

SUTURE

ISSUE 2026 (1)

ISSN 3093-5059

THE EVOLVING ROLE OF THE GENERAL SURGEON IN SRI LANKA

Thushan Gooneratne, Pramod
Chandrasinghe, Thathya De Silva

THE KIDNEY
STONE REFERRAL
CENTRE –
MEERIGAMA
SLAUS

BALANCING SCIENCE AND
HUMANISM IN HEALTHCARE
Prof. Mandika Wijeyaratne

WOMEN
IN SURGERY
Dr. Melani Amarasooriya

TIGERS IN
INDIA
Dr. Chandima Amarasena



IN THIS ISSUE

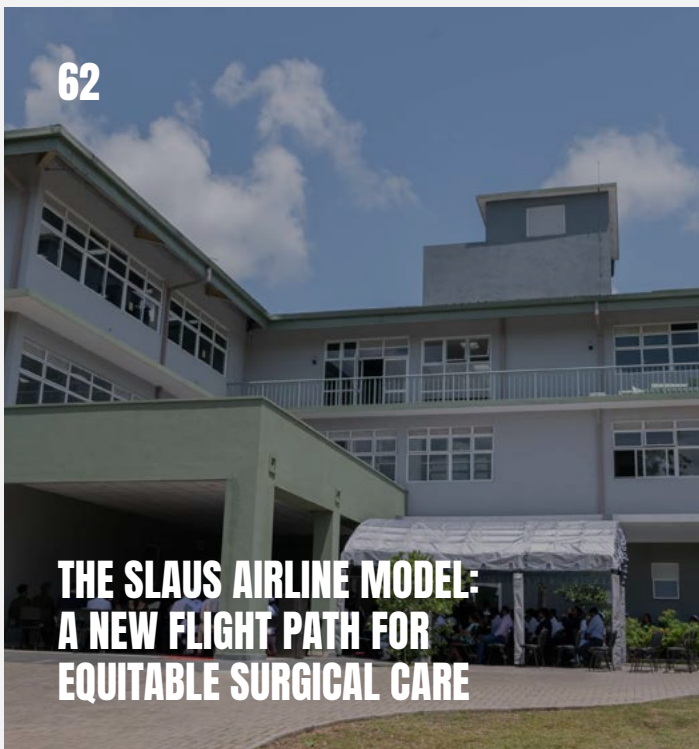
ISSUE 2026 (1)

CONTENTS

COVER STORY	4	The SLAUS Airline Model:	62
Cover story	4	A New Flight Path for Equitable Surgical Care	
COUNCIL 2026	6		
COLLEGE FOCUS	8	WOMENS CHAPTER	64
EDITORIAL	10	OFF THE SCALPEL	70
The Evolving Role of the General Surgeon in Sri Lanka: A Challenge or an Opportunity	12	Tiger – The Striped Monarch of The Jungle	70
'THE PULSE'	32	DID YOU KNOW???	76
		The Code of Hammurabi	76
FEATURES & NEWS	40	THE SURGEONS' CROSSWORD	78
Sri Lankan Society of Vascular Surgery - Vascular Surgery Coming of Age	42	LETTERS TO THE EDITOR	80
		Robotic Surgery	81
Sri Lanka Association of Minimal Access and Digital Surgeons	44	Reflections on the First Robotic Cholecystectomy in Sri Lanka: A Personal Perspective	82
Sri Lanka Association of Paediatric Surgeons	46	SCRUB IN FOR LAUGHS ..	84
From the Provinces	48	ANNOUNCEMENTS	87
INTERVIEWS / COMMENTARIES	56	SPONSOR	93
Beyond evidence-based medicine: Balancing science and humanism in healthcare	58		



**INAUGURATION CEREMONY -
SCIENTIFIC SESSION 2026**



ROBOTIC SURGERY IN SRI LANKA: WORTH THE HYPE?

This segment for SUTURE was contributed by Dr Avinash Jayasekara
Senior registrar in Vascular surgery

The recent arrival of two robotic surgery systems in Sri Lanka has generated a whirlwind of excitement, debate, and critical inquiry regarding their potential role in our healthcare landscape—a theme echoed throughout this issue of SUTURE.

