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Guest Editorial

Our Children: The most vulnerable in the current crisis in the country

SLMA ANNOUNCEMENT

The Expert Committee on Snakebite is
pleased to announce
that the revised guidelines for the
Management of Snakebite in Hospital
is now available
on the SLMA Website.

Access it through <slmalk/sbe/>

From the Homepage
you can click on buttons to take you to:
History (of the Expert Committee);
Guidelines: Prevention & First Aid: Hotline
and a list of the current **Committee members**.
Included are links to download two e-Books:
Management Guidelines &
a Gallery of Venomous Snakes.

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SLMA President

Prof. Samath D. Dharmaratne
MBBS (Colombo)
MSc (Community Medicine)
MD (Community Medicine)
President
Sri Lanka Medical Association

Save the children in Sri Lanka

Dear SLMA Members,

We, as a country, are in a crisis. There are shortages in the health sector especially of medicines. Countrywide, accessibility and affordability of food is affected severely from food shortages and escalating food prices. Insurmountable fuel shortages are affecting the normal day to day life of the people in the country with drastic consequences to the health sector. On top of all this, Sri Lanka is in a state of a severe shortage of dollars and rupees.

All these issues are affecting the children, the jewels of the future of Sri Lanka. There are reports of increased fainting episodes in schools and an increase in biscuit sales. Parents are feeding children with biscuits due to the unaffordability of food. Transport is affected, both public and private due to the fuel shortage. Education is in shambles. Even the available and affordable food may not be accessible. A strong foundation for an epidemic of malnutrition (both under and over) has

unfortunately been laid. We as the medical community know for sure that in a food crisis, the first affected group will be the children.

Childhood diseases that need regular treatment and follow-up can be and is affected from the fuel shortage, high price of medicine and transport problems. Add the food shortages to this and the situation becomes grave. We at the Sri Lanka Medical Association (SLMA) urge the authorities to take note of all these issues and to adequately address the situation as soon as possible to prevent a catastrophic breakdown of the health status of the children of our beloved Motherland.

Sri Lanka's state health system is not only free but is also the very backbone of the people's health. We call upon everyone to support it so that it does not collapse from the current crisis. The SLMA urges the authorities to prioritize health and to allocate the last rupee or dollar left, to the health sector. We at the SLMA, believe that the health system is the most important determinant between life and death of the people of Sri Lanka and urge all to help to ensure diligently that it does not keel over from this crisis affecting our country.

Professor Samath D. Dharmaratne
President - SLMA

Impact of current economic crisis on children in Sri Lanka

Sri Lanka is facing its worst economic crisis in the post-independence era with an alarming increase in inflation, weak finances in government and shortage of foreign currencies. It has wreaked havoc on the economy and devastated the lives of many families. The vulnerable population in our country has been hit really hard with food and fuel in short supply. This situation has led to cuts in electrical supply and long queues outside petrol stations and cooking-gas outlets.

Lack of fuel has affected transport of children with many of them struggling to go to school. Bus fares have gone up and the recent increases in such fares are considerable. This has disrupted their education again, following the earlier closure of schools when lock down of a region was undertaken as a public health measure to control the COVID-19 pandemic. Although online education has become the mainstay of education, children are unable to study without electricity and the internet.

As families are affected by inflation, parents are anxious and stressed, cutting out all non-essential activities and expenditures. While children may not understand the economics of these behaviour patterns, they do react with anxiety and fear, and the change in their family behaviour and activities. They are not able to interact with their peers in class room settings. The opportunities to gain experience in team dynamics, working with peer groups, interacting with teachers, are lost. They have to restrict sports activities and competing with other teams to gain experience. Even engaging in their hobbies and leisure activities will become difficult with financial constraints. These things build up more pressure mentally on children and their behaviour is likely to change.

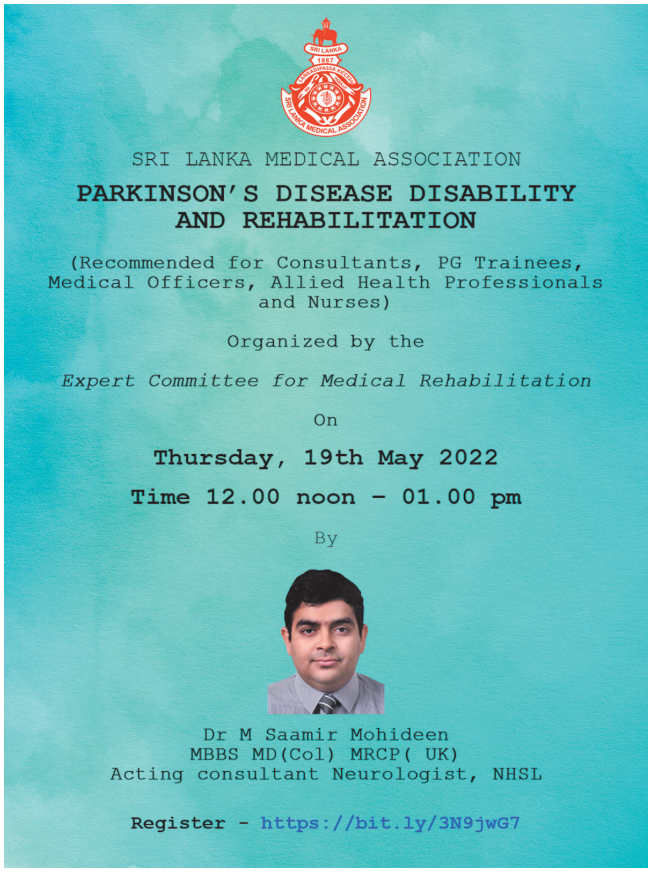
Food inflation in Colombo set a record high of 57.4 percent and widespread shortages of fuel for cooking and transport means poor families are struggling to afford food. Nearly five million people, or 22 percent of the Sri Lankan population, are food insecure and in need of assistance. Nutritious foods, such as vegetables, fruits and protein-rich products are now out of reach for many families. Recent surveys indicated 86 percent of families are resorting to at least one coping mechanism, including eating less, eating less nutritious food and even skipping meals altogether. We expect the situation to get worse in the months to come. Children and pregnant mothers are the most vulnerable in food insecurity and it is most visible in the families of estate populations and urban populations. Recent data collected in certain districts indicate an increase in wasting and loss of weight for height and in the coming months to years we may observe stunting in growth. Like in some countries who are facing similar situations we may observe increase in malnutrition and impairment of the cognitive functions which will affect their learning abilities as well.

The current twin crises of political instability and economic disaster in Sri Lanka will affect all the areas linked to the wellbeing of children. The need of the hour is to understand the grave situation and develop a strategic plan with clear objectives and practical time lines. These plans should involve Ministries of power and energy, health, agriculture, transport, trade, fisheries, estate and rural development and education. Best think-tanks and educated experts in our country should come forward to lend a hand to pull us away from our current plight rather than wasting time by criticising everything at petrol queues. We may see some light at the end of the tunnel at least in a few years' time if only we use this last opportunity to salvage the situation.

Dr. Surantha Perera
Consultant Paediatrician & Neonatologist – Neonatal Intensive Care Unit, CSHW
Vice President - SLMA

Activities in Brief (16th May - 15th June)

19th May



SLMA Expert Committee on Medical Rehabilitation organized a lecture on 'Parkinson's Disease, Disability and Rehabilitation' by Dr. M Saamir Mohideen, Acting Consultant Neurologist, NHSL.

20th May

A donation of equipment was done by the Rotaract Club of Colombo to the SLMA to be distributed to hospitals.

Those present at the occasion were;
Prof. Samath Dharmaratne, President SLMA
Dr. Surantha Perera, Vice President SLMA
Prof. Ishan de Zoysa, Hon. Secretary SLMA

24th May

The President, Vice president and Secretary SLMA attended a meeting with Mr. Ruwan Wijewardena, the Prime Minister's liaison for health issues. Discussions covered the support for getting donations of medicines and how SLMA can assist in resolving health issues.

