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SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE 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

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Official Newsletter of
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PRESIDENT'S MESSAGE

April was a relatively quiet month for the SLMA due to the many holidays that fell during the month. However, those involved in the preparations for the Annual Academic Congress were kept busy. The Academic committee has been working tirelessly with the support of many others to make this event a success. Of course, the success depends on the participation at the Congress. In this regard, I would like to remind the members that we have not made any changes to the registration fees and that they remain the same as last year. The registration fee is subsidized to encourage all doctors and other healthcare professionals to attend the Academic Congress and I fervently hope that this opportunity will be made use of by all concerned. It would not be possible to subsidize the registration fees without the support of our sponsors. Although the country is facing economic difficulties, we are grateful to the many sponsors who have pledged to generously support the Academic Congress and other activities of the SLMA. I would also like to remind you that facilities for registration for the Congress will be available online using the online payment scheme through the SLMA web site.

The closing date for submitting manuscripts for orations was on 15th April. I am pleased to inform you that sixteen (16) applications for orations and a further eighteen (18) submissions for awards have been received. The orations and awards committee will review the submissions and finalise the selections by the end of this month.

The guest lecture for April was delivered by Prof. Peter Gaines, Professor from Sheffield and Hallam University, United Kingdom. He discussed the recent advances in endovascular treatment of lower limb ischemia. The Expert Committee on Medicinal Drugs organized a therapeutic update on anaphylaxis which was well attended and appreciated by all who were present.

A request received from the Japan Medical Association seeking SLMA's support for the candidature of their president for the presidency of the World Medical Association for 2017-2018 was approved by the Council.

I am pleased to inform you that The Association of Clinical Pharmacology and Therapeutics has offered an award for the most outstanding research paper in pharmacology presented at the Annual Academic Congress of SLMA from this year. We thank the Association of Clinical Pharmacology and Therapeutics for encouraging researchers in the field.

Thank you
Dr.Iyanthi Abeyewickreme

THE SLMA'S RESPONSE TO RECENT FLOODS

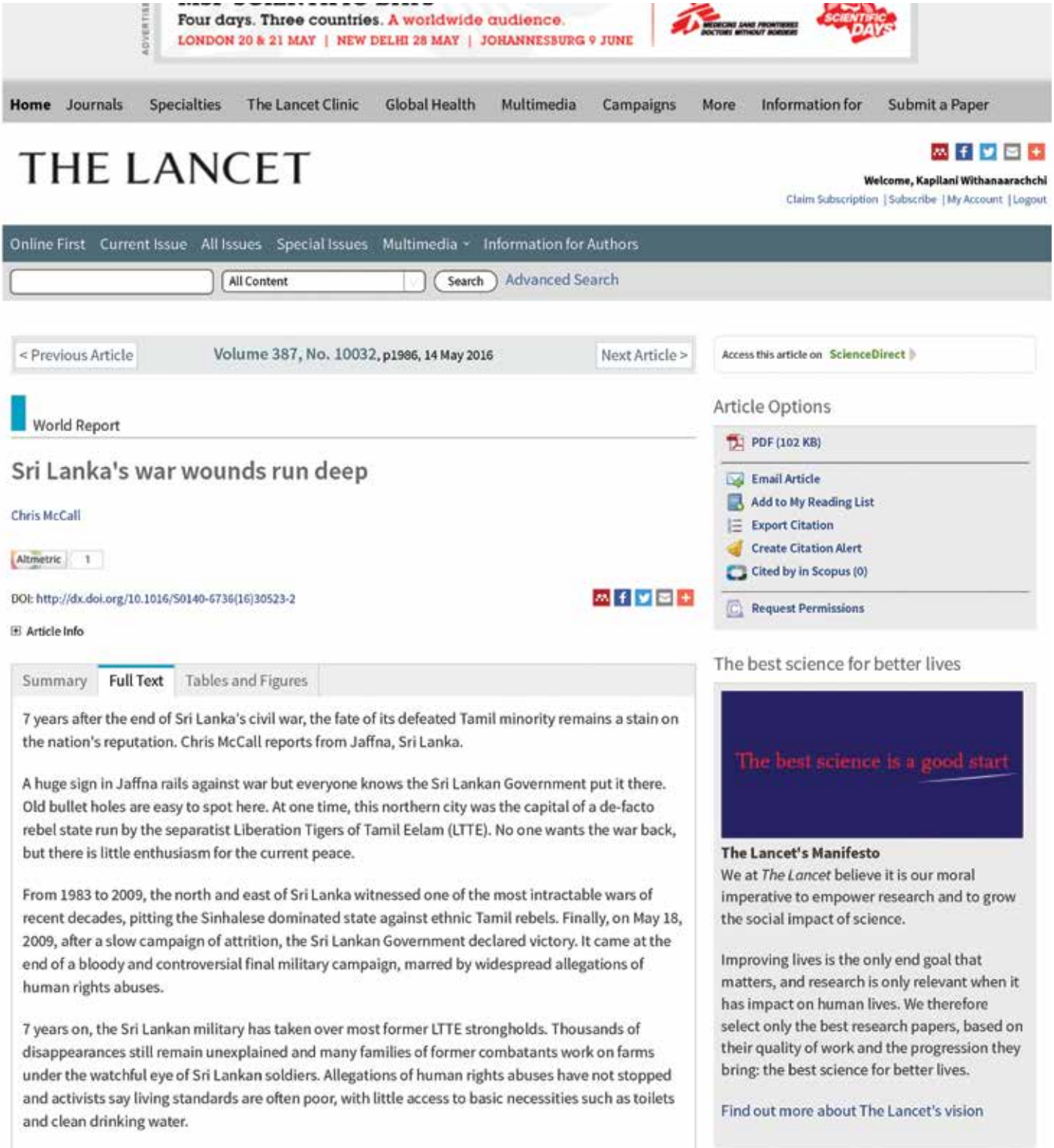
By Dr.Sumithra Tissera
Assistant secretary-SLMA

SLMA members both in Sri Lanka and abroad contributed enthusiastically by handing over dry rations to the SLMA office, which in turn were handed over to the Vipassana Bhavana Centre. These provisions had been used to provide cooked meals to the displaced persons in the camps in Kaduwela and Kolonnawa MOH areas.

