



Anecdotal Reflections of a Veteran Physician

1973 – 2025

Kolitha H Sellaheewa

Final year Medical Student

- Only 2 weeks for the exam
- Done only two deliveries
- **Record book – not signed by the Prof. O & G**
 - Strict disciplinarian
 - Firm
- Friend to the rescue
- **Prof is in the office – show this book and get it signed**
- **How many deliveries have you done? TWO sir**
- What is this book? Given to me by a friend
- Warned me BUT **SIGNED the book – Eligible to sit the exam**

Honesty Prevailed



**LESSON
BE
HONEST & TRUTHFUL
ALWAYS**

*SIMC.COM
2025
Zambo*



Preparations for the Internship

- ▶ No career guidance
- ▶ **No pre-intern workshops**
- ▶ **Skills labs were non existent**
- ▶ Did not work as Pre-interns in private hospitals
- ▶ Not developed the competencies
 - ▶ CPR
 - ▶ Intubation
 - ▶ Lumbar punctures

BUT

Sound & through knowledge of theory including procedural techniques

- ▶ Expected to learn and master practical skills during the internship
- ▶ No Internet, computers or smart phones

Internship Oct. 1973

Colombo South General Hospital

- ▶ **ONLY TWO intern MOs** – one each for female & male wards
- ▶ **No Registrars, SRs or medical students**
- ▶ No time even to get acquainted to the unit and the hospital
- ▶ **APH, PPH, Severe Eclampsia Ruptured Uterus – within the first 48 hrs.**
- ▶ Person who cannot swim – dumped into the deep end as the first lesson in swimming



- ▶ Taught me – how to group & cross match blood
- ▶ I was running to & fro between the ward and blood bank
 - ▶ Grouping, cross matching and dispatching



Hand centrifuge

Long Duty Hours

- ▶ **Both Intern MOs worked every day:**
 - ▶ 8am – 12n
 - ▶ 3pm -5pm
 - ▶ 9pm -11pm
 - ▶ One Intern MO was on call
- ▶ **Salary app.490/= per month – NO Over Time payment**
- ▶ Took only half a days leave for the entire year – Half a day's pay deducted
- ▶ Interns were **NOT entitled for leave**

**Did not strike
Duty Bound
and
Duty Conscious**

Post Intern Appointment District Hospital Mirigama 1974

- ▶ DMO, 2 AMPs, 4 MOs, NO Consultants
- ▶ ALL MOs - 8am to 12n 3pm to 5pm
- ▶ After 5pm ONE MO for the entire hospital OPD & Wards
 - ▶ Salary app.850/= NO Private Practice NO Overtime
 - ▶ Barred from leaving the country – 5yr Compulsory Service
 - ▶ PGIM -infancy
- ▶ Lab facilities – hardly any
 - ▶ No radiology
 - ▶ No biochemistry
 - ▶ No Hematology
- ▶ Ward test – Test tube
 - ▶ **Glycosuria – Benedict test**
 - ▶ Brick red
 - ▶ Orange
 - ▶ Yellow
 - ▶ Green
 - ▶ Blue
 - ▶ Proteinuria – boiling test

**DM - Dose Adjustments
Depended
On this
Contraction**



Limited Resources 1970s and 1980s

- ▶ **Sophisticated equipment – non existent**
 - ▶ **US Scans, CT, MRI**
 - ▶ **CXR, X-ray Abdomen – was a luxury**
 - ▶ **ONE packet of catgut** was used to suture episiotomies in **TWO patients**
 - ▶ **Common sense – avoided contamination**
 - ▶ Access for accurate information and **rapid communication - lacking**
 - ▶ No Internet, computers or smart phones
 - ▶ **Call book sent by ambulance to the consultant's home**
 - ▶ **Thorough clinical evaluation**
 - ▶ **Intelligent application of fundamentals**
 - ▶ **Common sense**
- Dictated our Diagnostic & Therapeutic pathways

