virology and other relevant fields from countries such as Sri Lanka, Australia, China, Hong Kong, Malaysia and Singapore. The expert panel from Sri Lanka connected live from Wijerama House, Colombo while the participants and international resource persons connected via the webinar platform Over 1000 participants from over 40 countries participated in this virtual conference and played a pivotal role in bringing about an international dialog on the COVID-19 pandemic. The moderators of this webinar were Professor Indika Karunathilake, President SLMA and Vice President APACH and the President of APACH Professor Wayun Low. The objective was to create a platform for different countries mainly in the Asia Pacific region to share experiences and strategies. Professor Wayun Low began the programme with the welcome address and she stated that APACH was glad to create this opportunity for discussion and debate among countries.

Next, different countries presented how they are combating the pandemic. The elite panel of experts from Sri Lanka consisted of Lieutenant General Shavendra Silva, Chief of defense staff and commander of the Sri Lanka Army and at present the Head of National Operations centre of COVID-19, Dr. Anil Jasinghe Director General Health Services (DGHS), Ministry of Health, Sri Lanka and Dr. Ananda Wijewickrama, President Ceylon College of Physicians the Chief Senior Physician at the Infectious Disease Hospital, Sri Lanka. In addition, members from other medical specialties and non-health disciplines, tri-forces, Sri Lanka police and law enforcement were also present to share their views.

The expert panel from Sri Lanka lead by the Lt. Gen Shavendra Silva spoke of how Sri Lanka is managing the pandemic emphasising on the fact that this was identified that this was a combined effort of the different sectors based on the three pillars of containment of affected cases, prevention of further spread and minimizing the losses of life.

The uniqueness of the Sri Lankan approach and the contribution of the military towards the effort was discussed. Dr. Anil Jasinghe spoke about the public health response. He mentioned how the Sri Lankan public health sector has had previous success in elimination and control of infectious diseases. Dr. Ananda Wijewickrama spoke regarding the clinical management and the case loadand the difficulties faced.

Following the presentation from Sri Lankan experts, Dr. Malik Peris, an eminent virologist from Hong Kong discussed their strategies and concepts. He discussed how Hong Kong was a central city where much travelling and movement takes place especially from mainland China and the challenges faced in handling this pandemic in such a setting. The steps taken, particularly aggressive social distancing and the method of testing and how the disease was contained without a lockdown or curfew was pointed out.

The situation in Malaysia was discussed by Professor Awang Bugiba, President of APACH - Kuala Lumpur Branch and also the head of the National Task force of for COVID-19 pandemic in Malaysia. He highlighted that there may be a resurgence of cases following easing of restrictions. He also discussed the problems they would face and the solutions identified pertaining migrant workers, the homeless and the indigenous population.

The report from Singapore was presented by Professor YY Teo, Director for the Center of Epidemiology and Research, Singapore who spoke of problems faced due to the migrant workers and the community. He explained that the strategies carried out are similar to those in Sri Lanka, Malaysia and Hong Kong. He emphasized on the importance of data and evidence-based approach, and clear communication especially to the public. He also explained the importance of statistical mathematical modelling to identify the infectivity rate and the resource requirement

Professor Gordon Liu, the director of China center for Economics and Research spoke of his observations of China. China has a very strong central government leadership and as a result the control of the virus was successful. As hospital care was focused more on COVID patients, he stated that morbidity and mortality from non-COVID illnesses may increase in the coming months as a consequence. He also discussed how socio-economic standards and inequality also play role in the

control of the disease and its progression. The need for holistic care was stated and to not neglect the other health care problems in the wake of COVID-19.

Professor Colin Binns from Australia, Past Vice President of APACH spoke of the situation in Australia. And pointed out that the restrictions are less than in some other countries. Similar strategies to other nations are carried out with regard to testing, tracing and prevention. He also stated that nutrition may have had a favorable impact as more people are consuming home cooked foods.

The panelists from Sri Lanka concluded the discussion by highlighting that people would not have to learn to live with COVID-19 and reiterated the importance of sharing information. Dr. Anil Jasinghe expressed the need for a balance between economy and health with gradual normalization of the situation.

This virtual conference was enriched by the lively and engaging dialogue between the participant and the panelists from different countries. Eminent personalities in the audience including Professor Harendra de Silva, President Sri Lanka Medical Council, Dr. Padma Gunaratne, President elect-SLMA, Professor Manuj Weerasinghe, Vice President- SLMA and Mr. Jagath Wickramaratne, President's Counsel made valuable contributions to the discussion.

Professor Wayun Low and Professor Indika Karunathilake concluded the session by thanking all the panelists, the APACPH executive board, the SLMA and their IT team as well as the participants for their valuable contributions.


Sri Lanka Medical Association


Dr. Anil Jasinghe


Dr. Ananda Wijewickrama
Prof. Indika Karunathilake

The SLMA's continued efforts against COVID-19

Professor Indika Karunathilake
President, SLMA

While continuing its efforts to positively contribute to the country's response to the COVICD-19 pandemic, the Sri Lanka Medical Association has undertaken man novel initiatives to broaden its activities over the last month. One of the highlights during this month has been the international virtual conference on COVID-19 organised in collaboration with the Asia Pacific Academic Consortium for Public Health. A detailed description on this event is published elsewhere in this magazine. The following is a brief account of the other activities undertaken by the SLMA during this time.

SLMA Webinars

The SLMA has conducted weekly webinars on COVID-19 focusing on timely topics as the pandemic progressed in the country.

Webinar on Institutional preparedness

On the 2nd of May, a webinar on institutional preparedness was conducted in collaboration with Ceylon Chamber of Commerce and National Chamber of Commerce. The speakers included Dr. Ananda Wijewickrama, President - Ceylon College of Physicians, Dr. L. T. DDG Environment, Occupational Health and Food safety unit, MOH, Dr. Shirani Chandrasiri, President Sri Lanka College of Microbiologists, Professor Saroj Jayasinghe, Professor of Medicine, Faculty of Medicine, University of Colombo, Professor Lal Chandrasena, Health Sector Advisor of the National Chamber of Commerce, Professor Manuj Weerasinghe, Professor of Community Medicine, Faculty of Medicine, University of Colombo. Over 125 participants in key positions attended the webinar.

https://www.youtube.com/watch?v=jKfGaem3A1M

Webinar on Breaking the Transmission Chain through Community Engagement and Empowerment

A tri-lingual panel discussion with experts in infection control, transport systems, apparel industry, health communication and law enforcement was held on 8th May 2020. The discussion was moderated by Professor Indika Karunathilake and Dr. B. Kumarendran, Consultant Community Physician. Professor Athula Sumathipala, Professor of Psychiatry, Faculty of Health, Keele University, united Kingdom, Mr. Ajith Rohana, Deputy Inspector General of Police, Professor Amal Kumarage, Senior Professor, Department of Transport and Logistics Management, University of Moratuwa, Dr. Shirani Chandrasiri, President Sri Lanka College of Microbiologists, Mr. Hiran Cooray, Chairman, Jetwing Hotels, Dr. Dinil Abeygunawardena, Director of Institute of Multimedia Education, Mr. Ranil Vitarana, Chief Innovation Officer, MAS Holdings.

