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SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

ETCA, Trade Agreements and Professional View Point

'Programme at a Glance' - 129th Anniversary International Medical Congress of The SLMA

Walk for Health! SLMA Health Run & Walk

Cover Story...

Joint CME Programme of SLMA

MALARIA COUNT 2016 **22**

SLMA 2016

Sri Lanka Medical Association

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SLMA President

Dr. Iyanthi Abeyewickreme

MBBS (Ceylon),
Diploma in Venereology (London),
MSc, MD (Colombo),
FCVSL, Hon. Senior Fellow PGIM
Consultant Venereologist

Editorial Committee 2016

Official Newsletter of
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PRESIDENT'S MESSAGE

May was an extremely busy month for the SLMA due to the work in preparation for the 129th Anniversary International Medical Congress and the Health Run and Walk to be held in July. As in the past, the Health Run and Walk has been organized with the twin objectives of celebrating its 129th anniversary and promoting a healthy life style among the medical fraternity as well as the general public. This event and its related activities are scheduled to be held on 17th July 2016 at Viharamahadevi Park, near the open air theater commencing at 7.00am. HE the president, health minister and government officials along with the doctors and general public have been invited to participate. The organizing committee in charge of the Run and Walk has arranged a very attractive programme including the 'Take the Test' campaign to promote screening for Diabetes Mellitus which will commence a week prior to the event where the public can get their random blood sugar (RBS) tests done at a reduced rate from identified hospitals in the private sector. RBS testing and testing of vision and hearing will be made available free of charge at the venue on the 17th of June.

The Academic committee co-chairs, Hon Secretary and the Pre-Intern along with other members have been working round the clock to get more than 340 abstracts reviewed, edited and assigned to appropriate sessions. The Congress programme has been finalised and include topics that would generate much interest to all those who attend. The Congress provides an opportunity to present original research papers, update knowledge and interact with local and overseas resource persons through the various plenaries, symposia and guest lectures. This year there is also an Emergency Skills workshop running parallel with the scientific sessions on Day 2 of the Congress. International and local resource persons will share their expertise and experiences at the Congress. The slots available for the Pre-Congress workshop on 'Medical Writing' were taken within a few days of advertising for the workshop. The SLMA office was inundated with requests to accommodate more participants. We regret our inability to accommodate all. The pre-congress workshop on 'Political Initiatives Impacting Health' will be held at the N D W Lionel memorial auditorium at the SLMA.

I invite SLMA members and all medical professionals across the different specialities to join with us to make this year's Anniversary International Medical Congress a memorable event.

Thank you
Dr. Iyanthi Abeyewickreme

THE PATIENTS OUR TEACHERS

They nurture our learning but suffer in silence!

By Dr. Duncan Bujawansa
Dr. Percy Motha
Dr. Eugene Corea
Mr. Ashraff Junaideen

Dear Colleagues,

There is a widespread perception that many doctors are not delivering care to patients in a humane manner. We do not see the medical profession or those in authority showing much concern about this state of affairs. Sometimes it even appears as though we are in denial. This lack of concern may be due to poor motivation and commitment to behave in a patient centered manner. However, in recent times there seems to be a desire on the part of medical teachers and seniors to come to grips with this problem. This is to be appreciated particularly because medical education depends heavily on the participation of patients in the teaching - learning process.

Edmund Pellagrino, a legendary ethicist, in a passionate appeal to doctors to be altruistic, argues that the physician's knowledge is not individually owned and should not be used primarily for personal benefits. According to Pellagrino, society sanctions the invasion of privacy as in dissecting bodies of individuals, participating in the care of the sick, or experimenting with human subjects so that doctors may learn.

Sri Lankan medical students and doctors learn almost exclusively from patients in public sector institutions. Many of them are "floor patients". In the process patients often lose their privacy, human dignity, confidentiality and, most important of all, suffer physical and mental distress in the process. From history taking, to examination and to the carrying out of procedures, this activity sanctioned by society is practiced in all our institutions with little realization or appreciation of this fact.

The first palpation, auscultation, phlebotomy, suturing, rectal and vaginal examination even ophthalmoscopy represent a voyage of discovery to the novice. A voyage sponsored by patients, the latter are just instructional material in the hands of the fumbling student. Little children, infants and even the unborn are not spared. As the career advances, the first appendicectomy, caesarian section, laparotomy, stenting, bypass, craniotomy are all learnt by trial and error.

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The Patients...

Mistakes do happen when you learn. Unintentionally patients become the guinea pigs of doctors when they learn so that the society may be made whole. The fact that this process is played out almost exclusively in the public sector means that it is the most disenfranchised and helpless group of sick human beings in our society who make the greatest sacrifice in the learning that is freely obtained by students and doctors. Our faltering first steps are among sick people who are poor.

Furthermore, throughout their professional lives doctors continue to learn. The sponsoring agencies of these continuing professional development (CPD) programmes in turn are able to donate money because they too earn good profits from patients. Though doctors and medical students frequently and publicly bemoan the hardships they face and the great sacrifices they make, the patients who are their guinea pigs suffer in silence. Neither do we see a commensurate concern for them among doctors.

Students worship their school teachers and look after their needs. Medical students and doctors venerate and commemorate their medical gurus. Professional drivers pay obeisance to their vehicles beside the steering wheels at the beginning of each working day.

Tell us dear colleagues, please tell us what we must do for our patients who nurture our learning and sometimes lose their lives in the process.