The SLMA President and a few members assisted the MOH Kolonnawa by providing much needed medical services and medicines to conduct health clinical at the camp located at Vidyawardhana Vidyala at Kotikawatta on 20th of May 2016.

We wish to thank all our members who supported these initiatives.

THE LANCET ARTICLE ON SRI LANKA'S WAR



World Report

Sri Lanka's war wounds run deep

Chris McCall

Altmetric 1

DOI: http://dx.doi.org/10.1016/S0140-6736(16)30523-2

Article Info

7 years after the end of Sri Lanka's civil war, the fate of its defeated Tamil minority remains a stain on the nation's reputation. Chris McCall reports from Jaffna, Sri Lanka.

A huge sign in Jaffna rails against war but everyone knows the Sri Lankan Government put it there. Old bullet holes are easy to spot here. At one time, this northern city was the capital of a de-facto rebel state run by the separatist Liberation Tigers of Tamil Eelam (LTTE). No one wants the war back, but there is little enthusiasm for the current peace.

From 1983 to 2009, the north and east of Sri Lanka witnessed one of the most intractable wars of recent decades, pitting the Sinhalese dominated state against ethnic Tamil rebels. Finally, on May 18, 2009, after a slow campaign of attrition, the Sri Lankan Government declared victory. It came at the end of a bloody and controversial final military campaign, marred by widespread allegations of human rights abuses.

7 years on, the Sri Lankan military has taken over most former LTTE strongholds. Thousands of disappearances still remain unexplained and many families of former combatants work on farms under the watchful eye of Sri Lankan soldiers. Allegations of human rights abuses have not stopped and activists say living standards are often poor, with little access to basic necessities such as toilets and clean drinking water.

Among Sri Lanka's Sinhala-speaking majority, the LTTE are still uniformly referred to as "the terrorists". They certainly earned the name, carrying out successful assassinations of a Sri Lankan president and a former Indian prime minister, a bombing of one of Sri Lanka's most venerated Buddhist shrines, and well documented intimidation of their own people. Nevertheless, many Tamils quietly say they were better off under the LTTE than now. "The country is polarised. It is one big mess. The country has not recovered from the war", said Anuradha Mittal, executive director of the independent policy think tank the Oakland Institute, CA, USA, who has visited Tamil areas of Sri

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The Lancet...

Lanka. "It is a community that has been crushed. They don't have access to basic things. You have very limited access to water. You have very limited access to electricity. You have very limited access to water for your land."

Human rights monitors estimate that 40000 people died in the final stages of the war, with many of the deaths blamed on indiscriminate shelling by the military, although the rebels are also accused of abuses.

For all their ruthlessness, the Tigers' disappearance has left gaps. The LTTE ran its own courts, had its own government structures, and even its own navy. Only about 11% of Sri Lankans are Tamil, but in the north and east they are the main group, with strong links to the nearby Indian state of Tamil Nadu.

Critics say there has been no real attempt at reconciliation or investigation. Elil Rajendram, from the Jesuit Refugee Service, a Catholic non-governmental organisation that aids refugees, said the Tamils left in the last conflict zones were among the most vulnerable, literally those who could not afford to leave. Some are now living on farms for papaya, bananas, and other crops that were once operated by the rebels and are now controlled by the military. Sexual harassment there is common, Rajendram said, and there are pre-schools run by the military, which he sees as an attempt at "instilling fear" in a defeated population. "All those who remain in the former war zones are people who could not afford to go out of the country", he said. "I don't think people can re-establish themselves."

One of the most concerning issues has been a lack of resources for mental health, given the high rates of post-traumatic stress disorder. "There is no programme designed to deal with it", Rajendram said.

Doctors assigned to the region are frequently Sinhala speakers who do not know Tamil, he said. Most of their patients do not know Sinhala, so communication is inevitably poor.

The government has made it clear it is determined to prevent a resurgence of the LTTE. Complicating the picture is the fact that the Tamil war widows include women who were themselves fighters for the LTTE. It had a large female contingent and used female suicide bombers, including one who assassinated former Indian Prime Minister Rajiv Gandhi in 1991. In recent years, Tamil organisations have alleged deliberate "colonisation" of Tamil areas by Sinhala speakers in an attempt to change the demographics in favour of the victorious side.

Hopes were high when new Sri Lankan President Maithripala Sirisena was elected in 2015, defeating the man who oversaw the 2009 offensive, former President Mahinda Rajapaksa. However, critics say little has substantially changed. "I think if the country really wants to heal, it will require strong leadership that will stand up to the Sri Lankan army. It will require real political leadership", said Mittal.

The Sri Lanka Medical Association and the Sri Lankan Ministry of Health, Nutrition and Indigenous Medicine were invited to contribute to this report but neither responded to requests for interviews.

Associated Press
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THE SLMA'S RESPONSE TO THE LANCET ARTICLE

This is the SLMA's response to the article published in the Lancet Vol. 387 of 14th May 2016 titled "Sri Lanka's war wounds run deep" by Chris MacCall.

Dear Editor,

We are forced to draw your kind attention to the World Report published on 14th May 2016 in the Lancettitled 'Sri Lanka's War Wounds Run Deep' by Chris McCall, a medical journalist (McCall C. Sri Lanka's war wounds run deep. The Lancet. 2016; 387:1986

Towards the end, the article states that the Sri Lanka Medical Association (and the Ministry of Health, Nutrition and Indigenous Medicine) were invited to contribute to this report. We, at the Sri Lanka Medical Association (SLMA) have not found any such request and urge the author to submit further details of this request so that we could investigate, if such a lapse has occurred. If some evidence for the said request claimed to have been made from the SLMA cannot be produced, it is justifiable to assume that the statement made in the article has been a deliberate attempt to tarnish the reputation of our Association which was founded in 1887 as the Ceylon Branch of the British Medical Association.

We are greatly dismayed to detect deep levels of bias in this Report, far too excessive, certainly for a prestigious medical journal like the Lancet.