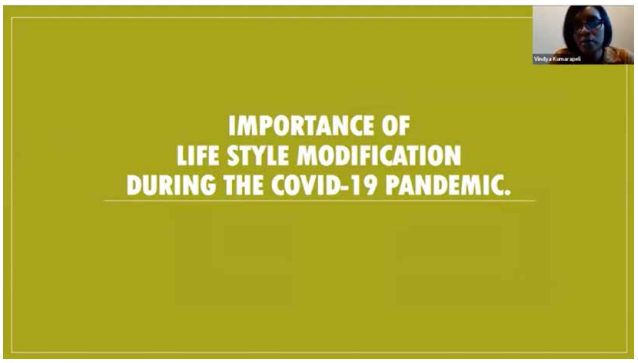
https://www.youtube.com/watch?v=jKfGaem3A1M

Another webinar was held in collaboration with the Ministry of Public Administration to share experiences to ensure sustenance of healthy practices in the society for new normal life

Webinar on Non-Communicable Disease (NCD) Screening and Management

A Virtual classroom session for the module on "NCD screening and Management during COVID-19 pandemic was held on Thursday, 8th May from 4.00 pm to 6.00 pm with the participation of key experts representing the Ministry of Health, Sri Lanka Medical Association and other professional organizations and academia. This webinar was conducted as part of the online continuous professional development (CPD) programme on primary care and it was attended by 88 course participants.

https://www.youtube.com/watch?v=4kfRsiCqLx0



Working with the Ministry of Health

The SLMA has established the Intercollegiate Committee (SMIC) with the participation of all medical professional colleges in Sri Lanka to create a platform to foster dialogue between specialties and to provide consensus recommendations. Recommendations submitted to Ministry of Health from SLMA Intercollegiate Committee include;

Recommendations submitted to Ministry of Health from SLMA Intercollegiate Committee include;

- Recommendations on restarting essential medical services.
- Recommendations of different specialty colleges regarding COVID 19 management.
- Recommendations on performing RT -PCR testing before high risk procedures.
- Recommendations to stop unethical media reporting.
- Unsuitability of decontamination chambers to prevent the spread of COVID-19

A SMIC delegation also met with the Secretary, Ministry of Health and presented the work done so far and discussed the way forward for collaboration. A bi-monthly meeting between the Secretary and SMIC was agreed upon. Possibilities of an online CPD program for doctors too was discussed.

Collaborative Projects with the World Health Organisation (WHO)

The SLMA has initiated several collaborative projects with the WHO on COVID-19. These include;

- A rapid qualitative assessment of public perceptions to support Risk Communication and Community Engagement (RCCE) for COVID-19 preparedness and response

- An assessment of the perceptions of the current COVID-19 situation, its health, social and economic impact and experiences related to obtaining medical services

- Situational Analysis of the preparedness of secondary and tertiary curative settings for COVID-19 response in Sri Lankaes.

Collaboration to evaluate COVID-19 inventions

The SLMA, SMIC, the Sri Lanka Association of Young Scientists (SLAYS) and the National Inventions Commission is currently working in collaboration on COVID-19 inventions. A meeting with all the relevant parties was held on 6th May 2020 at the SLMA office to discuss this collaboration.

Health Education Campaign

The SLMA has worked tirelessly to educate the public, to clarify doubts, clear misconceptions and bring clarity during these confusing times. Office bearers and members of the SLMA council continued to make numerous appearances on national and electronic media and published many articles on national media to this effect. The posters and videos produced by the SLMA to educate the public are also being widely circulated in social media.

The tobacco industry and COVID-19: A vector trying to adapt to a challenging situation while we look on dejectedly?

Dr. Mahesh Rajasuriya
Director, Centre for Combating Tobacco (CCT), Faculty of Medicine, University of Colombo
Senior Lecturer, Department of Psychiatry, University of Colombo
Consultant Psychiatrist, Sri Lanka National Hospital, Colombo
Chairman, Alcohol and Drug Information Centre (ADIC), Sri Lanka

One may not believe that the tobacco industry managed to convince the world that the addictive toxic chemical nicotine is an essential medicine? If you want to know how they did it and how they still utilise the same tactics, following is what you need to read now for the next four minutes.

In 1980s, the tobacco industry opposed the newly emerging nicotine replacement therapy (NRT). Today, they market their own NRT products [1]! Why and how did they change their stance?

Centre for Tobacco Control Research and Education (CTCRE) of University of California, San Francisco, USA, carefully examined internal tobacco industry documents between 1960 and 2010 to understand the dynamic view of the tobacco industry on NRT. And, this (see table 1) is what they found, in brief:

Prior to approval of NRT as a therapeutic agent in 1984, the tobacco industry perceived NRT as a threat. After the Orwellian year 1984, three things happened: Firstly, the world apparently changed the negative view they had on nicotine. Secondly, the tobacco industry started to realise that main usage of NRT for smokers is to compliment smoking not to quit it. Thirdly, the tobacco industry started promoting NRT and marketing their own NRT products [1].

Table 1: Timeline of NRT Research and Development by Tobacco Industry (TI)

Timeline	NRT Research and Development
1950	TI initiates research on nicotine gum, but then later abandons as they fear being regulated by FDA
1970	TI finds that the consumer perceives nicotine as a dangerous toxic chemical, and later starts research on reduced nicotine products
1984	FDA approves nicotine gum (patches, few years later) for smoking cessation; heavy NRT marketing begins
1987	TI realises that the consumer no longer perceives nicotine as a dangerous toxic chemical
1991	TI gives up research on reduced nicotine products
1992	TI finds out that use of NRT has little effect on quit rates in the real world
1994 – 2008	TI starts classifying NRT as a competitor product, just like cigars or smokeless tobacco products
2009	The World Health Organisation (WHO) proposes inclusion of NRT in the Model List of Essential Medicines
2014	TI begins marketing their own NRT products

Note:. FDA = US Food and Drug Administration; NRT = nicotine replacement therapy; TI = Tobacco industry
Sources: (1) (2)

And now, the whole world including health professionals have a positive 'feeling' about nicotine and NRT. The tobacco industry is earnestly doing the same with cannabis right now, which is going to be their new product soon [3].

Let us turn to the COVID-19 era now.

As evidence started to mount that smokers have a higher risk of contracting, spreading and dying from COVID-19 [4], the tobacco industry got alarmed. The impact of smoking on overall COVId-19 pandemic (not only smokers dying from it) was felt to be significant and damaging. Thus, the tobacco industry has every reason to be seriously worried not only over the current dent in their revenue, but mostly over the potential of smokers quitting en mass (or reducing use, as 2.7 million British did recently[5]. Further worsening of their black-sheep image as a barely wlegitimate industry is also a likely concern of the tobacco industry. There is even a potential for tobacco to be outlawed in countries that want to take a leaf out of effective tobacco control measures of Bhutan - predating COVID-19, (6) and South Africa [7] and India [8] - during COVID-19.

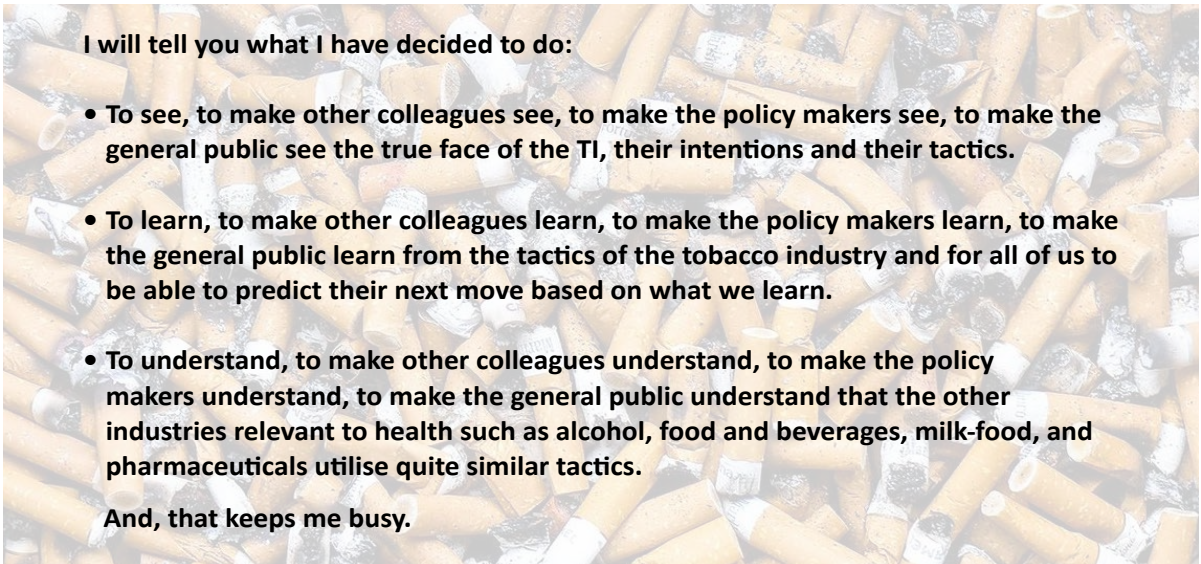
"Thus, the tobacco industry has every reason to be seriously worried not only over the current dent in their revenue, but mostly over the potential of smokers quitting en mass (or reducing use, as 2.7 million British did recently). Further worsening of their black-sheep image as a barely wlegitimate industry is also a likely concern of the tobacco industry."