ETCA, TRADE AGREEMENTS AND PROFESSIONAL VIEW POINT

Dr. Manuj C. Weerasinghe

Convener- SLMA Working Party on Trade and Health

After 2-3 years of silence, the issue of trade agreements and national interests has come to the forefront of the discussion. Although the discussion is making headlines in media every few weeks, the contribution from professional quarters is not so prominent. In order to involve professionals in an active manner,a new professional collective was established under the name of **United Professional Movement (UPM)** a year ago with the contribution of over seventy professional associations and trade unions. SLMA was invited to participate in the deliberations of UPM in April 2016.

UPM did many public events to harness the support of professionals and general public to pressurize the government to give due consideration to the professional viewpoint in national issues, particularly trade related agreements with other nations. Owing to public pressure, advocacy and active engagement, the government recognized and invited UPM for discussions on the ETCA. UPM has conveyed a clear stance on trade agreements to the government. First, a National Trade Policy should be prepared with the consensus of the professionals and the general public of the country. A legal and regulatory framework needs to be established to minimize any adverse effect of liberalization in trade of goods and services. Those should be the prerequisites before signing any trade agreement with any country. The UPM on behalf of all professionals in Sri Lanka clearly demonstrated to the government with adequate evidence that Sri Lanka does not have a National Trade Policy and an effective regulatory framework to liberalize services sector. Hence, the UPM has urged the government to identify such major lapses in the policy in the country and to take necessary steps to rectify them before embarking on negotiations with any country on trade liberalization. UPM is yet to receive a clear response on those issues from the government. Future action will depend on how the government would response to legitimate and evidence based requests presented by the UPM.

The SLMA at a special council meeting in May, took the position that the regulatory framework in the health sector is not sufficiently robust to prevent adverse effects of liberalization in the health sector and the health of the people of our country. Hence, the regulatory framework needs to be strengthened before any bilateral or multilateral liberalization is contemplated. The working party on trade and health of the SLMA is entrusted with carrying out work on this direction.

JOINT CME PROGRAMME OF SLMA AND KDU - JUNE 2016

By Dr.Sumithra Tissera
Assistant secretary-SLMA

The third SLMA's joint Continuing Medical Education Programme (CME) was held at the main auditorium, Kothalawala Defence University (KDU), Ratmalana on the 1st of June 2016 with an attendance of over 60 participants. The programme commenced with a joint welcome address by Dr.Iyanthi Abeyewickreme, President of the SLMA, and Prof. Jayantha Ariyaratne, Deputy Vice-chancellor Academic and Dean, Faculty of Medicine, KDU.

The first session was chaired by Prof. Rohini de Alwis Seneviratne, Senior Professor in Community Medicine and Dr. Neil Fernando, Senior Lecturer/ Head Department of Psychiatry, Faculty of Medicine, KDU. Lectures were given by Dr. Deepa Gamage, Consultant Community Physician (CCP), Epidemiology Unit, Ministry of Health (MoH) on 'The Recent Changes in National Immunization Programme and the Future Plans', Dr. Wasantha Wijenayake – Senior Lecturer – KDU/ Consultant Surgeon on 'Application of Endoscopy in Bowel Pathology', Surgeon Rear Admiral (Dr.) Lalith Ekanayake, Consultant Physician/ Gastroenterologist and Diving/ Hyperbaric Medicine on 'Use of Hyperbaric Oxygen Therapy in Healthcare Settings', Dr. Namal Wijesinghe, Interventional Cardiologist, Head- Department of Clinical Sciences and Medicine, KDU on 'Coronary Revascularization in Diabetic Patients' and Dr. Manjula Dhanansooriya, CCP, Anti Malaria Campaign, MoH on 'Resurgence of Malaria'.

The second session was chaired by Dr. Dennis J. Aloysious, Past President, SLMA and Dr. Rohini Fernandopulle, Senior Professor in Pharmacology, Faculty of Medicine, KDU. The lectures were delivered by Dr. Malik Fernando, Member of SLMA Expert Committee on Snakebites: 'Management Problems of Snake bite in Sri Lanka', Prof. Narada Warnasooriya, Consultant Paediatrician, KDU on 'Clinician's role in Infant Nutrition', Dr. Ishani Rodrigo, Consultant Paediatrician/ Senior Lecturer, KDU on 'Epidemiology of Childhood Obesity' and Prof. Chandrika Wijeyaratne, Professor in Reproductive Medicine, Department of Gynaecology, Faculty of Medicine, Colombo on 'Medical Disorders in Pregnancy'.

The meeting concluded with Dr. Aindralal Balasuriya, Head, Department of Para Clinical Sciences/ Senior Lecturer in Community Medicine, KDU delivering the vote of thanks.

All participants were awarded a certificate of participation. The meeting was sponsored by J.L.Morrioson Son @ Jones (Ceylon) pvt Ltd's 'SOLO' low calorie sweetener.

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"SRI LANKA HAS ELIMINATED LYMPHATIC FILARIASIS" SAYS WHO

World Health Organization (WHO) media centre has made a press release stating that Maldives and Sri Lanka have successfully eliminated lymphatic filariasis. The quoted press release is given below.

Quoted from http://www.searo.who.int/mediacentre/releases/2016/1626/en/

Maldives and Sri Lanka eliminate lymphatic filariasis

SEAR/PR/1626

New Delhi, 3 June 2016 - In a significant progress against neglected tropical diseases in WHO South-East Asia Region, Maldives and Sri Lanka have eliminated lymphatic filariasis, a disease that was crippling people for decades, forcing them to lead a life of stigma, discrimination and poverty.

"The achievement by Maldives and Sri Lanka demonstrates the resolve of these countries and the Region as a whole to eliminate all neglected tropical diseases, which have no reason to continue and mar the lives of people," Dr Poonam Khretrapal Singh, Regional Director, WHO South-East Asia Region, said. The success in Maldives and Sri Lanka follows intensified mosquito control efforts; treatment of the infected population, disability prevention and control; strengthening of surveillance; and closely monitoring and evaluating these efforts which together helped eliminate lymphatic filariasis (LF) as a public health problem.