Currently, these systems are available only in the private sector. However, their introduction into the government sector remains a topic of active discussion, particularly given our current economic climate, where even essential medical supplies are frequently in short supply. Nevertheless, there is a strong case for establishing at least one or two state-sector centres. Such centres would be invaluable for training and ensuring equitable exposure to robotic surgery for all surgeons in the country.

Though new to Sri Lanka, the da Vinci system received FDA approval in 2000. The past 25 years have witnessed remarkable

advancements in robotic technology, alongside the emergence of newer, more cost-effective systems.

WHAT ARE THE ADVANTAGES OF ROBOTIC SURGERY?

Foremost among these is ergonomics. The surgeon operates from a seated console, significantly reducing the physical strain associated with prolonged or complex laparoscopic procedures. Furthermore, the system offers seven degrees of articulation, enabling precise, controlled movements that make intracorporeal suturing easier, even in anatomically challenging areas such as the deep pelvis.

This precision translates into tangible clinical benefits. In genitourinary surgeries, such as prostatectomies, and gastrointestinal procedures, including funduplications and anterior resections, robotic assistance has been associated with improved quality-of-life outcomes. Patients may experience less blood loss, fewer nerve injuries, and a marginally faster recovery. Robotic platforms are already used across a broad spectrum of subspecialties—from neurosurgery to cardiac and vascular surgery—and it seems a matter of when, rather than if, these disciplines will embrace the technology in Sri Lanka.

AND THE CHALLENGES?

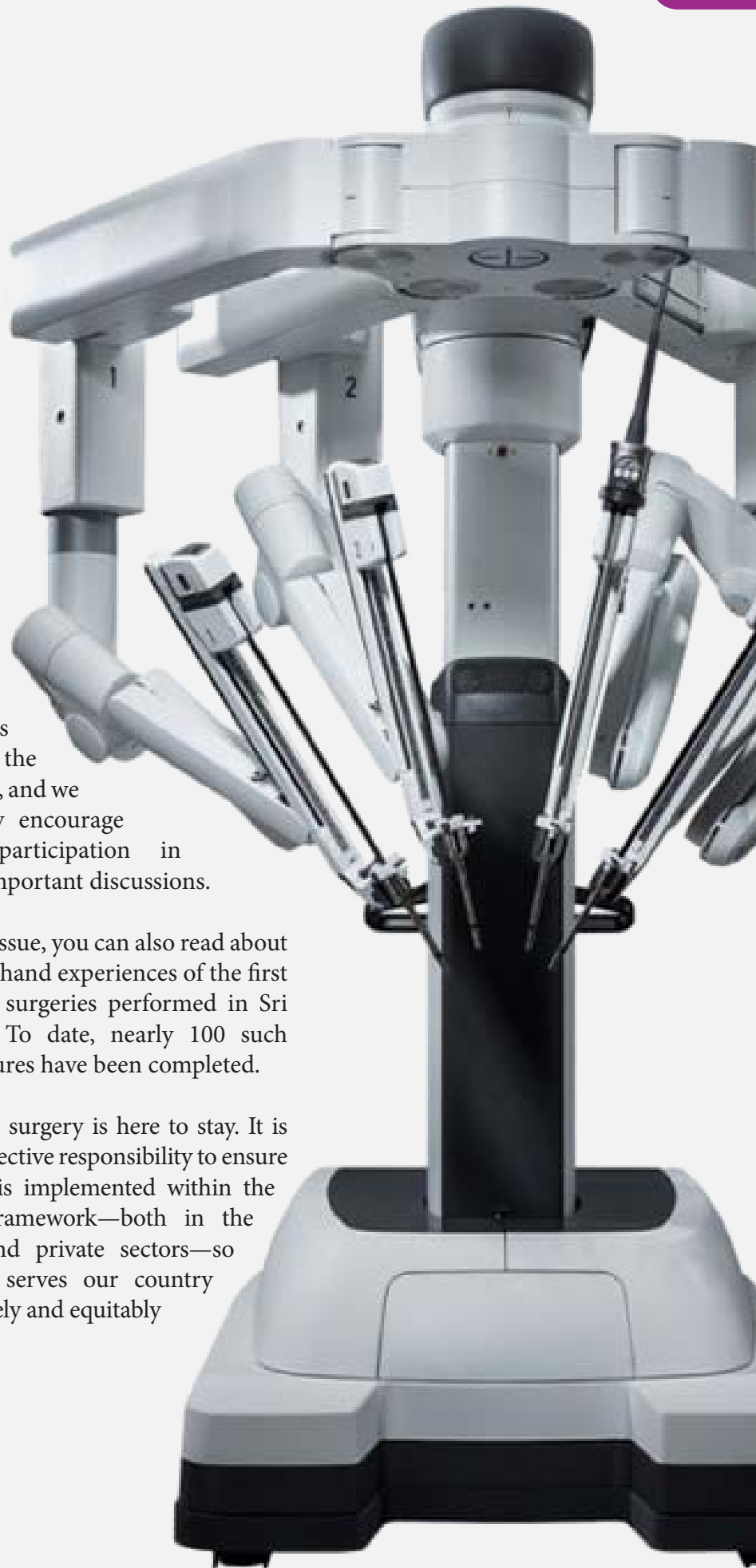
The most significant barrier in our setting is cost. Robotic procedures incur a substantial premium, with patients paying an average of LKR 150,000–200,000 more than for a conventional laparoscopic surgery. Additionally, prolonged anaesthesia time—partly due to system docking—and longer overall theatre occupancy further increase the financial burden on patients.