The two main sources of McCall's report are: Anuradha Mittal (from the Oakland Institute, USA) and Elil Rajendram. The method of assessment or the sampling frame used to make

sweeping derogatory statements by Mittal is not stated (e.g. "Among Sri Lanka's Sinhala speaking majority, the LTTE are still uniformly referred to as 'the terrorists'" and "….many Tamils quietly say they were better off under the LTTE than now").

We suspect that Mittal's views were partly biased by the work she did in Sri Lanka prior to the Sri Lankan Presidential Elections in Sri Lanka in January 2015. A description of her work is given in the Report she authored, titled "The Long Shadow of War: The Struggle for Justice in Postwar Sri Lanka" in 2015 published by The Oakland Institute, an institute founded by her in 2004 (https://en.wikipedia.org/wiki/Oakland_Institute). The latter is hardly an'independent think tank' and has numerous publications that are one-sided. It has even hosted a petition titled "Demand an International Judicial Process for War Crimes in Sri Lanka", which was discontinued because it achieved only 560 signatures !!!.

The other source for the World Report includes Elil Rajendram a relatively unknown person in Sri Lanka, who had previously written to the Oakland Institute as well. (http://www.oaklandinstitute.org/statementfatherelilrajendram). He is from a Jesuit Refugee Service a non-governmental foreign organization which is not registered in Sri Lanka. (http://www.ngosecretariat.gov.lk/) Both these sources, you will note, have been conducting a campaign since the end of the terrorist activities, to tarnish the good work of all those trying to improve the conditions of the Northern population. Naturally a lot remains to be done as the entire infrastructure and the fabric of life has been destroyed by the Tamil terrorists and the inevitable government attempts to subdue them.

We also note that the Lancet Report has deliberately chosen to ignore the vast changes that have taken place after the end of the Civil War and the election of a new government on 8th January 2015. The current leader of the opposition of the National Parliament is from the Tamil based parties in the North and East of the country. The Northern Province is also governed by the same conglomerate of Tamil parties. The hospitals and road networks have been expanded rapidly and almost all camps with displaced persons have been closed. There is no racial bias in deploying doctors to any part of the country. It is based on their performance at an examination and they exercise their right to choose, and the hospital they wish to work in. However, many Tamil doctors from the North prefer to work in the Southern parts of the country while many from the South, not very proficient in Tamil, volunteer to work in the North. The newly improved Teaching Hospital in Jaffna and The Faculty of Medicine in Jaffna Medical schools have state-of-the-art facilities and are hubs for medical education and training. The Jaffna Hospital itself is one of the centres for Postgraduate Training in all relevant specialties. That hospital now has even better facilities than some of the institutions in the rest of the country.

We are greatly dismayed and thoroughly offended that the Lancet too has joined in promoting 'Sri Lanka bashing', which has become a favourite pastime for some individuals and institutions.

In fairness to us, please be kind enough to afford us the opportunity to request equal prominence to this communication, as was afforded to the World Report in question.

Dr Iyanthi Abeyewickreme
President
Sri Lanka Medical Association

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MOBILE PHONES, MEDICAL PHOTOGRAPHY AND ETHICS

Professor Saroj Jayasinghe
Council Member SLMA
Professor-Department of Clinical Medicine
Faculty of Medicine Colombo

The almost universal presence of mobile phones has led to a new era in medical photography. No longer have doctors or medical students got to obtain the services of a photographer. The high resolution camera is now with them, all the time. The ease of photographing a clinically or educationally useful picture is, however, fraught with ethical and legal issues. This article attempts to explore some of these issues that arise in hospitals or clinics and challenge the readers to think and reflect.

Let's focus on a particular situation that is increasingly common in Sri Lanka: doctors (and even medical students) photographing patients having 'interesting' physical signs. Superficially, the issue is one of exposing the identity of the patient that would amount to a violation of autonomy, and the main ethical issue is one of breaching confidentiality of the patient. Though this sounds simple, there are many factors to consider in this process.

1. Who obtains consent?

When reflecting to write this paper, I realized that the important question was, who should obtain consent to obtain a photograph. Sri Lankan society is hierarchical and there is enormous asymmetry of power between the doctor and patient. As a result, the latter would feel obliged to satisfy the doctor and informed consent has no meaning. It is extremely unlikely that a patient would therefore refuse his or her pictures being taken by the attending doctor. As a result, we have agree that an attending doctor should NOT obtain consent to take photographs of his or her patients. Consent is best obtained by another person, preferably someone who is not in the medical team caring for the patient. The next three points relate to the content to be discussed during the process of obtaining informed consent.

General Circular Letter No. :- 02 -23 /2006

My No. DDG(MS)47/2005
Department of Health Services,
"Suwasiripaya",
385, Baddegama Wimalawansa Thero Mw,
Colombo 10.
26 .01. 2006.

All Provincial/Deputy Provincial
Directors of Health Services,
All Heads of Decentralised Units of Health Services,
All Directors of Teaching Hospitals & Specialised Campaigns,
All Medical Superintendents & District Medical Officers
of Provincial & Base Hospitals

Use of Mobile Phones with Cameras in Government Hospitals

Mobile phones are very commonly used by the general public as well as the hospital staff at present. The modern mobile phones are equipped with cameras. Though mobile phones are very useful for healthcare workers, certain restrictions have to be placed on the use of cameras attached to the mobile phones to ensure privacy and rights of patients.

The Ministry has decided that –

1. Mobile phones **without** cameras can be used in hospita's. However, the users should ensure that the patients are not disturbed with the noise of the phones.
2. Mobile phones **with cameras are not allowed** in labour rooms, operating theatres, intensive care units and in hospital and field clinics.
3. **No pictures of patients should be taken** using mobile phones, digital cameras, ordinary cameras or any other photographic equipment. However, photographs for academic purposes are allowed at the discretion of the Director/ Medical Superintendent of the respective hospital with the permission of the patients concerned and the concurrence of the respective consultants in-charge of the units.

The Heads of Institutions should ensure that the staffs adhere to the instructions given in this circular. Please bring this circular to the notice of all members of the staff in your hospital.