"The neglected tropical disease (NTD) is typically of the 'neglected' population, the poor and the marginalised. By eliminating this NTD as a public health problem, Maldives and Sri Lanka have shown the way for reaching these populations with other health interventions, much needed to improve their overall health," Dr Khetrapal Singh said.

Eliminating NTDs is also critical to sustainable development goals which emphasises on 'no one being left behind'.

"Maldives is committed to enhancing health and wellbeing of its population. Achieving the goal of eliminating lymphatic filariasis, as a public health problem, has been possible with tireless efforts of hundreds of health workers across the island nation," Ms Iruthisham Adam, Minister of Health, Maldives, said.

"Lymphatic filariasis elimination as a public health problem in Sri Lanka is a major public health success which has been possible with our strong commitment, dedication of our health workforce and active participation and support of the community," Dr Rajitha Senaratne, Minister of Health, Sri Lanka, said.

Lymphatic filariasis (LF) is believed to have been endemic in Maldives since 12th and 13th century and is traced back to much earlier in Sri Lanka, with the mosquitos transmitting the bug found in abundance across the two countries.

Commonly known as elephantiasis, LF occurs when filarial parasites are transmitted to humans through mosquito bites. Infection is usually acquired in childhood and the painful and profoundly disfiguring visible manifestations appear much later in life, often in the form of elephantiasis which causes permanent disability. These patients suffer the disease and also suffer mental, social and financial losses contributing to stigma and poverty.

In 2012, the WHO neglected tropical diseases roadmap set the year 2020 as a target for achieving elimination of lymphatic filariasis as a public health problem. For LF elimination, WHO's strategy is based on two key components - stopping the spread of infection through large-scale annual treatment of entire populations at risk in an area or region where infection is present; and alleviating the suffering caused by lymphatic filariasis through increased disease management and disability prevention measures.

In the South-East Asia Region, WHO has been prioritising finishing the task of eliminating diseases on the verge of elimination. Following Maldives and Sri Lanka's success, LF endemic countries working towards elimination is now reduced to seven in the Region."

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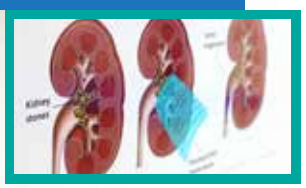

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LET US COMMUNICATE!

"Uh, oh. Looks like bad news."

By Dr.B.G.D.Bujawansa
(drbgd.bujawansa@gmail.com)

The entire medical community is involved in healthcare delivery directly or indirectly. Even a medical academic teaching a non clinical subject ultimately endeavors on maintaining and improving healthcare. Modern healthcare has numerous disciplines which operate at primary, secondary or tertiary care levels. There is no doubt that communication among us will improve our final product namely, healthcare.

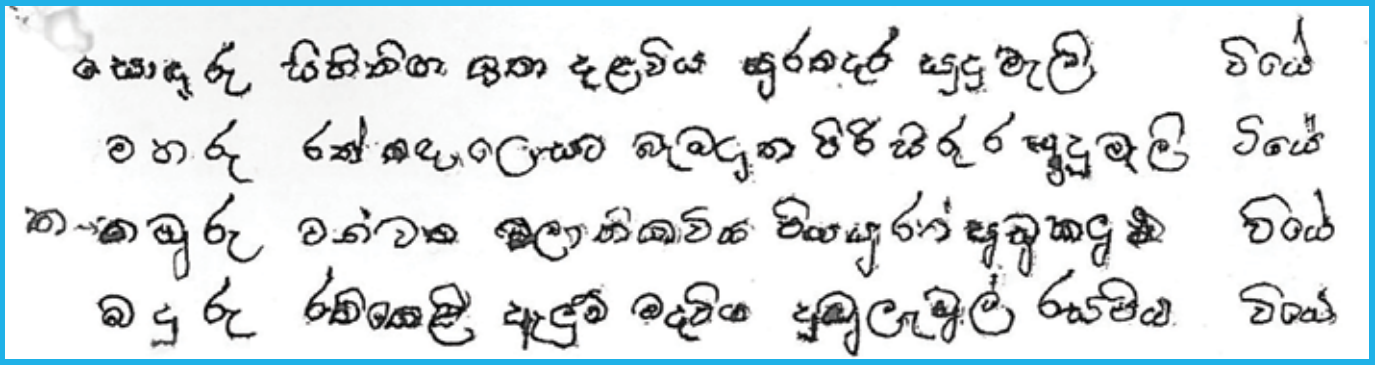
Four decades back, when the author entered the discipline of family medicine communication facilities were less. Internet, e mail, mobile phones were non-existent. Available land phone services were frequently breaking down. But the communication among healthcare providers was better. Why have we changed for worse? How can the deterioration be rectified? These are the questions left to be answered.

Lack of communication or poor communication results in duplication of investigations. This involves wastage of resources. Duplication of radiological investigations results in undue exposure of patient to irradiation. Duplication of invasive investigations carries a risk to the patient. Sometimes patients are seen taking the different brands of the same drug prescribed by two different doctors. Functioning of the medical profession as a community deteriorates when communication within the profession is poor.

Time constraints are supposed to discourage communication with colleagues. All doctors working in third world countries are burdened with effective time managemet. Good time management is essential in systems with shortage of personnel. One does not become an effective time manager if one does not communicate with colleagues when necessary. Along with the time factor specially when working in private sector monetary reasons are mentioned as a factor discouraging communication with colleagues. One does not have to sacrifice millions of rupees when taking few seconds or minutes to communicate with a colleague.