So, the industry had to respond. They responded in order to mitigate the serious damage in three major ways: sowing doubt and confusion over the relationship between smoking and COVID-19; coming forward to help governments to deal with COVID-19 control; engaging in research related to COVID-19 control, mainly in vaccine production. Preprint from France[9], which shadily concludes smokers are less likely to get COVID-19, receiving wide exposure before peer review; Phillip Morris donating ventilators to the government of Greece [10]; and British American Tobacco's involvement in development of a potential vaccine in the US [11] are a few examples.

"They responded in order to mitigate the serious damage in three major ways: sowing doubt and confusion over the relationship between smoking and COVID-19; coming forward to help governments to deal with COVID-19 control; engaging in research related to COVID-19 control, mainly in vaccine production."

As the medical professionals, the frontline stakeholders who are battling the COVID-19 pandemic, what are our duty, role and responsibility now? Just look on while the vector of the tobacco pandemic, the tobacco industry quickly exploits the COVID-19 pandemic to the detriment of millions of people? Or, do something about it? It is up to us to decide.

"what are our duty, role and responsibility now? Just look on while the vector of the tobacco pandemic, the tobacco industry quickly exploits the COVID-19 pandemic to the detriment of millions of people?"



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Smoking is injurious to health.

Smoking kills

Photograph by Ashan K. Bobitiya

Training the next generation amidst a pandemic: challenges and opportunities

Professor Gominda Ponnamperuma, Department of Medical Education,
Faculty of Medicine, University of Colombo, Sri Lanka

The most debilitating imposition that the current COVID-19 pandemic has placed on educational programmes is social distancing. Medicine is learnt and practised by people, with people and for people. Social distancing separates people from each other, rendering the in-person interactions among students, teachers and patients a near impossibility. This poses special challenges to education in general, but more so to medical education, where face-to-face interactions are often thought to be absolutely essential. Following is a brief discussion on how medical education, both undergraduate and postgraduate, can overcome the challenges of social distancing, when delivering its educational programmes under the current circumstances.

Teaching and learning

Thanks to modern technology, teaching and learning of theoretical knowledge has been the least affected during the current crisis. Amidst an abundance of software applications that support online and real-time teacher-self and self-peer three-way interaction, delivery of knowledge with the same flavour as that would have happened during face-to-face teaching is no longer fiction. Not only the delivery of knowledge, but the application of knowledge can also be effectively taught and learnt remotely with the help of relevant case scenarios. These scenarios can even be animated with videos that closely simulate real-life. Some students seem to like such delivery of information even more than its face-to-face equivalent, as they can learn in the comfort of their homes and will have additional benefits like recording the teaching and learning sessions. So, the challenges related to in-class teaching and learning can be vastly overcome using technology. If such teaching and learning can be accomplished to cover the knowledge component during the period that formal face-to-face teaching is impossible, then the laboratory and other hands-on practical sessions could be conducted with a short resumé to recap heory, once the students are back in the institutions. This sequencing of the theory and practical learning may not be the ideal, but given the situation it is an option that most educational institutions world over have resorted to.

Teaching and learning in the hospital/community setting, however, remains a formidable challenge. With no safe undergraduate access to these settings, it seems that training in these settings has come to a standstill. Even certain postgraduate students may have limited access to these settings during the current pandemic.

"Teaching and learning in the hospital/ community setting, however, remains a formidable challenge."

Nonetheless, everything is not lost. If one considers a typical clinical encounter, a considerable portion of it can be simulated. The entirety of history taking can be simulated through the distance learning mode, using virtual patients or human simulated patients. These virtual/simulated patients can even provide feedback to the students on their socio-emotional and history taking skills. It is the practice/learning of physical examination and practical procedures that may suffer most. That being said, physical signs elicited using the eye or the ear of the student are remotely deliverable with the existing technology (e.g. cyanosis, skin rashes, heart murmurs, breath sounds). Only the signs elicited using the hands (e.g. palpation, percussion) or using instruments (e.g. performing a knee jerk, ophthalmoscopy) that may not be possible. Even palpation may be possible using high-fidelity simulators supported by haptic technology, to a level good enough even to train postgraduates. However, there seem to be two stumbling blocks: the non-availability of this type of high-fidelity simulators and even if they are available, the learning will still have to happen using expensive add-ons such as goggles and tactile sensors or in specialised centres. The latter means students need to travel to identified centres, even compromising social distancing guidelines. Also, it is true that this type of simulated learning could rarely replace the actual patient encounter. Although these remain palpable disadvantages, keeping the students engaged at least with a few of these learning modalities could shorten their training time with real patients, whenever that may become feasible. Hence, some lost time could be gained.

"Although these remain palpable disadvantages, keeping the students engaged at least with a few of these learning modalities could shorten their training time with real patients, whenever that may become feasible. Hence, some lost time could be gained."

Assessment

If teaching and learning in the clinical/community settings is considered problematic, then assessment seems even more so. One tends to think that written examinations can be delivered fairly reliably using online means. However, on the one hand, there is no guarantee that technology, as it stands today, will deliver a written test within a specified time, securely and unfailingly. Reports of intermittent data transmission interruptions are not uncommon during online teaching and learning. Just one such instance during an assessment will make the entire assessment null and void. On the other hand, although there are ways to control copying and impersonations when an assessment is delivered remotely, they remain at best, less than satisfactory. For example, one way of countering copying is to time the assessment to be tight enough so that any reference to other material will not allow the candidate to complete the test. Keeping the video of the candidate's computer on right throughout the assessment along with intermittent biometric checks should deter impersonations. However, no one can vouch for the absolute validity and veracity of these measures. Hence, many institutions all over the world still require students to visit an examination centre to take a test, despite it being delivered paperless. In the current context, some educational institutes have managed to conduct online tests in multiple centres simultaneously, honouring the stipulations of social distancing and limiting human gathering to the number permitted under the quarantine laws.

As discussed under teaching and learning, clinical examinations remain a distant dream, unless the students are permitted to visit a specialised centre to undergo assessment with simulated patients. This has happened elsewhere and may have to happen in Sri Lanka if the worst comes to the worst, possibly as the last resort. Alternatively, using carefully selected, pre-screened and pre-tested (i.e. 'non-infective') actual patients for selected high-stakes examinations may also be possible. In such instances, the ethics of using a real patient even with proper consent and the vulnerability of the patient to possible cross-infection will have to be carefully weighed. Even if real patients are not used, gathering of candidates in a single centre is a major concern under quarantine laws. Hence, equivalent forms of the same assessment will have to be conducted in different centres, maybe in different universities in all provinces. The logistics involved in such an operation is daunting but not insurmountable if necessity demands for it to be so.

Endemic issues

Apart from the pandemic-related constraints discussed above, there are two fundamental issues that all educational programmes will have to overcome if the reliance on e-based distance learning is to be effective. They are related to quality and equity. Quality of the e-learning material will have to be ensured so that the student experience at least approximates that of face-to-face learning. For this, teacher training and availability of resources would go a long way. Equity is even a more fundamental issue. Students from remote locations use different devices, data connections and learning conditions to access learning. If all students do not have the basic opportunities of learning even during these unfortunate times, the true goals of education will never be realised. Authorities have taken commendable efforts such as providing free internet access to students to ameliorate some of these issues. These have created, by-and-large, a level playing field. However, more of such efforts will never be 'more'

"Apart from the pandemic-related constraints discussed above, there are two fundamental issues that all educational programmes will have to overcome if the reliance on e-based distance learning is to be effective. They are related to quality and equity."

