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December 2014, VOLUME 07 ISSUE 09

SLMA NEWS

THE OFFICIAL NEWSPAPER OF THE SRI LANKA MEDICAL ASSOCIATION

The President, Council and Staff of the
Sri Lanka Medical Association
wish all our members a
Merry Christmas
and a
Happy New Year!!

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EFFICACY

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SLMA NEWS
THE OFFICIAL NEWSPAPER OF THE SRI LANKA MEDICAL ASSOCIATION
December, 2014 Volume 07 Issue 09

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SLMA news Editorial Committee-2014

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President's message

This is my last message to our popular newsletter as the President. We held our last Council Meeting on the 5th of December and made plans to hand over the responsibilities to the new Council by the end of the year. As I write this the main items of work remaining are the Medical Dance on the 13th of December at the Cinnamon Grand (which will be over by the time you read this), and the Annual General Meeting on the 20th December. The President Elect has planned the Induction for the 3rd of January 2015.

First and foremost I want to take this opportunity to place on record my deepest thanks and sincere appreciation for the inestimable and spontaneous support I received from the Executive Committee, the Council and many of the members of our Association. I was so fortunate to have such a great bunch of colleagues who always went that extra mile to make sure that things always went right. Consequently, and as I have mentioned a few times earlier, my Presidential term turned out to be one of the most enjoyable and (relatively) stress free periods of my life! I am hoping that it was the same for my colleagues in the Council!

I believe we delivered a rich, diverse and beneficial programme of activities, to cater to the multiplicity of academic and social interests of our membership. This was evidenced by the wide participation and the responses we have had from a wide cross section of them. As a recent example, we launched the latest edition of the Vaccines Guidelines and I was so happy to hear the glowing accolades paid to the SLMA for this work; so too with many of our other initiatives. Over the years the SLMA has been growing in stature, earning recognition and respect from the health and health related segments of our society, as well as from overseas colleagues and institutions. In fact the theme we had adopted, "Globalizing the paradox of health achievements and challenges" turned out to be both apt and prescient in many ways as we had extensive international collaboration in many of our activities. We also set the scene for the continuation of these partnerships and I am quite certain that they will grow and expand in the years to come. I might expand on some of these in my report at the Induction – this message is already getting too long!

I have learnt firsthand what a great organization and heritage we are proud heirs to, the contribution it has made over these long years and continues to make to the health care scene in our country. It was so satisfying and a matter of pride to recognize that when the SLMA speaks on any issue related to health policy, the rest do listen. We should, as custodians of this landmark organization, and with our collective wisdom on major health issues, leverage its historical value, its medical and social significance, realize its enormous potential for health development in our country.

Finally let me wish each and every one of you the Compliments of the Season, a Merry Christmas and a Happy New Year!

Dr Palitha Abeykoon
President, SLMA

HIV: Where are we?

Summary of the symposium on 'HIV: where are we?' held on 21st August 2014. The resource persons were Dr. Iyanthi Abeyewickreme, Consultant Venereologist and Former Director, National STI/ AIDS Control Program (NSACP) ,Dr. Lilani Rajapakse, Consultant Venereologist, NSACP, Dr K. A.M. Ariyaratne, Consultant Venereologist, NSACP, Dr. Ananda Wijewickrama, Consultant Physician, Infectious Disease Hospital, Colombo and Dr. Jayanthi Eltvitigala, Consultant Microbiologist, NSACP.

Compiled by
Dr. Thanuja Wickramarachchi,
Demonstrator, Department of Microbiology, Faculty of Medicine, Colombo and Professor Jennifer Perera, Chairperson, Expert Committee on Communicable Diseases of SLMA.

The global scene

The first cases of unusual immune deficiency were identified among gay men in the USA in June 1981. Although Acquired Immune Deficiency Syndrome (AIDS) was defined in 1982, HIV was identified as the cause of AIDS in May 1983.

The first HIV antibody test became available in 1985 with the WHO launching the Global Programme on AIDS and the first therapy for AIDS and in 1987 of zidovudine (AZT) was approved for use in United States of America (USA). Introduction of first regimen to reduce mother to child transmission of HIV in 1994 and the launch of highly active antiretroviral treatment (HAART) in 1996 were important landmarks in the management of HIV. There is now hope for a beginning of the end of the AIDS epidemic due to the decline of new HIV infections by 38% since 2001 and AIDS-related deaths by 35% since the peak in 2005 **(Figure 1).**

Reported new HIV infections among children have declined by 58% since 2002. Providing anti-retroviral therapy for pregnant women living with HIV has averted more than 900,000 new HIV infections in children since 2009. Almost half of all people living with HIV (48%) now know their status.

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HIV...

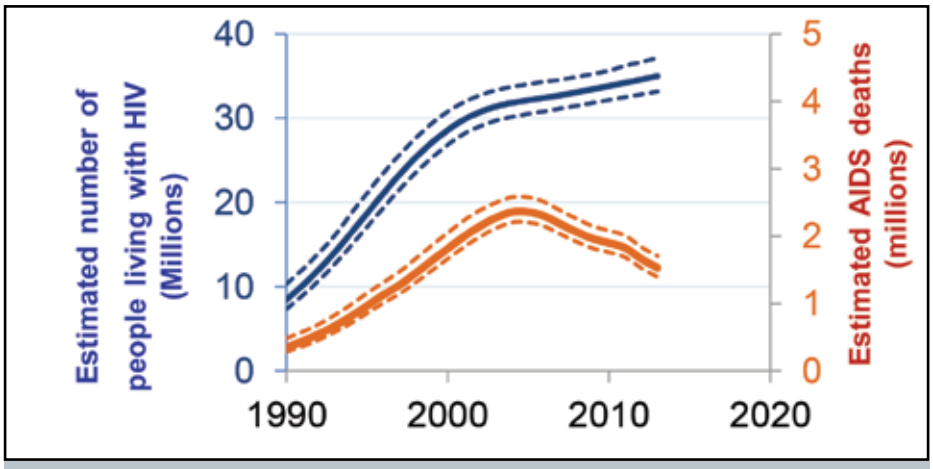

Figure1. Number of people living with HIV & HIV-related deaths (Source: UNAIDS Global Report 2014)

12.9 million people were receiving ART globally at the end of 2013. The percentage of people living with HIV who are not receiving antiretroviral therapy has been reduced from 90% in 2006 to 63% in 2013. Estimated HIV-associated TB incidence and mortality have been reduced globally during the period of 1990-2012.