Given these added costs, the critical question remains: do patients truly benefit? A wealth of data and expert opinion on this subject will be shared at the Annual Academic

Sessions of the College, and we strongly encourage your participation in these important discussions.

In this issue, you can also read about the firsthand experiences of the first robotic surgeries performed in Sri Lanka. To date, nearly 100 such procedures have been completed.

Robotic surgery is here to stay. It is our collective responsibility to ensure that it is implemented within the right framework—both in the state and private sectors—so that it serves our country effectively and equitably



COUNCIL 2026



President
President-Elect
Vice President
Immediate Past President
Secretary
Assistant Secretary
Treasurer
Assistant Treasurer
Editor
Assistant Editor

Council Members

Professor Ajith Malalasekera
Professor Bawantha Gamage
Professor Rezni Cassim
Dr Duminda Ariyaratne
Dr Thathya de Silva
Dr Dulantha De Silva
Malik de Soysa
Dr R Gnanasekaram
Professor Pramodh Chandrasinghe
Dr Thushan Gooneratne

Dr Yasas Abeywickrama
Dr Mihira Bandara
Prof Arinda Dharmapala
Dr Gayan Ekanayake
Dr Kamal Jayasuriya
Dr Chathuranga Keppetiyagama
Dr Kavinda Rajapakse
Dr. Achala Samarasinghe
Dr Ranga E Wickramarachchi
Dr. Kanchana Wijesinghe

Past Presidents

Prof A P R Aluwihare
Prof A H Sheriffdeen
Professor Mohan de Silva
Prof Ranil Fernanbdo
Dr Jayaindra Fernando
Prof Srinath Chandrasekara
Dr Satish K Goonesinghe



COUNCIL 2026

SAARC Surgical Care Society
SL College of Oncologists
SL Society of Gastroenterology
Association of Neuro Surgeons
Association of General Surgeons
SL Orthopaedic Association
SL Association of Urological Surgeons
Association of Plastic Surgeons
Association of Paediatric Surgeons
Association of Cardiothoracic Surgeons
SL Society for Vascular Surgery
SL Association of Minimal Access
and Digital Surgeons

Dr Narendra Pinto
Dr Minoli Joseph
Dr Isuru Upanishad
Dr Stravinsky Perera
Dr Roshan Dassanaieke
Dr U Nandakumara G K Amarasinghe
Dr Munipriya Willararachchi
Dr K Sivasunganthan
Dr Ravibindu Ranawaka
Dr Mahendra Munasinghe
Dr Aruna Weerasooriya
Dr Rasitha Manatunga

CSSL Chapters

Central Chapter
Northern Chapter
Southern Chapter
Eastern Chapter
Wayamba Chapter
Uva Chapter
Sabaragamuwa Chapter
North Central Chapter
Western Chapter

Dr Vajira Jayasinghe
Dr P Srigrishna
Dr Kapila Gamage
Dr. S. Sutharsan
Dr Mahinda Mallawatantri
Dr Duminda Dissanayake
Dr Rasika Bulathsinhela
Dr S Srishankar
Dr Manjula Pathirage

COLLEGE FOCUS



Thathya de Silva
Honorary Secretary – CSSL- 2026

As the College of Surgeons of Sri Lanka moves through the second half of 2026, this has been a year of remarkable momentum — momentum built on the bedrock of the Council and the dedicated team working tirelessly behind the scenes, all guided by the vision of the current President, Prof. Ajith Malalasekara, and shaped by the legacy of the Presidents who came before him. As Secretary, it is a privilege to reflect on the dedication that has brought the College to this pivotal moment.