Facing the future: lessons learned

As history has taught us, this will not be the only pandemic to visit us. No one even knows how many waves that this pandemic will go through. Hence, it is opportune to consider how best can we face a similar situation in the future, while trying to cope with the present. It is this preparedness that stood in good stead for Far Eastern countries. Their experiences with previous SARS and H1N1 pandemics made them more resilient in coping with the present crisis. For example, most of the improvements in e-learning in these countries were shaped by their past experiences of other pandemics. If we think along the same lines, then there is no doubt we should develop stronger e-learning systems.

Concerning assessment, we may have to introspect radically our assessment practices and their underlying rationale. At present, most of our assessments are summative assessments held at the very end of training. Formative assessments of variable validity and reliability are held sometimes. Even when they are held, they mostly go undocumented. Assessment in the modern day is viewed as a process that collects information about the candidate's ability throughout training, as opposed to a final big-bang examination at the end of training. Had we subscribed to this philosophy of assessment by institutionalising an appropriate array of workplace-based assessments with a portfolio to document their

"Assessment in the modern day is viewed as a process that collects information about the candidate's ability throughout training, as opposed to a final big-bang examination at the end of training."

results, we could have taken defensible decisions about the candidate's ability even without a big-bang final assessment or even with a rather compromised final assessment. If we have such reliable information on each candidate collected during their training, the strain on conducting examinations under constrained conditions could be eased out considerably, if and when a pandemic or some such disaster hits us next. Above all, pandemic or no pandemic, this way the students can be offered a fairer deal.We live in uncertain times. Uncertain times call for ingenuity and resilience. Medical education cannot evade this reality. Rethinking, reimagining and reinventing the future training landscape is not an option anymore; it is a must.

"Rethinking, reimagining and reinventing the future training landscape is not an option anymore "

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

The impact of "COVID-Age" on clinical practice

Dr Himantha Atukorale
Consultant in Rheumatology and Rehabilitation, Teaching Hospital Anuradhapura

"To touch can be to give life."- Michelangelo

Bath City in the United Kingdom is a world-renowned UNESCO heritage site because of ancient Roman hot water baths. Annually over 3 million visitors visit the city just to get a glimpse of the luxuries people indulged in during "Pax-Romana". But the city of Bath is also famous because of a patient based disease measurement scale termed Bath Ankylosing Spondylitis Disease Activity Index (BASDAI). BASDAI is the brainchild of a group of rheumatologists and physiotherapists from Bath city who created a scale that the patient could complete at home without meeting a doctor. At the Royal National Hospital for Rheumatic Diseases - Bath, patients who are diagnosed with Ankylosing Spondylitis are offered the opportunity to complete BASDAI at home, online, before arriving for their appointments. The clinic even has tablet personal computers (PCs) installed at the reception where the patient gets to complete the BASDAI and other questionnaires before they meet their rheumatologist. This well-established clinic routine enables the doctor to know the disease status of the patients even before meeting them in person.

We as physicians have entered the COVID-Age after going through atomic, space, and information ages. Minimising doctor-patient contact during the COVID-Age is a hot topic these days because of the highly virulent nature of the virus. Other than BASDAI there are similar indices in rheumatology which utilise patient experience or discomfort without establishing much physical contact. My specialty chiefly revolves around pain management. Therefore grading pain and adjusting medication accordingly might suit our patients. The reliability of such treatment modalities in other specialties, based solely on patient opinion; sans physical examination is doubtful and needs further evaluation.

As a medical student, I was taught the core elements of "Aseptic Non Touch Technique" which included practices such as hand hygiene, non-contamination, use of gloves, and disinfection. The question arises: in future are we compelled to use this non-touch technique for safety during most of our doctor-patient encounters? And how does the usual physical contact matter in improving compliance? In a study by Cocksedge et al. on how physical touch was perceived by patients, most believed expressive touch by the doctor was acceptable, especially in situations of distress. Although the practitioners feared misinterpretation in their use of touch, patients were keen that these concerns should not prevent doctors from using expressive touch in consultations.

The fundamentals of patient encounters begin with history taking and physical examination. History alone is insufficient in making decisions. Physical examination

"The question arises: in future are we compelled to use this non-touch technique for safety during most of our doctor-patient encounters? And how does the usual physical contact matter in improving compliance?"

involves numerous procedures that are done within proximity to the patient. COVID-Age is bound to revolutionize the whole science of physical examination. Earlier the clinician had the comfort of having a health care assistant or even a nurse within the examination room, while he concentrated purely on the physical signs. Concerns about acquiring COVID will introduce certain elements like fear and panic to not just the clinical team but the patient as well. The challenge that we would face, will be on overcoming these fears while putting our minds to the physical signs.

Does the facial expression of the patient influence the decision-making process? Most of us who have practiced medicine in this part of the globe would nod our heads in full agreement! It is proven that facial expressions, especially of an emotional patient or a person suffering from pain, affect the clinical judgment or even the treatment modalities of the clinician. But what happens inside a clinic where everyone is concealing their facial expressions with facemasks? Eye movements or in certain instances the tone of the patient's voice might be the new supplemental cues on how "bad" one's ailment is! Hand gestures are considered a powerful non-verbal communication method and also is known to involve Broca's area similarly to speech. Will the patients opt for hand movements then? And how capable the doctors are in interpreting hand gestures of masked patients? A "vocabulary" of hand gestures featured in the Oxford "hand" book of clinical medicine perhaps?!

I work with the therapists for the rehabilitation of patients at Anuradhapura hospital. Both occupational and physiotherapy involve working with a disabled patient sometimes for over an hour. Although the active exercises can be taught and guided within a short lapse of time, the passive movements require the therapists to impart somewhat forceful movements for prolonged periods. There is no possible method in physiotherapy that allows the therapist to do their tasks through non-touch methods. In rehabilitation medicine, we look after children who suffer from speech delay. The speech therapist does the initial patient assessment through observation of lip, tongue movements; vocalisation. the

Even the swallowing assessment requires close monitoring. When it comes to therapy sessions, demonstration of certain oral movements is considered the key to successful teaching experience. Face masks and social distancing is not possible in these scenarios.

"When it comes to therapy sessions, demonstration of certain oral movements is considered the key to successful teaching experience. Face masks and social distancing is not possible in these scenarios."

Time spent with the patient has a direct impact on components of care. Patient satisfaction, the outcome of chronic diseases, physician satisfaction, prescribing practices, and risk of malpractice claims are some of them. In a study by Laine et al., patients ranked the importance of providing disease-related information by the clinician second only to clinical skill. Also in another study by Zyzanski et al., patients who wished they spent more time with the clinician were less satisfied. When evaluating prescribing practices, it is proven that shorter doctor-patient visits lead to inappropriate and increased rates of medicine prescriptions. COVID infection risk invariably promotes shorter clinic consultations. It is heartening to note that telemedicine has been introduced in certain government hospitals. Patient information leaflets are also popular these days. But will these methods triumphantly succeed in replacing the classical doctor-patient interphase? In a country where we boast of very high literacy rates but have very low comprehension rates, it is doubtful that novel methods will replace the traditional ones.

Ward rounds of "yesteryear" are handy routines for exchanging information as a health care team. The lessons that are learned and the strategies that are adopted in managing a patient are undoubtedly life lessons for any health care personnel. Social distancing will amend how these traditional "rounds" are done.

COVID-Age will invariably promote robotics in surgeries. Robotic technology enhances surgical procedures through improved precision, stability, and dexterity. Complex imaging methods and sensors for registering the patient's anatomy are needed for these high tech surgeries. Already robotic technology is famous in specialties like neurosurgery and orthopaedics. The advantage of "operating" from a distant location will tempt surgeons to use these novel methods.