25th May

The President, Vice President and Secretary SLMA attended a meeting hosted by the Prime Minister, Hon. Mr. Ranil Wickramasinghe, to discuss the current health crisis.

27th May

Professor Samath Dharmaratne, President, SLMA attended a discussion on the current issues faced by the Health Sector on 'Jathika Mehewara', TV 1 channel (MTV).

28th May

The SLMA Saturday Talk on 'Lifestyle modification to treat non communicable diseases' was done by Dr Nilwala Jayasinghe, Specialist Consultant in Internal Medicine, Army Hospital, Colombo.

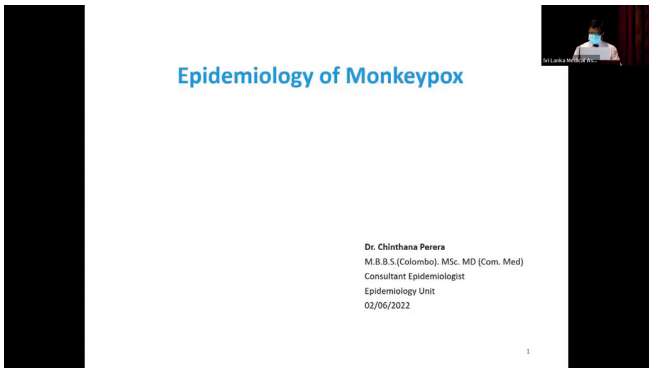
30th May

A meeting was held with Hon. Keheliya Rambukwella, Minister of Health and the members of the SLMA Inter-Collegiate Committee at the MoH Auditorium.

Forty one Presidents representing many Colleges and Associations attended this important meeting.

2nd June

An update on Monkey Pox was conducted by the SLMA Expert Committee on Communicable Diseases.



The resource persons were;

'Epidemiology of Monkeypox' by Dr Chinthaka Perera, Consultant Epidemiologist, Epidemiology Unit, Colombo, 'Clinical Features & Management of Monkeypox' by Dr Mahesh Harischandra, Consultant Physician, Lanka Hospital, 'Laboratory Diagnosis of Monkeypox' by Professor Chandima Jeewandara, Department of Immunology & Molecular Medicine, University of Sri Jayawardenapura and 'Prevention of Monkeypox' by Dr Rohini Wadanamby, Consultant Microbiologist, Lanka Hospital.

3rd June

'Microplastics and You' - Sri Lanka's first book in all 3 languages addressing the health impacts due to plastic pollution, a Joint national level publication of the Sri Lanka Medical Association and the Ministry of Environment was launched at the Environment Ministry Auditorium.

Dr. Sajith Edirisinghe, Assistant Treasurer was the main author of the publication. Mr N.S Gamage from CEA, Dr Palitha Kithsiri and Mr Ashok Weerakoon from NARA contributed to the relevant chapters.

4th June

The SLMA Saturday Talk on 'Obstetric Emergencies' was done by Dr. Indunil Piyadigama, Consultant Obstetrician & Gynaecologist, de Zoysa Maternity Hospital, Colombo.

10th June

Handing over of equipment to LRH through the SLMA Relief Fund was held at the SLMA Council room.

The following were present at the occasion;

- Dr G Wijesuriya, Director of the Lady Ridgeway Hospital
- Dr H S J Sepanapathi, Deputy Director
- Professor Samath Dharmaratne, President SLMA
- Dr Surantha Perera, Vice President SLMA
- Professor Ishan de Zoysa, Hony. Secretary SLMA
- Dr B J C Perera Consultant Pediatrician, Past President, SLMA
- Dr Anula Wijesundera - Consultant Physician, Past President, SLMA

11th June

The SLMA Saturday Talk on 'Ending AIDS in 2030; Is it a myth or a reality?' was done by Dr. Geethani Samaraweera, Consultant Venereologist, President, Sri Lanka College of Sexual Health & HIV Medicine.

Iron Deficiency Anaemia in Children

Professor Sachith Mettananda

MBBS, DCH, MD-Paed, DPhil, FRCP, FRCPCH, FRCPE

Professor of Paediatrics, University of Kelaniya

Iron is an essential cofactor of many proteins, including haemoglobin. Iron homeostasis of the human body is primarily regulated at its absorption, with approximately 1-2 mg absorbed every day. Hepcidin, the master regulatory peptide hormone of iron absorption, inhibits the incorporation of transmembrane iron transporter protein ferroportin to the basolateral membrane of the intestinal epithelial cells, thus decreasing iron uptake.

Iron deficiency occurs through numerous mechanisms (Table 1). Dietary iron deficiency due to inadequate intake of iron-rich food is the most common cause of iron deficiency worldwide. This is due to poor knowledge and lack of availability of iron-rich food. Chronic intestinal blood loss, increased iron requirement due to chronic infections, and genetic mutations of the enzymes responsible for iron metabolism are other recognised causes of iron deficiency.

Table 1 - Mechanisms and causes of iron deficiency

Mechanism	Causes
Dietary iron deficiency	Inadequate intake of iron-rich food
	Decreased intestinal iron absorption e.g., celiac disease, Crohn's disease
Chronic gastrointestinal blood loss	Hookworm infections
	Cow's milk protein-induced colitis
	Meckel's diverticulum
	Intestinal haemangioma
	Inflammatory bowel disease
Increased iron requirement	Chronic infections
Genetic causes	Mutations of enzymes of iron metabolism e.g., *TMPRSS6*/matriptase-2 gene mutation
Other causes (in infants < 6 months)	Prematurity
	Perinatal haemorrhage
	Twin-to-twin transfusion syndrome

Iron deficiency anaemia (IDA) is the most recognised consequence of iron deficiency in children. In fact, IDA is the commonest nutritional anaemia in the world. Its prevalence is high in Africa and Asia and among children aged between six months to five years. The prevalence of IDA among children in Sri Lanka is estimated to be around 7-8%.

The clinical features of IDA are non-specific. They include features caused by the deficiency of iron and features of anaemia (Table 2). However, most children with IDA are asymptomatic and are detected incidentally.

Full blood count (FBC) is the most useful investigation in children with anaemia. In IDA, FBC shows low haemoglobin, low mean corpuscular volume (MCV), low mean corpuscular haemoglobin (MCH) and high red cell distribution width (RDW). Blood picture shows hypochromic microcytic red blood cells, pencil-shaped cells, with marked anisopoikilocytosis. Reactive thrombocytosis due to thrombopoietic activity of erythropoietin is also common.

IDA shares common haematological features of microcytic anaemia with heterozygous carrier states of α- and β-thalassaemia; hence FBC is not diagnostic. The definitive diagnosis of IDA is supported by serum ferritin or iron studies. Most children with IDA have low serum

Table2 - Clinical features of iron deficiency anaemia

Symptoms of iron deficiency	Pica
	Pagophagia (desire to ingest ice)
	Behavioural changes
	Cognitive defects
Symptoms of anaemia	Anorexia
	Fatigue
	Irritability
	Dyspnoea
	Palpitations
	Headache
Signs of iron deficiency	Angular stomatitis
	Glossitis
	Damaged hair
	Koilonychia
Signs of anaemia	Tachycardia
	Cardiac flow murmurs
	Cardiac failure

ferritin (<15ng/dL) levels. However, as ferritin is an acute phase reactant, it can be falsely elevated in the presence of infection, inflammation, liver diseases or malignancy. The serum iron profile reveals low serum iron, high serum iron-binding capacity and low transferrin saturation (<16%). Other laboratory features that have shown to be useful in diagnosing IDA are high soluble transferrin receptor level, high erythrocyte zinc protoporphyrin and low serum hepcidin.

IDA is treated with oral iron 3 - 6mg (elemental iron)/kg, preferably given in 2-3 divided doses daily. The amount of elemental iron that is available in different iron preparations varies from 10-14% in ferrous gluconate, 20-30% in ferrous sulphate, to 33% in ferrous fumarate. Side effects of iron therapy include unpleasant taste, abdominal pain, constipation, diarrhoea, and grey staining of teeth. Because the response to oral iron is rapid, the only indication for parenteral iron is malabsorption due to gastrointestinal diseases. Blood transfusions are indicated only for children with impending cardiac failure due to severe IDA.