Dr. H.A.P. Kahandaliyanage
Director General of Health Services

Copies to All Provincial Secretaries of Health – f.i.

This is an old circular with current importance.

2. Removing ALL identification

The easiest to contend are pictures where limbs or torso are involved and the patient cannot be identified. However, would an alert relative or friend of the patient be able to identify the patient? What would be the situation where the patient is easily identifiable, for example, the case of a Bell's palsy where blacking out the patient's eyes would not prevent a relative from identifying the person! The situation is even more difficult to blur identity in videos of patients, e.g. to demonstrate gait.

The way to resolve this issue is perhaps to show or describe to the patient, how the picture would ultimately look in its final form. He or she should be aware of the potential for identification by friend or foe!

3. For what purpose are you taking the photograph?

Is the photograph for your own personal records of an interesting 'case' or for educational purposes (e.g. for teaching students or for an examination) or to be published as a 'case report'?

Contd. on page 10


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Contd. from page 08

Mobile Phones...

Each of these has different implications because the picture would be viewed by progressively larger numbers of persons. With the advent of the internet, these margins are increasingly blurred. In these days of social media, using a picture of a patient taken with the expressed wish of using for educational purposes may ultimately end up in Google Images, and viewed by millions! It is unlikely that the real 'owners' of these pictures (i.e. the patients) will ever be aware of this 'publicity'!

Therefore, it is important to inform the patient the purpose of taking the picture and the potential number of persons who may view it (i.e. will it be in the professional domain or easily viewed by the public). As a precaution, such photographs should not be exhibited in social media sites such as Facebook nor transmitted through insecure emails that could be hacked. Such precautions during transmission are necessary even when we transmit images to colleagues in order to plan patient care (e.g. images of CT brains being sent to the neurosurgeon for comment).

4. Consequences

Finally, it is important to consider a few possible consequences. Despite taking the relevant precautions and informed consent, could a patient subsequently accuse a doctor for violation of the principle of confidentiality? Or, could the patient charge the hospital for breach of confidentiality? If I develop an image library of 'interesting cases' and upload on my personal webpage where access requires a payment, should the patient be paid royalties? Thus a clause to cover such consequences is important in the consent form.

Conclusion

Ubiquitous medical photography is here to stay! Consent for photographs should be obtained by a person who is NOT the attending doctor. Doctors and medical students should NOT be allowed to click pictures during ward rounds or clinics.

The process of taking consent needs to be formalized and obtained by a person 'outside' the team caring for the patient. The process should explicitly describe the areas of the body or face that would be photographed, how they would be shown, and what the images would be used for. The consent forms used by the Audio-Visual Unit of the Faculty of Medicine, Colombo, could be a good starting point.

In the meantime, we need a simple guide to direct us. One method is to use the litmus test on ourselves: 'if it is my photograph that would appear in the slide or case report would I consent to be photographed?' Proceed ONLY if the answer is a definite 'YES'.

It is time the Ministry of Health bans unethical photography of patients, and we develop guidelines for the process.

WOMEN'S MENTAL HEALTH IN SRI LANKA

Dr.Shashini Somaratne
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University Psychiatry Unit
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Kalubowila

Dr. Amila Isuru
Acting Consultant Psychiatrist
Base Hospital Thambuththegama

Professor Samudra Kathriarachchi
Professor and Consultant Psychiatrist
Faculty of Medical Sciences
University of Sri Jayawardenepura and
President
Sri Lanka College of Psychiatrists

Background

As Sri Lanka celebrates the 68th Independence Day on 4th of February 2016, as a nation we have witnessed positive aspects such as ending of civil war, escalation of the country's economy, health profile and nutritional status of the population etc. All these contributed to shift the country's status from that of a low income country to a middle income one. It is through the dedicated efforts of various stakeholders that our nation achieved significant standards in the field of health such as eradication of small pox, polio, reduced infant mortality rate, maternal mortality rate and increased expectancy of life at birth etc.[1] In spite of these achievements major challenges continue to exist in the areas of mental health and service delivery. This is especially true regarding the mental health of women who comprise of nearly half of Sri Lanka's population[2] and contribute significantly to economic growth of the country while fulfilling the needs of their families. Though Sri Lanka boasts the highest level of literacy among women in South Asia, the same cannot be said about mental health literacy. Meanwhile many South Asians including Sri Lankans underestimate the importance of mental health and its impact on physical health.

Women in particular are conditioned to accept their mental distresses as part of life or as a result of karma of previous birth. These deeply ingrained belief systems delay or prevent seeking help. In addition there are certain cultural expectations of a woman on gender assigned stereotypes such as a woman has to be a good mother, obedient wife, good daughter and caring daughter in -law etc. For many women meeting all these expectations is a daunting task while achieving a career role. Resultant frustration and guilt is often not understood by the person and those who are close to her, leading sometimes to disastrous consequences. The modern day Sri Lankan woman plays all these multiple roles in addition being a career woman. Coupled with rapidly changing family structure, the evolving social networks and lack of support systems make Sri Lankan women more vulnerable to modern day stressors.

Contd. on page 12

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Women's mental...

Women are more vulnerable to develop certain types of mental illnesses than men. The underlying risk factors such as lack of confiding relationships, unemployment, having three or more children below the age of 12 years[3], poverty and social disadvantage, physical and sexual abuse have been demonstrated through research as contributing to development of mental illnesses among women. Postpartum period itself is associated with increased risk of relapse of several major psychiatric disorders such as bipolar disorder, schizophrenia and depressive disorder[4]. In addition to above factors, women in the present generation have witnessed the effects of the civil war, tsunami devastation and violence in the society resulting in death and separation of family members, loss of property, displacement, disruption of educational, community support and health systems making them more vulnerable to develop mental illnesses.