The disadvantages would be the high cost and the training that is required to operate such sophisticated machinery.

Academic activities within teaching hospitals have recommenced through cloud-based video conferencing tools. There are certain advantages of video conferencing such as staying within your comfort zones while listening to lectures. The academic institutions will also benefit from minimising electricity and lecture hall maintenance costs. So far no medical faculty has thought about merging lectures and delivering these to the entire Sri Lankan medical student community through a single lecturer. How satisfied the lecturers are by conducting online teaching needs evaluation.

Would webinars replace medical congresses? Is acquiring knowledge the sole purpose of a congress? Aren't congresses events that we look forward to, essentially because they provide us opportunities to meet friends within our academia? The irreplaceable factor of any national or international medical congress is the banquet, gala dinner, and glamour. COVID-Age will pave the way to a modern method of convening as academics. Will someone workout on a banquet personal protective equipment (PPE) and make masks mandatory in the dress code?

It is well understood that physicians have received a hefty dose of anxiety, concern, and fear because of the viral outbreak. For over a million years anxiety has proved itself to be an excellent survival strategy for us. But currently, it is considered that our levels of anxiety are no longer proportionate to the actual dangers of living. Constant anxiety will lead to chronic stress within the medical fraternity. Burnout syndrome among healthcare volunteers was first described in 1974. It is measured across three dimensions namely emotional exhaustion, depersonalisation, and low personal accomplishment. In a study conducted on over 3000 resident doctors in Syria by Alhaffer et al., 93.7% had high levels of burnout in at least one of the three domains mentioned above. We have to avoid COVID pandemic related burnout of doctors at all costs. As this will directly affect their skills and work efficacy. The patients will be at the receiving end of physician burnout. What we have strived for years especially in controlling the non-communicable diseases would go to waste.

"Burnout syndrome among healthcare volunteers was first described in 1974. It is measured across three dimensions namely emotional exhaustion, depersonalisation, and low personal accomplishment."

COVID-age will make provisions for novel and systematic methods of patient assessment. Providing a sense of security to our team of health care workers will be challenging. Considering the viral outbreak as an opportunity to update our routine strategies is necessary. In a world that is changing rapidly, we as clinicians will have to move along unchartered waters while safeguarding ourselves and the patients.

Being psychologically well during a pandemic

Professor Piyanjali de Zoysa
Professor and Clinical Psychologist, Faculty of Medicine, University of Colombo
In conversation with Dr Nimani de Lanerolle, Assistant Secretary, SLMA

The current COVID-19 pandemic is seen to lead to stress and anxiety amongst some individuals. This maybe more so amongst medical professionals - particularly those who are actively engaged in patient care and in laboratory services. Thus, these doctors, and indeed the entire health team, are in a unique position where they must manage their own anxieties, if any, whilst being professionally active. However, the level of fear and stress may defer from person to person. In a recent survey in England amongst the general public, 14% reported being immobilized by fear whilst 25% experienced minimal amount of stress during the COVID-19 pandemic (BBC, 2020). This varied reaction maybe based on several factors unique to a given person. Hence, for some, the stress and fear felt during times such as this is an opportunity, enabling them to become more resilient and mobilizing their mind to face the situation with strength. For them, the strengthening of their mind also leads to future benefits such as increased self-reliance. For others however, stress and fear may lead to certain unhealthy patterns, such as:

- Avoidance: work-related matters or even one's daily activities
- Irritability: maybe towards one's family and friends or towards patients. This reaction may be detrimental to both personal and professional relationships
- Restlessness: the mind wanders with difficulty in concentrating
- Changes in sleep and eating patterns
- Substance use: reliance on alcohol, tobacco, etc, to get through the day

Learning strategies to increase our psychological wellbeing is indeed useful. Other than the boost such a person gets, his/her general health- and safety-related activities will also improve. These include using recommended physical protective measures such as personal protective equipment (PPE)s, maintaining physical distance in a general practice and in clinic settings, and if appointments are given doing so in a staggered manner. Hence, the doctor would take measures to ensure that s/he and those in his/her life are protected from possible exposure. Such a doctor takes these measures wisely, rather than through anxiety, thanks to his/her psychological well-being.

There are many ways in increasing one's psychological wellbeing. These include mobilizing one's already existing healthy coping strategies that have been utilized in a previous difficult situation such as ending a challenging relationship. These may include a program of exercise or pursuing artistic interests. There are also other strategies a doctor, or anyone for that matter, would benefit from:

- **Stop fighting reality and have an attitude of acceptance:** accepting the current reality of the pandemic is essential if we are to cope with it. This involves abstaining from complaining about it and instead adjusting one's mind to 'embrace' it. This will uplift us and others around us as well. It will also allow us to take constructive action required to tide through difficult times.

- **Having a daily and a weekly plan:** Having a daily and a weekly plan is helpful to successfully cope with the current situation. This may not be your usual routine prior to the pandemic. However, keeping to the same structure as the pre-pandemic is useful, such as the waking-up and going-to-bed times. However, it is also important that we do not set unreasonable goals and expectations on ourselves during this time.

- **Self-compassion:** Compassion is goodwill towards others and tolerance of their weaknesses. In most instances we do not have this towards ourselves, and when we do, it is 'self-compassion'. Having an attitude of self-compassion is essential. Self-compassion makes us kind towards ourselves, and when our own mind attacks us, it helps us sooth ourselves. Therefore, if you identify your own self being inconsiderate of yourself, ensure to make self-compassionate self-statements over-and-above those inconsiderate self-statements. For example, if you 'hear' yourself saying 'You are so scared. What kind of doctor are you?". Superimpose that statement with "I am scared, yes, but I am giving my best to the world, in my own way". We must frequently remind ourselves that all people tend to downgrade oneself at one time or another, and that in spite of that, we are good enough and are doing our best. Ensure that every time your mind puts yourself down - as not doing adequate work or not dealing with your patient load - to remind yourself that you're doing your best and that tomorrow you may do better. By living in the present moment, self-compassion can be increased.

- **Live in the present:** Your mind needs to dwell on the present instead of wandering to the past, future or to a fantasy world of your own creation. The act of living in the present requires practice. It is cultivated by directing one's mind to the activity at hand - if you are filling a bottle of water, keep your mind on that activity; if you are treating a patient, keep your mind on the patient. Every time the mind wanders, gently bring it back to the activity at hand - do this every time. Remember, practice makes perfect. A mind dwelling in the present is like a well thatched roof - it doesn't leak in the 'rain' of stress, fear, irritability etc. If you feel a negative emotion such as fear, stress, irritability or jealousy arise, know that it has arisen and re-focus on the activity at hand. This can be further supported by mentally labelling the emotion felt, whether it be positive or negative. With time, you would realize that the positive emotions are similar to the up-side of a wave whilst negative emotions are similar to a trough - and that both these types are a part of human life and that they come and go. With practicing living in the present, you would 'embrace' the varied emotions felt rather than being carried away with it.

  Living in the present also gives us a window of opportunity, to change any negative behaviors we may be considering doing. It helps us see if whatever we are attempting has a negative impact and will help us anticipate its consequences. Such a thought process may prevent these actions and spare us of its negative repercussions.

- **Gratitude journal:** this is an opportunity to identify the positives in your life. At the end of each day, identify three things you are grateful for, in that day. These could be written in a journal or noted in one's electronic device. By doing so, you would go to sleep with a positive mind frame and would wake up with a positive attitude.

- Within the context of a ward or a group practice, the leading doctor plays a key role in ensuring the psychological wellbeing of his/her staff. Sustaining a cohesive team, with a team meeting at the end of the day, of all medical and non-medical staff, to discuss the day's proceedings is essential, during challenging times such as a pandemic. Further, providing space and opportunity for the staff to rest and recuperate in a comfortable environment is paramount.