However, it is reported that there are 6,000 new HIV infections each day. Two out of three new HIV infections are in sub-Saharan Africa and one out of three new HIV infections are in youth (15-24yr). Among key high risk populations such as men who have sex with men (MSM), people who inject drugs (PWID), female sex workers (FSW), about 50% are unaware of their HIV status. According to WHO TB report, 13% of 8.6 million new TB cases were in people with HIV **(Figure 2)** and 320 000 deaths were from HIV-associated TB.

Some shortcomings have also been identified in HIV management. Stigma being a barrier to HIV services is experienced by sex workers, MSM, transgender groups, people who use drugs and migrants. 76% of children living with HIV are not receiving HIV treatment and 31% of patients are lost for follow up within 5 years after starting ART according to WHO data. Prevention of mother-to-child transmission (PMTCT) coverage in Asia and the Pacific lags behind the global average **(Figure 3).**

It was shown that, of the 35 million people living with HIV, 4–5 million have hepatitis C and 2-4 million have hepatitis B. HIV has accelerated HCV and HBV related progression of liver fibrosis increasing the rate of end-stage liver disease and mortality. HIV and Hepatitis B co-infection has higher rates of chronicity, less spontaneous HBV clearance and hepatocellular carcinoma.

Transmission

Modes and probabilities of HIV transmission depend on the type of exposure including mainly parenteral, sexual and mother to child transmission. Blood transfusion carries the highest risk of transmission being

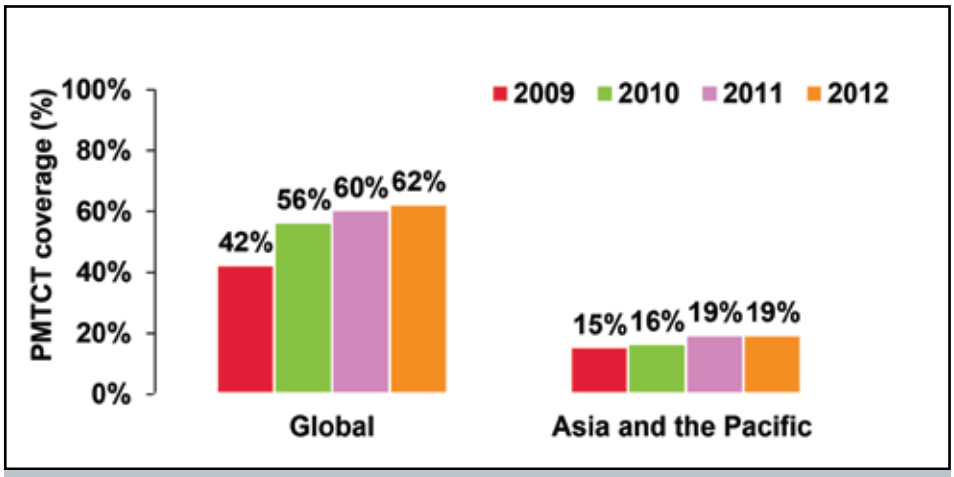

Figure 3. Prevention of mother-to-child transmission (PMTCT) coverage

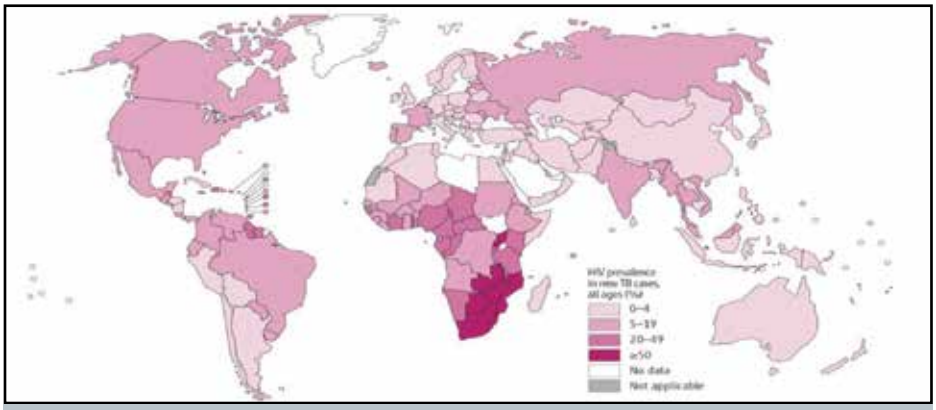

Figure 2. HIV prevalence in new TB cases, 2012 (Source: WHO TB Report 2013)

90%. Needle-sharing during injection drug use and receptive anal intercourse showed relatively higher risk than peno-vaginal intercourse. The estimated risk of mother to child transmission seems to be 250 per 1000 exposures which can be further reduced up to 10 per 1000 exposures with prevention measures including anti-retro viral (ARV) prophylaxis.

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HIV...