In addition to iron therapy, dietary modifications to improve the consumption of iron-rich food (meat, fish, poultry, liver, legumes, nuts, and green vegetables) is an integral component of management. Food of animal origin contains heme iron which has a higher bioavailability (20-30%) compared to non-heme iron (bioavailability 5-10%) found in plant food. Consumption of vitamin C containing food in the meal increases the absorption of non-heme iron. Tannins in tea and coffee and calcium in milk interfere with iron absorption; therefore, they should not be consumed along with main meals.

A rise in the haemoglobin of 1-2g/dL after one month indicates an adequate response to iron therapy. However, iron replacement treatment should be continued for 3-4 months after haemoglobin and red cell indices have normalised to replenish iron stores. If the response to iron treatment is poor, non-dietary causes of iron deficiency (malabsorption, chronic gastrointestinal blood loss and genetic causes) should be considered.

Consuming a diet rich in iron to fulfil the recommended dietary allowance (7-10mg/day) prevents iron deficiency in children. Universal supplementation with iron preparations (1-3mg elemental iron /kg/day) to prevent IDA is recommended for children in high-risk areas.

Some Nomadic Musings on Childhood Asthma

Dr B.J.C. Perera

MBBS(Cey), DCH(Cey), DCH(Eng), MD(Paed), MRCP(UK), FRCP(Edin), FRCP(Lon), FRCPCH(UK), FSLCPaed, FCCP, Hony FRCPCH(UK), Hony. FCGP(SL)

Specialist Consultant Paediatrician and Honorary Senior Fellow, Postgraduate Institute of Medicine, University of Colombo, Sri Lanka.

Childhood asthma is undoubtedly the commonest, and possibly the most troublesome, recurrent or chronic respiratory disorder in childhood[1]. There are several phenotypes of this disorder and even after decades of intense research into the intricacies of this condition, one cannot truly say that our knowledge of the subject is all that complete. To compound matters further, there are geographical differences in presentation, prevalence and mortality, as well as in response to therapy[2]. This makes it quite a bit difficult to extrapolate the results of research across different continents.

There is a rather quaint but fascinating gender relationship to the prevalence of asthma in childhood. Asthma occurrence is more in boys during childhood with a male-to-female ratio of 2:1. This rate tends to change around puberty, when the male-to-female ratio becomes 1:1. Later on, after puberty, it becomes more common in females[3]. The majority of adult-onset cases diagnosed in people older than 40 years occur more in females[3]. Boys are also more likely than girls to experience a decrease in symptoms by late adolescence. These imply some rather curious relationship with the hormonal status of the body, as well as the changes that occur during puberty, but there is a dearth of decisive scientific evidence on such a contention. We have only prevalence data but cause-and-effect relationship information is rather sparse.

Acute Severe Asthma, or so-called Status Asthmaticus, used to cause a lot of problems even in the early and middle segments of the last century. We had only a limited number of bronchodilator drugs such as isoprenaline, adrenaline, aminophylline, as well as systemic corticosteroids to deal with it. The final option was to resort to mechanical ventilation for the intransigent cases. The drugs that were in use at that time were effective but had a side-effect profile that was of some concern as well. The ventilators were not all that sophisticated and there were considerable problems with pulmonary barotrauma and volutrauma as well as ventilator-associated infections. Unfortunately, some children succumbed to the disease as a result of all these problems; a most regrettable situation when one considers the fact that the entire problem was due to a potentially reversible airway constriction.

This position changed significantly with the arrival of inhaled short-acting selective beta-agonist drugs in the 1970s and 1980s. The first study on the effectiveness of salbutamol nebulisation in Sri Lankan children was reported from the Badulla General Hospital and the results were quite impressive[4,5]. Despite a few cynical opinions expressed in some quarters, nebuliser therapy caught on rapidly and this made a seminal difference in the management of acute asthma in childhood. Subsequently, another study from Sri Lanka provided a simplified dosage schedule for the nebulisation of salbutamol in children with a dose of 0.5 millilitres of the salbutamol respirator solution for those under 5 years and a dose of 1.0 millilitres for those over 5 years[6]. Later on, the provision of similar inhaled therapy with selective beta-agonist metered-dose inhalers coupled with spacers too proved to be quite effective. In one Sri Lankan study on adults, even cheap paper cone spacers coupled with metered-dose inhalers were also shown to be as effective as the much more expensive commercially available spacers[7]. Inhalation therapy with beta-agonists has now become the cornerstone in the management of acute asthma in childhood, together of course with the added anti-inflammatory effects of corticosteroids. There is evidence that the use of systemic corticosteroids early in an attack of childhood acute severe asthma helps to prevent progression, reduces hospital stay and delays relapse in the short term [8].

The strategy that is universally employed in the long-term management of childhood asthma is to resort to various forms of prophylaxis. The current indications for starting prophylaxis, with special reference to the Sri Lankan scenario, are as follows: -

- Chronic persistent asthma that restricts normal life.
- Following severe life-threatening acute attacks of asthma
- Frequent episodic asthma that interferes with normal life
- Significant loss of schooling due to asthma
- Significant exercise-induced asthma
- Troublesome nocturnal cough or asthma that interferes with sleep

- A recent increase in frequency or severity of asthma
- Inaccessibility of medical care and for social reasons

There is pretty good evidence in the literature of the usefulness of inhaled corticosteroids and more recently, the combination inhalers of corticosteroids with long-acting beta-agonists, in the prophylaxis of childhood asthma. Their effectiveness and safety, even in long-term therapy, are quite well elucidated by now. There are loads of research work that unequivocally establish these as facts

Yet for all that, there were some concerns about the cost-effectiveness of using these inhaled forms of prophylaxis in childhood asthma. In that context, there is a really convincing study from Sri Lanka that has shown very clearly that the use of inhaled steroids is quite effective in preventing break-through acute attacks while reducing the direct and indirect costs of the illness by over 80%, even in a developing country such as ours[9].

The scholars are not too sure as to whether prophylactic therapy is forever or whether it could be safely withdrawn after some time without inducing a recurrence of symptomatic disease. Such doubts were catalysed by the argument that in adult asthma very prolonged and even life-long prophylaxis is necessary. This dispute was resolved to a certain extent by another Sri Lankan study which showed that successful withdrawal of prophylaxis with inhaled steroids in children could be safely achieved by very slowly back-titrating the inhaled steroids and withdrawing it, after an extended period of good control on these drugs[10]. On a follow-up period extending for several years, there was no significant recurrence in the vast majority of those in whom the drugs were successfully withdrawn[10]. Unfortunately, there are no other similar studies with protracted therapy followed by gradual tapering off with final withdrawal with follow up data for several years in the scientific literature. As a result, most Asthma Management Guidelines fight shy of making definite recommendations regarding this aspect of asthma prophylaxis in children.

Finally, in the Western hemisphere and in countries like Australia and New Zealand as well, there is abiding interest in a condition that they call "difficult-to-control childhood asthma". These are the children who are quite resistant to the standard prophylactic therapy. Some of them have a form of quite severe disease that interfered markedly with their quality of life and they also run a high risk of dying from intractable severe asthma. The whole situation led to the authorities in those countries being forced to resort to sophisticated second-line therapies like biologics such as monoclonal antibodies and cytokine inhibitors. These forms of treatment are extremely expensive and have to be administered parenterally, but they have shown some effect in these unfortunate children.