Duty Consciousness Dominated Personal Wellbeing DH Mirigama 1975

- Only MO in the station
- Attack of severe asthma – NO nebulizers
 - Ephedrine
 - Theophylline
 - Phenobarbitone
- Hardly able to breathe – **Did NOT report sick**
- Era without Tuk-Tuk, Uber, rapid communication facilities, mobile health services
- Drove the car myself to hospital
- **Adrenaline SC rested for 5 mts. – did a complete HOSPITAL ROUND**

Ephedrine co

Poems by Dr S.G.De Silva on retirement 2008

**Never worried about Health
Wealth or Fame
Ran a race as if there was no
race.....**



EL 3717

Posting as a Consultant Physician

G.H. Anuradhapura - 1990

- Only 2 weeks notice
- Not a popular station
- LTTE activities were rampant
- Advice from colleagues
 - DO NOT Report for work – report sick
 - Workout a post close to Colombo
- Reluctance to use influence & duty consciousness – **did the exact opposite**
- **Reported for work – quarters under repair, stayed in a hotel**
- Within 3 months – **Elam war 2 commenced**



Anuradhapura

- **Many challenges**
- Wealth of experience
- Tested and developed clinical skills to the utmost
- **Junior doctors – only 4 intern MOs**
- **No SHOs, registrars or SRs – not a Teaching Hospital**
- **NO SUB-SPECIALITIES**

- Cardiology
- Pulmonology
- Neurology
- Nephrology
- Gastroenterology
- Dermatology
- Rheumatology
- Hematology
- Intensive Care

- **Two ward rounds every day and saw all the patients**

**Only Specialists(2)
in
INTERNAL MEDICINE**



**Krait in the bed room
Russell's viper in the
garden**

**Dengue
Cerebral Malaria
Japanese Encephalitis**

Anuradhapura - Facing Challenges

Elam War II - 1990

- **ICU opened overnight**
- **NO consultant anesthetist**
- Experience in intensive care
 - Registrar SICU
 - Expertise in ventilation
- Consultant in charge – organized & managed
- **Shock lung – Jonny mines common**
 - **Precise ventilation – challenging**
 - Avoid barotrauma
 - Permissive hypercapnia
 - Calibrated the Blood Gas machine referring to the manual on my lap



Optimal Utilization of Limited Resources

G.H. Anuradhapura 1990s

- Investigations – judicious
- Clinical - Congenital or Valvular Heart Disease – MS, ASD, AS etc.
 - CXR
 - ECG
- G.H. Anuradhapura ↔ Cardiac Clinic G.H. Kandy ECHO

Hospital Ambulance (Free Service)

- Transfers - G.H Colombo (NHSL)
 - **Benefit the patient** – Mitral Valvotomy, Closure of ASDs
 - **Avoid unnecessary Transfers & wastage** – Massive dilation of the heart for Double valve replacement
 - Diplomatic yet firm and decisive

Optimal Utilization of Limited Resources

G.H.Anuradhapura 1990s

- **Adaptability & innovation**

- **IPPV in the ward** Krait bite, organophosphate poisoning – **Bedside Acoma ventilators**
- **Checking Ser. K⁺ to optimize Minute ventilation**



- **Applying precise knowledge of fundamentals to specific clinical situations**

- **Hyperventilation – Respiratory alkalosis – Renal compensation – K⁺ exchanged for H⁺ Hypokalaemia**

- **Non availability of ABG – not a deterrent** to provide **OPTIMAL CARE & SAVE LIVES**

Optimal Utilization of Limited Resources

BH Avissawella - 1993

- ▶ Middle aged woman
- ▶ **Headache** for 2 days, **sudden onset** – seen 3 doctors no relief
- ▶ Walked into the consultation room
- ▶ **Severity of the headache was evident in the face**
- ▶ Neck stiffness ++
- ▶ Suspected SAH – **No CT facilities**
- ▶ Admitted – **LP confirmed Dx**  **Transferred to NSU GHC**
 - ▶ Carotid angiography – Aneurism circle of Willis
 - ▶ Neurosurgery – **Life saved**
- ▶ **Optimal utilization of state resources – best care provided within a few hours without any contacts**
- ▶ **Cost for the patient** - Consultation fee of **60/=**