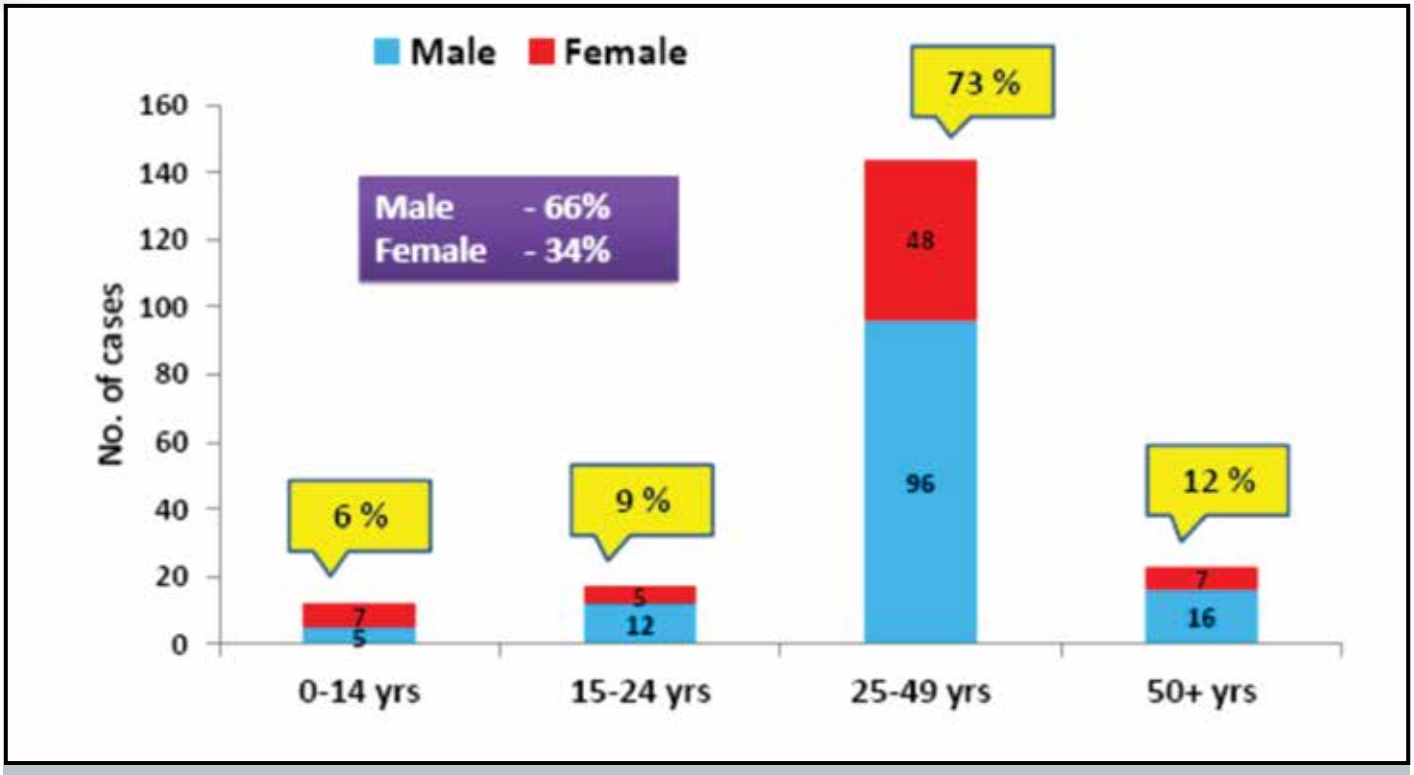

Figure 4. HIV positives by age and sex (new cases in 2013; No. = 196)

Prevention and treatment

Prevention of HIV can be achieved by behavioural interventions like abstinence, being faithful, using male and female condoms, HIV counselling and testing, pre and post exposure prophylaxis, and treatment of sexually transmitted diseases.

According to WHO 2013 treatment guidelines, anti-retro viral therapy (ART) should be commenced when the CD4 count is equal or less than 500. ART is started regardless of the CD4 count for HIV sero-discordant couples and pregnant women. It is recommended to use tenofovir (TDF) + 3 lamivudine (TC) or emtricitabine (FTC) + efavirenz (EFV) as the first line regimen as it is simple, effective, well tolerated and with once-daily dosing facilitates compliance. It is more affordable as costs have declined significantly since 2010. Viral load is recommended as the preferred monitoring approach to diagnose and confirm ARV treatment failure. If viral load estimation is not routinely available, CD4 count and clinical monitoring should be used to diagnose treatment failure. All TB patients should be offered HIV testing.

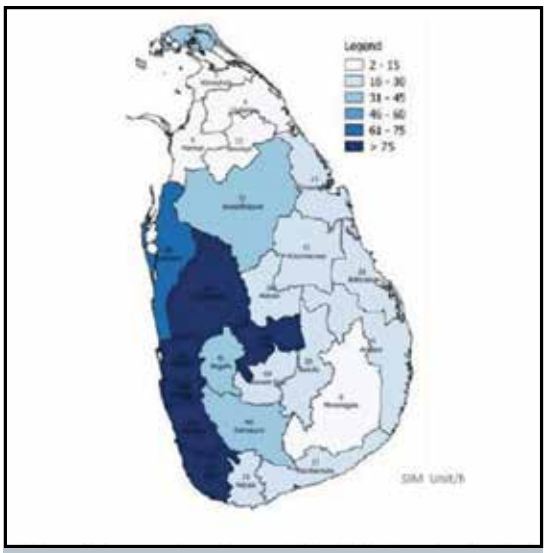

Figure 5. Cumulative number of reported HIV infections by district, 1987-2013

Epidemiological concepts of elimination and eradication are not readily applicable to AIDS as millions are living with HIV and with no cure being available.Key step to “the end of AIDS” is epidemic control (reduction of disease incidence, prevalence, morbidity or mortality to a locally acceptable level as a result of deliberate intervention measures the point where HIV no longer represents a public health threat and no longer among the leading causes of country’s disease burden). HIV epidemic control is achievable by the means of early ART, circumcision and pre-exposure prophylaxis. However, a vaccine or cure is essential for elimination.