This is a genuine enigma for us in our part of the world. We hardly ever come across such severe intransigent and unresponsive childhood asthma that has been properly and unequivocally diagnosed as asthma. Our problems of poorly controlled asthma are primarily due to improper therapeutic decisions or non-compliance with prescribed treatment. We have generally been able to control childhood asthma with the available armamentarium of inhaled steroids, inhaled combination drugs, montelukast and even mast cell stabilisers, all being used sometimes in tandem. This takes us back to different phenotypical presentations, perhaps due to several confounding factors, which mitigates the occurrence of such severe disease in the developing world. Quite frankly, after 50 years of working with children, this author has hardly ever, if not never, seen truly obdurate and obstinate "difficult-to-control" versions of childhood asthma. Perhaps, we are that much luckier than we think we are.

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Medical Negligence: A fact beyond fiction

Professor Clifford Perera

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University of Ruhuna
Galle

"Physicians and nurses need to accept the notion that **error** is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of system flaws not character flaws. Until and unless that happens, it is unlikely that any substantial progress will be made in reducing medical errors."

Leape, Lucian L. Error in Medicine. *JAMA* 1994;**272**(23):1857

The concept that every person who enters a learned profession undertakes to bring a reasonable degree of care and skill dates back to the laws of ancient Rome and England. The writings on medical responsibility can be traced back to 2030 BCE when the Code of Hammurabi provided that "If the doctor has treated a gentleman with a lancet of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman with a bronze lancet, and has caused the loss of the gentleman's eye, one shall cut off his hands."

Under Roman law, medical malpractice was a recognized wrong. During the reign of Richard Coeur de Lion at the close of the 12th century, records were kept in the Court of Common Law and the Plea Rolls. These records provide an unbroken line of medical malpractice decisions, all the way to modern times.

Early documented Lawsuits in MEDICAL MALPRACTICE

What looks to be the earliest recorded case of medical malpractice litigation happened in 1164 in England. The case, **Everad v. Hoskins**, involved a servant and his master collecting damages from a physician for practicing "unwholesome medicine."

In **Stratton v. Swanlond** (1374), Agnes of Stratton and her husband sought damages from surgeon John Swanlond for breach of contract. In the United States, the first instance of a medical malpractice case was in 1794, just five years after George Washington's inauguration.

Negligence vs. Malpractice

The terms "negligence" and "malpractice" are frequently used interchangeably, but there are clear differences between the two legally. In general, negligence involves a person's failure to exercise care in a way that a reasonable person would have done in a similar situation. The majority of personal injury claims revolve around this idea.

Malpractice is a more specific term that looks at a standard of care as well as the professional status of the caregiver. The courts define malpractice as the failure of a **professional person** to act in accordance with the prevailing professional standards, or failure to foresee consequences that a professional person, having the necessary skills and education, should foresee.

The same types of acts may form the basis for negligence or malpractice.

- If performed by a non-professional person, the result is negligence;
- If performed by a professional person, the acts could be the basis for a malpractice lawsuit.

Negligence - definition

Negligence is doing something, which a prudent (sensible) and reasonable man would not do, or omission to do something, which a prudent and reasonable man would do in a given situation.

Negligence is:

- A general term that denotes conduct lacking in due care;
- Carelessness;

and

- A deviation from the standard of care that a reasonable person would use in a particular set of circumstances.

Anyone, including non-medical persons, can be liable for negligence.

Negligence is a legal concept described in 'Tort Law' and not a medical diagnosis. A 'tort' is an act or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability.

In order to prove negligence or malpractice, the following criteria must be established:

Criteria to establish Negligence

1. Duty of care
2. Breach of duty of care

3. Causation/Causal relationship
4. Damage - physical/mental/ financial

Duty of Care

A duty of care will arise from an act of a person where the requirements of foreseeability, proximity, fairness, justice and reasonableness, establish such a duty as stated in ***Donohue vs Stevenson***. An alleged breach of duty occasioned by an omission will only arise where a legal duty of care already exists.

Those with a duty of care must act as a reasonable person would do in their position. If they fail to do so, they will have breached their duty. The standard of care to be applied should reflect the extent of the duty of care.

In many situations the law already recognises that a duty of care will exist (for example; by employers to their employees and by health care professionals to their patients)

Breach of duty

The ordinary principles of the law of negligence apply to determine whether the defendant was in breach of a duty of care towards the victim. Whether or not sufficient care has been taken by the individual to discharge the particular duty of care placed upon him is tested by the objective standard of reasonableness.

In ***Bolam v Friern Hospital Management Committee***, the trial judge, McNair, put it in this way: "a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

This means that in order to prove that a doctor has breached his or her duty of care it must be proved that there is no responsible body of doctors who would regard the treatment as acceptable. However, the **'standard of care'** is objective, and as such, does not consider the weaknesses or inexperience of the particular defendant.

Causation

'Causation' is a legal term that refers to the required proof regarding a particular issue that stems from a specific action. The plaintiff must prove that the defendant's action(s) or failure to act in some way (among other things) contributed to the damages he/she suffered. 'Causation' in medical negligence cases means proving that negligence as a result of a breached duty of care has caused injury. Proving this is known as 'establishing causation' which itself is a difficult task in the court of law.

Medical Negligence

Definition: Medical negligence is the breach of a duty of care towards a patient which results in, harm to a patient. This could be by an act of commission or omission by the medical staff. This duty is owed by all those professionals who hold themselves out as skilled in medical, nursing and paramedical fields. It arises independently of any contractual relationship. Although medical accidents and misadventures are an expected social phenomenon, medical negligence is not.

For a successful action of medical negligence, the plaintiff (patient) must establish that the doctor was in breach of his duty of care. There is no breach of duty unless the doctor has failed to meet the required standard of care. The standard of care and what constitutes a breach of that standard must be determined, based on the facts of a particular case with the assistance of medical experts.

The term "medical negligence" is often used synonymously with "medical malpractice," and for most purposes that is adequate. Strictly speaking though, medical negligence is only one required legal element of a meritorious (legally valid) medical malpractice claim.

In short, medical negligence becomes medical malpractice when the doctor's negligent treatment causes undue injury to the patient.

Instances of medical negligence

Anaesthesia

- Failure to adhere to accepted practice
- Failure to use correct dosage of drugs
- Any fault in the equipment
- Failure to keep an adequate record of the anaesthetic procedure
- Inadequate monitoring of the patient by the anaesthetist

Surgery

- operating on wrong patient/ side/site/limb/finger
- failure or delay in diagnosing cancer, nerve, tendon or vascular damage
- retained swabs or instruments
- failure to diagnose internal bleeding
- failure to provide prophylaxis for known complications such as DVT

Obstetrics & Gynecology

- Unacceptable and substandard management of labour
- Failed sterilisation resulting in conception

Psychiatry

- Inadequate supervision of psychiatric patients who harmed themselves/others or committed suicide
- Failure to inform potential adverse outcome of treatment procedures eg. ECT

Paediatrics

- Failure to diagnose a clinical condition
- Perinatal asphyxia or injuries
- Errors in calculating and administering the appropriate dose of drugs
- Complications following immunization
- Failure to visit or admit sick children

Medical Negligence - proof

The complaint of medical negligence should be proved by the plaintiff (patient) in the relevant courts.

Res ipsa loquitor

Res ipsa loquitor can occur when the defendant was in exclusive control of the situation and the plaintiff would not have suffered injury but for someone's negligence. It is also referred as **presumptive negligence** or "**facts speak for itself**".

Examples

- permanent brain damage following anaesthesia
- failure to remove a surgical pack from the abdominal cavity
- meningitis following spinal injection
- cutting the cheek of a baby during a caesarean section

Vicarious Liability

Vicarious liability is a legal doctrine that imposes responsibility upon one person for the failure of another, with whom the person has a special relationship (such as a parent and child, employer and employee, or owner of vehicle and driver), to exercise such care as a reasonably prudent person would use under similar circumstances. It is also referred to as **imputed negligence.**

In ***Cassidy v Ministry of Health***, the claimant was a patient at a hospital run by the defendant who required routine treatment to set the bones in his wrist. Due to negligence on the part of one of the doctors, the operation caused his fingers to become stiff. The claimant sued the defendant in the tort of negligence on the basis of vicarious liability.