The Sri Lanka Surgical Congress 2026 - A Testament to Hard Work

The most significant event on the College's calendar this year is the Sri Lanka Surgical Congress 2026, taking place from 3–5 September at the Cinnamon Grand, Colombo. Under the President's guidance, the Congress Committee, Council, and office staff have worked tirelessly — through countless late nights and meticulous coordination — to curate a programme set to be a landmark in the College's academic calendar. The response has been overwhelming, with an unprecedented number of delegates and speakers expected from around the world.

This year's Congress is themed "Shaping Tomorrow's Surgeon," built around three foundational pillars — Academia, Integrity, and Accountability. Set by Prof. Malalasekara as the guiding mission for

the College this year, these are not merely words on a page; they are the principles

There remains a firm commitment to advancing surgical education and cultivating a culture of lifelong learning.

that define the College, and they will run through every session, workshop, and discussion at this year's gathering.

Academia lies at the heart of the Congress and of the College's work as a whole. There remains a firm commitment to advancing surgical education and cultivating a culture of lifelong learning. The programme reflects this through masterclass pre-congress workshops, live-streamed demonstrations from operating theatres, and rigorous research symposia — alongside an outstanding lineup of eminent international and local resource persons, including distinguished representatives from the Royal College of Surgeons of Edinburgh and other sister colleges. This same commitment underpins the College's

year-round training programmes, from the National Trauma Management Course (NTMC) to Advanced Trauma Life Support (ATLS) and its pioneering cadaveric workshops, as well as the new Collaborative Research Programme, which ensures practice remains evidence-based and aligned with the cutting edge of global surgical science.

Integrity is the bedrock of the profession. In an era of growing complexity and ethical challenge, the College stands firm in upholding the highest standards of professional conduct. The surgeon of tomorrow must possess not only technical excellence but also moral clarity



In an era of growing complexity and ethical challenge, the College stands firm in upholding the highest standards of professional conduct.

and a deep sense of responsibility to patients, colleagues, and society — values instilled through every stage of training and mentorship, and values this Congress is designed to reinforce.

Accountability keeps the College answerable to the communities it serves. Patients place profound trust in surgeons, and the College remains committed to embedding accountability across every aspect of practice — from the operating theatre to the boardroom, from training to outcomes. Assessment frameworks and quality assurance mechanisms continue to be refined to ensure members deliver safe, effective, and compassionate care.

Reaching Out to the Provinces - Bridging Gaps

A key focus of the President's tenure and the Council this year has been bridging gaps in surgical care across Sri Lanka. The Council has visited chapters in Kandy, Jaffna, Batticaloa, and other regions to hear directly from surgeons

working in the periphery. These visits are not ceremonial — they strengthen the provincial chapters and affirm that the College stands behind every member, regardless of where they practise. The commitment remains to make excellence

in surgical care accessible and equitable, bringing continuing professional development, mentorship, and collegial support closer to every community.

Looking Forward

As the College prepares to gather in Colombo this September, the responsibility and privilege carried by surgeons across the country is worth reflecting on. The future of surgery in Sri Lanka rests on a collective commitment to excellence, integrity, and service. None of this would be possible without the quiet, sustained effort of the Council and the team working behind the scenes, nor without the vision of the President and the Presidents who have led this College before him. On behalf of the Council, sincere gratitude is extended to Prof.