Recent research evidence and anecdotal reports have shown a gap in the delivery of mental health care services to women, especially the subpopulation of pregnant and postpartum women. To quote an example, even though the maternal mortality rate shows a downward trend during the last few decades, maternal suicide rate has shown an upward trend. According to a recent survey conducted by the Family Health Bureau of Sri Lanka revealed that suicide is the second leading preventable cause of maternal deaths (49/ 100,000 live births in 2010)[5]. Suicide has a strong association with several major mental disorders[6]. Much emphasis needs to be given to maternal mental health to improve wellbeing of the nation, as the delay in detection and intervention of maternal mental health problems increase maternal morbidity and mortality, impair mother- child bonding and has detrimental effects on the whole family functioning. Thus, health care providers and other stake holders should take necessary steps to improve awareness on the subject, promote help seeking behaviour, provide mental health services and mentoring assistance to empower women to achieve their potential while achieving a work and life balance.

Common mental health issues in women

Perinatal mental health disorders

Childbirth presents many challenges to the mother such as physical trauma due to child birth, sleep deprivation, breastfeeding, adjustments in conjugal and other relationships and social isolation. A recent systematic review showed higher rates of common perinatal mental disorders among women from low- and lower-middle-income countries, where the mean prevalence of these disorders was found to be 15.6% in pregnant women and 19.8% in women who had recently delivered. The review identified several risk factors: having a less empathetic partner or overtly antagonistic, subjected to gender-based violence, being socially disadvantaged, having no reproductive autonomy, having an unplanned pregnancy, having pregnancy-related illness or disability, receiving neither emotional nor practical support from one's mother[7].

Perinatal mental disorders such as depression affect the brain development of the fetus and cognitive and emotional development of child. Hence psychiatric disorders in puerperium cast a long shadow in children's life. Mechanism underlying this association in animal models has shown that the stress experienced by the mother has a direct influence on the development of the hypothalamic—pituitary—adrenal (HPA) axis in the foetus[8].

Postpartum depression

Postpartum anxiety and depression is the number one cause of maternal morbidity, associated with adverse cognitive and social development of the child[8]. Less severe depressive disorders are much more common than puerperal psychosis with a prevalence of approximately 10% in early weeks of post-partum. Incidence of post-partum depression is between 11 and 42% in the world. In Sri Lanka in Galle district with a total of 18,865 live births in 2011, the expected number of postpartum depression ranged from 2075 to 7923. However referrals to the specialist maternal mental health service were only 41 (0.002%). This shows that many perinatal psychiatric illnesses remain under-reported. Tiredness, irritability and anxiety are often more prominent than depressive mood changes. The main risk factors are previous history of depression and social adversity. Many postpartum depression states go and undetected and thus remain untreated. Therefore those providing care for the baby and the mother need to be conscious about the possibility of post-partum depression. Social and psychological measures are usually as important as antidepressant medication. Most women with post-partum depression can be treated effectively in primary care with support, supervision and medication. Those with severe postpartum depression or complex problem need referral to the psychiatric services.

Postpartum psychosis

Sri Lankans having high tolerance to symptomatology of post-partum psychosis are more likely to under-recognize psychotic symptoms and even when recognized, under-utilize psychiatric services. Only the patients with severe symptoms are likely to be referred to the psychiatric services. This condition affects one admission per 500 births.

The risk factors are previous major psychiatric illness[9,10] and family history of mental illness. Risk is 20-30% with an established diagnosis of bipolar disorder, rising to 57% with a family history. It is more frequent in primi-para and unmarried mothers. The onset of puerperal psychosis is usually within the first 1-2 weeks after delivery and bipolar affective disorder is the most common clinical presentation.

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Women's mental...

Potential risk to the mother and baby warrants a prompt assessment and it is essential to ascertain mother's ideas concerning harm to the baby (patients may entertain delusional ideas that child is malformed or evil, leading to attempts to kill the child to spare future suffering). Treatment is given according to the clinical syndrome and admission to a hospital is usually required.

Postpartum blues

Post-partum blues affect approximately half to two third of women. It has transient relatively mild mood symptoms in the initial days of partum, which has spontaneous recovery within two weeks. These women experience brief episodes of irritability, lability of mood and crying with symptoms reaching a peak on the third or fourth day post-partum. Maternity blues are more common among primigravida and is not related to complications at delivery. No treatment is required as the condition resolves spontaneously within a few days. Support by family and care givers help mothers to adjust to new life.

Depressive disorder

Twelve month prevalence of major depression in the community is around 2-5% while life time rate is 10-20%. Male to female ratio is 1:2. Clinical presentation of depressive disorder is varied and subdivided in a number of different ways. The central features are low mood, lack of enjoyment, reduced energy and negative thinking which lead to decreased social and occupational functioning. Negative thoughts consist of worthlessness, pessimism and guilt. Thoughts of hopelessness may progress to suicide. Depressive disorder is associated with significant morbidity and loss of productivity. According Global burden of disease study the massive but largely unrecognized burden of mental illness is obvious, with neuropsychiatric disorders filling five of the top ten causes of disability. Unipolar depression at 10.5% is the leading cause of disability worldwide, as measured by years lived with a disability (YLD) [11]. Antidepressants are effective in major depression of at least moderate severity, with short term response rates of 50% for patients on active treatment compared to 30% for those on placebo[12]. Maintenance treatment of depression with antidepressants reduces relapse rates by 41% on placebo to 18% on active treatment[13]. All depressed patients require psychotherapy which provides education, reassurance and encouragement. Cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT) are as effective as antidepressant treatment for moderate depression and both recommended by National Institute of Clinical Health and Excellence 2011.

Post-traumatic stress disorder (PTSD)

The necessary cause of PTSD is an exceptionally stressful event. Lifetime prevalence of PTSD is 7.8%, nearly twice the number of women compared to men experience it. This enhanced risk is not explained by the differences in the type of traumatic event. The principal symptoms include hyperarousal, intrusions (flashbacks and recurrent intrusive thoughts and frightening dreams) and avoidance.

Maladaptive coping responses including persistent aggressive behaviour, excessive use of alcohol or drug abuse and deliberate self-harm may occur. The general approach to short term cases is to provide emotional support, encourage recall of traumatic events to integrate them into the person's experience and facilitate working through the associated emotions. The treatment of PTSD can be difficult once the disorder has been established for more than one year. Trauma focused cognitive behaviour therapy and eye movement desensitation and reprocessing (EMDR)[14] have the strongest evidence base for effectiveness. Even though a number of antidepressants have demonstrated efficacy in clinical trials, drug treatment has a lower effect size than structured psychotherapy[14].

