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SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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MALARIA COUNT 2017

06

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SLMA Theme 2017

Patient Engagement - Professional Enhancement

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PRESIDENT'S MESSAGE

Dear Members,

I thank you for the singular honour of electing me as the 120th president of the SLMA in its 130th year. I accept this position with humility, being acutely aware of my responsibilities in upholding the principles upon which this great institution was founded in 1887. In keeping with its motto *Lankadipassa Kkcesu Ma Pamajii* meaning "to act without delay for the betterment of our nation", I pledge to preserve the SLMA's long traditions, and further uplift its commitment to advocacy, service, training and research in health, and protect the good standing of our profession to benefit the whole of Sri Lanka.

A very sincere 'thank you' to outgoing President Dr Iyanthimala Abeywickrema and her Council, for your able leadership as the 10th lady president, and commitment to enhance our work environment. I also thank the chairs and convenors of expert committees and the innumerable members of SLMA for giving their best to champion for time appropriate health related issues. I salute their passion and dedication in venturing voluntarily into paths previously not tread and accepting responsibility and tasks with sometimes uncertain outcomes. Their vision to address gaps in policy, champion for novel approaches and lead health advocacy with one single purpose, for the betterment of our society rather than self is recalled with gratitude and admiration.

They have inspired in me the need to carry the mission forward and steer the SLMA with a holistic approach, develop a connected view of education and service and encourage every Sri Lankan doctor to be a proud member of the SLMA. The induction ceremony held on 21st January 2017 at the BMICH, was in reality a sincere recognition of all those who have aimed towards these goals in the past 130 years, on behalf of the SLMA. A special feature about the ceremony was the award of Honorary Membership to Past President Dr Dennis J Aloysius. This was a most fitting tribute to a very senior member, who over five decades, has given his utmost to help bring the SLMA to what it is today. We also felicitated another very special person, for her untiring dedication to the SLMA, and that is none other than Chrissy c/o Hon Member Dennis Aloysius. Her support to enliven the 'family of doctors' over 33 years through her stewardship of the Doctors' Wives' Association is greatly appreciated.

The reputation of the SLMA for its leadership in ensuring the good health of our nation and working towards providing quality health care that adheres to all ethical norms of practice is our singular pride. I shall endeavour to take our organization further forward as the leading apex body of medical professionals in our country with connectivity within the international arena. I thank the executive committee and members of the incoming Council for their enthusiasm, encouragement and dedication to work towards achieving SLMA's goals. I invite all members, for your continued commitment to SLMA's activities, and provide us regular feedback and constructive criticism.

I pledge to do my best and seek your support and encouragement at all times. I extend to each and every member of the SLMA, my very best wishes for good health and happiness throughout the year.

Yours sincerely,
Chandrika N Wijeyaratne
President SLMA

SLMA INDUCTION OF THE PRESIDENT 2017

Professor Chandrika N Wijeyaratne was inducted as the Honorary President of the Sri Lanka Medical Association by the Immediate Past President, Dr Iyanthi Abeyewickreme, at a ceremony held on 21st January 2017 at the Lotus Lounge of the BMICH, Colombo. Dr Dennis J Aloysius received the honorary life membership award 2016. The Presidential address delivered by Professor Chandrika N Wijeyaratne highlighting the SLMA theme for 2017 "Patient Engagement - Professional Enhancement" is given below.

Sri Lanka has witnessed amazing improvements in health indices over the past five decades, at a very low expenditure. Our health transitions mirror those of more developed countries. Life expectancy at birth, in 2015, has increased to 72 years for men and 78 years for women, with an average of 75 years; that is well ahead of our neighbouring countries. A recent analysis shows that we spent US$ 369 per person per year to achieve this, while more developed countries spent manifold more to achieve an equivalent outcome. However, we need to review our health status from yet another angle.

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INDUCTION OF THE PRESIDENT...

We are now 67th in the world ranking for life expectancy when compared with countries like the Maldives, Cuba and Vietnam, who are ahead of us. Of even greater concern is the downward trend of our ranking - that isn't good news. There are a multitude of questions that flash through our minds regarding this trend and require our due attention.

Death is inevitable for us all. Our concern is about reducing premature deaths and enabling our people to live longer, under better living conditions and help them enjoy life to the fullest and experience a 'good death'. Our all-cause mortality has declined over the past fifty years, where death among young females fell by 85% due to highly successful programmes in maternal health and immunization. Among males however, the decline was less (47%), with stagnation since 1970, chiefly due to external factors such as trauma, accidents and natural disasters in addition to chronic disease.

Just a few weeks ago two members of our own profession were lost in the prime of their lives due to road traffic accidents. Young, highly productive lives continue to be snatched away by injuries, and contribute to approximately 15% of deaths annually – chiefly premature deaths. But, this statistic does not portray the larger proportion with trauma induced permanent disability, loss of productivity and economic cost to the individual, the family, society and country. In the immediate aftermath, from a medical perspective, we all mourned about missed opportunities during the golden hour of survival and the lack of state of the art trauma care facilities. More importantly we must emphasise the importance of upholding road rules to prevent such tragedies in the first place. The SLMA must revive the task force to prevent RTA initiated by Professor Sheriffdeen and advocate deterrent punishment, heavy fines and uphold road safety at all times.