Dr. P.D. Samitha Samanmali v. BMICH (District Courts Colombo)

Dr. Samanmali who was a medical student at the time of this tragedy, sustained severe injuries on February 15, 2008 at the BMICH, when she was organising the setting up of stalls for a medical exhibition. The accident occurred when an iron rod fell on her head damaging her spine and skull when she was at the BMICH to set up exhibition stalls for MEDEX. On Feb. 27, 2015, the Colombo District Court ordered the BMICH to pay Rs.187 million with legal interest to Dr. Samitha Samanmali as damages.

The damages were ordered to be paid **not** by the third party that erected the marquee, but by the BMICH on the grounds that the BMICH administration was liable to provide a 'safe environment' and owed a 'duty of care' to visitors to the premises. (duty towards invitee)

According to medical reports, the student, Samitha Samanmali would not be able to carry out the tasks as a doctor or lead a normal married life, but would be confined to a wheel chair for the rest of her life. Although this is not a case of medical negligence, the final verdict of the court became a landmark judgment not only because of the magnitude of the compensation awarded to the victim but rather, it gains significance by its strong precedence to the recognition of the citizens' rights for which majority do not fight.

Defences for medical negligence

- Assumption of risk by the patient
- Contributory negligence by the patient
- Negligence was not that of the defendant
- Denial of negligence
- Inevitable accident or misadventure
- Public policy and illegality

Criminal medical negligence

The medical officer is prosecuted by the state (not by the patient) in this situation.

The case is heard in the High Court. The damage caused is severe and it almost amounts to a crime.

Eg. grossly negligent treatment indicative of disregard for the life and safety of the patient

The relevant legal provisions are Sections 298, 327, 328 & 329 of the Penal Code of Sri Lanka.

Civil medical negligence

The patient/plaintiff sues the medical officer in this situation. The case is first heard in the District Court. ***Arsecularatne v. Priyani Soysa*** & ***Dr. Ranjit Fernando v. Sri Lanka Medical Council*** are the only two cases on alleged medical negligence which proceeded up to Supreme Courts of Sri Lanka.

Bolam Test (1957)

An essential component of an action in negligence against a doctor is proof that the doctor failed to provide the required standard of care under the circumstances. Traditionally the standard of care in law has been determined according to the **Bolam test**.

This is based on the principle that a doctor does not breach the legal standard of care, and is therefore not negligent, if the practice is supported by a responsible body of similar professionals. The Bolam principle, however, has been perceived as being excessively reliant upon medical testimony supporting the defendant. Bolam test is now modified by a more recent Bolitho case.

Bolitho case (1997)

Bolitho was a clinical negligence case that reached the House of Lords in the United Kingdom. **Patrick Bolitho**, a two-year-old child, suffered catastrophic brain damage as a result of cardiac arrest due to respiratory failure. The senior paediatric registrar did not attend to the child, as she ascribed to a school of thought that medical intervention, under those particular circumstances, would have made no difference to the end result.

The central legal issue was whether or not non-intervention by a doctor caused the plaintiff's injury. Patient had expert evidence that a reasonably competent doctor would have intubated in those circumstances; the Doctor had own expert witnesses saying that non-intubation was a clinically justifiable response.

Medical opinions are still required to assist the court in its deliberation. However, the court must be satisfied that the body of opinion is logical; clearly this is a rejection of the Bolam test. Bolam test has been challenged and rejected in America, Canada, Australia, South Africa and Malaysia. It is now a matter for court and not medical opinion to decide on the standard of professional care.

Five "Key Messages" of Professor Carlo Fonseka

Professor Carlo Fonseka, a renowned physiologist representing medical academia of Sri Lanka once writing a reflection about his career, stated the following.

- All doctors are fallible.
- The natural reaction of all doctors is to hide them or rationalize them away.
- It is unscientific and unethical to refuse to face our errors.
- There is no cathartic ritual in our profession to expiate the sense of guilt generated by our errors.
- Since knowledge grows mainly by error recognition, facing our errors squarely is the path to medical wisdom.

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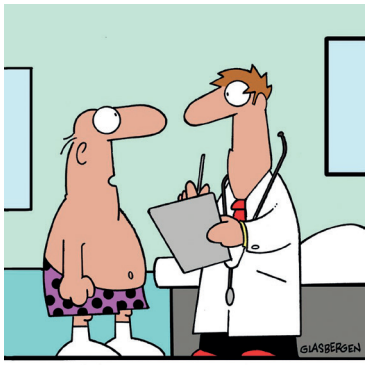

"My bones are getting softer, but my arteries are getting harder, so it balances out!"

"It's normal for a man your age to have chest pains when he drips hot, melted pizza cheese on his shirt."

"Many women fear the word 'menopause', so I prefer to call it Puberty, Part II."

It IS possible to change your negative thoughts

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We become particularly aware of our negative thinking patterns during challenging times. It is not that these thinking patterns were not within us during calmer times – it was. However, because challenging times are, well, challenging, these patterns become more pronounced and more frequent.

We in Sri Lanka our currently going through a most challenging time – with two years of a pandemic somewhat behind us, and at present a massive socio-economic and political upheaval. Large scale stressors such as pandemics and social unrest are characterized by a high degree of uncertainty, complexity, and ambiguity; extremely fertile ground to unearth our dormant negative thinking patterns. However, in some of us, even in the absence of such extreme stressors, negative thinking patterns prevail. In fact, for some of us, most days, extreme challenge or even no apparent challenge, our minds are predominantly filled with negative thoughts. "*Do they like me*?", "*Am I good enough*", "*I so dislike him*", and "*Why can't my son do as well as his son*?" are some of the more mundane negative thoughts are minds are filled with throughout the day. Associated with these negative thoughts are negative emotions: irritability, annoyance, envy, and unhappiness at the less extreme, whilst anger, rage, revenge, and depression, at the more severe end.

We may have got used to having these negative thinking patterns and negative emotions. We may think that is a given part-and-parcel of life. I am sure you may have even come across those who consider negative emotions such as anger as a most useful frame of mind to get what they want!; little realizing that anger, though a powerful emotion, is also a most destructive emotion that can create havoc in one's relationships and indeed life in general.

Thoughts and feelings

Our emotions (roughly speaking: how we feel) are intimately associated with our thoughts. Psychologists indicate that thoughts are followed by its corresponding emotional state. Thoughts are usually experienced as either statements (e.g., "*I think she likes me*"; "*Am I good enough*?"; "*I so dislike him*"; and

"*Why can't my son do as well as his son*?") or images (e.g., an image of being socially isolated by colleagues; image of being overpowered by one's spouse; an image of getting that coveted award). Emotions on the other hand are described with one word (e.g., irritability, annoyance, anger, rage, envy, unhappiness, depression) and felt in our body. We tend to detect our emotions better than we can detect its underlying thoughts.

What would our life be if we had fewer negative thoughts?

A life with fewer negative thoughts - Have you ever considered this possibility? You may wonder why I have written as "fewer negative thoughts" rather than "no negative thoughts". Well, it is because it would be quite a task to keep our minds devoid of all negative thought. But it does not mean that it cannot be done' it can be. However, to reach those beautiful states of mind, which most spiritual traditions aspire to teach us, requires a great deal of dedication, continuous monitoring and working on one's mind. A task that most of us may not feel inclined to do to such an extensive extent. HOWEVER, with SOME effort we could certainly be a carrier of a mind that has fewer negative thoughts than what we originally had. So, for the intents of this article, I would be focusing on this latter objective rather than on how to arrive at loftier states of mind.

So, what would a mind with fewer negative thoughts be like? A clear and calm mind is essential to make suitable life decisions. When our mind is filled with negative thoughts (such as thoughts coloured by anger, irritability, envy, and sadness), we are not in the best position to make suitable life decisions. This is so, not only in our personal lives, but also in our professional lives. For instance, as a doctor, you maybe invariably placed in a position which requires you to make life-changing decisions on behalf of your patients. If your mind is encompassed by negative thoughts, these professional judgments of yours would get affected.