Communication is necessary not only in patient care but in continuing professional development (CPD) activities, work in academic bodies editing Journals and newsletters and being authors of contents of journals and newsletters. Hierarchy of academic bodies and associations sometimes do not respond to communications from the general membership. This amounts to poor etiquette and rudeness. If one discloses an email address following an article, a write up or an abstract of a paper presented at an academic session or a conference one must at least acknowledge the emails if he is too busy to reply them. Not practicing this dyscourtsey if not professional misconduct of a minor degree.

Good communication with colleagues certainly improves healthcare delivery. It helps in professional development of all of us. Above all it is a very pleasant activity. To prove this I am attaching a Sinhala poem sent to me by late Dr.Deshamanya P.Anthoinis. He was an expert time manager, commanded a lucrative practice but communicated with colleagues well. He will telephone soon after seeing a referred patient. A letter referring back used to be brought by the patient. He was being a role model in this area for us. He has leant the poem from his father. The poem is about signs of early pregnancy. It mentions loss of libido, pallor pigmentation of nipples etc.



By late Dr. Deshamanya P. Anthoinis

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REPORT OF MEDICINES EVALUATION COMMITTEE
(UNDER NATIONAL MEDICINES REGULATORY ACT)

Report by Dr. Sarath Gamini De Silva
SLMA representative

Following decisions were made at the Medicines Evaluation Committee meeting held on 3 rd May 2016.

Decisions

• **NSAID local applications** combined with other analgesics (for example Methyl salicylate) will not be allowed.

• **Orphan drugs** list should be updated. They should be imported by the SPC.

• **L-asparigenase** is often used by the oncologists but it still issued on 'no objection letters'. Therefore it should be registered for regular supply.

• **New Chemical Entities (NCE)**

Following applications for further pharmaceutical evaluation were rejected as they are not registered by a recognized regulatory authority.

- Alcaftadine ophthalmic solution
- Nadifloxacin cream
- Ebastim tablets
- Citicolone oral drops
- Lormancam tablets
- Indocyamin green tablets

Following NCEs were approved for further evaluation

- Famciclovir tablets
- Lacosamide tablets
- Voriconazole tablets

Registration application for IV paracetamol was rejected in view of the potential for abuse and overdosage.

MONTHLY CLINICAL MEETING - JUNE 2016
Recurrent infections: immune and genetic defects

By Dr.Kushlani Jayatilleke
Assistant Secretary-SLMA

A guest lecture titled "Recurrent infections: immune and genetic defects" was held on 3rd of June 2016 from 12 noon to 1 pm, at the Lionel Memorial Auditorium of the SLMA. The speaker was Prof Suranjith Seneviratne (DPhil (Oxon), MBBS, MD, FRCP, FRCPath, FCCP), Consultant and Professor in Clinical Immunology and Allergy, Royal Free Hospital, University College London and University of Colombo. The meeting was chaired by Dr Rajiva de Silva, Consultant Immunologist, MRI, Colombo.

S.Thumilan
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PROGRAMME AT A GLANCE

129th Anniversary International Medical Congress of the Sri Lanka Medical Association

Programme at a Glance

17th July, 2016	SLMA 129th Anniversary Health Run and Walk	6.00 am at the Vihara Maha Devi Park

Pre Congress Workshops 20th – 23rd July			
Wednesday 20th July 2016			
Workshop 1	9 am – 12 noon	**Political initiatives impacting health – have we succeeded in our advocacy?**	SLMA Auditorium
Thursday 21st July 2016			
Workshop 2 (Day 1)	8.30 am – 4 pm	**Interactive workshop on medical research**	SLMA Auditorium
Friday 22nd July 2016			
Workshop 2 (Day 2)	8.30 am – 4 pm		
Saturday 23rd July 2016			
Workshop 3	8.30am - 4 pm	**Training tomorrow's medical leaders**	Hotel Kingsbury Colombo

Sunday 24th July 2016 at Cinnamon Grand Hotel, Colombo	
Sunday 24th July 2016 **5.45 pm onwards**	**Inauguration of the 129th Anniversary International Medical Congress** **&** **SLMA Oration** **Epidemiology of Melioidosis in Sri Lanka** ***Dr Enoka Corea*** Oak Room, Cinnamon Grand Hotel, Colombo

Monday, 25th July 2016 at Hotel Galadari			
8.00 am – 8.30 am	**Registration**		
8.30 am – 9.15 am	**Keynote Address:** ***Rise and fall of clinical guidelines – the current status*** Dr Ruvan Ekanayaka		
9.15 am – 9.45 am	**Plenary 1:** ***Great expectations*** Prof Graham Taylor		
9.45 am – 10.30 am	**Professor N D W Lionel Memorial Oration:** ***Hepatoprotective effects of medicinal plants against chemically induced hepatotoxicity*** Dr R P Hewawasam		
10.30 am -11.00am	**Tea & Poster Viewing**		
	Hall	**Hall**	**Orchid Room**
	Clinical Medicine	**Behavior & Health**	**Medical Leadership**
11.00 am -12.30 pm	Symposium 1 **Management dilemmas in cardiology**	Symposium 2 **Sex and health**	Symposium 3 **Clinical leadership ensuring and assuring high quality health care**
12.30 pm -1.00 pm	Guest Lecture 1 **Statins revisited** Dr Naomali Amarasena	Guest Lecture 2 **Improving behaviour for health** Prof Diyanath Samarasinghe	
1.00 pm – 2.00 pm	**Lunch & Poster Viewing**		
2.00 pm – 3.30 pm	Free Paper Session 1	Free Paper Session 2	Free Paper Session 3
3.30 pm – 5.00 pm	Symposium 4 **DNA: The smart tool for solving crime**	Symposium 5 **Speed thrills but kills**	
5.00 pm – 5.30 pm	**Tea**		

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Programme at a Glance...

