Editorial

The past and the future

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Sri Lanka College of Paediatricians greets the new millennium with a change of the name of its official publication, Ceylon Journal of Child Health to Sri Lanka Journal of Child Health.

Sri Lanka College of Paediatricians is the successor to the Sri Lanka (Ceylon) Paediatric Association inheriting its members, its journal and its finances.

In Sri Lanka, at the beginning of the 20th century children were not as important as they are today. Many children were born, many died, a few survived. Children were considered mini adults and were treated by adult physicians. Parents and extended family accepted the responsibility of the children, the able, the physically disabled and the mentally retarded.

The Lady Ridgeway Hospital for children was opened in 1910. But the children continued to be treated by adult physicians and obstetricians. It was only in 1937 that a qualified paediatrician, L. 0. Abeyratne was appointed to take over the Lady Ridgeway Hospital. In 1949 C. C. de Silva was appointed the first Professor of Paediatrics, University of Ceylon and Physician at Lady Ridgeway Hospital. Prof. Milroy Paul Professor of General Surgery continued to teach paediatric surgery.

Ceylon (later Sri Lanka) Paediatric Association was inaugurated in 1952 with L. 0. Abeyrathne as first President, C. C. de Silva Vice President and Milroy Paul as Secretary. Besides the few Paediatricians the back bone of the Association was General Practitioners who were then responsible for the care of the children. They enjoyed the confidence and trust of mothers; love and kind words were more important to mothers than academic knowledge. The Association held monthly meetings, clinical demonstrations and embarked on an educational programme. The first annual Congress of Paediatrics was held in 1961 with Dr. Martin Bodian of Great Ormond Street, London, as Guest Lecturer. Dr. Sydney Gellis of Boston was the Guest Lecturer in 1962. The British Council and the American Embassy sponsored these lecturers. We have continued to hold an annual Congress each year with foreign distinguished paediatricians as participants.

The Sri Lanka Paediatric Association flourished and with the assistance of the Department of Health, UNICEF and WHO, contributed to health education, improved environmental and personal hygiene, introduced immunisation and family planning.

Nutrition was improved and although poor nutrition still exists, we no longer see marasmus and kwashiorkor seen in the middle of the century.

Vitamin Deficiency is less seen though not eliminated. Blindness due to keratomalacia (Vitamin A deficiency), vitamin D deficiency rickets, scurvy (vitamin C deficiency) are now very rare.

Introduction of ORS has been a boon in prevention of severe dehydration.

lmmunisation has contributed to the elimination of suffering and death. Some of us recall the agony of seeing a child gasp for breath due to laryngeal diphtheria, the horrors of the old tracheostomy room. The poliomyelitis epidemic of 1962 with inadequate facilities for ventilation was a nightmare. The introduction of Oral Polio Vaccine has been effective. Diphtheria and Poliomyelitis are diseases of the past. DPT and Measles coverage has been good (there is 90% coverage) but there has been a recent resurgence of whooping cough and measles. This demands a review of our immunisation programme and vaccine used. Overall improvement of childcare is seen by our infant mortality, an improvement to 15.7 per thousand live births in 1997 from 140 per thousand live births in 1943.

Ours is not a total success story. New diseases have replaced the old e.g. Dengue Haemorrhagic Fever, Kawasaki Disease. Solving the problems enumerated earlier has resulted in survival and increase in childhood population. Recently the College has directed its attention to wider problems in the community e.g. Child Abuse, Children of Armed Conflict, Rehabilitation of the Displaced Child.

The problems faced in the new millennium are many and demand a solution. With the cessation of external resources, limitation of personnel we are dependent on the government for support. There is a laudable scheme to appoint a paediatrician to every district

hospital strengthening primary and secondary care throughout the country (except north and east, war zones). Tertiary care must be improved. Experts in for e.g. Cardiology, Neurology, Nephrology and Intensive Care are an urgent need. The time has come for an Institute of excellence catering for these; the new wing to be opened at the Lady Ridgeway Hospital should be the answer.

Health education at school level, continuous medical education of doctors need to be reinforced. There is an urgent need to renew the old ideal of service together with a stress on clinical experience. The pressing problems are limited resources, unacceptable workload for the staff, limited consultation time, shortage of beds. These can be solved with short admissions to hospitals, increased care in the community with a shift of responsibility to the family and general practitioners. A domiciliary service can be established under the supervision of the hospitals with the cooperation of the general practitioners. The practice of medicine has to be changed; more emphasis should be given to accurate diagnosis not to irrational treatment. This calls for better prescribing habits, and refraining from prescribing costly drugs, avoiding third generation antibiotics as the first line of treatment. Drugs should not be available over the counter, drug information should be provided to the consumer. There is a recent urge on the part of the mother to want quick results for e.g. reduce temperature immediately; they even resort to Voltaren suppositories repeatedly confusing the diagnosis and giving false security to the mother. This habit must be discouraged and nature allowed to take its course.

Good medicine is an art as well as a science; results will depend on patient's compliance. Authoritative communication with patients is vital. The tragedy of today's consultations is the perpetual rush, doctors having little time to explain and reassure the patients. Times have changed, public expectations are different; the public want to be partners in the treatment of their illness. Good clinical and communication skills, patience and tolerance must be encouraged. The public expects good care. This can be achieved by our association without extra resource and extra cost to the patients.

References

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