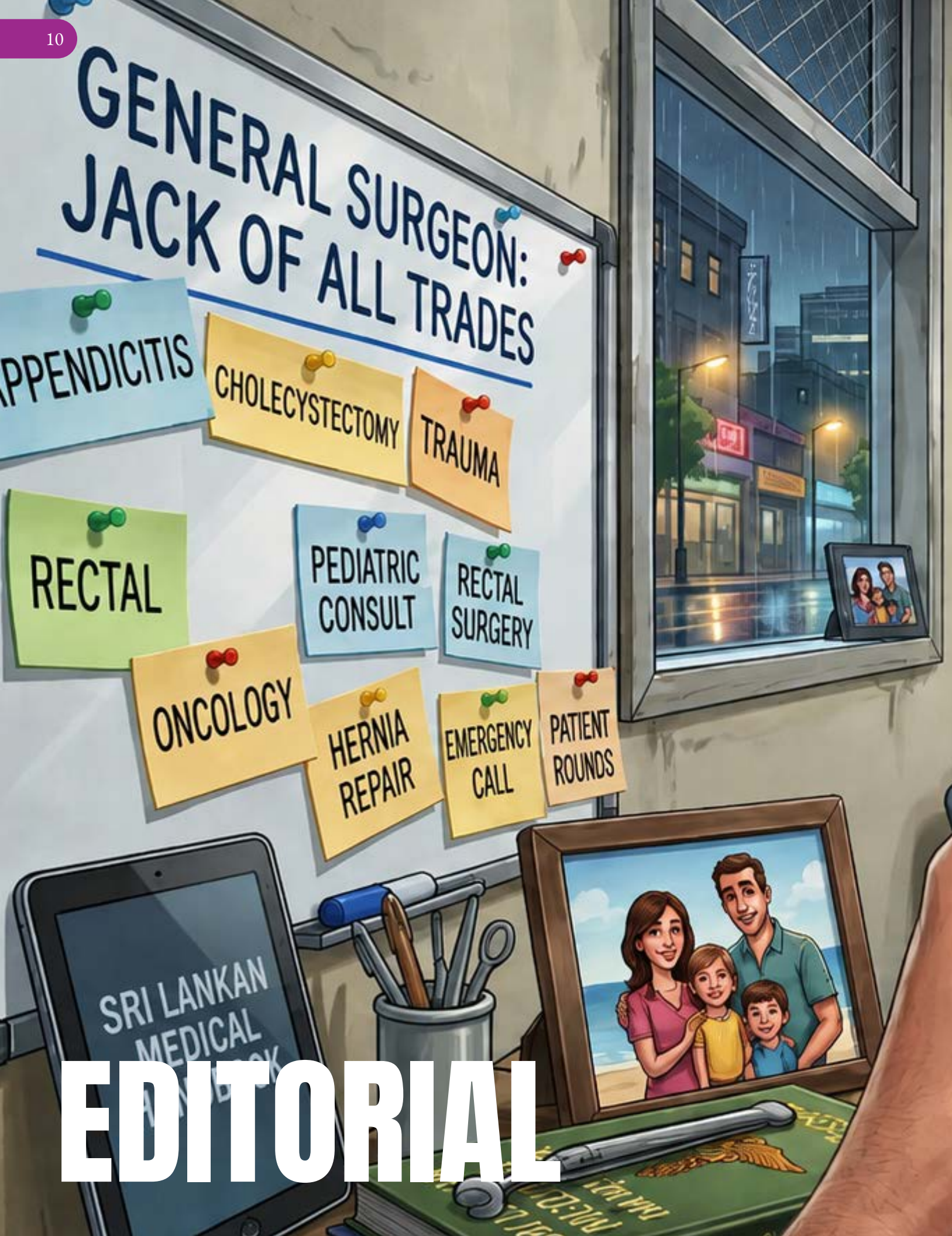


The future of surgery in Sri Lanka rests on a collective commitment to excellence, integrity, and service.

Malalasekara for his steadfast leadership this year, to every past President whose contributions continue to shape the College's path, and to every Fellow and member for their continued dedication

to patients and the profession.

The Congress promises to be a memorable and productive gathering for the entire surgical community





Dear Dad,
We miss you.
- Emily and Sam.

THE EVOLVING ROLE OF THE GENERAL SURGEON IN SRI LANKA:

A CHALLENGE OR AN OPPORTUNITY.

Thushan Gooneratne, Pramod Chandrasinghe, Thathya De Silva
Editorial Team - SUTURE

There was a time, not very long ago, when “the surgeon” and “the general surgeon” meant the same thing. He — and it usually was he — took out the gallbladder in the morning, repaired the hernia after lunch, ran the trauma list at night, and by the weekend had probably also fixed a fracture, delivered a baby, drilled a burr hole and repaired a popliteal artery injury for good measure. That surgeon was the backbone of every district and base hospital in the country, and in large part, still is. But the profession around him has changed almost beyond recognition, and the College must now ask, honestly and without sentiment, what we intend the general surgeon of Sri Lanka to become.