By utilizing these strategies medical professionals can uplift their psychological wellbeing and enable themselves to function in a healthy manner during this pandemic. Engaging in these strategies at this current time will also help fortify their mental ability to manage a stressful or traumatic future situation as well. In addition to these mechanisms if one is feeling overwhelmed or are unable to cope, seeking help from a friend, family member or professional is often beneficial.

SLMA AWARDS AND RESEARCH GRANTS 2020

It is hereby called for applications for the following awards and grants for year 2020

CNAPT Award: Applications are invited from doctors and others for the best research publication (article, book chapter or book) in medicine or in an allied field, published in the year 2019, for the Richard and Sheila Peiris Memorial Award. Five copies of the research proposal should be submitted.

GR Handy Award: Applications are invited from Sri Lankans, for the best publications in cardiovascular diseases published in the year 2019 for the G R Handy Memorial award. Five copies of the research proposal should be submitted.

Glaxo Wellcome Research Award: Applications are invited from members for research proposals on topics related to medicine. Five copies of the research proposal should be submitted.

Professor Wilfred SE Perera Fund: Applications are called from life members of the SLMA, requiring financial support to attend an academic conference, provided an abstract has been selected for presentation at the event. Five copies of the application should be submitted.

SLMA Research Grant: This grant is offered for research proposals on topics related to any branch of medicine. The maximum financial value of the grant is LKR 100,000.00. The grant is targeted at young researchers in their early career, for proposals on applied research that could be initiated (e.g. pilot study) or completed (e.g. audit) with the grant. Five copies of the research proposal should be submitted. The project should have a supervisor.

Dr. Thistle Jayawardena SLMA Research Grant for Intensive and Critical Care: This grant is offered for a research project with relevance to the advancement of Intensive and Critical Care in Sri Lanka. The maximum financial value of the grant is LKR 100,000.00. Five copies of the research proposal should be submitted.

FAIRMED: This grant is offered for a research project with relevance to the advancement of Neglected Tropical Diseases in Sri Lanka. The maximum financial value of the grant is LKR 350,000.00. Five copies of the research proposal should be submitted.

CLOSING DATE: 31st July 2020

For further details please contact:
The Honorary Secretary, SLMA
"Wijerama House", 6, Wijerama Mawatha,
Colombo 7
Telephone: 2693324

133rd Anniversary International Medical Congress of the Sri Lanka Medical Association

The SLMA Anniversary International Medical Congress 2020 will be held as planned on 25th & 26th July at the Lionel Memorial Auditorium, Wijerama House, Colombo 07.

It will be projected as an exclusively virtual live online congress. The registrants will be able to join on any internet connected or online data enabled screen device. There will not be any facilities for registrants to attend the proceedings in person. Only the orators, abstract presenter and a few invited speakers will be accommodated at the venue.

The theme of the congress this year will be ***"Professional Development for Quality Enhancement of Healthcare: Beyond the COVID-19 Pandemic"***

The tentative topics covered include non-communicable diseases (NCDs), communicable diseases, sexual & reproductive health, psycho-social issues, the new normal in health care provision and COVID-19 response.

The congress will encompass a keynote address, 7 guest lectures, 6 symposia, oral and poster abstract presentations, orations and many more academic activities.
Latest updates on the conference will be posted in our website (www.slma.lk) and the Facebook page (https://www.facebook.com/SLMAonline/).

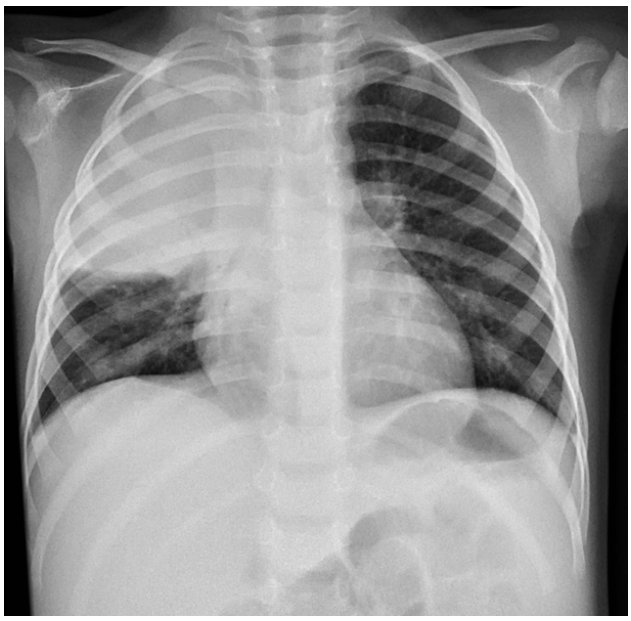
The exact logistics and the final programme will be shared with you in due course.
Please keep the dates free and inform your medial colleagues in Sri Lanka and abroad.

Dr. Sumithra Tissera
Secretary
Sri Lanka Medical Association

Picture Test

By Dr. P.S.M.J.U. Samarakoon

Case 01



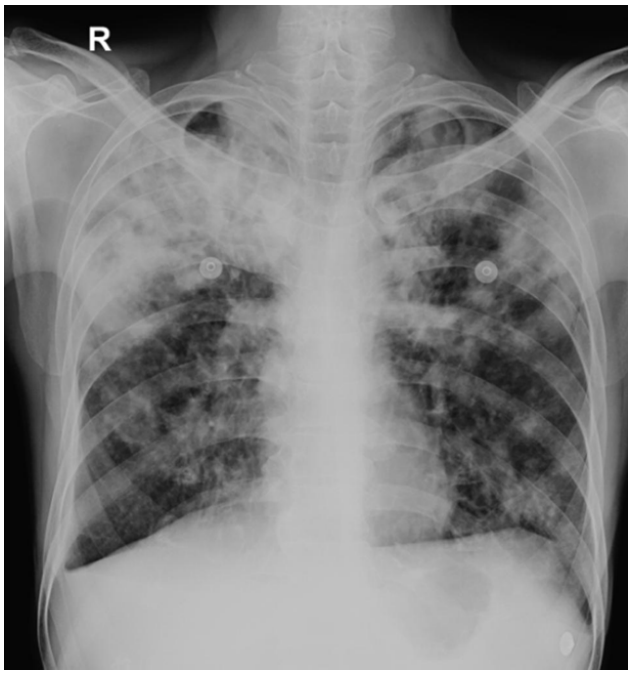
A 17-year-old boy presented with fever and persistent productive cough for a couple of weeks. He has developed worsening breathlessness and tiredness over the last 2 days. His chest radiograph is shown here.

1. What is the abnormal finding in this chest radiograph?

2. What is the most probable diagnosis?

3. This patient was started on empirical treatment, but he continued to have ongoing fever spikes after 5 days of treatment. What complications would you anticipate in this case?

Case 02



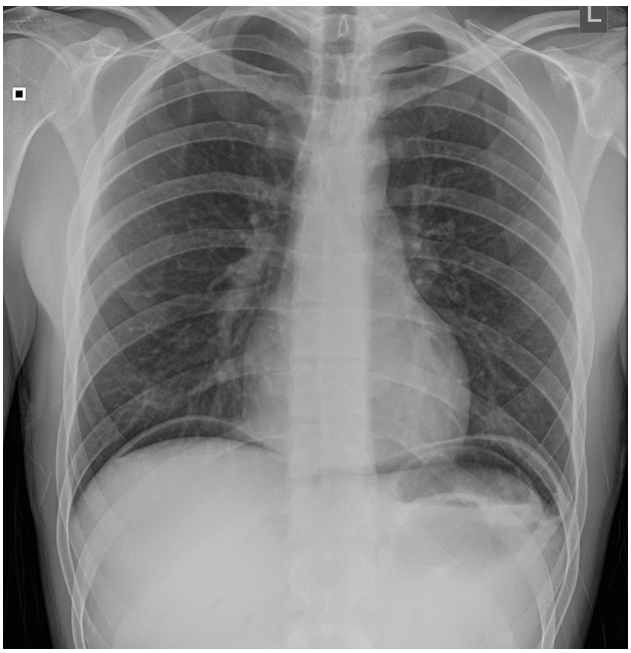
A 65-year-old male presented with cough for 3 weeks. He had developed on and off evening pyrexia with loss of appetite for 1-week. He is a heavy smoker.