Domestic violence

Domestic violence has a strong association with mental disorders and wellbeing of the victims which results in contact with mental health services. All over the world one in four women will experience domestic violence in her lifetime. Sri Lanka has recorded rates range from 11- 34%[15].The victims of domestic violence experience high rates of depression, anxiety disorders and PTSD, sleep disorders, and poor general health. Children exposed to domestic violence experience high rates of abuse and neglect (30%-60%) and are more likely to have health problems and be at risk of injury and even death. Domestic violence is a pattern of abusive behaviour in a relationship that is used by one partner to gain or maintain power or control over intimate partner. While multiple economic, legal, cultural and political factors contribute to domestic violence no victim is to be blamed for it. The prevention of domestic violence act, no 34 of 2005 provides various measures from civil remedies, issuing of protection orders to punishments set out in the Penal Code for the aggrieved party. The interventions include multidisciplinary approach involving all stakeholders to provide basic needs such as food, accommodation, ensure safety of the victim and children and health care in the initial stage. Assessment by medico-legal and mental health professionals for legal proceedings and psychiatric interventions constitute a major part of the management. The specific psychiatric interventions will depend on the presence of mental health issues but all the victims would benefit from crisis intervention, psychological support and counselling provided by health care professionals and non-governmental organizations such as 'women in need' (WIN).

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Women's mental...

Some government hospitals have established services for victim women ('Mithuru Piyasa') and it is essential that all health professionals should be competent in detection and referring the victims of domestic violence to those services and mental health services. A coordinated national approach and awareness campaign is essential in eradicating this condition from the country.

Women empowerment

Sri Lanka became an early party to the Convention on the Elimination of Discrimination against Women (in 1981) and its protocol (in 2002). The United Nation's emphasis on economic empowerment and poverty eradication, with a key focus on education, especially through the full use of technology and innovation will bring enormous benefits to women and girls around the world, but it will be the responsibility of states themselves to implement their international commitments domestically. Sri Lanka's political leadership and policy framers recognized early, the mutually reinforcing links between gender equality, rapid economic growth and poverty eradication and sustainable development. As a result girls who compete on equal terms with the boys to gain access to institutions of higher learning in the country, comprise the majority who graduate from the medical, teaching and nursing schools and constitute a significant portion of the public service. While many accomplishments for women of Sri Lanka need to be celebrated, it should not distract from addressing the many remaining challenges.

Sri Lanka's women having been politically empowered since 1931, it was not surprising that Sri Lanka produced the first democratically elected woman Prime Minister in the world in 1960. However, women's political representation at the national level remains at a low of 5% and at the local and provincial levels it is lower. According to anecdotal evidence, women have shown little enthusiasm to enter into politics. This has resulted in lack representation of women and giving voice to issues and challenges faced by women in their personal lives and in the society including at the workplaces and failure to address them through drafting necessary laws. This is an area that is being studied by the Government with the assistance of the United Nations Development Programme (UNDP) and civil society. There also exists evidence that women are paid less for the same amount of work and less opportunities in certain employment categories. The stake holders should continue to expand the legal framework to create gender sensitive legislation, set up mechanisms and seek institutional support to bridge the implementation gaps to deal with the areas where gender equality remains inadequately addressed.

Mental health services

The past decade had seen vast expansion in the number of trained mental health professional, establishment of acute psychiatric inpatient units, deinstitutionalization and decentralization of mental health services encompassing the whole country.

Establishment of a directorate in mental health, mental health policy and training different categories of staff in delivery of mental health services (psychiatrists, diploma holders in psychiatry, medical officer of mental health, community psychiatric nurses, psychiatric social workers, counselors and occupational therapists) have all been instrumental in achieving better mental health delivery to masses, yet lack of coordination has hampered equitable distribution of limited resources. Inclusion of psychiatry as a subject in the final year medical curriculum paved way for better mental health literacy among health professionals leading to better mental health care across the life cycle. However gap in mental health literacy is seen among public and different stake holders who care for vulnerable women.

Conclusion

In conclusion, women's mental health should be a top priority of health care providers, policy makers and opinion leaders in Sri Lanka. A coordinated framework is required to improve standards of care delivered and all opportunities should be utilized to improve awareness on the topic. Sri Lanka College of Psychiatrists has launched a national programme in this regard and invites all stake holders to join in this endeavor in improving mental health of the fare gender of the country.

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SOLVE FOR FUN AND KNOWLEDGE!