Let us explore as to what diseases are taking away lives. Three fourths of our people die from non-communicable diseases (NCDs), viz. chronic conditions that cause heart attacks, strokes, asthma, cancer, kidney failure. The risk of a premature death (age <65 years) from chronic NCDs remains at a substantial figure of 18%. Cardiovascular disease (CVD) remains the leading cause among young adults while asthma deaths afflict predominantly the poor. This loss of life due to NCDs is 20–50% higher in Sri Lanka than in developed countries. It is noteworthy that diabetes, a chief contributor to CVD, occurs at a younger age in our people than the majority of countries. Yet we outlive our neighbours such as India and Pakistan. I ask you to ponder on what this all adds up to? It suggests our population is rapidly ageing and at high risk for NCDs from their early life - a virtual time bomb and ready recipe for unhealthy ageing!

What can we do to get the best out of the existing medical armamentarium? I ask you whether we need more medications. Bigger and even bigger hospitals? More complex surgical operations? Greater spending?

This story might give us better insight.

Mrs SL, a 52 years old science teacher from the suburbs of Colombo, a mother of two, is admitted to hospital with a 3 day history of high fever. Her blood glucose exceeds 550 mg/dL. She has a severe urinary tract infection. She collapses due to sepsis and requires resuscitation. This is her third hospital admission within one year and the first to the ICU.

She was found to have diabetes during her 2nd pregnancy 22 years ago. Since then she consulted different doctors at primary and tertiary care levels. Her mother, also a diabetic, has been chair bound from the age of 64 due to a stroke and heart failure. Her daughter of 22 has features of the metabolic syndrome and PCOS – a virtual time bomb!

During her prolonged recovery phase, Mrs SL recounts how she has tried very hard to adhere to doctors' orders. "I did take over 100 units of daily insulin. I tried my best to swallow the 14 different tablets each day. I saw my local doctor at least 3 times every year – of course only when I felt unwell. Latterly I meet my specialist doctors when I get admitted to hospital." Mrs SL has worked out that provided she takes her medications she can lead a near normal life. "I have learned about diabetes from science books, newspapers, TV discussions and the internet. It is the worst disease one can get. I hate to be reminded of it on a daily basis. But now I am really scared."

She knows that much of the responsibility lies with her alone, where self-management of diabetes is vital. However, she runs out of time due to being a career woman with multiple demands and gives low priority to her own health. "On most days I am afraid of being late to work. I wake up at 4 am and cook for the family and prepare my day's lessons. I then rush to work by van. I take a bun and banana for breakfast. I inject my morning insulin whenever I can eat between classes. I developed hypos on two occasions at work. So I take some sweets with me at all times. I don't take my glucometer to work. Lunch is my home cooked packed meal. I eat a lot of rice. The timing of the meal is variable, often late afternoon around 2.30."

"Although my husband reminds me to join him on his daily evening walk, I refuse due to the tuition classes I conduct at home. I simply love my job." "I have no home help.

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INDUCTION OF THE PRESIDENT...

We buy cooked food for dinner – string hoppers or hoppers. Quite often I eat dinner around 10 pm. I may or may not take my evening insulin." "I don't feel ill even if the blood sugar is 300", she smiles. Her feet are constantly numb with burning pain and are deformed. She has had repeated attacks of bad cellulitis. Her doctor has prescribed her a special shoe to be worn at all times. Mrs SL admits she did not like to wear this shoe for quite a few years. Following frequent admissions for leg infection she now adheres to wearing the special shoe at all times.

She asks me from her ICU bed, 'Can't I go home now - the children are doing their OLs' and when I tactfully declined she reflects "Paw Lamainta".

In our care of the sick we encounter numerous stories in the same vein. Over the years, our profession has often unwittingly, acted on such stories that have indirectly helped improve our service, research and training. However, do we ever reflect on these stories adequately?

This responsible science teacher is battling with her chronic disease. She is aware of her need to achieve "good" metabolic control day in and day out. But how successful has she been?

Should we discard her as a "non-compliant patient"? Or should we collectively try to help her? Please bear in mind that Mrs SL is intelligent, literate, has a supportive family and is financially stable. How about the thousands of less capable patients who are ill supported at home, at work or in our clinic setting? No further prescriptions, tablets or even money can improve the health outcomes of chronic NCDs without patient empowerment and participation. We need to appreciate the social and psychological dimensions that are interwoven with chronic disease. Loss of independence, becoming a burden on one's family and affordability are their biggest worries. This is augmented among those who approach retirement and when complications surface. The concept of empathy must not be underestimated.

Trusted, meaningful relationships are built and maintained through therapeutic, face-to-face conversations between people. People want their physicians to listen to what they have to say.

They want to be understood by physicians as thinking, feeling human beings … and not just a disease. Patients are often reluctant to verbalize their health needs and concerns directly to physicians. Simply addressing an "interesting case" of symptoms and signs written down in a medical record, is always inappropriate. Patient adherence in chronic disease is centred on the patient, the physician and society. We need to recognize that, going back to Hippocrates, human connections between those "doing the caring" and those "being cared for" are what health care is about. The doctor-patient relationship should in itself be therapeutic. An emphasis on treating patients as humans with individual stories, is always appropriate. Would a biannual few minute outpatient consultation with a specialist doctor in a bustling environment be sufficient for Mrs SL?

Our Annual Health Bulletin of 2014 reports that 55 million patients visited government outpatient departments (OPD) that year. Of this 24 million were to specialist clinics. In-patients was 6 million (just 9.8% of the entire case load). But the health expenditure for OPD facilities was only 20% of the budget! This raises some rational questions:

Is this large patient throughput well documented?

What is their quality of care and clinical outcomes?

Do we evaluate and improve the service?

How well matched is the service to the available human resource?

It is also interesting that State versus. Private outpatient care is 52: 48. This translates to 105 million outpatient visits - an average of 5 visits per person per year!