The Sri Lankan scene

The first Sri Lankan with HIV was reported in 1987 and the first case of locally acquired HIV infection was found in 1989. Since then a cumulative total of 1995 (517 in AIDS stage) HIV infections, 320 deaths and 71 incidents of mother to child transmission have been reported in Sri Lanka by June 2014.

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HIV...

According to NSACP's new HIV estimates, adult HIV prevalence is still less than 0.1% in Sri Lanka. New infections are less than 500 and annual AIDS deaths are below 100.

Two thirds of the affected population are males and 73% of the affected patients belong to the age group 25-49 years **(Figure 4).** A high prevalence of HIV infection has been reported in Colombo, Gampaha, Kalutara, Galle, Kurunegala and Kandy districts **(Figure 5).** Female sex workers, MSM, IVDU, migrant workers, prisoners and beach boys are the high risk populations for HIV in Sri Lanka.

A higher proportion of sexual transmission is noted among heterosexuals (48%) compared to homo/bisexual (27%) patients. Perinatal transmission (6%) and transmission due to intravenous drug use (2%) account for a lesser degree of transmission. A gradual increase of HIV prevalence among MSM population has been noticed since 2008.

Management of HIV at STD clinics and Infectious Disease Hospital in Sri Lanka

The aim of management of HIV in Sri Lanka is to achieve zero AIDS deaths, zero discrimination and zero new infections. The role of the clinician in the management of HIV is to diagnose early, treat and prevent new infections. Early initiation of ARV reduces viral load and risk of transmission. It also improves the general health of the patient. Oesophageal candidiasis, Pneumocystis pneumonia and TB (extrapulmonary, such as lymphadenitis and abscesses) are commonly seen clinical presentations at clinics. The diagnosis of Pneumocystis is mostly based on clinical features.

HIV status can be diagnosed only through a blood test. A high index of suspicion and Provider Initiated Testing (PIT) is essential for early diagnosis to provide comprehensive care and improve both quality and quantity of life. Comprehensive care includes non-judgmental attitude, maintenance of confidentiality, concern about the person's dignity, introducing positive living and hope, and counseling for the patient and immediate family members.

There are HIV clinics and ART centers in Colombo, Kalubowila, Ragama, Kandy, Anuradhapura, Kalutara, etc.

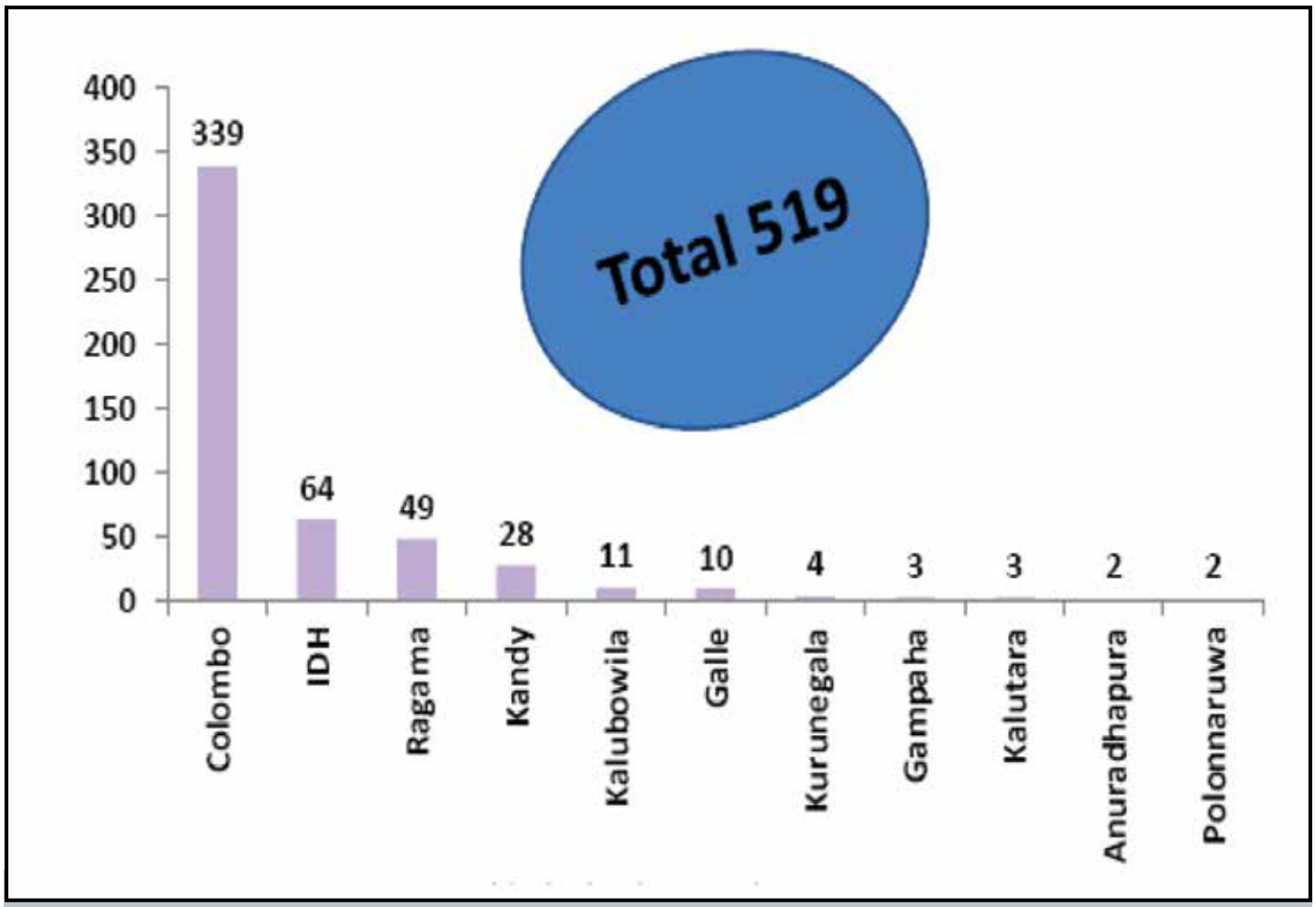

Figure 6. Number of patients who initiated ART 2004-2013

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HIV...