A SPECIALTY IN TRANSITION

None of this evolution was the product of a master plan. Cardiothoracic and neurosurgery, plastic surgery, paediatric surgery, and urology broke away as standalone specialties early; GI surgery, vascular surgery, and surgical oncology followed between the late 1980s and mid-1990s — largely because individual surgeons had the interest, opportunity, and overseas training to pursue them, at a time when board certification was considerably more liberal than today.

The 2012 introduction of a formal special interest pathway within general surgery was an attempt to correct for that drift — a deliberate PGIM effort to give the general surgeon comparable standing. What followed has been anything but settled: special interests added and removed for reasons rarely made public; dual board certification, once available, subsequently banned outright; and most recently the

point of declaration itself moved from the end of the first year of Post MD training to immediately before board certification.

These changes sit underneath two worrying trends: a growing reluctance among trainees to take up general surgery in preference for subspecialty training, and a corresponding

frustration among general surgeons already in practice, who have watched the ground shift under a specialty they were trained to believe was stable.

LET’S TAKE A STEP BACK - WHAT DOES THE COUNTRY ACTUALLY NEED?

Sri Lanka’s health service is unique in being entirely free, with unlimited access. At one end of the requirement sits the generalist — the surgeon capable of carrying the 24-hour burden of emergency trauma and acute general surgery, competently and alone if necessary, wherever in the country that need arises. This is not a ‘lesser role’. It is, and will remain, the single largest and most constant surgical need of the country.

At the other end sits a genuinely specialised cadre, deliberately kept small — ie for organ transplantation, bariatric surgery, and complex oncosurgical work, that demands

The 2012 introduction of a formal special interest pathway within general surgery was an attempt to correct for that drift - Has it worked ?

concentrated volume to keep outcomes credible against international standards.

Between those poles sits something the system has never quite defined or protected: a middle tier equipped to manage elective and semi-elective disease to a genuinely evidence-based standard.

Too often, this tier of general surgeons competes directly against the subspecialists alongside it — for caseload, theatre time, private practice, and perhaps more importantly, for self-worth and standing in the public eye. In some centres there is beautiful symbiosis, a general surgeon with a genuine special interest complementing rather than duplicating the subspecialist next door. But that has more to do with the goodwill of individuals in a given unit than anything the system has deliberately built.

WHY FEWER TRAINEES ARE CHOOSING GENERAL SURGERY?

Is it actually true that general surgery, as a primary choice, is losing its appeal? PGIM records of MD Part 2 pass-outs who go on to select general surgery say yes, and the pattern tracks the pathway's own history closely (see table 1). In the four years before the special interest pathway was introduced in 2012, almost 58% of successful candidates chose general surgery. Even with the introduction of the special interest, over the following 12-year era (2012–2023), that fell to 43%. And in the three years since declaration was pushed back, it has fallen further again, to under 34%. Data that should be read with appropriate caution given the many confounders, but the fact remains: it is a third consecutive step down rather than a recovery.

The shortage of general surgeons is real and compounding, through migration, resignation, early retirement, and trainees who never take up substantive posts at all. Precise Ministry of Health figures on current cadre vacancies — overall, and split

between peripheral and tertiary centres — and on how many general surgeons have left service were not available when inquired, but, no one will dispute that there is a significant shortage.

Globally, the role of the general surgeon is contracting and re-forming around subspecialty lines, and Sri Lanka is not exempt from that pressure. But we cannot simply import foreign systems directly, due to the unique nature of our health system. The periphery of this country still depends, and will continue to depend, on a surgeon capable of doing almost everything, on call, often alone.

Part of the answer lies in perception. But



Subspecialists enjoy fewer and more predictable hours than general surgeons, with a shorter working week that leaves more time closer to home

the arithmetic does not favour the choice. State pay is the same regardless of path, but the general surgeon works the full seven days of the week, further from home, for it. Private practice is thinner for the generalist in the far periphery, while the more remunerative elective work migrates toward whoever holds the relevant label in a bigger station. Single-surgeon stations don't give a surgeon the liberty to pursue academic and career development. From the first appointment, the peripheral surgeon without a declared focus risks being absorbed into undifferentiated caseload, and slow to build professional identity. The subspecialist is based centrally from early

on, carries a lighter and more predictable on-call burden, and is seen to have the more comfortable life.