In 2015, the Director General Health Services recommended to the UGC the importance of strengthening primary care services through training in first contact care, promoting a personalized and family centred care approach and enhancing continuity of care. Would this help change Mrs SL's care for the better? Hence, medical education comes to the forefront; it requires regular review and revision and must be appropriate to our current needs. It is an accepted fact in our medical community that learning is not an interlude of a few years but rather a lifetime venture. Continuing Medical Education (CME) enhances our patient care, supports our professional goals and improves our knowledge of the latest developments. Sadly we still lack a formal process of CPD quantification that requires our due attention. I propose bringing all stakeholders into a healthy discussion and revive this essential support for our members and the profession. Medical education must also extend to appreciating the knowledge and skills of other health care providers (HCPs) in nursing, midwifery and the allied health professions. The need for team building and team work through respectful communication is so often overlooked.

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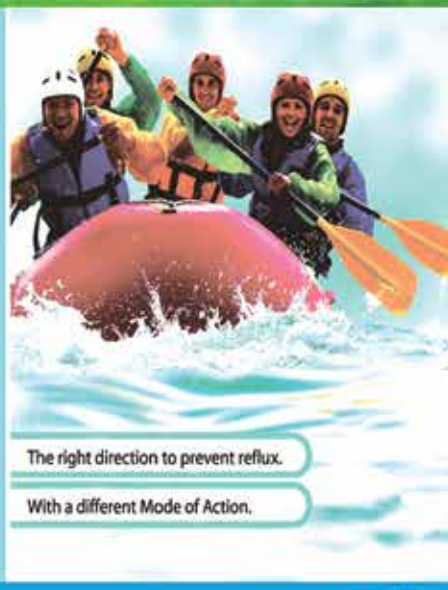

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YOUR HEART WILL GO ON

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INDUCTION OF THE PRESIDENT...

Being the institutional lead that encourages such a cohesive inclusivity of the differing sections of the medical profession, the SLMA must not miss this opportunity to support all groups in developing efficient and effective teams with a common goal. The need is most where primary care and family medicine services to focus on a chronic care model. If Mrs SL received such care over the past 20 years, would not her quality of life have been better today? I propose SLMA gives wholesome support to improve the quality of OPD care in all government hospitals. The 'Family Medicine Training Centres' (FMTC) at divisional hospitals must play a lead role. I had the good fortune of visiting four FMTCs on behalf of the PGIM in November 2016. These facilities are well located, led by capable board certified consultants in Family Medicine and well supported by the Nirogi Lanka project trained nurses. They must be used as reference centres for service and training. We must ensure the Family Medicine facility at a Local Hospital is not considered as just another OPD service.

A champion for redesigning health care in the USA, Prof Kevin Volpp, proposes giving patients more of what they actually want: better health. What does he mean? Let me explain, Mr SL is 40 years, earns Rs 40,000 a month by selling pharmaceuticals. He does not have a disease, but is quite stressed at work and sleeps poorly, particularly after the drug price reductions were enforced recently. Nevertheless, he is enjoying two packs of cigarettes a day, half a bottle of arrack twice a week, eats really well and has a BMI of 32 kg/m2, and a waistline of 38 inches. He gets himself a health check which confirms he is normoglycemic, normotensive, has borderline lipid levels, with a normal ECG, chest X-ray and ultrasound imaging. The Doctor tells him he has no disease. Yet, Mr SL feels 'Unhealthy'.

Health is not simply the absence of disease. The WHO defined Health in 1948 as the state of complete physical, mental, emotional and spiritual wellbeing. The BMJ Editors in 2011 initiated an extensive global conversation to redefine health. They expressed that this original definition "would leave most doctors unhealthy most of the time." The WHO definition quite unintentionally enabled the medicalization of society, as more and more human characteristics were identified as risk factors for disease. Was this wrong? I draw your attention to the Sri Lankan context. Many of our citizens undergo a poorly standardized "health check" with an emphasis on laboratory testing and get into a comfort zone of being issued "a clean bill of health!" How safe is this?

The BMJ Editors further opined that, in the face of an ageing global population with an increasing burden of chronic disease, such a cold clinical approach "minimises our ability to cope autonomously with life's ever changing challenges and to function with fulfilment and a feeling of well-being with a chronic disease or disability." The new dynamic concept of health takes into account the six main dimensions of health (physical, emotional, social, spiritual, occupational, environmental) and "the ability to adapt and self-manage," in the face of many challenges. To most doctors, health means the absence of disease. But to many patients with chronic disease, like Mr and Mrs SL, this definition has a very limited meaning. We all know that such patients will never return to a state that is free of disease – both in mind and body. Research has shown time and again, there is often a notable lack of concurrence between what physicians think... and what patients actually want. Hence, partnering

with our patients is the key.

Quite often the best we can aim for is symptom control and minimize secondary complications to achieve a decent quality of life. Therefore I propose that engaging patients with chronic disease will enable us to give them more of what they want. A growing body of evidence demonstrates that patients who are more actively involved in their health care experience have better health outcomes and incur lower costs. "Patient activation" refers to a patient's knowledge, skills, ability, and willingness to manage his or her own health and care.

"Patient engagement" is a broader concept that combines patient activation with interventions designed to promote positive behavior, such as obtaining preventive care or exercising regularly. This empowerment approach is once again particularly appropriate for type 2 diabetes. Empowerment begins when doctors acknowledge that the patient is in control of his/her daily diabetes care. To maximize the chance for success, patients must be internally motivated (e.g. "Losing weight is really important to me") rather than be externally motivated (e.g. "My doctor wants me to lose weight").

There are widespread misconceptions about the empowerment approach. We doctors have regarded health behaviours as being out of our sphere of influence and medical training. More recent appreciation of the importance of behavioral and social aspects of the practice of medicine has encouraged our profession to appreciate that engaging patients is a fundamental need to overcome challenges faced particularly by the burden of chronic NCDs.