1. What is the finding in this chest radiograph?

2. What is the most probable diagnosis?

3. What other investigation(s) should be done in this patient to confirm the diagnosis?

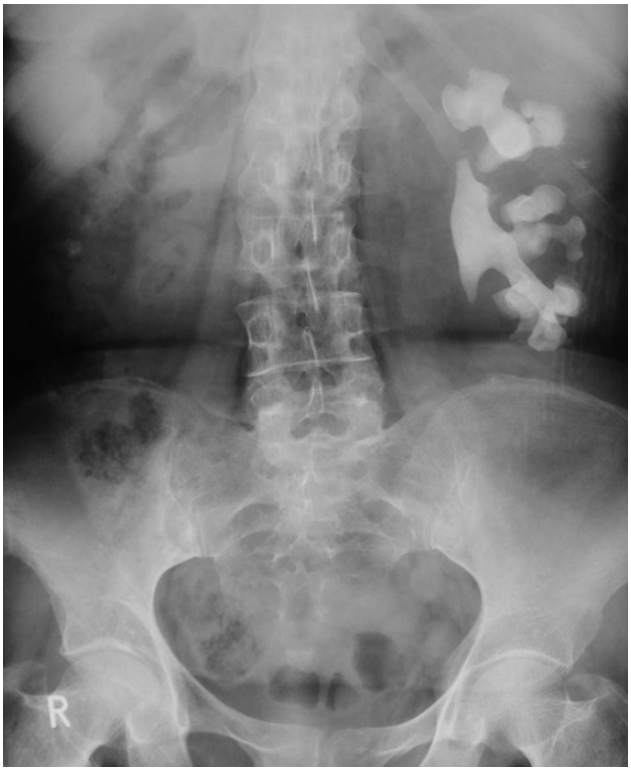
Case 03



A 45-year-old male was brought to the emergency department following a road traffic accident.

1. What is the finding in this chest radiograph?
2. What is this sign called?
3. What is the most probable cause for the findings?

Case 04



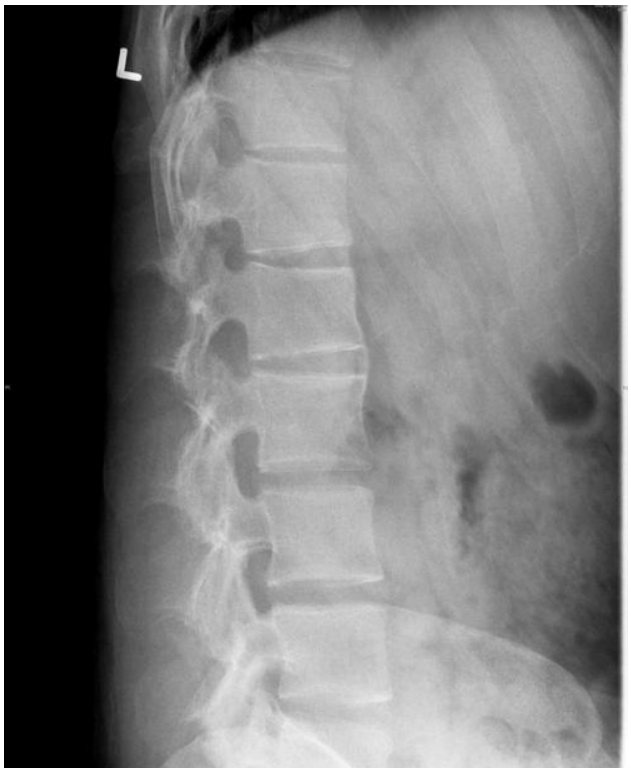
A 35-year old female patient presented with a one-week history of fever, haematuria and back pain. She has also had a history of recurrent urinary tract infections in the past.

1. What is the finding in this X ray?

2. What is the treatment option?

3. If left untreated for long what are the complication that can result?

Case 05



A 38-year old male patient presented with backache for 4 months duration. The X ray of his lumbar spine is shown here.

1. List two findings in this X ray.
2. What is the most probably diagnosis?
3. List 3 extra-articular manifestations of the above disease.

Answers

Case 1

1. Dense consolidation in the right upper lobe. Air bronchograms point to consolidation
2. Consistent with pneumonia
3. Development of empyema or lung abscess

Case 2

1. Diffuse bilateral, largely upper lobe, consolidation and pulmonary infiltrates. Small area of cavitation at the left lung apex. Right sided pleural effusion
2. Pulmonary tuberculosis
3. Sputum for acid fast bacilli (AFB), sputum for GeneXpert study

Case 3

1. Gas under the diaphragm
2. Leaping Dolphin sign
3. Rupture of an intra-abdominal viscus

Case 4

1. Staghorn calculi (coral calculi) in the left kidney
2. Staghorn calculi need to be treated surgically, usually percutaneous nephrolithotomy (PCNL)with or without extracorporeal shockwave lithotripsy (ESWL) and the entire stone should be removed
3. Xanthogranulomatous pyelonephritis, chronic renal

Case 5

1. Syndesmophyte formation, vertebral body squaring
2. Ankylosing spondylitis
3. Anterior uveitis, cardiovascular diseases (aortic root and rarely of the aortic valve, acute coronary syndromes (ACS), strokes, venous thromboembolism, and conduction abnormalities), interstitial lung disease

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THE IRISH WAKE

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

A very important part of Irish way of life is death.
If anybody else, anywhere else in the world, dies, that is the end of it. They are dead. But in Ireland, when somebody dies, they lay him up and watch him for a couple of days.
It's called a wake. It's great. It's a party. It's a send-off.
There's drinking and dancing and all the food you can eat and all your friends come from all over the place.
They stand around the table looking at the dead person, with a full glass in hand and say 'Here's to your health'.
They have a custom that the dying man is allowed to ask one question before he dies and that question must be answered completely and truthfully.
There is this little Irishman dying. He's got four sons. They are standing at the foot end of the bed. Three of them were the biggest fellows that you have ever seen in your life. The fourth is a skinny little one, a puny nothing.
The dying Irishman asks the wife "Mary, Mary, are you there?" and she goes "I'm here my love, here beside you".
The Irishman says "I am going, I am going....., but before I go, tell me.., tell me....., is that skinny little one standing beside you, is he really my son?"
She answers "He is, honest to God, he is your son". Then he leaves this world, God bless him.
Then Mary sighs and mutters "Thank God he did not ask about the other three".

COVID-19, Man Made Misery?

Dr. Sarath Gamini De Silva
Senior Consultant Physician

Heard the birds singing, calling for a mate
Rolling in bed, disturbed, waking up late
Yet an empty day ahead, a prospect I hate
Reassuring myself soon, it's everyone's fate

Listening to news, the worrying new total
To know only from clusters, it is pivotal
Number of those to whom it proved fatal
Reminding myself that no one is immortal

Only excitement is coming from the road
Bread, dairy, fish, grocery, choice is broad
Vendors welcome, though enough on board
With bad days ahead, just buying to hoard

Powerful nations brought down on their knees
On reaching the peak, slipping down on grease
Wealth, power and freedom now in deep freeze
Blown away like dust, it was an invisible breeze.

Punished for past sins, may not be a fallacy
Looking for divine help, pleading for mercy
How some predicted, with pinpoint accuracy
Is it a man-made virus, a misfired conspiracy?

Hidden behind masks we are moving around
Still feeling unsafe until a remedy is found
Though news of vaccines very much abound
To overcome COVID, must break new ground.

Escaping the trap where we are badly caught
Making a new beginning, starting from naught
Not back to old ways, where danger is fraught
Preserve nature with respect, we've been taught.