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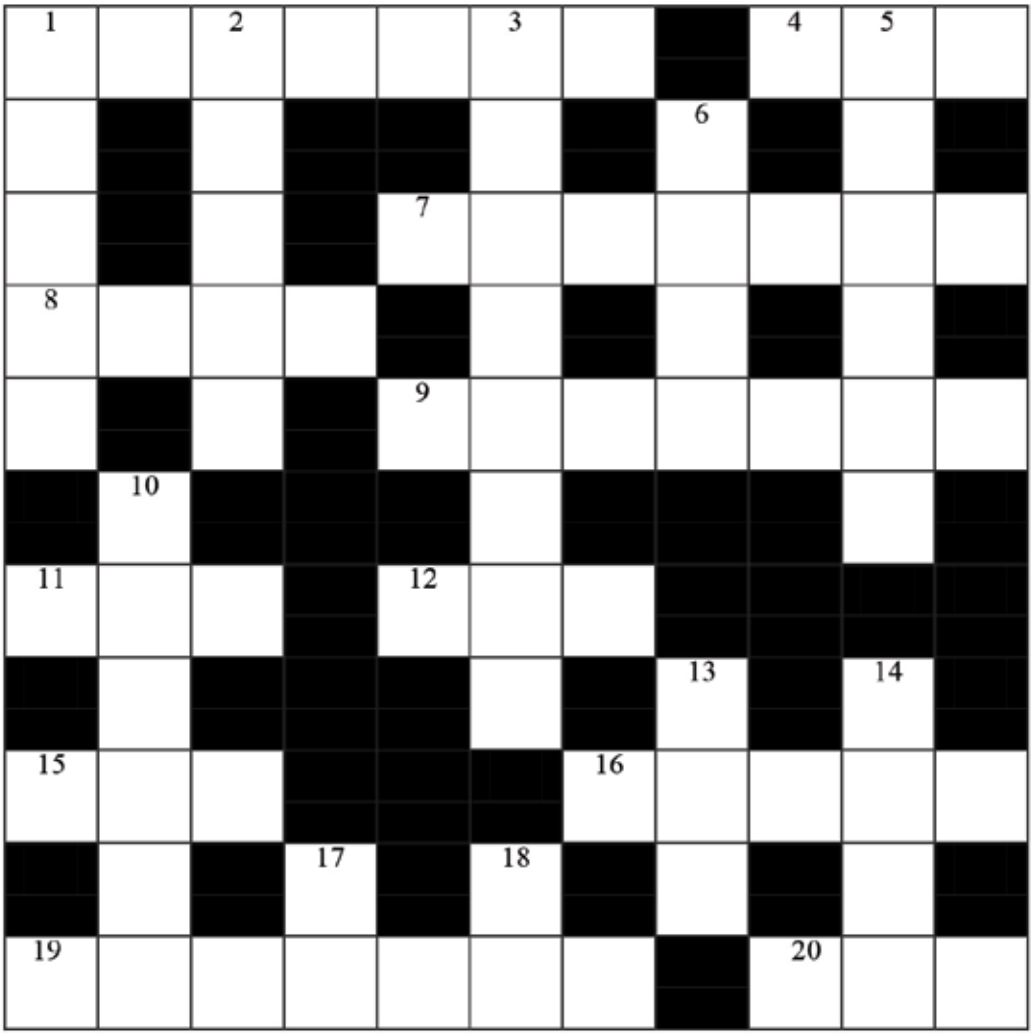

Across

1. Best avoided for fever without a focus
4. Increased blood levels are found in allergies
7. Infant presents with vomiting when the thickness increases
8. An androgen effect
9. Deferisirox and desferrioxamine …… excess iron
11. Often prescribed in cow milk allergy
12. Useful investigation in children with hypotonia (abbrv.)
15. Shorten form for influenza
16. First line treatment in rheumatoid arthritis (abbrv.)
19. Louis Pasteur developed the first effective vaccine for ……..
20. Haematocrit (abbrv.)

Down

1. A study that was conducted to find prevalence of atopic disorders (abbrv.)
2. Most metabolites are excreted in …….
3. A clinical feature of cellulitis
5. French word for 'drop'
6. Exposure to burning of this substance is bad for lungs
10. Allergen responsible for hay fever
13. Screening test for prostate cancer (abbrv.)
14. A micronutrient
17. Shorten form for cancer (abbrv.)
18. Finding in a blood gas report

CRITICAL CARE MEDICINE IN SRI LANKA NEEDS LICENSED COMPETENT FULL-TIME PILOTS

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Sri Lankan Society of Critical Care and Emergency Medicine (SSCCEM) is proudly presenting the biggest ever international critical care conference to be held in Sri Lanka on 31st of July 2016 at 'Waters Edge', Colombo. 'CritiCon' Colombo 2016 is jointly organized with the Association of SAARC Critical Care Societies (ASAARCCS) and the Sri Lankan Society of Critical Care Nurses (SSCCN). It will also feature two international certificate workshops. These are Asia Ventilation Forum workshop, a two-day event and Emergency Neurological Life Support (ENLS) course.

This is also an opportunity for us to reflect on our past and gather momentum for the future. We have more work to do to ensure our critical care service offers the best to our patients. Promoting education and maintaining competencies is the key.

Despite establishment of an intermediate level diploma qualification for doctors in 2009 and recognition of critical care medicine as a separate specialty by the Government of Sri Lanka in 2011, we are yet see fully dedicated intensivists in this country. Even today, critical care practice is considered a secondary subject area that can be managed effectively by visiting professionals with shared responsibilities, for example, anesthetists, physicians or surgeons. The Ministry of Health is still supportive of this long gone 'open concept' of intensive care uinit (ICU) management. Moving to closed concept ICUs' led by intensivists improves outcomes for patients and it is now the accepted norm in the world.

Similar to airline industry, the main concern of Ministry of Health (MOH) should be its customers, i.e. safety and welfare of patients. As the biggest employer of doctors in this country, the Ministry of Health(MOH) should strategically move towards provision of more skillful and trained hands to improve care and in doing so to have better health statitstics for the country. Promotion of critical care medicine can be one of the important steps in this development towards a better 21st Century.

Critical Care Medicine (CCM) is a separate specialty in developed countries and also in most developing countries. The General Medical Council adopted a stand in 2010 to offer a separate CCT (Certificate of Completion of Training) for critical care doctors, no matter what profession they originated from. However, they all had to complete a set of competencies to obtain CCT in CCM.At the same time the relevant UK Colleges took an initiative to ensure that employment trusts took action to prevent shared ownership of critical care units and consolidate the inputs of consultants and resident specialists to promote best outcomes for the patient. These doctors have chosen, CCM as their primary specialty and not a secondary one unlike in Sri Lanka today. These intensivists have formed Colleges (Australia and New Zealand), Societies (European Society for Intensive Care Medicine) or faculties with multidisciplinary inputs (UK) that are fully dedicated for CCM training.

In airline industry there are two kinds of pilots. There could be 'titular'pilots who may have obtained an initial qualification but do not have the necessary number of flying hours or evidence of regular competency checks to allow them become 'licensed' as commercial airline pilots or instructors. This is to ensure that pilots are safe and competent all the time. The main focus is passenger safety. Critical Care Medicine is similar. We need officers who not only have the necessary training but also the necessary commitment to CCM. They should have completed a minimum number of hours of training on the ground (e.g. a number of on-site resident hours and on call hours) and shown a record of fulfilling all skills needed to manage critically ill patients within a complementary multi-disciplinary environment.