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INDUCTION OF THE PRESIDENT...

Patient empowerment is a process designed to facilitate self-directed behaviour change. Such an approach must be designed to help patients make their own choices and set meaningful, realistic goals, especially in body weight, nutrition, and physical activity in their daily life. Therefore, patient engagement is the only strategy to achieve the "triple aim" of improved health outcomes, better patient care, and lower costs.

But how focussed are we doctors on patient engagement and in addressing health behaviour? This leads us to the important aspect of a long-term doctor-patient relationship in a Chronic Care Model (CCM). The CCM identifies the essential elements of a health care system that can encourage high-quality chronic disease care. Its essential elements are the community, the health system, self-management, decision support and information systems. In combination, they foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.

We need to appreciate that shared decision making is a key to achieving positive behaviour. We must also be mindful that when following directions for changes in behavior not all patients adopt a positive behaviour. Communication skills – also play a major role. Patients' perception of inadequacies in communication arises from what doctors say, how doctors say it, and how we structure our interactions and build relationships with patients. I hope I have convinced you of the need to give priority for better patient engagement, particularly by enhancing its authentic and effective use in chronic NCD care and education. It must most certainly become an integral part of our health education and health promotion practices. Most practitioners appreciate that chronic care and education requires a paradigm shift. Such a shift must be a genuine philosophical shift towards patient empowerment.

This is particularly so in community empowerment – I am proud to say that the SLMA is already on track as we have already got a taste of what it does. I am happy and proud to refer you to the experts who initiated Nirogi Diviya (Prof Diyanath Samarasinghe, Dr Carukshi Arambepola, Dr Manoj Fernando, Dr Sarath Amunugama) now ably led by Dr Palitha Karunapema, the most sustainable component of the Nirogi Lanka project. Personally, I have come to learn a lot and observe with delight how our existing systems can finally bridge the gap between doling out health care versus ensuring, encouraging and enabling good health in our impoverished and vulnerable communities in a sustainable manner.

I propose SLMA's theme for this year as "Patient Engagement - Professional Enhancement".

Besides death – do we give due attention to the quantum of disability and suffering from these same diseases? Current estimates indicate that chronic NCDs directly contribute to 87% of the burden of chronic ill-health in Sri Lanka. Sadly their main drivers remain ill addressed.

The WHO highlighted in 2008 that dramatic differences in health are closely linked with the degree of social disadvantage found within countries. In Sri Lanka there is inequity in the poor having access to good medical care and most importantly in adopting a healthy lifestyle. These inequities arise because of the circumstances we live in. I ask you to reflect for a moment, whether we as a responsible group give due attention to the SDH and address health inequities. Dr Santhushya Fernando was kind enough to share with me the transcripts from some narratives of her excellent recent research. She purposely selected cases from the same area, for this presentation, to depict the spectrum of inequity.

CS, Male aged 64, Resident of Kolpetty (Colombo 3)- Corporate Business owner

"I have diabetes and I'm on insulin. I will not give up my scotch, ever. I play golf and play the Cello some of the days. My wife has dementia. She and I both fly to Singapore every few months for our treatment. Flying to Singapore for medical treatment is cheaper for me because the service is just so quick and time is money. And they listen and respond. I have no children or grandchildren living here. Opening presents is the only thing my wife enjoys. Loneliness may kill me before my diabetes.

(Narrated in English)

FV Male aged 40, Resident of Kolpetty (Colombo 3)-

When I was 7 years I saw my house being burnt in the 1983 riots. We have moved since. Over the years we were evicted again and again by the UDA. Now I live here on rent with my family. It feels like we are running, panting. All my family except my children are diabetic. It's better to get cancer than to be diabetic. Madam, I'm living in a hell within that heaven"

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INDUCTION OF THE PRESIDENT...

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SW, Female aged 53, Resident of Tharawatta* (Colombo 3) – Daily domestic worker

"I have been living here for more than 23 years. It remains just as it was then. I worked in Saudi for 7 years. When I came back I realized my husband has wasted all the money I sent on alcohol. He has Kidney Disease. I do not want to test for any diseases, even if you test me for free. Who will pay for the drugs if I am diagnosed as having a disease? I do some things in exchange for small amounts of money and sometimes even for food packets. There is no greater indignity than starving children under one's roof"

("මම තාරවත්තට ඇවිත් දැන් අවුරුදු විසිතුනක්. ඒ කාලෙත් මෙතන මෙහෙමමයි. මම සවුදියේ අවුරුදු හතක වැඩ කරලා එනකොට මහත්තයා එවපු සල්ලි වැඩි හරියකින් බීලා. මහත්තයාගේ වකුගඩු නරක වෙලා. නිකන් දුන්නත් මම ලෙඩ වලට ටෙස්ට් කරන්නේ නැහැ. මට ලෙඩක් කියල දැනගත්තත් එවාට බෙහෙත් ගන්න සල්ලි දෙන්නේ කවුද? මම බත් පැකට් එකකට, පොඩි ගානකට එක එක දේවල් කරලා තියනවා. තමන්ගේ වහල යට දරුවොා හාමතේ ඉන්නවට වඩා වැඩි අවනම්බුවක් තියනවද?")