Closer to home, your personal life too is greatly impacted by your thinking pattern. A mind, less burdened by negative thoughts, would be happier. And isn't that what we ultimately want from life? – happiness. We do all that we do, towards that end goal. Yet, many of us wonder why we are not happier despite possibly having comfortable lives, material wealth, a family and children, as well as being in a prestigious profession. One key reason for this lack of happiness is our maladaptive thinking pattern. Of course, there are other reasons too, but those are not within the purview of this article.

Why do we 'generate' negative thoughts?

There are many reasons for this. According to psychology, one of the main reasons for a negative thinking pattern is that it was learned in childhood. Maybe your parents or significant others in your life tended to put a negative spin on most things (such as the father who never realised that you were not clever enough; or the aunt who showed from her facial expressions that you were not as pretty as your cousin; or the mother who seemed to find negativity in any given situation, etc). Having grown up in such an environment, it could make you also 'learn' to view life negatively. Another reason could be the exposure to a traumatic event such as a natural disaster, physical or sexual harassment, or a partner who abandoned you, for instance. These experiences could colour the way you look at life and may make you view life through a greyer tone. Further, there is research that shows that our in-born temperament could affect the way we look at life too. So, there isn't just one reason, there are many. Humans are complex beings and all these factors, and many more, could make us the thinking persons that we are.

Is our thinking pattern carved in stone or could we change it?

You certainly can change it, fortunately. However, you need to want to change it. You may think that most people would want to change their negative thinking patterns. Why wouldn't they want to be happier and more productive?: two of the many benefits of a healthier mind. But, what we see is that some people (i) don't even KNOW they have that many negative thoughts; (ii) even if they feel discomfort because of their negative thoughts, they don't realize that there is another way of thinking they could adopt, (iii) don't feel sufficiently MOTIVATED to put forth the effort to change their thinking patterns, and/or (iv) don't know THE STRATERGIES needed to change their negative thinking patterns.

So, how could we tame our negative thinking patterns?

1. Be aware

Let us say you want to fully understand the workings of a car engine. The most effective way to do so is to pay full attention to its workings. But, say, while you are studying it, you reach out to your phone every time a notification sounds, or your eyes keep contemplating the trees around you, etc, it is highly unlikely that your

objective would be accomplished. Likewise, for you to change your thinking pattern, you first need to be familiar with it. The way to be familiar with your thinking pattern is to be fully aware of your thoughts (negative or otherwise). Hence, during your waking moments, strive to keep your attention on whatever activity you are doing, rather than being distracted, or engage in multitasking or fantasizing, or living in the past/future. In short, train your mind to be in the present moment, which then opens the window to your thinking patterns.

2. Realize that thoughts are not facts

Imagine your best friend in grade 5, at school. You may have been so very fond of him/her. You may have thought your friendship will never dwindle. Fast forward to yourself now. Are your thoughts about that best friend just the way as it was in grade 5? Is he/she still your best friend? Most likely not. You may be having neutral thoughts about him/her now, or even unfriendly thoughts. So, which group of thoughts is factual?; the 'then' thoughts or the 'now' thoughts? Neither are, because thoughts are just working HYPOTHESES at a given time. Hence, thoughts are not facts. Tell yourself that when you realise you are in the grips of your thoughts and are behaving slavishly according to them.

3. Keep a thought record

A candid way to understand the extent of your negative thoughts is by keeping a thought record (Beck, 2011). You may want to keep a thought record for a week. Record the thoughts that were in your mind at every two-hour interval during your waking hours. A thought record would look like this:

Date and time	Situation	Thought	Feeling (%)	Behaviour
4th May 2022; 5 am	Got up	I wish I could just get back to bed. Life is too boring.	Unhappy (40%)	Pulled myself up from bed and got a drink of water.
4th May 2022; 7 am				
4th May 2022; 9 am				

4. Catch the first thought

Now that you are practicing being aware (1, above) and keeping a thought record (3, above) for a week, you may be more skilled at catching the beginnings of thoughts. Hence, in the past, you may have been only aware of your thoughts when it was fully 'grown', but now, you may be able to detect them at a less mature level. For instance, in the past, you may have realized you are angry only when you started frowning at another. But now, you may detect angry thoughts before they are shown on your face.

5. Assess if the thought is true

Assess if this initial thought is true: remember we said that thoughts are not facts? For instance, when your daughter is intently watching a movie and didn't acknowledge you when you came home from work, you may get the thought that she does not care about you enough to leave the film aside and greet you. BUT is that thought true? Could there be an alternative explanation/s for your thought? [see point (6) below]

6. Generate an alternative REALISTIC thought

Look for evidence FOR and AGAINST the negative thought you had. In our example above, of your daughter, what is the evidence that your thought is true (evidence FOR: e.g., for the last several days she had seemed as if she is in her own world; she seems more keen to spend time with her friends than family) and untrue (evidence AGAINST: e.g., she usually is a loving girl; she had told you that she had a fall-out with her best friend, and maybe she is preoccupied with that; it is known that most teenagers prefer spending time with friends than family). Once you have generated this evidence for and against, combine that generated information with your initial negative thought and formulate an alternative, more realistic thought. In the current example, an alternative thought may be: "My daughter seems intent on her entertainment and friends. It's hurtful that she does not seem to engage with me, unlike in the past. But she is usually a loving child. She did say that she is very hurt that she had a fall-out with her best friend. So, maybe it is not that she is disengaging from me, but is preoccupied with her concerns". Now how is your level of distress? Is it more or less than your initial negative thoughts?

Let's do another example, so that we know how to generate alternative realistic thoughts:

Date and time	Situation	Thought	Feeling (%)	Behaviour	Evidence FOR	Evidence AGAINST	Alternative thought	Feeling (%)
4th May 2022; 5 am	Got up	I wish I could just get back to bed. Life is so boring.	Unhappy (40%)	Pulled myself up from bed and got a drink of water.	Yesterday was another boring day, the usual routine. Dropped the kids at school, hospital work, groceries on the way home etc etc.	I was able to spend time with the mother of a dying child - listening to and consoling her grief. Though it was sad, I also felt I did my part for the world.	Today wouldn't be too different to yesterday, yes. But within every new day, there could be new experiences - opportunities to help others and that brings meaning and joy to my life.	Unhappy (25%)

Remember that by practicing in this way, negative thoughts and its associated negative emotions would not go away immediately. Rather, the intensity of the negative thought may reduce as would its associated emotion - as in the second example above. The reduction in its intensity makes life feel better. Further, as we practice alternative thinking, with time, it becomes second-nature to us where we do not need to put in so much effort to generate evidence for and against. Hence, with time, you would have reprogrammed your mind to think in a more holistic way.

7. Test out your new alternative realistic thought

Once we have generated an alternative realistic thought (i.e., a thought that has been generated after considering the situation holistically, rather than taking as fact the negative thought that was generated from your mind) you may feel calmer and lighter. Now that you have a modified perspective on the matter, you could put that frame of mind into action and see if it holds true! So, in the example above, how about talking to your daughter first, even though she didn't acknowledge you as you had wished? How's her response? Was it different from what you had in mind about her?

Take back your power from your negative thoughts. Reinvent you!