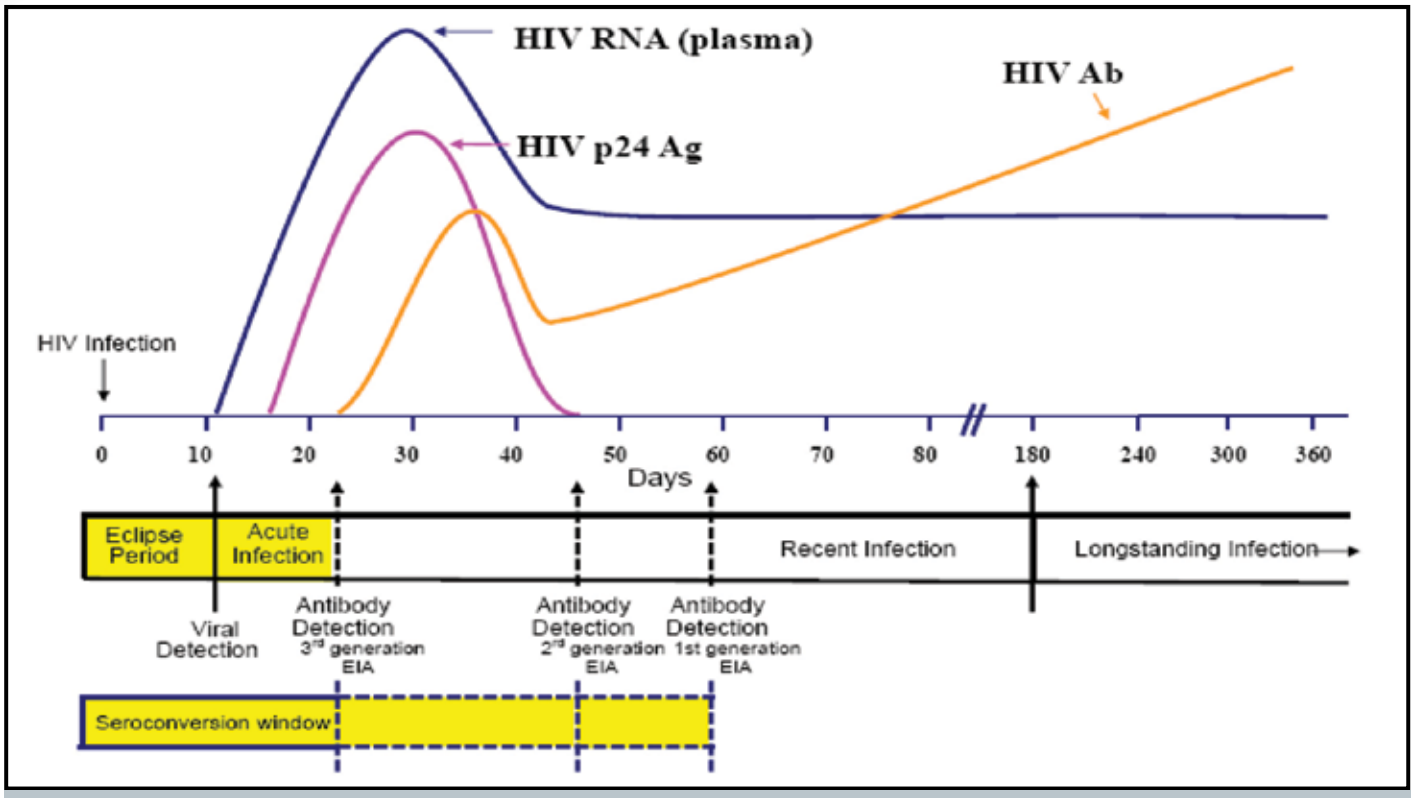

Figure 7. HIV Infection and Laboratory Markers

STD clinics encourage those seeking services by conduct of daily clinics with out-patient management using a multidisciplinary approach. Counselling sessions conducted by STD clinics address issues related to prevention of HIV transmission, prevention of opportunistic infections, positive living with proper nutrition, psychological and social wellbeing, etc. Patients with HIV are advised on the importance of ART adherence, development of drug resistance, prophylaxis and management of other infections. Apart from these clinics, Infectious Disease Hospital (IDH), Colombo has been managing patients with HIV since 1987.

Screening is carried out to detect occult opportunistic infections like TB, Hepatitis B and C, toxoplasma, CMV, Cryptococcal infection, syphilis and gonorrhoea. Baseline screening includes liver and renal function tests, haematological tests, blood sugar, lipid profile, HLA B 5701, pregnancy test and a cervical smear test. HIV infection status is assessed by the CD4 count and viral load testing.

The CD4 cell count is an indicator of prognosis of HIV infection with a normal value of 800-1,050 cells/mm3.

It is tested at 6 monthly intervals in untreated cases. 50% of diagnosed patients in Sri Lanka had less than 350 cells/mm3 at the time of diagnosis. Co-trimoxazole is started for patients with CD4 counts <200 /mm3 as prophylaxis for opportunistic infections such as Pneumocystis carinii pneumonia. Quantitative plasma HIV RNA (viral load), correlates with declining rates of CD4, progression to AIDS, risk of opportunistic infections (especially in patient with CD4<200) and thereby with prognosis of disease. It is also used to assess the probability of transmission and therapeutic monitoring.

STD clinics also provide antiretroviral therapy, vaccination for Hepatitis B, family planning services and links with support groups.

When is ART commenced?