These snap shot case studies illustrate how the root causes of disease go well beyond the current paradigm of our health sector's domain. They clearly depict the traces of social isolation, wealth, poverty, disease; violence, marginalization, dispossession, stigma, eviction, loss etc., that clearly play a pivotal role on the health and wellbeing of our people. We need to appreciate that poverty as well as social determinants of health contribute significantly to our behavioural risks - such as smoking, unhealthy diet, harmful intake of alcohol, physical inactivity and mental stress. We may give some attention to the intermediate risks such as hypertension, diabetes mellitus, obesity and abnormal blood lipid levels, with a 'medicalized' approach. But we tend to neglect behavioural risks, which are collectively responsible for >60% of loss of healthy life years due to CVD alone.

NCDs severely dent our economy. The World Bank estimates that were NCDs completely eliminated our GDP could increase by 4–10%. It is well known that 40% of household expenditure for treating NCDs is financed by household borrowing and sales of assets, indicating significant levels of financial vulnerability to those with NCDs. The odds of incurring catastrophic expenditure are nearly 160% higher for those with cancer.

Meanwhile we are a rapidly ageing population with a rapid decline in the youngest age group. This change in demography predicts a phenomenally high dependency ratio among our elders in the years to come. Are we adequately prepared for this? Has our aging has been accompanied by a parallel increase of personal income and social welfare? The answer is a clear NO - thus further augmenting the risk for unhealthy ageing. Ageing and the inevitable end of life issues is yet another huge burden our people face in hospitals and at home. Inappropriate communication between care giver and receiver, prolongation of suffering and the dying process with inappropriate interventions and poor pain control adversely affects the final days of the life of many. Therefore as a responsible group we also need to work towards the inevitable - a "Good death".

Let me share with you my final story. A much loved and respected teacher in Gampaha was 89 years, with moderate respiratory and cardiac disease, well controlled with a few medications. He was independent as can be for his age – and lived with his wife until 3 months ago. But frailty overtook him when he started falling repeatedly. When his swallowing mechanism and level of alertness failed he was hospitalized with the doctors offering ICU care. His former students, now medics, counselled the family to bring him back home with assured support to give him tender loving care within his own familiar territory of over 50 years. He received home based nursing care with oxygen and passed away very peacefully in his own bed - truly a good death.

Premature chronic disease and disability with unhealthy aging severely challenge our healthcare system. As the apex national medical association I pledge to you that we shall strive to work with our policy makers and implementers to make Sri Lanka a better place.

In summary, my sincere wish is to

a) Bring the need for patient engagement in the care for chronic NCDS to the forefront

b) Encourage health care providers to focus on producing health as opposed to providing health services alone!

With a special focus on the inevitable aspects of ageing, end of life issues, palliative care and endorsing a "good death".

By year end the outputs I would love to see

a) The launch of SLMA assisted patient support groups

b) An ethos of patient engagement in our health systems both curative and preventive

c) Dignity and decorum in end of life issues and a good death

d) Greater attention to prevention of neglected NCDS like COPD and the adoption of food based dietary guidelines

A vision of the relationship between doctors and patients that respect both the professional integrity of the medical doctor and the autonomy of the patient is our ultimate goal.

SLMA

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Consultant Cardiologist
General Hospital Trincomalee

VACANT POSITIONS IN SLMA COMMITTEES

Vacant positions in the following SLMA committees are hereby advertised.

- **Communicable Diseases**
- **Ergonomics**
- **Medicinal Drugs**
- **Prevention of Road Traffic Crashes**
- **Tobacco, Alcohol and Illicit Drugs**
- **Research Promotion**
- **Media**
- **Health Care Quality**
- **Working Group on Disability**
- **Health Management**
- **Ethics**
- **Non Communicable Diseases**
- **Snake Bite**
- **Women's Health**
- **Sri Lanka Clinical Trials Registry**
- **Medical Education**

No formal qualifications are required from the applicants. Preferably the applicants should be life members of the SLMA. However few positions will be available for non members who have demonstrated a keen interest and dedication towards the subjects of relevant committees. The deadline for submitting the applications is **1st March 2017.** Please send the duly filled application form to the following address.

Honorary Secretary
Sri Lanka Medical Association
Wijerama Mawatha
Colombo 07

Alternatively the information can be e-mailed to office@slma.lk

The final decision regarding selection of committee members will be taken by the SLMA Council. A sample application form is shown below.

Sample application form

Name with initials : .....

Hospital/Institution (Address) : .....

Designation : .....

E-mail and Phone Number : .....

Special Interests : .....

SLMA membership number : .....

Preferred committee (1st three preferences)

1. .....
2. .....
3. .....

.....
Signature

FIRST COUNCIL MEETING OF 2017

The first Council Meeting of the year was held on the 6th of January 2017 at the Council Room, SLMA. After a short time for fellowship, the oil lamp was lit and the Council meeting commenced with the singing of the National anthem. As the first item in the agenda, a photograph of the Immediate Past President, Dr. Iyanthi Abeyewickreme was ceremonially unveiled by the President SLMA, Professor Chandrika Wijeyaratne. In her speech the President thanked Dr. Iyanthi Abeyewickreme for the yeoman service rendered, especially in the refurbishment of the SLMA office.





REFERRAL FEE – A NEW FORM OF PATIENT EXPLOITATION

A. H. Sheriffdeen F.R.C.S (Eng.) DSc. (Hon. Colombo)
Emeritus Professor of Surgery
Consultant General and Vascular Surgeon,
Colombo, Sri Lanka.
Phone: 94-01-2691899 Email: proahs@sltnet.lk

20/37 Fairfield Garden,
Colombo 8
Sri Lanka.

22nd December 2016

Hon. Dr. Rajitha Senaratne FICCDE, MP
The Hon'ble Minister of Health
Ministry of Health
385, Rev. Baddegama Wimalawansa Thero Mawatha
Colombo 10

Dear Sir,

Referral fee – a new form of patient exploitation

I had an unfortunate experience which brings to light a perverse practice prevailing among some laboratories, Private hospitals and doctors of all categories in Sri Lanka.