“

Lesson Do NOT Expect Ideal Conditions

”

There Will be Limitations
Problems

Every Problem has a Solution
Be Innovative, Flexible & Adoptable and Move on

Clinical Acumen

- **Observe every detail**
- Systematic detailed examination of every patient – several hundreds as MO
- **Recognize subtle changes**
 - Patterns of breathing
 - Pulse volume
 - Consistency and grades of tenderness of the abdomen
 - Soft
 - Firm
 - Rigid
 - Board like rigidity
- **Discern** – Perforated DU, Appendicitis, Peritonitis, Haemoperitonium

Abdominal Pain, Guarding, Rigidity – **Common to all**



Referred to surgeons **without US SCANS** Operated

**G.H.Anuradhapura
1990**





**Japanese
Encephalitis
Vacant expression**

**NO CT/MRI
NO Viral Ab Panel**

Connect with the Patient

SHO SICU GHC 1980

- ▶ Teenage school girl
- ▶ Suspected with **Mesencephalitis**
- ▶ **Admitted to SICU for LP**
- ▶ Drowsy flaccid limbs
- ▶ Suspected organophosphate poisoning
- ▶ **Too weak to talk**
- ▶ **Eyes told the story**
- ▶ Father – go back **search the room thoroughly**
- ▶ Came back with a **suicidal note – missing clue**
- ▶ Clinical deterioration – impending respiratory failure
- ▶ **Atropine & Pralidoxime – Dramatic response**

Clinical Diagnostic Precision
Avoided Harm
Cost effective Care



Avoided LP
Potential Harm
Avoided Ventilation
Potential Discomfort Harm and Expense



Rubber tapper 1993 BH Avissawella

- ▶ Young adult male
- ▶ In pain
- ▶ Great discomfort
- ▶ Hardly able to talk – No detailed history
- ▶ **Severe burning sensation in chest & abdomen**
 - ▶ **Mainly retrosternal**
- ▶ Stable general condition



KOLITHA

Observation

Circumoral burn marks
Black coloured urine

Circumstances

Rubber tapper
Easy access to acetic acid

Deduction

Acetic acid poisoning



Acute IVH



**Haemoglobinuria
NO Dipsticks**

Intervention



BLACK URINE



**Initiated Forced Diuresis
AKI Prevented**

**Dx & Managed without investigations
Avoided Delay of Rx
with
Attended Prognostic Benefit**



Different Aetiologies

Same Clinical Problem – Acute IVH – Black Urine

n = 82

- ▶ **Aetiological Diversity**

- ▶ Ingestion of *Acalypha indica* n=78
- ▶ Copper sulphate poisoning
- ▶ Acetic acid poisoning
- ▶ Dengue fever
- ▶ Malaria *P. falciparum*

- ▶ Essential to **diagnose early – Black urine**

- ▶ Management priority

- ▶ **Prevent AKI Free Hb** → Acute Tubular Necrosis

- ▶ **Forced diuresis** – promote tubular flow

- ▶ **Early, Aggressive, Dynamic** approach to fluid therapy

Diagnostic & Therapeutic Decisions Based on Observing the Urine Colour Bedside – NOT on Investigations



Before Diuresis



During Diuresis



After Diuresis

**AKI Prevented
by
FORCED DIURESIS**

**N= 82
NONE DIALYSED
Cost of RX that of
SALINE & FUROSEMIDE
Given EARLY
At
Inception of Haemolysis**

Limitation of Investigations Not a Deterrent

**Astute Observations
Circumstantial Evidence**



Provide Care

Rapid

Accurate

Economical

- **Avoid harm**
 - Investigations – Invasive & Inappropriate
 - Medication – Adverse consequences of blind therapy
- **Ensure – Comfort, Safety, Recovery**