ART is started in asymptomatic adults when the CD4 count is less than 350 cells/mm3. It is also recommended to start ART for symptomatic patients, sero-discordant couples, key affected populations (FSW, MSM), pregnant women and patients with TB, Hepatitis B or C. The numbers of patients who initiated ART in respective clinics in different districts are given below **(Figure 6).**

ARV agents used in Sri Lanka are nucleoside reverse-transcriptase inhibitors (NRTI) like zidovudine, emticitabine, lamivudine, abacavir; non-nucleoside inhibitors (NNRTI) like nevirapine, efavirenz, nucleotide reverse-transcriptase inhibitors (tenofovir), integrase inhibitors (raltegravir) and protease inhibitors (lopinavir, ritonovir, atazanavir, darunavir).

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HIV...

Reduction of morbidity and mortality from HIV/AIDS, restoring and preserving immune function and prevention of transmission are the goals of ART treatment. Patients are counseled before commencing ART emphasizing the importance of continuation of this life long suppressive treatment, to prevent viral replication and avoid development of drug resistance.

Multiple issues like poor adherence to treatment, side effects, drug interactions and resistance have become barriers for successful treatment with ART. Patients who are on treatment are monitored by the CD4 cell count (every 6 months), HIV viral load (at 6th months and annually thereafter), full blood count, liver function tests, renal function tests, fasting blood sugar and lipid profile.

Treatment failure is identified when;

- Plasma viral load is above 1000 copies/ml or
- With repeated detection of HIV RNA after viral suppression or
- When the CD4 levels are lowered to the baseline or lower or
- CD4 levels are <100 cells/mm3 persistently or
- CD4 counts drop by 50% or more from the peak value or
- When a new or recurrent clinical event occurs indicating severe immune deficiency condition (WHO clinical stage 4) after 6 months of effective treatment.

ART in children

ART should be commenced in all HIV infected infants aged less than 12 months. All children with AIDS or significant symptoms should be started on ART. The CD4 count is an additional guide to starting ART in children as given in **table 1.**

Table 1. When to start ART in children

Aged 1-3 years	CD4 < 1000 cells/mm^3 or CD4 percentage <25%
3-5 years	CD4 < 750 cells/mm^3 or CD4 percentage <25%
>5 years	CD4 <350 - 500 cells/mm^3

Prevention of mother to child transmission of HIV has been achieved by creating awareness, counselling and testing, starting ART at 14 weeks, obstetric management by LSCS, infant feeding with formula milk and giving ART for baby for 6 weeks.

Development of laboratory facilities for HIV testing

Laboratory facilities are essential for diagnosis and monitoring of HIV infections.

The pattern of emergence of laboratory markers is highly consistent and allows classification of HIV infection into 4 distinct laboratory stages **(Figure 7).**

1. The eclipse period - initial interval after infection with HIV when no laboratory markers are consistently detectable.
2. The seroconversion window period - interval between infection with HIV and the first detection of antibodies.
3. Acute HIV infection - interval between the appearance of detectable HIV RNA and the first detection of antibodies. (Duration also depends on the design of the antibody immunoassay and the sensitivity of the immunoassay during seroconversion.)
4. Established HIV infection - stage characterized by a fully developed IgG antibody response sufficient to meet the interpretive criteria for a positive Western blot or IFA

The spectrum of HIV tests include laboratory-based immunoassays (IAs), rapid tests (point-of-care or near patient), Western blot (WB), immunofluorescence (IFA), nucleic acid amplifications tests (NAAT) for proviral DNA or RNA, molecular viral load assays, antiretroviral drug susceptibility tests, genotype, phenotype and tropotype tests. Selection of tests depends on the potential population, the clinical situation and intended use of the assay.

"76% of children living with HIV are not receiving HIV treatment and 31% of patients are lost for follow up within 5 years after starting ART according to WHO data."

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HIV...

Immunoassay (IA) is a biochemical test that detects the presence of a substance in a biological specimen using the binding of an antibody to its antigen.

Enzyme immunoassay (EIA or ELISA) is an immunoassay that uses the catalyzing properties of an enzyme for detection of an immunological reaction. Chemiluminescent assay (CIA or CMIA) is an immunoassay in which the signal is generated by a compound that emits light as a result of the chemical reaction.

Nucleic acid test (NAT) (qualitative) is a molecular assay for detection of the presence of viral nucleic acids (DNA or RNA). Nucleic acid test (NAT) (quantitative) is a molecular assay for quantification of viral nucleic acids (DNA or RNA). It is also referred to as the viral load assay. Western blot and IFA are 1st generation tests with high specificity.

There are 4 generations of serological assays. 1st generation immunoassays (IAs) detect HIV antibodies (Ab) (IgG) using viral lysates as the antigens (Ag). 2nd generation IAs detect HIV Ab (IgG) using recombinant protein and peptide Ags and 3rd generation IAs detect HIV Ab (IgG and IgM) using recombinant protein or peptide Ags as an "antigen sandwich". 4th generation IAs detect HIV Ab (IgG and IgM) and viral p24 Ag.

There are rapid tests which can provide test results within 30 minutes. Most of these rapid tests are 2nd generation tests. According to the recommended algorithm by CDC USA published in 2014, serum or plasma specimens should be tested for HIV positivity by HIV1/2 Ag/Ab combination immunoassay, HIV1/HIV2 antibody differentiation immunoassay and HIV NAT.

Serum or plasma is the most widely used specimen. Whole blood (both finger prick and venepuncture), oral fluids, urine, cerebrospinal fluid, cadaveric blood, dried blood spots (DBS) can also be used as specimens. Whole blood collected on filter paper are suitable for qualitative DNA or RNA analysis for diagnosis of infections in infants, quantitative viral load measurements and gene sequencing for detection of drug resistance and this is used for shipping specimens for testing overseas.