No trainee is going to choose the same pay, more work, and a longer distance from home, purely on principle. What might make them choose it anyway is the credible promise of becoming genuinely excellent at something specific — a promise the system, right now, offers very few of them with any confidence.

THE DECLARATION PROBLEM

Declare too early, at the end of the first year of post-MD training, and you ask someone to commit before they have seen enough of surgery to know what genuinely interests them. Declare late at the end of the fourth post-MD year, after the overseas attachment is also complete, and the training meant to build the special interest has already happened — or, more often, has not happened at all, because no formal interest was declared at the time to give it shape.

We should be honest with ourselves: a small minority of Sri Lankan trainees will pursue focused training both locally and abroad on their own initiative, driven by personal ambition or opportunity, regardless of what the PGIM does or does not provide. That minority will always exist, and we should be proud of them. But the PGIM cannot design a training programme around the exceptional few. We exist to serve the majority — the trainee who needs a structure, a dedicated mentor, a timeline, and a reason to work toward something specific.

A more coordinated mechanism is not hard to imagine, even if harder to implement: declare early but allow a mid-way change of course against defined benchmarks; set those benchmarks clearly, so trainee and trainer both know what the training is meant to produce; build in regular appraisal, so continuation is a considered decision

rather than a default; restore a meaningful board certification at the end of it; and work with the Ministry on how special-interest-qualified surgeons are actually appointed and deployed, so training and posting stop being two disconnected conversations.

THE ELEPHANTS IN THE ROOM

Some of what drives this editorial is spoken about freely in corridors and consultant lounges, and almost never in print. It should be, even at the risk of discomfort, because an editorial that avoids the sensitive parts of this issue is not being fully honest with its readers.

Subspecialists enjoy fewer and more predictable hours than general surgeons, with a shorter working week that leaves more time closer to home. Most specialties besides general surgery carry no round-the-clock on-call commitment until they reach a multi-consultant station — largely an effect of structural design, not personal choice, yet it still shapes trainee decisions, and denying it helps no one. It sits awkwardly beside a second fact: a good number of subspecialists continue to perform general surgical work privately, often after hours. It is fair, not hostile, to ask why that same willingness cannot be extended to the public emergency rosters.

There is also an inconsistency worth naming in how we have organised subspecialisation itself. Most has developed along anatomical lines — upper GI, lower GI, hepatobiliary, breast. Yet some necessarily cut across organ systems altogether, i.e. subspecialties such as Oncosurgery, Gastro intestinal surgery and the special interest in Endocrine surgery. They are essential to multi-disciplinary teams, but working alongside general surgeons in that space can create real tension over territory and caseload.

This bears on how specialised surgical care should be organised. Complex, high-volume work plausibly justifies two or three deliberately resourced centres of

excellence. Harder to justify on that same logic is distributing subspecialists across every teaching hospital and district general hospital, when a general surgeon with a genuine special interest — given the right training and support — could manage the same patient to an equally evidence-based standard.

Finally, much of the instability in how special interests have been introduced, redefined, and abandoned has had less to do with a coherent workforce plan than with the preferences of whoever held institutional influence at the PGIM at a given time — a pattern that has cost the PGIM's stewardship a measure of the profession's confidence. The more recent period appears more considered and less personality-driven, an improvement worth protecting deliberately.

WHERE DOES THE COLLEGE STAND?

It would be convenient, and incomplete, to lay all of this at the door of the PGIM or the Ministry. Ask who is responsible, and each side has a ready answer for why it isn't them: the PGIM's curriculum is built around cadre and service requirements set by the Ministry, not designed independently; the Ministry, for its part, is not equipped from within the civil service to define how a surgical specialty should be structured. There is merit on both sides.

What neither has done is step forward and own the vision — and that gap is most plausibly a College problem. True, the College of Surgeons of Sri Lanka may not have the legal mandate, but we are the one body with the institutional memory, expertise, and clinical authority to define what we are training surgeons for, and to bring the PGIM and the Ministry to that table.

Dr S. A. Cabraal, President of the College of Surgeons (1976 -77), went on to become the first Director of the PGIM — the College and the nascent Institute grew

up together, at a time when the College's voice on curriculum, cadre projections, and accreditation was assumed, not requested. The senior statesmen of this College, many still among us, will confirm this was no symbolic arrangement.