Tuesday, 26th July 2016 at Hotel Galadari			
8.00 am – 8.30 am	Registration		
8.30 am – 9.00 am	Plenary 2 : *CKDu in Asia* Prof Georgi Abraham		
	Hall	**Hall**	**VIP Room**
	NCD	**Preventive Medicine**	
9.00 am – 10.30 am	Symposium 6 **CKDu in Sri Lanka – have we found the culprit?**	Symposium 7 **'Can we end AIDS in Sri Lanka before 2030?'** **An interactive session**	**Emergency Skills Workshop** **9.00 am – 3.30 pm**
10.30 am -11.00am	Tea & Poster Viewing		
11.00 am -11.30 am	Guest Lecture 3 **Childhood obesity in Sri Lanka – time to act** Prof Pujitha Wickramasinghe	Guest Lecture 4 **Are chest X-rays still useful for general medical practice?** Prof Philip Eng	
11.30 am -1.00 pm	Symposium 8 **Diabetes mellitus- pearls of practice**	Symposium 9 **How safe is the air we breathe?**	
1.00 pm – 2.00 pm	Lunch & Poster Viewing		
2.00 pm – 2.30 pm	Guest Lecture 5 **Paediatric endocrinology – the Saudi experience** Prof A S Alherbish	Guest Lecture 6 **Can Sri Lanka sustain its malaria-free status?** Prof Kamini Mendis	Guest Lecture 7 **Where we are today with HIV, HBV and HCV** Dr Ranjababu Kulasegaram
2.30 pm – 3.30 pm	Free Paper Session 1	Free Paper Session 2	Free Paper Session 3
3.30 pm – 5.00 pm	Symposium 10 **Thyroid diseases - Do we know what we don't know**	Symposium 11 **Vaccines - the way forward**	
5.00 pm – 5.30 pm	Tea		
5.30 pm onwards	**Dr S C Paul Oration :** ***Newly identified risk factors for severe dengue infection*** Dr K C Jeewandara		

Wednesday, 27th July 2016 at Hotel Galadari		
8.00 am – 8.30 am	Registration	
8.30 am – 9.00 am	Plenary 3 : *Burden of anti microbial resistance in South-East Asia* Dr Sirenda Vong	
9.00 am – 9.45 am	**Dr S Ramachandran Memorial Oration :** ***Addressing the inequity in providing renal replacement therapy for children in Sri Lanka*** Prof Asiri Abeygunawardena	
9.45 am – 10.15	Guest Lecture 8 **How do we reduce maternal and new born morbidity and mortality?** Dr Gagan Gupta	Guest Lecture 9 **Safety and accountability in surgery** Prof Ranil Fernando
10.15 am -10.45 am	Tea & Poster Viewing	
	Hall	**Hall**
	Obstetrics & Gynaecology	**Miscellaneous**
10.45 am -12.15pm	Symposium 12 **Maternal Mortality – What more to be done to save the mother**	Symposium 13 **Are we moving to a post-antibiotic era?**
12.15 pm – 12.45 pm	Guest Lecture 10 **Obstetric ultra sound - what's new?** Dr Tiran Dias	Guest Lecture 11 **Digital health** Prof Vajira Dissanayake
12.45 pm – 1.45 pm	Lunch and poster viewing	
1.45 pm – 3 pm	Debate ***Social media do more harm than good***	
3.00 pm – 5.00 pm	Free paper session 1	Free paper session 2 Free paper session 3
5.00 pm – 5.30 pm	Tea	
7.00pm Onwards	Doctors' concert	

Post-congress Workshops			
Date	**Time**	**Title**	**Venue**
30th July, 2016	9.00 am – 12.30 pm	**Healthy living**	SLMA
30th July, 2016	2.00 pm – 5.00pm	**Workshop on palliative care**	SLMA

MERCY KILLING, SUICIDE BY PROXY, DNR AND DR. DEATH!

Euthanasia: The Medico-legal Aspect

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Euthanasia is the practice of intentionally ending a life in order to relieve pain and suffering.[1] However, the general understanding of euthanasia is the bringing about of a good death or 'mercy killing', where one person ends the life of another person, for his or her sake.[1, 2] To justify such acts and circumstances, the ethical principles applied frequently are the "right to die" and "right to terminate life".

Euthanasia is practiced at different stages of life. At the 'beginning of life', it is practiced in circumstances such as locked twins, where one child is killed by the obstetrician to facilitate the delivery of the other. 'During life', it is practiced among the terminally ill or patients with incurable illnesses. The terminally ill are the patients with no hope of recovery and are either fully conscious or deeply comatose. However, patients with incurable illness such as disseminated malignancy also have no hope of recovery but are not terminally ill. At the 'end of life', euthanasia is practiced to achieve a 'death with dignity'.

Classification of euthanasia depends on several factors. When the consent of the person is considered, it can be classified in to three; voluntary, non-voluntary or involuntary and based on the method of application, it is classified in to active or passive euthanasia.

When a person knowingly declares the wish to end his life or specially requests that his life be terminated it is termed 'voluntary euthanasia'.[2] This request may be made prior to the development of illness in way of 'living will' or 'advanced directive', or during the course of the illness.

When considering 'non-voluntary euthanasia', the patient leaves the 'decision making capacity' with a physician or a relation.[3] The physician or relation makes the decision on his behalf upon the request of the patient. This is called "Suicide by proxy". Here, someone directly or indirectly ends another person's life, because they believe it is in their best interest in order to relieve pain and suffering from an incurable or terminal condition. This is practiced in instances of death of a patient for his own good, where the patient is unable to express any view on the matter, for example in patients who are in a permanent vegetative state. Non-voluntary euthanasia is also known as 'Mercy killing'.