Situation in Sri Lanka with regard to investigations

The available tests for diagnosing & monitoring HIV include, ELISA, particle agglutination, rapid tests, western blot, viral load, CD4 count, biochemical or haematological tests and testing for opportunistic infections. Tests for early infant diagnosis (EID) and determination of drug resistance are still not available. STD clinic attendees, individuals in ante-natal clinics, donor blood, voluntary groups, foreign employees and clinically suspected patients are being tested for HIV. Sentinel surveys are conducted to cover female sex workers, MSM, beach boys, drug users, prisoners, etc. Surveillance studies are carried out once in two years.

Testing algorithm includes a screening test (ELISA) followed by the confirmatory test (western blot assay) for positives. In the future, HIV-1/2 Ag/Ab Combo rapid test will be made available as this detects infection one to two weeks earlier than rapid tests, and one to three days before third-generation HIV antibody tests, but three to four days after fourth-generation antigen/antibody HIV tests.

Annual Academic Sessions of the Awissawella Clinical Society in collaboration with the SLMA

The annual academic sessions of the Awissawella Clinical Society in collaboration with the Sri Lanka Medical Association was held on the 8th November 2014 at Purple Sun Holiday Resort, Awissawella. Dr. Palitha Maheepala, DGHS graced the event as the chief guest. Dr. Randeel Wellaketiya, President, Awisawella Clinical Society delivered the welcome speech. Dr. Palitha Abeykoon, President SLMA also addressed the gathering enlightening the audience with the proud history of SLMA and the importance of being a member of SLMA.

The program consisted of three sessions. The first lecture of session 1 was on cardiac supra-ventricular arrhythmias by Dr. Suresh Kottegoda, Consultant Electrophysiologist, NHSL. Dr. Dhammika Dissanayake, Consultant Plastic Surgeon, NHSL delivered a very attention-grabbing lecture on 'Hand injuries' sharing his experiences with the audience.

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Annual Academic...

A lecture on 'Diabetic Retinopathy' was delivered by Dr. Deepani Wellewela, Consultant Eye Surgeon from DGH, Kegalle.

Session 2 commenced with a lecture on 'leprosy' by Dr. Indira Kahawita, Consultant Dermatolreogist, BH Karawanella, who is also a council member of SLMA.

Dr. Dilip de Silva, Consultant Dental surgeon delivered a very exciting lecture on 'Public Finance and Taxation' which is an alien subject to a medical audience. The final lecture of session 2 was on 'Abdominal pain in Paediatrics' by Dr. Sharmane Rajendrajith, Consultant Paediatrician and senior lecturer in Paediatrics.

Session 3 commenced with a lecture by Dr. Lasantha Malavige, Vice president SLMA and Specialist in Sexual Medicine on 'Sexuality in midlife and beyond'. Dr. Dulshika Was, Consultant Psychiatrist delivered a lecture on 'Moody adolescents'. Consultant surgeon Dr. Philip Veeresingham delivered his lecture 'Zero hour' on spiritual aspect of the dying patient making the audience think of a different aspect of life and death.

As the final task, Secretary of Awissawella Clinical Society delivered the vote of thanks concluding this successful program and the participants enjoyed a time of fellowship and lunch afterwards.

Joint Academic Sessions of Sri Lanka Medical Association with the Jaffna Medical Association

The Joint Academic Sessions of SLMA with the Jaffna Medical Association (JMA) was held on the 29th and 30th of October 2014 at the Faculty of Medicine, Jaffna.

The sessions commenced with the pre-congress Symposium on Medical Ethics held on 29th October. Dr. Palitha Abeykoon, President SLMA and Dr. Murali Vallipuranathan, President JMA addressed the gathering welcoming the audience. Dr. R. Surenthirakumaran from the Department of Community Medicine, Faculty of Medicine, Jaffna, gave the audience an overview of ERC and ethical approval in Jaffna. Dr. Panduka Karunanayake, Senior Lecturer, Department of Clinical Medicine, Faculty of Medicine, Colombo, talked on 'Expedited Review'. Dr. Senaka Pilapitiya, Director, Centre for Education and Research in Complementary and Alternative Medicine, University of Rajarata enlightened the audience on Ethical issues in Complimentary and Alternative Medicine Research to conclude the symposium.

The inauguration ceremony was held at the Green Grass Hotel, Jaffna on the 29th of October.

After the ceremonial procession Dr. Palitha Abeykoon and Dr. Murali Vallipuranathan, Presidents of SLMA and JMA, respectively, welcomed the audience. The launching of the guidelines on 'Decompression Sickness' by Dr.Malik Fernando followed, along with a brief introduction to 'Decompression sickness'. The plenary lecture was delivered by Dr. Muthukrishna Sathanandan on 'Medical and ethical issues in treating subfertility over the age 40'. This was followed by the launch of the JMA newsletter by Dr. Ajantha Keshavaraj, Editor, JMA and the newsletter was distributed among all the guests. The vote of thanks was delivered by Secretary JMA . The evening concluded with a cultural show which was an unique event and the reception.

On 30th October the sessions consisted of two symposia and two plenary lectures. Dr. Ruvaiz Haniffa, secretary SLMA and Senior Lecturer, Department of Family Medicine, Faculty of Medicine, Colombo, delivered the first lecture on 'Care of the elderly in General Practice'. Dr. Ajantha Kesavaraj, Consultant Neurologist, Teaching Hospital, Jaffna talked on Parkinson Disease using video demonstrations. Dr. Lasantha Malavige, Vice President SLMA, and specialist in Sexual Medicine conducted an interesting plenary lecture on 'Sexuality in midlife and beyond'. Following the tea break Dr. Ruwanthi Perera, Consultant Paediatritian, Colombo South Teaching Hospital enlightened the audience with an overview of Sri Lankan Adolescents. Next Dr. Ayodhya Wataliyadda, Acting Paediatrician, Base Hospital, Point Pedro delivered a lecture on 'Nutritional issues in adolescents'. A lecture on 'Transition from Paediatric to adult congenital heart disease' was delivered by Dr .I.R Ragunathan, Consultant Paediatric Cardiologist, Teaching Hospital, Jafffna. A Plenary lecture on 'Management of Dengue Haemorrhagic Fever' was given by Dr. T. Peranantharajah, Consultant Physician, Teaching Hospital, Jaffna. Dr. Deepal Wijesooriya, Public Relations Officer, SLMA shared his experiences on social media for Medical Associations with the JMA members and discussed the ways of further developing the JMA media system, which concluded the academic sessions.