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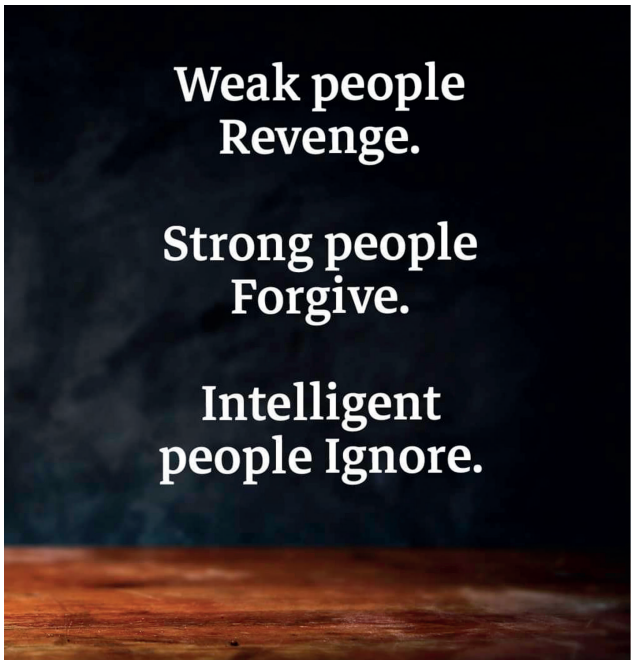

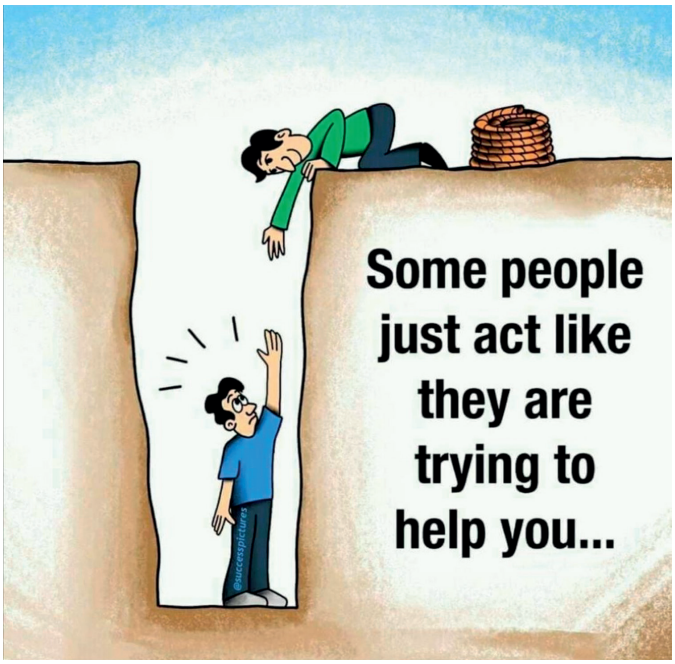

Sound Advice for Retirees

- Between 60 and death. It's time to use the money you saved up. Use it and enjoy it. Don't just keep it for those who may have no notion of the sacrifices you made to get it. Remember there is nothing more dangerous than a son or daughter-in-law with big ideas for your hard-earned capital.
- Warning: This is also a bad time for investments, even if it seems wonderful or fool-proof. They only bring problems and worries. This is a time for you to enjoy some peace and quiet.
- Keep a healthy life, without great physical effort. Do moderate exercise (like walking every day), eat well and get your sleep. It's easy to become sick, and it gets harder to remain healthy. That is why you need to keep yourself in good shape and be aware of your medical and physical needs. Keep in touch with your doctor, do tests even when you're feeling well. Stay informed.
- Always buy the best, most beautiful items for your significant other. The key goal is to enjoy your money with your partner. One day one of you will miss the other, and the money will not provide any comfort then, enjoy it together.
- Don't stress over the little things. You've already overcome so much in your life. You have good memories and bad ones, but the important thing is the present. Don't let the past drag you down and don't let the future frighten you. Feel good in the now. Small issues will soon be forgotten.
- Regardless of age, always keep love alive. Love your partner, love life, love your family, love your neighbour and remember: "A man is not old as long as he has intelligence and affection."
- Don't lose sight of fashion trends for your age, but keep your own sense of style. You've developed your own sense of what looks good on you – keep it and be proud of it. It's part of who you are.
- ALWAYS stay up-to-date. Read newspapers, watch the news. Go online and read what people are saying. Make sure you have an active email account and try to use some of those social networks. You'll be surprised what old friends you'll meet.
- Respect the younger generation and their opinions. They may not have the same ideas as you, but they are the future, and will take the world in their direction. Give advice, not criticism, and try to remind them that yesterday's wisdom still applies today.

Never use the phrase: "In my time." Your time is now. As long as you're alive, you are part of this time.

- Some people embrace their golden years, while others become bitter and surly. Life is too short to waste your days on the latter. Spend your time with positive, cheerful people, it'll rub off on you and your days will seem that much better. Spending your time with bitter people will make you feel older and harder to be around.
- Don't abandon your hobbies. If you don't have any, make new ones. You can travel, hike, cook, read, dance. You can adopt a cat or a dog, grow a kitchen garden, play cards, checkers, chess, dominoes, golf.
- Try to go. Get out of the house, meet people you haven't seen in a while, experience something new (or something old). The important thing is to leave the house from time to time. Go to museums, go walk through a park. Get out there.
- Speak in courteous tones and try not to complain or criticise too much unless you really need to. Try to accept situations as they are.
- Pains and discomfort go hand in hand with getting older. Try not to dwell on them but accept them as a part of the life.
- If you've been offended by someone, forgive them. If you've offended someone, apologise. Don't drag around resentment with you. It only serves to make you sad and bitter. It doesn't matter who was right. Someone once said: "Holding a grudge is like taking poison and expecting the other person to die." Don't take that poison. Forgive, forget and move on with your life.
- Laugh. Laugh away your worries. Remember, you are one of the very blessed ones. You have managed to have a life, a long one. Many never get to this age, never get to experience a full life.

My valued friends, enjoy a peaceful life at this point in your life.

I found the above advice very useful and thus hereby sharing them.

Extracted from an e-mail sent by Professor Sanath P. Lamabadusuriya

Presented by Dr B. J. C. Perera

Medi KAL Nutrience

SCIENCE BASED NUTRITION

8 GOLDEN RULES FOR HEALTHY KIDNEYS*

1 Keep fit be active

2 Eat a healthy diet

3 Check & control your blood sugar

4 Check & control your blood pressure

5 Take appropiate fluid intake

6 Don't smoke

7 Don't take over-the-counter pills regular basis

8 Get your kidney function checked

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* https://www.worldkidneyday.org/facts/take-care-of-your-kidneys/8-golden-rules/

KALBE

Exploring History: An Unusual Pursuit of a Doctor

Dr Ajith Amarasinghe

MBBS, DCH, MD (Colombo), MRCP, MRCPCH (U.K), MBA(Health Care), Diploma in Allergy and Asthma (Vellore)