Rational Prescribing

- ▶ Clear understanding of mechanisms of action

Nifedipine - vasodilator

Consequences



Offset the adverse consequence of reflex tachycardia

Combine Ca⁺⁺ blocker with Beta blocker – Rational prescribing

Judicious Use of Antibiotics

- Penicillin
- Streptokinase
- Gentamycin
- Chloramphenicol
- Amoxicillin/ Cloxacillin
- Erythromycin
- Sulphas
- Nitrofurantoin
- Nalidixic acid
- Metronidazole

Antimicrobial
stewardship (**AMS**)

**Cultures were not
readily available nor
reliable**

Empirical use – Rational

Fully conscious of

- ❖ **Emergence of drug
resistant strains**
- ❖ **Cost**
- ❖ **Patients comfort**
- ❖ **Oral vs Parenteral**

HAZARDS OF IV THERAPY

Thrombosed vein



Extravasation – Necrosis
Injudicious use of Inotropes



Thrombosed vein
Needed surgery





Fatal Outcomes due to Missed Diagnosis

Only Two

First - During internship

Second - Consultant in Anuradhapura

Intern MO CSGH 1973

- ▶ Middle aged male
- ▶ Vague upper abdominal pain
- ▶ Mild pyrexia
- ▶ Abdomen
 - ▶ Soft
 - ▶ NO tenderness, guarding or rigidity
- ▶ **Not an acute abdomen**
- ▶ **Looked ill**

What is the Diagnosis?

- X-ray abdomen NAD – **NO clue to the diagnosis**
- Except confident exclusion of an Acute abdomen
- BUT
- Looked ill - can not be ignored
- Something was seriously wrong but I did not know what it was ???
- **Managed conservatively**
 - Nil orally
 - IV fluids
 - **Repeated clinical review for new signs – Non developed**

What is the Diagnosis?

- ▶ **Consultant surgeon saw the patient**
 - ▶ Continue the conservative care
- ▶ I felt uneasy as **no definitive Dx was made**
 - ▶ Continued repeated clinical reviews for new signs
 - ▶ Nothing appeared
- ▶ **Then suddenly**
 - ▶ **Severe R/S chest pain**
 - ▶ **Collapsed in shock**
- ▶ **Physician consulted – Resuscitation failed**



Missed Diagnosis – 2 Days in Hospital Fatal Outcome – Cause of Death?

- ▶ Pathological PM
- ▶ Amoebic liver abscess – **superior surface**
 - ▶ Typical clinical features were absent
 - ▶ Fullness & tenderness – intercostal spaces
- ▶ Ruptured into pleural cavity – shock
- ▶ **CXR instead of X-ray abdomen**
 - ▶ May have saved that life ? [X rays were limited in 1973]

General Hospital Anuradhapura 1990

- ▶ Middle aged man
- ▶ **Fever**
- ▶ **Unconscious patient**
 - ▶ **NO focal neurological signs**
 - ▶ **NO neck stiffness**
- ▶ Malaria was a common problem
- ▶ **NO CT Scans at GHA nor in Colombo**
- ▶ Diagnosed as **Cerebral Malaria**
 - ▶ Empirical treatment - **Quinine IV started emergently**
 - ▶ Pending blood film reports
- ▶ **No rapid diagnostic kits**
- ▶ **Patient died within 6 hrs.**

Missed Diagnosis Fatal Outcome

- ▶ Post mortem revealed a **brain abscess**
- ▶ Availability of CT scans would have aided the Dx

LESSON

- ▶ **Cerebral abscess can present without focal neurological signs**
- ▶ Rapid access to neuroimaging