The incident I refer to is a call I received from a staff member of a Private hospital to inform me that there was some cash due to me, waiting to be collected. When I enquired as to how I had "earned" this cash, I was told that I had referred some patients for a particular investigation and this was a fee paid by the hospital for this referral. It was obvious that this "fee" was collected from the patients.

I felt a surge of nausea that I was a party to collection of a "commission" from the Hospital with the patient being the victim. My reply was that I did not want this dirty money and that it should be returned to the innocent patients.

I discussed this with a member of a Private Hospital and was told that this practice was wide spread and growing. Apparently private laboratories are competing with each othe offering commissions from 20 to 30% of the charge on an investigation to doctors, and these labs looking at this way of offering inducements to "attract business". Doctors are also being "offered" or demand commissions on referral of patients for admission to Private Hospitals; Doctors and Consultants are offered a "fee" ranging from 50,000 to 100,000.00 rupees for referral for certain major surgeries.
This is being called a referral fee which in my opinion is tantamount to a bribe extracted from the patient without his/her knowledge.

I am also told that this practice was widespread in India and that the authorities have come down hard to stem the rot.

I would be grateful if some urgent action is taken to curb this perverse practice. It is time for the Ministry, SLMC and the Colleges to be made aware, and for urgent steps to be taken to arrest the trend.

Thank you.
Yours sincerely,

A. H. Sheriffdeen FRCS
Emeritus Professor of Surgery

Measures proposed by the SLMA

The SLMA Council unanimously condemned the incident and proposed the following measures:

- Writing to the Ministry of Health (with a copy to the SLMC) expressing serious concern, and requesting for review of such unethical actions as being punishable (as per the Medical Ordinance) and to institute appropriate preventive action through circulars and in concurrence with the directorate overseeing the Private Health Sector of Sri Lanka
- Formulating a plan through the Newsletter of the SLMA to address this and other issues pertaining to 'ethical norms of practice' that our profession must not deviate from
- Requesting the Ethics Committee of the SLMA to deliberate on this in greater detail
- Requesting the academia to address such issues as a mandatory component in their undergraduate and postgraduate training programmes

Your opinion matters.....!

Please do let us know your views and suggestions on ethical norms of medical practice at:

E: office@slma.lk
sharminigunawardena@hotmail.com

P: Editor-in-Chief *SLMA News*,
Sri Lanka Medical Association,
6, Wijerama Mawatha,
Colombo 07, Sri Lanka

Call for Abstracts

The Sri Lanka Medical Association invites you to submit abstracts for the 130th Anniversary International Medical Congress - 2017.

All submissions should be made electronically through the online abstract submission system (http://conference.slma.lk/). Hard copy submissions directly to the SLMA office will not be accepted. One author will be permitted to submit a MAXIMUM of three (03) abstracts ONLY.

All authors of abstracts should be members of the SLMA, if they are eligible for membership.

All research studies should have obtained ethical approval. All Clinical Trials should be registered with a Clinical Trials Registry. Authors should provide letter of approval from an accepted Ethical Review Committee (ERC) for research studies and registration number for clinical trials upon request.

All the authors should declare any conflict of interests in your presentation at the congress.

The SLMA considers plagiarism as serious professional misconduct. All abstracts are screened for plagiarism and when identified, the abstract and any other abstracts submitted by the same author are rejected.

The SLMA reserves the right to make alterations and to edit the contents of the abstract to improve presentation.

Instructions for online abstract submission

Conference Profile

Before submitting an abstract, authors must create an author profile online. Any number of abstracts can be created through the author profile but one author will be permitted to submit a MAXIMUM of three (03) abstracts ONLY. After an abstract has been created, modifications can be made until the submission. Please note that NO amendments to the submitted abstracts (including the authors list) would be entertained after closing of abstract submission.

The deadline to submit the abstracts is **31st March, 2017 23:59 Sri Lankan Time.**

Abstract Structure

- The title of the paper should be concise and the SLMA reserves the right to modify the title where necessary.
- The Author(s) name(s) should be in the format of last name followed by initial(s). Please DO NOT use prefixes such as Mr./Dr./Prof.
- The body of the abstract MUST NOT exceed 250 words.
- The abstract must be structured as follows;
  - Introduction and objectives
  - Methods
  - Results
  - Conclusions
- Please insert the relevant category in the cage given in the abstract submission form.
- Please DO NOT include the title, names of the authors, institutions, sub-headings or any tables/graphs/figures or references within body of the abstract. Only the text of the abstract should be included.
- Please upload the abstract as a word document formatted according to the following specification through the link provided in the online submission form.

Font: Times New Roman, font size: 12, single line spacing

Title: BOLD CAPITAL LETTERS

Authors: Last name followed by initials, with the Presenting Author underlined. A superscript number should be placed after each name to refer to the respective affiliations. Affiliations must be listed below the authors.

Body of the abstract: Structured with the subheadings Introduction and Objectives, Method, Results and Conclusion.

Please note:

*Abstracts not conforming to the above instructions will be rejected. Accepted abstracts will be published in the book of abstracts.

Contd. on page 16

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Contd. from page 14

CALL FOR ABSTRACTS...

*Those abstracts that are accepted but not physically presented (oral or poster) at the congress will not be included in the Ceylon Medical Journal Supplement containing the abstracts. Failure to make a presentation (oral or poster) of an abstract once confirming participation by the corresponding author will be considered an episode of academic/scientific misconduct and the authors will be liable for punitive action.

A panel of reviewers will review abstracts anonymously and the decision of the Scientific Committee will be final. Successful applicants will be notified via email by Wednesday, 31st May 2017.