Consultant Paediatrician and Clinical Allergist

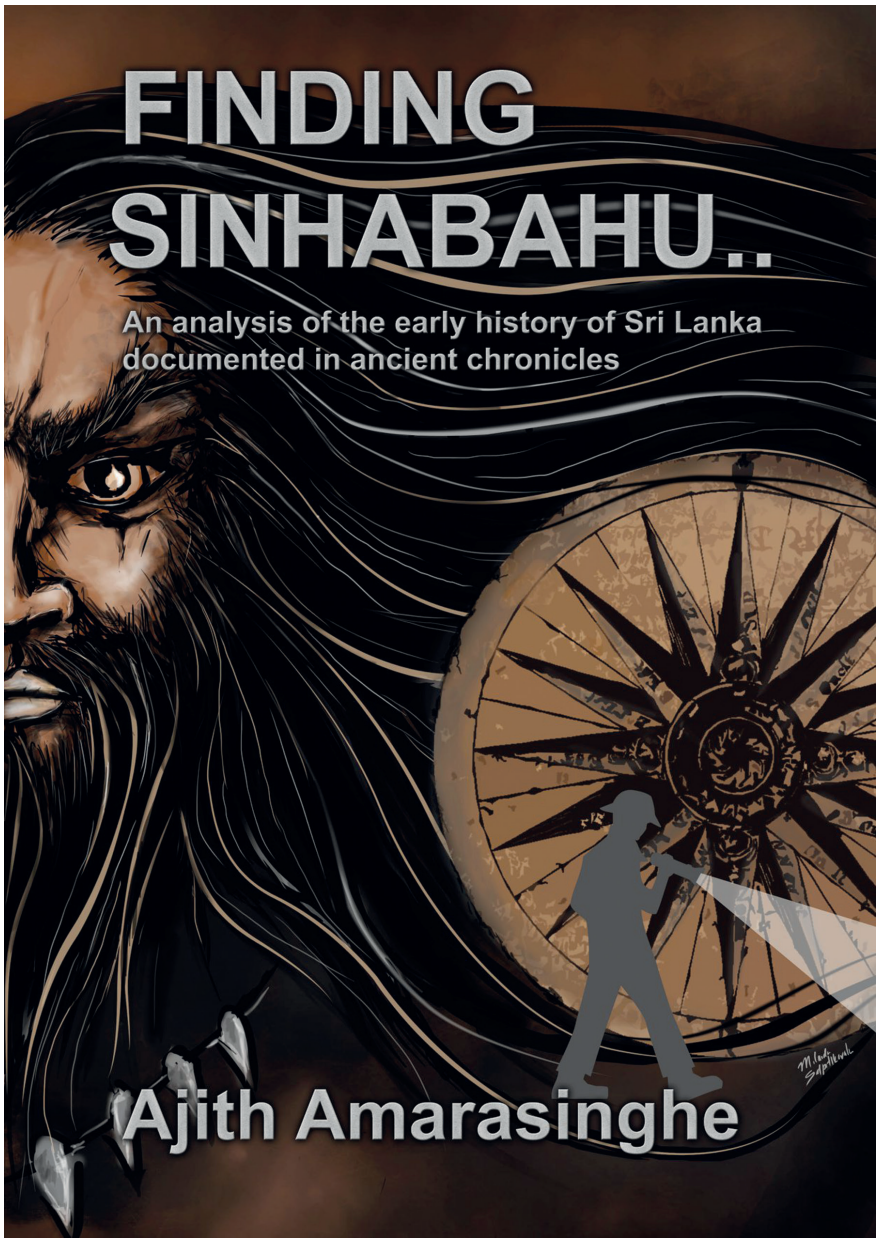
Q- Your historical research book, "Finding Sinhabahu" was nominated as the best research book at the "State Literary Festival". It is very unusual for a medical doctor to obtain a literary award in a non-medical discipline. What special features in your book do you think made you achieve this?

A- To my knowledge, it is after a long period of time that a historical research book written in English was nominated for a State Literary Award. Scientific historical research in our country has almost come to a standstill due to many factors. In my book, I have ventured into a territory which other historians have dreaded stepping into, which is the domain of the early history of Sri Lanka documented in Mahavansha and other ancient chronicles.

Q- Can you tell us briefly about the contents of your book?

A- Based on the contents of 2nd century B.C inscriptions, 5th century A.D copper leaf grants found in the Kalinga country of India and 12th century inscriptions in Sri Lanka, I have proof that the legend of King Sinhabahu, the father of the first king of the Sinhalese, Vijaya, is not a mythical story. I identified that the Sinhapura from where king Vijaya departed from India to colonize Sri Lanka, had been located at the present day Singupuram village, in the east coast of India.

Matching the recent Prehistoric, Protohistoric archeological findings with the anthropological, genetic and anatomical discoveries I have ascertained that the Yakkas (Demons) mentioned in Mahavansa, the ancient chronicle of the Sinhalese, were the ancestors of Vadda tribes, who inhabited the length and breadth of the island. Based on the same scientific findings, it is argued that the Sinhalese race sprang from an intermingling between the advanced segments of these indigenous Vadda tribes, who had reached the iron age by the 4th



- 5th century B.C and the Vijayan wave of East Indian migrants.

In addition, the stories of Pandukabhaya and his building of the city of Anuradhapura, the introduction of Buddhism to Sri Lanka by Arhath Mahinda, and the event of bringing the tooth relic to Sri Lanka, mentioned in ancient chronicles, are convincingly proven to be correct. Based on Tamil historical chronicles, I have established that the famous Aryachakaravarthi dynasty of northern Sri Lanka were not Tamils but a Kalinga royal clan, related to the first king of the Sinhalese, Vijaya. Based on scientific archeological, anthropological, genetic, and anatomical findings, I prove that despite having a different culture and language, there was significant mixing between the Sinhalese and Tamils of Sri Lanka in the past.

Q- How did you develop an interest in the field of history?

A- My interest in history developed at a very early stage of my life. When I was only four years old, my father was appointed as a judicial officer in Anuradhapura. There we were living amidst the ruins of the ancient city. I began to ask my parents about the history of the massive Stupas, tanks and ruins in the area. I contracted malaria, from which I suffered for almost one year, and even in states of delirium I dreamt of kings, royal courts, and ancient battles. During my primary school days, we moved to Tissamaharama and the school I studied at was in the location where the market of the ancient city was situated, 2000 years ago. Due to lack of classrooms, we were compelled to sit on fallen stone columns, which were arranged neatly as an open air classroom. In the evenings, I cycled in and around the city, admiring the ruins and determined to read the inscriptions on them one day. I wrote my first article in history at the age of ten years about "Yatalatissa Dagaba", which is the most ancient of all the Dagabas at Tisaamaharama, after having a lengthy discussion with the chief priest. Afterwards, during my school years, I wrote several articles on historical places, which were never published except in a handwritten class magazine which I published monthly.

During my middle school days I was studying in Matara, where our ancestral home was situated within walking distance to the Matara public library which was housed in the "Star Fort of Matara", a unique structure built by the Dutch. When I entered this library almost every week, I got the feeling that I was entering an ancient treasure trove, and my interest in any type of history book grew. I began to read avidly about the history of Sri Lanka and the world.

Q- What made you become a doctor?

A.There was no specific reason. My parents never insisted on me becoming a doctor. I feel it was due to pressure from my teachers and society that made me become a doctor. After obtaining best results at O/L in my school I was also scared that the society may think that I am out of my mind to select the arts steam. I wouldn't say that I had a passion to become a doctor, but I pursued biology without any regrets and entered the Colombo medical faculty. Later I qualified as a Consultant Pediatrician. My passion for writing became sharpened during the period when I worked as a translator in Wijaya Newspapers when the universities were closed for three years due to student unrest. During my medical school days and postgraduate studies, I continued to study history. My personal library had ten times more books on history than medicine.

Q- When did you start writing again about history?

A.After practicing Pediatrics for some time and settling down in life, I wanted to solve the historical puzzles that had interested me since my childhood. My first book, which was about a Chinese armada that came to Sri Lanka in the 15th century and abducted a king from Sri Lanka, was written in Sinhala. In that, I matched the Chinese historical chronicles with the local chronicles and revealed hitherto unknown historical facts. In fact, I traveled in search of a Sri Lankan royal family that settled down in China in that era and is now living in Taiwan. This book was serialized in a weekend newspaper and read by thousands of readers. In addition, I have written many articles on historical research in both Sinhala and English, which have been published in magazines and newspapers. As a result, I am frequently invited to deliver lectures in many forums on historical topics.

Q. Do you intend to continue doing research into history?

A.I do not embark on any research topic if I feel most of the facts about it have already been explored. Currently, I am writing a book on the early period of Portuguese occupation. In that, I am matching two Portuguese chronicles about that period with the Sinhalese chronicles. This venture too has revealed many hidden incidents in the history of Sri Lanka. In the west, my breed is known as "Hobby Historians." However, I take my hobby seriously as I will be doing injustice to history if I document facts which turn out to be incorrect.

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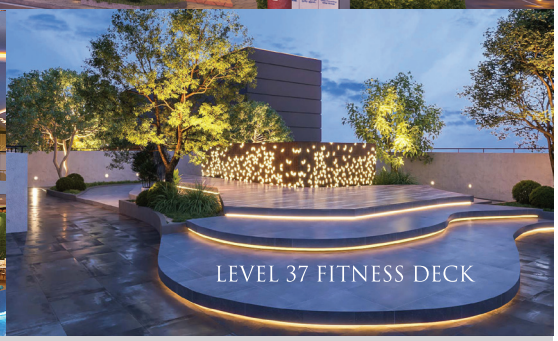

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