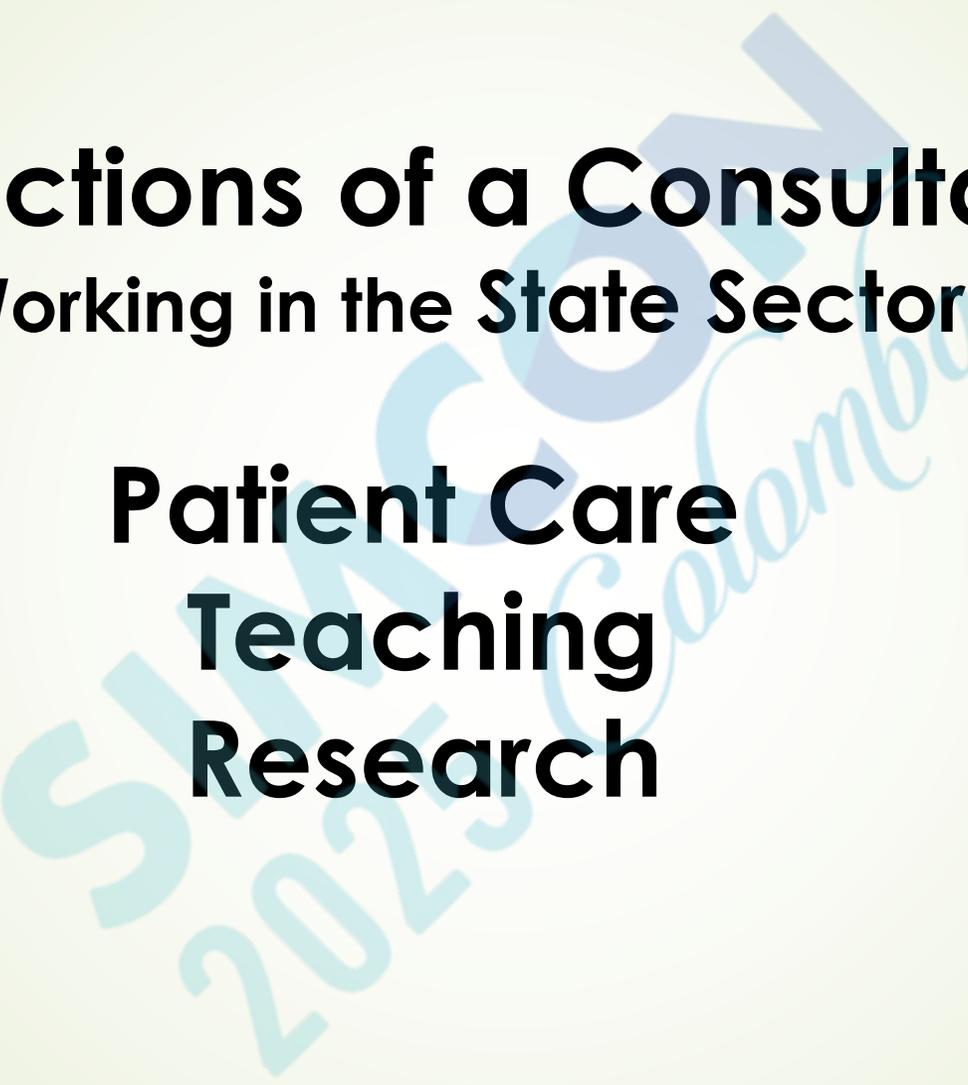
- ▶ Burr hole and aspirate

**“Never let the sunset twice in a patient with a
Cerebral Abscess”**



Functions of a Consultant Working in the State Sector

**Patient Care
Teaching
Research**





2253

Prof. Koththa Sellahewa





Gave Back ALL What We Knew



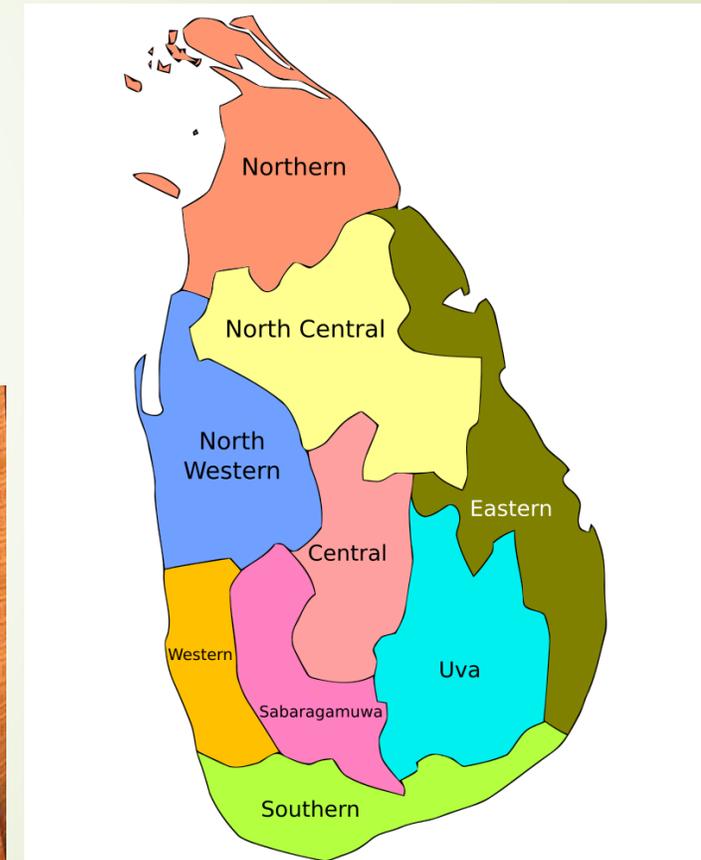
Bedside Teaching-Melaka G.H



Training in Snakebite & Dengue Improve Case Management

- Workshops
- Seminars
- All over the country
- **Jaffna during the war**
- Provide transport

INTENT
Reduce Deaths



Training Lay Volunteers Bag & Mask Ventilation First Aid Centers in the Field



Intent
Prevent Pre-Hospital
Deaths from Krait Bite



Training Extended Beyond our Shores

Dengue Epidemic
Lahore Pakistan – 2009

- **5000 cases every day**
- Did not know the **difference between DF & DHF?**
- This is the corridor of the ward Modified to accommodate the influx
- 2 patients in one bed
- **Learnt fast**
- **Implemented what we told them**
- **Succeeded**



Research

G.H Anuradhapura

➤ **Research** began

- **No** funds
- **No** computers
- **No** research assistants
- **No** secretaries
- **No** digital cameras
- Busy overcrowded wards
- **Patient care - Primary service commitment**
Exhaustive ward rounds twice every day
- Burning desire to **find answers to clinical problems**