The presenting author is required to register for the sessions upon acceptance of the abstract.

ABSTRACT SUBMISSION: IMPORTANT DATES

Abstract submissions deadline: 31st March 2017 23.59 Sri Lankan Time

Abstract Acceptance notification : 31st May 2017

Registration for presenting authors: 15th June 2017

SRI LANKA MEDICAL ASSOCIATION
CALL FOR ORATIONS, FREE PAPERS, POSTERS AND AWARDS

Orations:

Applications are invited for the following Orations to be held during 2017.

1. SLMA Oration
2. S C Paul Oration
3. Sir Nicholas Attygalle Oration
4. Sir Marcus Fernando Oration
5. Murugesar Sinnetamby Oration
6. Prof. N D W Lionel Memorial Oration
7. Dr S Ramachandran Oration

The SLMA Oration, S C Paul Oration, Prof. N D W Lionel Memorial Oration and the Dr S Ramachandran Oration will be held during the 130th Anniversary International Medical Congress of the Sri Lanka Medical Association which will be held from 13th - 16th July, 2017 at the Galadari Hotel, Colombo.

The SLMA Oration is the most prestigious oration of the Association. Instituted in 1979 it recognizes outstanding achievement in research. It is delivered at the Inaugural Ceremony of the Anniversary International Medical Congress of the SLMA. Hence the contents of the oration should be appropriate for a medical audience. Substantial proportion of the work should be conducted in Sri Lanka and/ or should have relevance to medicine in Sri Lanka. The oration should be based on a substantial body of original research.

Orations based on work published in peer reviewed journals will be given priority. In the case of multi-author research and publications the applicant should inform the other authors of his/her presentation and detail the contribution to design, data collection, analysis and writing of the manuscript by the applicant. A separate sheet which indicates the publications on which the oration is based should be attached to the submission.

The Murugesar Sinnetamby Oration should be preferably on a topic pertaining to Obstetrics & Gynaecology.

Format for submission

- The oration should be written in full. The IMRAD format is suggested unless the content requires otherwise.
- For all research involving human or animal subjects, state Ethics Clearance in the methods section. Randomized Control Trials should have been registered in a WHO recognized Clinical Trial Registry.

Contd. on page 17

Contd. from page 16

CALL FOR ORATIONS...

- The oration should be typed using Times New Roman size 12, line spacing double. Harvard or Vancouver system of referencing can be used.

The manuscript should be accompanied by a separate document which indicates the following;

1. The impact of the research in terms of advancing scientific knowledge, quality of clinical care and improvement of service delivery.
2. In case of multi-author research/publications, the contribution of the applicant to design, data collection, analysis and writing of publications/manuscript.
3. A declaration by the applicant that the other authors of the presented research have no objections to the submission of the oration.
4. The applicant should declare if all or part of the work included in the manuscript has already been presented as an oration.
5. Declaration of financial and other conflicts of interests.
6. A covering letter should indicate the oration/orations for which the manuscript should be considered.

Closing date for all orations will be **31st March 2017.** *Five copies of the scripts should be submitted.* Of these, two (2) copies should be with the name of the author and three (3) copies should be without the name of the author.

Each copy should be accompanied with a brief resume of the salient points in one sheet of paper (A4 size) indicating the contribution made to advances in knowledge on the subject. Further particulars may be obtained from the SLMA office.

Free Papers and posters: Closing date: **31st March 2017.**

The following prizes will be awarded for Free Papers and Posters accepted for presentation at the 130th Anniversary International Medical Congress:

1. E M Wijerama
2. S E Seneviratna
3. H K T Fernando
4. Sir Nicholas Attygalle
5. Wilson Peiris
6. Daphne Attygalle (Cancer)
7. Sir Frank Gunasekera (Community Medicine and Tuberculosis)
8. Kumaradasa Rajasuriya (Research Tropical Medicine)
9. Special prize in cardiology
10. SLMA prize for the best poster
11. S Ramachandran (Nephrology)

Please note that all submissions should be made electronically through the online abstract submission system. More details can be found on the SLMA Conference website (http://conference.slma.lk/)

CNAPT Award: Applications are invited from doctors and others for the best research publication (article, book chapter or book) in medicine or in an allied field, published in the year 2016, for the Richard and Sheila Peiris Memorial Award. All material should be in triplicate.

Closing date: 31st March 2017.

GR Handy Award: Applications are invited from Sri Lankans, for the best publications in cardiovascular diseases published in the year 2016 for the G R Handy Memorial award. All material should be in triplicate.

Closing date: 31st March 2017.

Professor Wilfred S E Perera Fund:

Applications are invited for travel grants from SLMA members of any specialty. Members of any Ethics Review Committee in Sri Lanka recognised under Strategic Initiative for Development of Capacity in Ethics Review (SIDCER) are also eligible to apply. Five copies of the Application should be submitted.

Closing date: 31st March 2017.

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

Telephone: 0112 693324
Fax: 0112 698802 **E-mail:** office@slma.lk

SLMA RESEARCH GRANTS 2017

The Research Promotion Committee of the SLMA is pleased to call for applications from SLMA members for the following research grants:

SLMA Research Grant

This grant is offered for research proposals on topics related to any branch of medicine. The maximum financial value of the grant is LKR 100,000.00. The grant is targeted for young researchers in their early career, for proposals on applied research that could be initiated (e.g. pilot study) or completed (e.g. audit) with the grant. The project should be supervised.

SLMA/ GlaxoWellcome Research Grant

This grant is offered for research proposals on topics related to any branch of medicine. The maximum financial value of the grant in 2017 is LKR 50,000.00.