Amendment to Gazette no 1847/56 by Ministry of Higher Education

The gazette no 1847/56 which was an amendment to the rules No. 1 of 2013 published in the Gazette Extraordinary No. 1824/21 dated August 22nd, 2013 by Ministry of Higher Education, was of deep concern for all medical professionals. The SLMA took a keen interest in this as many felt that it would have grave implications on the quality of medical education and health care in Sri Lanka in the future. After many discussions and meetings with the authorities, it is with pleasure that we inform our members that the amended Gazette Extraordinary No. 1891/9 was published on the 2nd December 2014.

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The Gazette of the Democratic Socialist Republic of Sri Lanka

EXTRAORDINARY

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Government Notifications

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THE UNIVERSITY ACT, No. 16 OF 1978

Rules under Section 137

RULES made under Section 137 read with Sections 70C and 70D of the Universities Act, No. 16 of 1978, by the Secretary to the Ministry of the Minister assigned the subject of Higher Education being the Specified Authority appointed under Section 70B of the aforesaid Act.

Secretary,
Ministry of Higher Education,
Specified Authority.

Colombo,
02nd December 2014.

RULES

The Specified Authority (Powers relating to Recognition of Institutes as Degree Awarding Institutes) Rules No. 1 of 2013 published in *Gazette Extraordinary* No. 1824/21 dated August 22, 2013 is hereby further amended as follows :-

(1) by the repeal of rule 31 and the substitution therefor of the following :-

"31. All Non-State institutes recognized as Degree Awarding Institutes which offer study programmes leading to Degrees in Medicine, Engineering, Architecture and other similar professional Degrees shall obtain a compliance certification from the specified professional body and submit such certification to the Specified Authority."

12-560

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The role of simulation in medical education

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Simulation Based Medical Education can be defined as any educational activity that uses simulative aids to replicate a clinical scenario. Simulation is founded on the idea of doing and practicing. Simulation is "a technique to replace or amplify real-life experiences with artificially contrived guided experiences."

Health care is becoming increasingly complex, making teaching requirements more challenging and sophisticated. The airline industry has often been cited as the example for healthcare to follow in learning to improve safety. Can a paradigm shift in healthcare culture be achieved so that simulation is routinely integrated into education and practice?

SBME enhances patient safety by removing the patient from the student's learning curve. It recreates scenarios that are challenging, but not frequently experienced in routine clinical setup. The increased number of students, need for regular and frequent training, legal and accountability issues argues for the need of SBME. Other advantages of SBME include potential to assess performance in challenging situations, better retention of knowledge and skills and availability for frequent and regular practice. Simulation also provides a safe and educationally orientated environment for both teaching and assessment.

A range of competencies including clinical skills, procedure-based skills, communication skills, leadership, team work, decision-making, interpersonal skills and professionalism could be trained through simulation. Options available for simulation include simulated patients, virtual patients, static and interactive manikins, hybrid patients, task trainers and computer-based simulations.

Simulated patients are trained to act as a real patient in order to simulate a set of symptoms or problems. This can provide cases that are needed at the time they are needed and simulated patients may tolerate more students than real patients. This also allows students to learn about situations they may not be able to manage in a real clinical setting. Virtual patients aim to capture the essence of clinical practice in a virtual environment by placing the student in the position of a doctor taking care of the patients. It simulates the continuity of seeing the same patient over long period of time and learning from the patient. Task trainers train a specific task-e.g. Suturing, lumbar puncture, injection techniques, which can range from low-cost to high cost and low fidelity to high fidelity. Hybrid patients are a combination of a simulated patient and a task trainer. This adds human element to the training with a task-trainer and makes simulation more realistic for the students. Computer-based simulation with realistic clinical scenarios can facilitate teaching of problem-solving and clinical decision making. 3-D Virtual simulation is now available with high-tech simulators that are of high-fidelity and are more exciting. However many advances in simulation have been made through low-fidelity, low-cost approaches. Training on much cheaper low-fidelity simulators can be just as effective. Low-fidelity simulation has huge potential to be used widely with a significant impact on training and patient safety.

Simulation is not a panacea to solve all the challenges within the health system. There are several limitations of SBME. High-fidelity simulation is very expensive and negative learning and false confidences are also concerns.

It is unlikely that simulation will replace the importance of key clinical experiences, and learning from them, but an understanding of the cost-effectiveness of simulation shall certainly enable more informed choices regarding SBME.

"Simulated patients are trained to act as a real patient in order to simulate a set of symptoms or problems. This can provide cases that are needed at the time they are needed and simulated patients may tolerate more students than real patients. This also allows students to learn about situations they may not be able to manage in a real clinical setting."

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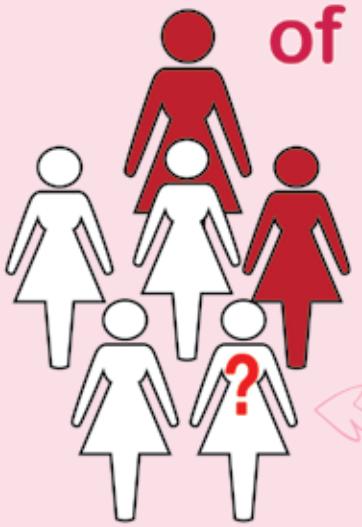

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