Research Beneficial Impact

SLMA ORATION
1996

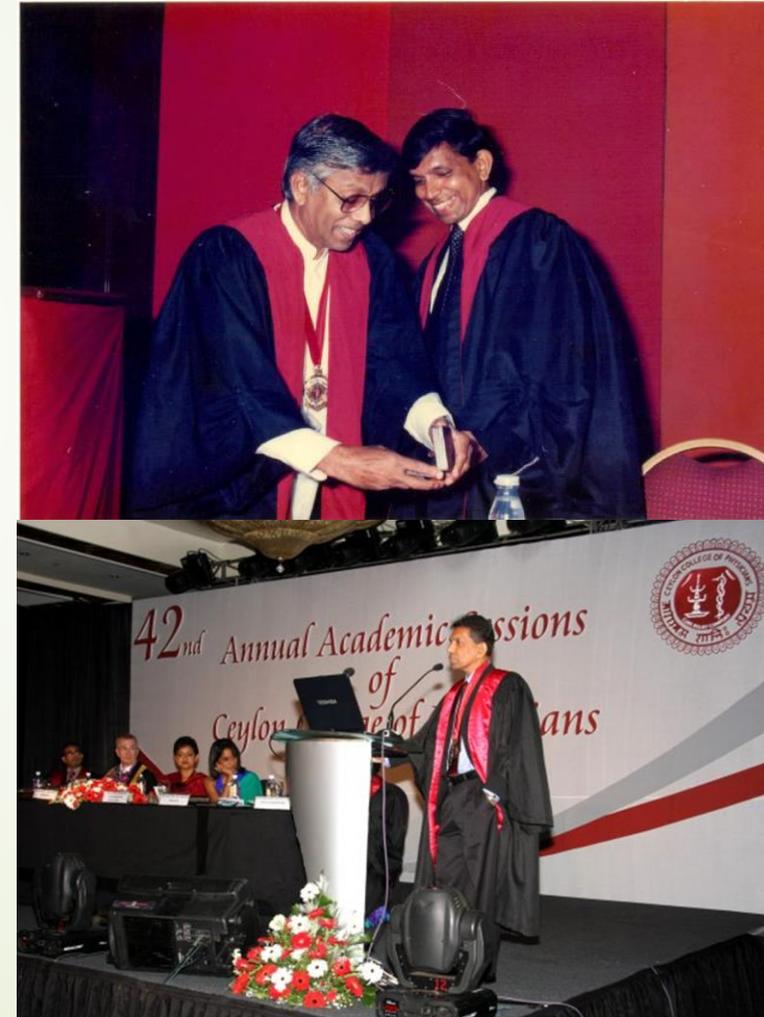
- ▶ **Use of AV for snakebite -1990s**
 - ▶ Patient selection
 - ▶ Dose of AV
 - ▶ Risk of reactions
 - ▶ Therapeutic options – IVIG, FFP - RCT
- ▶ **Hump-nosed viper – 1990s**
 - ▶ What are the clinical features?
 - ▶ What is the management?
 - ▶ How to prevent AKI?
- ▶ **Dengue – Epidemic – 2000s**
 - ▶ Fluid management
 - ▶ Management of thrombocytopaenia

**Improve patient care
Primary benefit
Clear Intent**

Spinoff Benefits of Research

Consequential NOT Intentional

- ▶ **Publications** – Local & International
- ▶ **Awards** – AAS of SLMA & CCP
 - ▶ S.E Senevirathne - twice
 - ▶ K.Rajasuriya
 - ▶ E.M. Wijerama - twice
 - ▶ Award for the best research presentation
- ▶ **Orations** – Inauguration of AAS of SLMA & CCP
 - ▶ SLMA -1996
 - ▶ P.B.Fernando - 2009
 - ▶ K.Rajasuriya – 2017
- ▶ **Points for professorship** – enough and more



Collaborative Research - Snakebite

Attempting to provide Species Specific AV



**Project Hijacked
Unfulfilled Requirement
Face debacles with equanimity**

“

Technology & Sub-specialization Enormous Benefits

”

Indubitable

BUT

Not without **LIMITATIONS & DANGERS**

Technology Bane or Benefit?

- ▶ Middle aged man in Medical ward **C.S.T.H 2000**
- ▶ **Clinical Dx** as a **Consultant Physician** - **Haemoperitonium**
- ▶ Transferred to surgical ward
- ▶ Seen and assessed by many Junior doctors **over several hours**
 - ▶ SHOs, Registrars, Senior Registrars
- ▶ Wanted an **US Scan** – fluid not sure **Blood or Ascites** – **Aspirated for confirmation**
further delays
- ▶ **Decided to operate – too late**
 - ▶ Patient died on the table
- ▶ **Similar problem same hospital G.H. 1973**
 - ▶ **Clinical Dx** as **Intern MO** - **Haemoperitonium**
 - ▶ **US Scans NOT available** nor SHOs, Registrars or SRs
 - ▶ **Operated within 30 mts.** – Patient survived

Technology & Sub Specialities Bane or Benefit?