FAIRMED Foundation – SLMA Research Grant

Three (3) grants funded by the Fairmed Foundation are offered in the area of Neglected Tropical Diseases. Preference will be given to projects on Leprosy and Leishmaniasis. The maximum possible financial **value for all three (3) grants in total is LKR 1,000,000.00** and the funding will be equitably distributed between the three selected proposals as per the merits and requirements of the studies. Please note that **a single proposal will not be given the full grant value.** The selection criteria for funding include the relevance of the research project to Sri Lanka and control programmes in Sri Lanka, and multi-centre collaboration within Sri Lanka.

Dr. Thistle Jayawardena SLMA Research Grant for Intensive and Critical Care

This grant is offered for a research project with relevance to the advancement of Intensive and Critical Care in Sri Lanka. The maximum financial value of the grant is LKR 100,000.00.

Institute for Health Policy – SLMA Research Grant

This grant is funded by the Institute for Health Policy and is offered for a research project in the areas of health economics, health systems and policy research. The maximum financial value of the grant is LKR 100,000.00.

N.B. All research projects should be completed within two years. Preference will be given for proposals that could be completed with the available grant. Utilization of grant funds should commence within six months. Proposals should include problem identification, detailed methodology, timeline, and itemized budget. Funding requests for conference registration and travel is discouraged. Ethical clearance should be applied for when submitting the grant application.

The deadline for applications is 31st of March 2017. The grants will be formally awarded at the SLMA Foundation Sessions in October 2017. The application forms are available from the SLMA office and the SLMA website.

Anything to Say?

If you have any comments, complaints or compliments regarding anything you read in the SLMA News, please do let us know at:

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sharminigunawardena@hotmail.com

P: **Editor-in-Chief *SLMA News*,**
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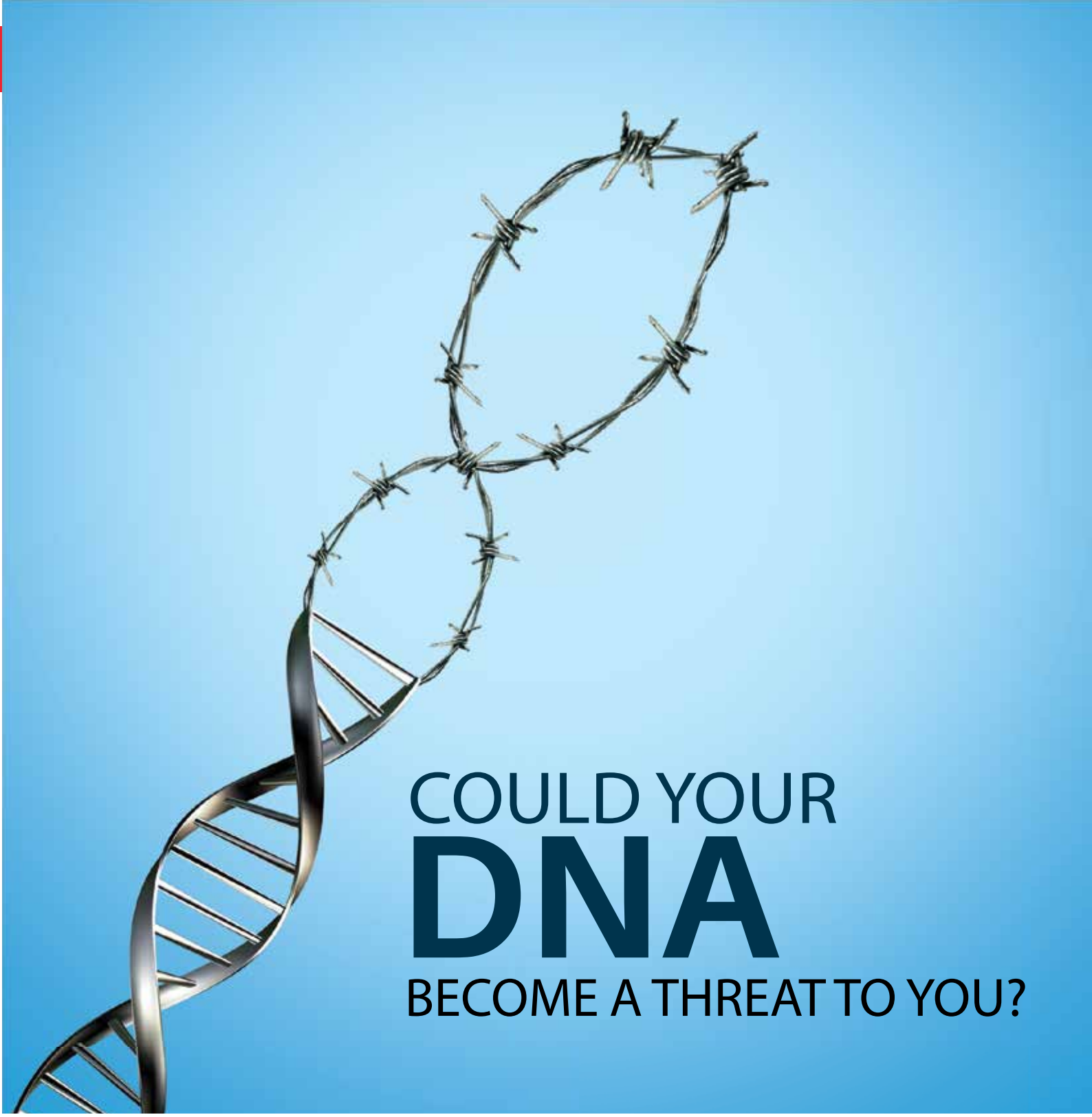

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