'Involuntary euthanasia' is performed against the will of the patient and the physician takes the decision on his own to terminate the life of the patient without a personal or proxy invitation and this amounts to homicide, whether active or passive.[4] When considering 'active euthanasia', death is brought about by an act of commission by the physician. Here, the physician determines the date and time of the death of the patient. However, active euthanasia is unlawful and unethical. For example, in such circumstances, the physician injects potassium chloride (KCl) or a "double effect drug" such as high dose of morphine, where both pain relief and respiratory suppression occur. In 'passive euthanasia', the death is brought about by an act of omission by the physician.

When voluntary euthanasia is considered separately, it can be further divided in to two types; voluntary passive and voluntary active euthanasia.

Voluntary refusal of treatment or voluntary refusal of food and fluids (VRFF) by a patient is 'voluntary passive euthanasia'[5] and it does not amount to homicide, because an adult patient with sound mind has the right to refuse treatment. This refusal can be done at the time of the illness or in advance by way of "living wills or advance directives".

Further, physician-assisted suicides (PAS), are also a type of 'voluntary passive euthanasia'. In this situation, a physician supplies information and/or the means of committing suicide to a person. For example, the physician supplies a prescription for a lethal dose of sleeping pills, so that the individual can successfully terminate his or her own life.[6]

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Mercy killing...

Some believe that patients with sound mind have the liberty and right to end their lives by adopting methods of all manners that do not involve physicians. However, the principle of "right to die" is a reward for the patient to utilize the "right to have a help of a physician to kill himself."[7]

Physician-assisted suicide is legal in Switzerland, Germany, Japan, Albania and in the US states of Washington, Oregon, Vermont, New Mexico, Montana, and California. [2]

In UK, in 1935, the British Voluntary Euthanasia Society (later known as "EXIT" and now as "Dignity in Dying") produced 'A Guide To Self-Deliverance" giving guidelines on how a person could commit suicide.[4] The publication was delayed amid controversy because of the UK Suicide Act of 1961 which states that the legal system can allow up to 14 years in prison for anyone that assists in suicide.[4] Its Scottish branch (now called EXIT) published 'How to Die with Dignity' in 1980 [8] and became the first publication on physician-assisted suicide (PAS) in the world.[6] The question among politicians in Britain today is why they force their citizens, people in the most terrible circumstances who are determined to end their suffering in a way of their own choosing, to leave their country and travel to Switzerland to exercise their free will? [6]

When considering physician-assisted suicides (PAS), Dr. Jack Kevokian, an American pathologist cannot be overlooked. He often appeared in the media as "Dr. Death" and publicly campaigned for terminal patient's right to die via physician-assisted suicide. He claimed to have assisted at least 130 patients to die and famously declared that "Dying is not a crime."[2] In physician-assisted suicide, the physician should play a passive role rather than an active one, for in some instances, when they play an active role, it turns in to 'voluntary active euthanasia', which is illegal and unethical. In 1999, Dr. Jack Kevorkian was arrested and tried for his direct or active role in a case of voluntary euthanasia. He was convicted of second-degree murder and served eight years of prison sentence. [2] Later, this story appeared in the film "You don't know Jack".

When non-voluntary euthanasia is considered individually, it can be further classified in to two groups: non-voluntary passive and non-voluntary active euthanasia.

Withdrawal of treatment in a terminally ill patient who has not given prior consent is 'non-voluntary passive euthanasia. In the Tony Bland case, the final decision was obtained by referring the matter to the courts. Anthony David Tony Bland was an 18 year old supporter of Liverpool Football Club and got injured on 15th April 1989, in the Hillsborough disaster, following a collapse of a pavilion. He suffered severe brain damage that left him in a persistent vegetative state for four years. The hospital, with the support of his parents, applied for a court order allowing him to 'die with dignity'. As a result, he became the first patient in English legal history to be allowed to die by the courts through the withdrawal of life-prolonging treatment. [9]

The concept of non-voluntary passive euthanasia is being debated endlessly. Len Doyal, a professor of medical ethics stated that "non-voluntary passive euthanasia should be legalized under appropriate circumstances and with proper regulations". [9] Arguing against legalization, Peter Saunders, the campaign director for 'Care Not Killing', called Doyal's proposals as "the very worst form of medical paternalism whereby doctors can end the lives of patients after making a judgment that their lives are of no value and claim that they are simply acting in their patients' best interests". [10]

Non-voluntary passive euthanasia is legal in various countries, such as India[11], Albania, Hungary and many parts of the United States and England.[9] On 7th March 2011, the Supreme Court of India legalized non-voluntary passive euthanasia by means of the withdrawal of life support to patients in a permanent vegetative state. The decision was made as part of the verdict in a case involving Aruna Shanbaug who had been in a Persistent Vegetative State (PVS) until her death in the year 2015.[12] Therefore, in such instances, especially in the countries where passive euthanasia is not legalized, similar to the Tony Bland case, it is justifiable to obtain a court order.

Non-voluntary active euthanasia is illegal in all countries in the world, although it is practiced in The Netherlands on infants under an agreement between physicians and district attorneys. Infants with conditions such as severe hydrocephalus can be subjected to non-voluntary active euthanasia in the Netherlands if parents and doctors decide it is the best choice for their child. [13]

Involuntary euthanasia can be further divided in to two groups; involuntary passive and involuntary active euthanasia. The non–treatment of a treatable condition by leaving 'Do not resuscitate (DNR) orders' is 'involuntary passive euthanasia'. Since it is involuntary, it is unethical and also amounts to homicide. [14]

However, involuntary active euthanasia is also practiced under some circumstances. For example, in 2008, Shirley Justins and Caren Jennings were found guilty of manslaughter for providing a lethal dose of medicine to former pilot Graeme Wylie in 2006. Justins stated that Wylie wanted to "die with dignity". The prosecution argued that Wylie did not have the mental capacity to make the crucial decision to end his life, classifying it as involuntary active euthanasia and they were found guilty. [15]

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Mercy killing...