Critical care medicine has two fundamental components in the provision of care: vital organ support and root cause identification and treatment. Although, traditionally, anesthetists have been trained to provide vital organ support, respiratory and hemodynamic in particular, the world has moved towards a model of having dedicated trained intensive care specialists to improve outcomes. This is because prioritized multi-organ support is now an essential pre-requisite for modern intensive care that requires multiple teams of expertise concurrently managing extra-corporeal systems such as ECMO, CRRT and establishing advanced monitoring such as ICP and cerebral perfusion whilst also managing newer therapeutic environments such as hypothermia.

At present the MOHis promoting shared critical care management. Almost all consultants looking after intensive care units have shared responsibility as an anesthetist, surgeon or physician. Thus, the care in ICUs has become secondary. The situation is made worse by 60% of juniors doctors working in intensive care units also having shared responsibilities as an anesthetist or physician.This also flaws the juniors training as they do not provide service cover 24/7 in their primary subject area of focus; a mandatory training requirement in all other clinical specialist education programs across the world.

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Critical Care...

The MOH should do away with this ad hoc, poorly patient centered unfriendly arrangement and advertise CCM consultant and medical officer posts with a full time commitment for intensive care. They should be resident at CCM units when on call. This is the only way we can improve patient safety and also promote CCM medicine as a specialty that will also support development of all other clinical specialties.It is also mandatory that training of intensivists conform to international standards and the arena should be a multidisciplinary, complementary participation.

Critical care involves critically ill patients. In other words, these patients have minimal or no reserve capacity and hence the need for critical care. Critical care has to be reliable and continuous i.e.a service with minimal unwanted variability in care devoid of errors and chaos. It cannot be intermittent and ad hoc. Think of the strides that can be made in saving lives in sepsis (dengue, leptospirosis), stroke management, myocardial infarction, trauma and transplant surgery and many more with a good intensive care back up.

In order to achieve this goal, qualified Intensivists are needed to take a lead role, whilst intermediate level training and certification is needed for both medical officers and nurses involved in critical care services. The lukewarm attitude of the Postgraduate Institute of Medicine (PGIM), Colombo in proving a dedicated training path to MD level in Critical Care is also a major setback against realization of this ultimate noble goal. It has also contributed to an exodus of diploma holders in critical care medicine. If the establishment of this training path is unlikely to take hold in the near future, the Sri Lanka Medical Council should consider licensing specialists trained abroad with required competencies as intensivists in this country. This is because, patient centered care and promoting medical education in keeping with the rest of world is the mission of priority for both the PGIM and MOH.

RESURFACING STIs IN THE ERA OF HIV

Dr.Hasini Banneheke
Secretary-Expert Committee on
Communicable Diseases of the SLMA

A symposium titled 'Resurfacing STIs in the era of HIV' organized by the Expert Committee on Communicable Diseases of the SLMA was held on 12th May from 11.30 am to 1.00 pm at Lionel Memorial Auditorium, SLMA, to update knowledge of doctors and other health care works about sexually transmitted infections and HIV. Dr. Ranjith Perera, the chairman of the Expert Committee welcomed the audience. Expert Committee member Dr. Jananie Kottahachchi, Consultant Microbiologist/ Senior Lecturer moderated the session. Dr. K.A.M.Ariyarathne, Consultant Venereologist spoke about the Sri Lankan situation of STIs while Dr. Jayadari Ranthunga, Consultant Venereologist from Teachinng Hospital, Ragama discussed the best methods of management and control of STIs along with HIV. Dr. Jayanthi Alwitigala, Consultant Microbiologist at National STD/AIDS Control Programme explained the type of techniques available for the diagnosis of STIs in Sri Lanka at present. President of the SLMA Dr. Iyanthi Abeyewickrema moderated the interactive discussion session which followed the proceedings. Certificates were awarded to resource persons by one of the senior members of the Expert Committee Dr. Lucian Jayasuriya.

CAN DENGUE KILL? NO, IT CAN'T!

The monthly clinical meeting of the SLMA- May 2016

By Dr.Kushlani Jayatilleke
Assistant Secretary-SLMA

The monthly clinical meeting of the SLMA for May 2016 was held on 17th of May from 12 noon to 1.30pm at the SLMA auditorium in collaboration with the Ceylon College of Physicians. The topic was "Can Dengue kill? No, it can't! ".

The case presentation was done by Dr. Amali Udayangika, Medical officer in medicine, Base Hospital, Wellawaya. The discussion and the review lecture as well as the MCQs and the picture quiz were done by Dr. Ganaka Senaratne, Consultant Physician, Base Hospital Wellawaya. The meeting was chaired by Dr. Iyanthi Abeyewickreme, President, SLMA.

Solve for fun and knowledge! (Answers)

1I	B	2U	P	R	3E	N		4I	5G	E
S		R			R		6C		O	
A		I		7P	Y	L	O	R	U	S
8A	C	N	E		T		A		T	
C		E		9C	H	E	L	A	T	E
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	E		17P		18C		A		N	
19A	N	T	H	R	A	X		20H	C	T

Excellent health statistics - smokers are less likely to die of age related illnesses.'

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GENERATION GAP

Generation gap is a gap of communication that leads to misunderstanding and disharmony. It refers to the gap between young and old. It is about mindsets and methods and it is not one-sided. Youth is full of passion and drive and is risk-friendly. The old have wisdom and experience and they are risk-averse. So, work together.

Just passion and risk-taking are not enough; neither are experience and wisdom because we live in a dynamic world. Strategies have to change and for this we need understanding and flexibility. The older and younger generations need to communicate, synergise and draw the best from each other. A healthy conversation and dialogue is essential to bridge the gap.

Sometimes adults behave like children and even need to be taken care of. Sometimes they want to pamper their children; at other times they expect children to behave like adults. Isn't this confusing?

Use the power of love and then you will know how to deal with old people. Yes, as they get old they behave like children. Give them love and understanding. Learn to enjoy dealing with them. They are also going through transition. Be committed and compassionate then you will get the right mode to help them. "He gives not the best, who gives the most but he gives the most who gives the best". Learn to give your best. Be the giver and then that giving itself enhances the quality of life. What is wrong if you pamper your parents? After all it is their second childhood. Don't you pamper your children? Don't use too much of logic but just shower love.

(The Speaking Tree)

May all beings be Well and Happy !

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