- ▶ 49 yr. woman with **Backache** – August 2025
- ▶ **Consulted Rheumatologist**
- ▶ Blood tests - NSAIDs
- ▶ One week later – pain spread to the back & **RIGHT side of chest**
- ▶ **Consultant Physician**
 - ▶ Blood tests
 - ▶ **Mammogram**
 - ▶ HRCT chest
- ▶ Problem not solved
 - ▶ Battery of expensive tests but NO biopsy
 - ▶ **NO Histological Dx**
- ▶ **Financial reserves exhausted** – Consulted me
 - ▶ Did not look at the investigations
 - ▶ **Examined the patient**

Referred to oncosurgeon

Discoloured skin



R breast BIGGER than L



Technology & Sub Specialities Bane or Benefit?

- ▶ In **1973** as Intern MO
 - ▶ NO Mammograms
 - ▶ NO HRCT
 - ▶ NO US SCAN
 - ▶ NO FNAC
- ▶ Palpable breast lump – **Excision biopsy**
- ▶ **Histological DX**
↓
- ▶ Definitive Management pathway
 - ▶ **Without delay**
 - ▶ **Without leaving the patient a pauper**
- ▶ **Medicine was not a large industry then**



The Dawn of the 21st Century

- ▶ Abundant & rapid access to information
- ▶ Technological advances – unprecedented
- ▶ Use of AI
- ▶ **Patient issues**
 - ▶ High expectations
 - ▶ Demanding
 - ▶ Litigation
- ▶ **Physician issues**
 - ▶ Competition
 - ▶ Insatiable desire and greed for wealth
 - ▶ High cost of living
 - ▶ Caught in a rat race
- ▶ **Entangled In a cascading vicious cycle**



Bridging the Gap

- ▶ CCP Presidential address 2000 – *“An Odyssey into the New Millennium”*
 - ▶ *“There will be a technological explosion in the new millennium”*
 - ▶ Strike **the right balance** with technology & our intuitive judgment
- ▶ Bombardment of Information & Technology
- ▶ **Guidelines** and protocols are **designed to Rx diseases not patients**
 - ▶ American
 - ▶ British
 - ▶ European
 - ▶ Australian
 - ▶ Sri Lankan
 - ▶ Various Colleges
 - ▶ Associations
 - ▶ Expert committees & many more

Solution to bridge the gap?



Bridging the Gap

- Art of medicine – Ability to apply guidelines in a humane way

*The quintessence of this art of medicine
Is simply providing a humane form of care*

- **HUMANE VALUES** practiced in the 20th century are **equally applicable** to the 21st century **more that ever before**
- **Treated patients THEN** and continue to **Treat patients NOW**
 - Human beings
 - Unique
 - individuality
 - ❖ Feelings
 - ❖ Mind
 - ❖ Emotions
- Address all these attributes

DILEMA
Humane Care – HOW?

Current Society

Volatile

Turbulent

MINDFULNESS

Is a

Powerful Tool



Reconcile and Protect



Protection Patient and Physician

- **Humane practice - Protects both parties**
 - It is a quality - Heart and Mind



- **Meditation & Mindfulness – Cognitive Development**
- **Patient should be foremost in your care**
- **Do NOT use patients** as a commodity for your **Fame and Gain**
- All our **thoughts, words & actions** in delivering this care must be **rooted in Righteousness**
- **Natural law**
 - Will **Protect** you
 - **Benefits** will follow you
- Your **Intentions** must be **Pure and Genuine**



Parting Thoughts

- ▶ Happiness comes from **what we give** NOT from what we gain and amass
- ▶ **Selfless service** with **no expectations** in return
- ▶ Serve your – family, friends, class mates, batch mates, Neighbours, known and the unknown
- ▶ **Contribute** your **time, expertise** and **knowledge**
 - ▶ Profession
 - ▶ Academia
 - ▶ Society at large
- ▶ **Free of debt** →
- ▶ If I did some good “**The Young Internists**” can do **very much more & better**

We have a debt to pay

Retirement
Happy
Grateful & Contented
Mind is Free & Fearless

no reservations

Mission fulfilled



Thank You

*SINACON
2025
Colombo*