In Tasmania, Australia, in 2005, a nurse was sentenced for two and half years in prison for assisting the death of her elderly father who had terminal cancer.[10] However, the judge later suspended the conviction because he believed that the community did not want the woman jailed. This sparked the debate about decriminalizing euthanasia. [11]

In Europe, active human euthanasia is legal only in the Netherlands, Belgium, Luxemburg and Switzerland. [16] The Netherlands is the only country where both euthanasia and physician-assisted suicide are practiced legally because physicians performing euthanasia are not prosecuted under some circumstances.[17]

In contrast, human euthanasia has been criminalized in Mexico, Thailand and the Northern Territory of Australia too. [2]

Therefore, euthanasia represents frequently disputed medical, ethical, legal and social issue worldwide. Further, none of these methods of euthanasia, whether active or passive, can be practiced in Sri Lanka.

Note: Some contents of this article were published in the Puttalam Medical Journal in 2015.

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LIST OF TRAINING CENTRES FOR TRAINEES IN FORENSIC MEDICINE

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1. NSW Institute of Forensic Pathology, Glebe, Australia.
2. Victorian Institute of Forensic Medicine and Department of Forensic Medicine, Monash University, South Bank, Melbourne, Victoria, Australia
3. Queen Elizabeth II Medical Centre, Nedlands , Perth, Western Australia
4. Sir Charles Gairdner Hospital, Nedlands, Western Australia
5. Professor of Forensic Medicine and Forensic Sciences, University of Coimbra, Portugal
6. The Victorian Institute of Forensic Mental Health (Forensicare), Fair Field, Victoria, Australia

Canada

7. Department of Pathology, Faculty of Medicine, University of Manitoba, Winnipeg , Canada
8. Forensic Science Department, University of Toronto, Mississauga, Ontario, Canada
9. Provincial Forensic Pathology Unit, Office of the Chief Coroner, Toronto, Ontario, Canada
10. Forensic Pathologist , Forensic Pathology Unit, Hamilton Health Sciences, McMaster University, Hamilton, Ontario, Canada

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Poland

12.Department of Forensic Medicine, Medical University of Lodz, Poland

UK

13.Charing Cross and Westminister Medical School, University of London, Fulham Palace Road, London, UK

14.Forensic Pathology Services, P.O Box 34934, Fulham SW6 2ZR, UK

15.University of Glasgow, Glasgow, UK

16.Sheffield Teaching Hospitals NHS Foundation Trust, Whitham Road, Sheffield, UK

17.University of Edinburgh, Division of Pathology (Forensic Medicine), Edinburgh, UK

18.Center for Forensic & Legal Medicine, University of Dundee, Dundee, UK

19.Department of Histopathology, Royal Surrey Country Hospital, United Kingdom

USA

20. King County Medical Examiner's Office, Harborview Medical Center, Seattle, Washington, USA

(Please note that these are centres where Sri Lankan postgraduate trainees had been trained before. Collected from previous postgraduate trainees for the use of future trainees)

ORATIONS 2016

Oration	Title	Orator	Dates	Venue
SLMA oration	Epidemiology of Melioidosis in Sri Lanka	Dr Enoka Corea Consultant Microbiologist Department of Microbiology, Faculty of Medicine University of Colombo	24th July 5.45pm onwwards	Cinnamon Grand Hotel, Colombo
NDW Lionel Memorial oration	Hepatoprotective effect of medicinal plants against chemically induced hepatotoxicity	Dr R P Hewawasam Senior lecturer, Department of Biochemistry Faculty of Medicine University of Ruhuna	25th July 9.45-10.30am	Hotel Galadari, Colombo
Dr. S.C. Paul Memorial oration	Emerging risk factors for severe dengue infection	Dr Chandima K Jeewandara Senior Lecturer Centre for Dengue Research University of Sri Jayawardenapura	26th July 5.30pm onwwards	Hotel Galadari, Colombo
Dr. S. Ramach-andran Memorial oration	Alleviating the inequity in providing renal replacement therapy for children in Sri Lanka	Prof. Asiri Abeyagunawardena Prof of Paediatrics Department of Paediatrics University of Peradeniya	27th July 9.00am-9.45am	Hotel Galadari, Colombo

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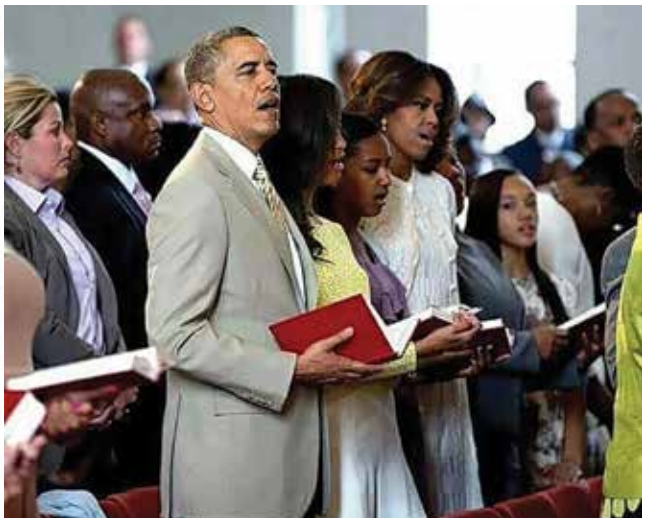

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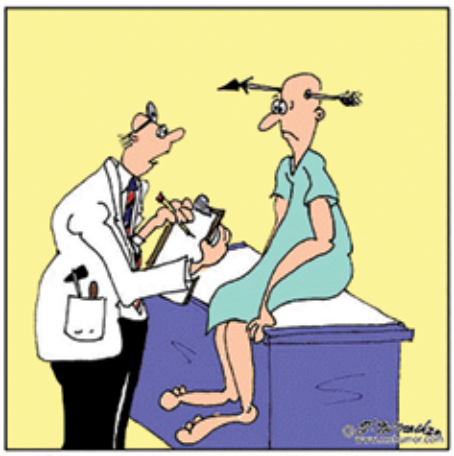

"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."