29.4.2020

The beauty of hindsight: what COVID-19 will teach us

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"Hindsight, ever the cruellest and most astute adviser"
R.J. Ellory, Bad Signs

The COVID-19 pandemic has changed the global landscape. Not only healthcare delivery but human interaction and social behaviour have been transformed. The collateral damage affecting businesses and enterprises is unimaginable. Words such as social distancing, self-quarantine and even furloughing, previously rarely used, have now become a part of the everyday vocabulary. A new world order is settling in. All this because of a tiny, 0.125-micron size virus that is taking the world by storm and tearing it apart. Aside from the carnage, there has been a silver lining though. The world has become less polluted, the smog has disappeared, the ozone layer is healing, and the fish are swimming in cleaner seas. A "new normal" is quietly taking over and looking back 5 years from now, we might be wondering what all the fuss was about. For those of us, who are trying to come to terms with this "new normal" now, it might actually make sense then. As Daniel Kahneman in his book Thinking, Fast and Slow says "Everything makes sense in hindsight"

Date - 05th October 2025

My daughter is now 10 years old. She is fussing about having to attend classes on her birthday; virtual classes which she attends from the comfort of our home I tell her that she should be grateful that she does not have to spend time on the road and be physically present in a classroom like before. She asks me to describe the times that attending a tuition class actually required us to be inside a hall with hundreds of other students in such close proximity to each other that we could almost hear our neighbour's heartbeat. This is almost a fairy-tale to her as now almost all her classes are done from home with only her laptop as the neighbour. I then would think to myself as to how the COVID-19 pandemic of 2020 has shaped our very existence.

Healthcare Delivery: a new hospital/doctor-patient relationship

Sir William Osler once said, "Soap and water and common sense are the best disinfectants". He may not have realised it back then, but 200 years on, those words are almost prophetic. During the pre-COVID era washing one's hands was something which was almost taken for granted. The importance of a simple practice in infection control was often overlooked. However, post-COVID, not only healthcare professionals but the general public have been re-taught the technique of correct handwashing. A 20 second hand-wash is not only second nature, but it is mandatory protocol before and after entering a healthcare facility. The 2008 World Health Organisations programme "Clean Care is Safer Care" has truly achieved its target.

The positive interaction between the doctor and the patient is the cornerstone of successful management and it determines the outcome of any disease. The usual norm of a face-to-face consultation with one's doctor was never questioned. However, today, post-COVID, this interaction is different. Most patients and doctors are preferring video or telephone consultations, limiting physical interactions to the minimum. The use of telemedicine has become the standard of care for the management of patients with chronic conditions, post-hospitalisation follow-up and medication management. Studies in the pre-COVID era had shown good outcomes of telemedicine, however the researchers then would have never expected the world would adopt this technology as the standard for patient care. The interaction between a doctor and patient has been redefined, less intimate, yet personal and effective.

Human Interaction: being socially responsible

Behavioural scientists and psychologists agree that social interaction is an important contributor to good health and longevity. Be it a family vacation or a group of friends going out for a meal, the question was when rather than how. Apart from that, a simple greeting of a handshake upon meeting someone was common social etiquette. However, now things have changed. We think twice before shaking someone's hand and even if we mistakenly do, we immediately reach for the hand sanitiser to clean our own. A simple "hello" with a smile is sufficient for the recipient to acknowledge the friendly intent of someone they just met. Physical interactions are now kept to a minimal. Restaurants are now conscious of keeping a safe distance between two tables. The capacity of the establishments has gone down, hence the prices have jacked up. On the flipside though, I can now actually hear my partner on the other side of the table. The atmosphere is different, but the experience is still divine.

In the past, "social responsibility" was a term associated mainly with big corporates. It incorporated ethical practices that contributed to society at large so as to achieve a balance between economy and eco-system. However, the pandemic has highlighted the importance of individual's social responsibility more than ever before. The actions of a single person could determine the future of many. At the peak of the outbreak in Sri Lanka, over 4000 people were under mandatory quarantine in government centres, many of whom has contact with a single positive patient. Social responsibility could range from simple self-discipline of staying at home if you are not feeling well to having second thoughts about attending a sporting event where a contagious disease could easily spread. A vast majority of the general public may have blatantly disregarded to these behaviours in the past. However, at present, with a little bit of hindsight, we know better.

Travel and Hospitality: a new dawn

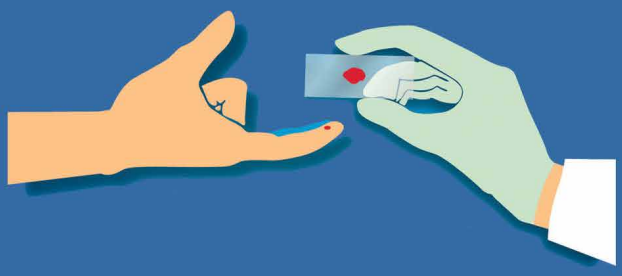
The COVID-19 pandemic brought the travel and hospitality trade to its knees. Some major airlines went bankrupt while most others had to cut staff numbers by the thousands. The livelihoods of many were affected. Mandatory quarantine imposed on overseas travellers meant tourism was virtually non-existent at one stage. A few years on, the industry has not really fully recovered. The problems start at the airports; extra precautions mean longer waiting times before boarding flights. This is on top of higher ticket prices to compensate for previous losses by airlines. The seating arrangements have changed, masks have become mandatory and there is a general sense of anxiety amongst all travellers until disembarking. The hotel environments have changed as well. Common areas are hardly used, buffet tables are set differently, and social interactions are kept to a minimum. Group holidays are now considered taboo, while more intimate travellers are encouraged. As most world economies are struggling to recover, travel and tourism still face a daunting challenge to overcome the after effects of a virus that punched well beyond its weight. In hindsight though, we find families ditching expensive vacations and indulging in more economical ways of spending time with family, a barbeque at home

Cleaner Air, Clearer Waters: the silver lining

With mortalities rising, stock markets crashing and the world in chaos, every news channel highlighted the doom and gloom caused by the pandemic. It was easy to overlook the positive effects on the world caused by this disaster. However, amid the catastrophic news of world economies crashing, we heard that the hole in the ozone layer was getting smaller, the smog in big industrial cities was disappearing and its citizens were breathing fresh air for the first time in decades, the waters were getting clearer with new oceanic life seen in places hardly seen before. We saw pictures of the canals in Venice sans the Gondolas, being taken over by sea life, we saw pictures of skyscrapers from distant mountain tops. It was a true miracle. Something that the world very badly needed. As the years went by, global citizens acknowledged this positive impact and strove to maintain the environmental gains achieved. We now breathe cleaner air and swim in clearer waters because of COVID-19, a true silver lining in the aftermath of a global disaster.

Final Words

Charles Darwin mentioned that human evolution is a prime example of "Survival of the Fittest". As the world recovered from one of the worst periods in its history since World War II, we now look back at the lessons learnt with the intent of not allowing history to repeat itself. The mistakes made have to be rectified and plans put in place to avert another disaster. The whole world is now on edge, not unlike a tight rope walker: balance is needed, one wrong step and there is no return. We all reflect on this period of our lives as a challenge beyond expectation but one where we learnt so many lessons on survival and humanity. The "New Normal" we spoke of so reluctantly has now become a way of life, just simply "Normal". I tell my daughter "Hindsight, my dear, is indeed a beautiful thing".



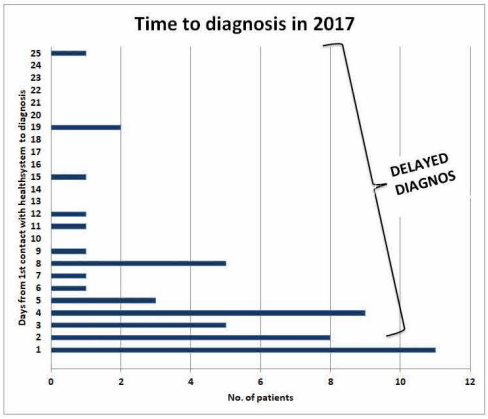
Reduce the Delay in diagnosing imported Malaria

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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