(The Editor wishes to thank Dr. B.J.C.Perera, Consultant Paediatrician, Council member-SLMA for sending these photos quoted from the web)

The 129th Anniversary International Medical Congress of the Sri Lanka Medical Association will be held from 24th – 27th July 2016 at Galadari Hotel, Colombo.

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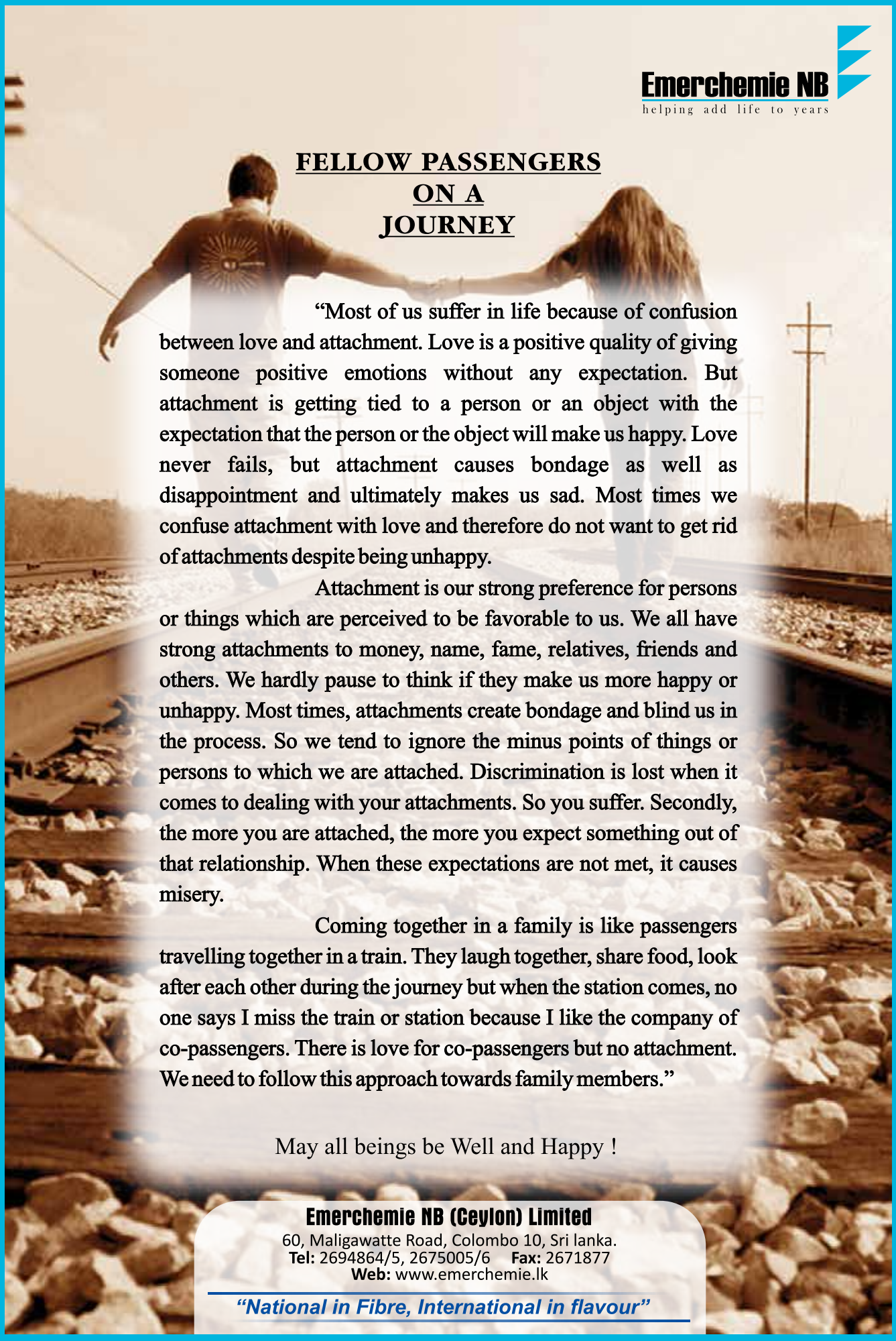

"Most of us suffer in life because of confusion between love and attachment. Love is a positive quality of giving someone positive emotions without any expectation. But attachment is getting tied to a person or an object with the expectation that the person or the object will make us happy. Love never fails, but attachment causes bondage as well as disappointment and ultimately makes us sad. Most times we confuse attachment with love and therefore do not want to get rid of attachments despite being unhappy.

Attachment is our strong preference for persons or things which are perceived to be favorable to us. We all have strong attachments to money, name, fame, relatives, friends and others. We hardly pause to think if they make us more happy or unhappy. Most times, attachments create bondage and blind us in the process. So we tend to ignore the minus points of things or persons to which we are attached. Discrimination is lost when it comes to dealing with your attachments. So you suffer. Secondly, the more you are attached, the more you expect something out of that relationship. When these expectations are not met, it causes misery.

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