Before asking the PGIM or the Ministry to do better, the College owes itself an honest answer: has it done enough? The General Surgery Specialty Examination, developed in collaboration with the Royal College of Physicians and Surgeons of Glasgow, marks an important milestone — and the effort behind it should serve as a foundation for the College to deliberately reclaim an active role.

A CHALLENGE, OR AN OPPORTUNITY

Sri Lanka still needs, and will continue to need, a surgeon in the periphery who can manage the breadth of general surgical work. The question is not whether that surgeon is needed — plainly, they are — but whether we make that role one a talented trainee would actually choose.



Instability created with Special interests been introduced, redefined, and abandoned haphazardly, rather than as part of a coherent workforce plan

Sri Lankan surgeon's entire training is free, which comes with an obligation most of us would accept: we owe the public service back for it. But an obligation is not a strategy, and the next generation of surgeons does not carry the same expectations as the one before it. If the obligation to serve is going to mean anything, the system has to make the periphery somewhere people genuinely want to work, not merely somewhere they are required to.

A POSSIBLE WAY FORWARD

Cadre vacancies should be planned around the country's actual peripheral service needs, not the collective preferences of the trainees in a given year. In practice, that likely means fewer subspecialist vacancies opened at entry, and a general surgery cadre restored to genuine primacy, with a 'meaningful' special interest available but perhaps not mandatory.

Base hospitals should be double-manned as a matter of course, so periphery service is never structured around one surgeon carrying the entire burden. A potential mechanism: two honest tracks rather than a false equivalence. A general surgeon WITH a special interest and

demonstrable progress against it should have a genuine, merit-based route to a middle-tier hospital equipped to support it. A general surgeon WHO OPTS OUT of the special interest, and instead carries the periphery's on-call burden should be rewarded properly — in pay, travel, and career progression — for genuinely yeoman service, not treated as having settled for less.

Where a special interest general surgeon and a relevant subspecialist share a space, the goal should be explicit synergy rather than quiet competition: shared conferences, real participation in the sister colleges, genuine mentoring from both. And the genuinely complex, high-volume work — transplantation, advanced oncological surgery — is better concentrated in three or four national centres, staffed by surgeons allowed to build careers centrally, as the acknowledged reward for work that is both harder and rarer.

None of this is achievable by any one institution alone. It requires a standing round table — the College, the PGIM, and the Ministry, together, laying down an actual framework rather than a sequence of individual decisions, reviewed annually and re-appraised every five years. Within it, the Ministry and PGIM remain best placed to train and deploy the right people in the right numbers; the College's task, different and overdue, is to define — with the authority of its own history — what this country actually needs its surgeons to be.

That round table may be closer than it looks. In the informal conversations behind this editorial, the Ministry of Health confirmed it is developing a five-year cadre projection intended to identify which specialties are genuinely short and which are in surplus, and expressed real willingness to mediate and convene exactly this kind of stakeholder roundtable. It is momentum, and the College should hold the Ministry to it.

This issue of SUTURE carries several individual perspectives on exactly this question, from Prof Ranil Fernando, Dr Duminda Ariyaratne, Dr A. S. K. Banagala, Dr Manjula Pathirana, Dr Rifzan Jameel, and Dr Ravindran Dhanushkar —each adding their own viewpoint on this issue, all well

worth reading alongside this editorial rather than instead of it.

The evolving role of the general surgeon in Sri Lanka is, in the end, both a challenge and an opportunity — but only one of those futures is available to us by default. The other has to be built. The College's task, in the years ahead, is to decide which one it is prepared to build, and then to do the harder work of actually building it.

TRAINEES SELECTING GENERAL SURGERY AFTER MD PART 2, 2008–2026

Year	Batch size	Selected General Surgery
2008	26	11 (42.3%)
2009	54	30 (55.6%)
2010	29	20 (69.0%)
2011	24	16 (66.7%)
2012	23	12 (52.2%)
2013	30	17 (56.7%)
2014	25	13 (52.0%)
2015	27	9 (33.3%)
2016	16	5 (31.3%)
2017	30	7 (23.3%)
2018	25	10 (40.0%)
2019	27	11 (40.7%)
2020	43	18 (41.9%)
2021	22	10 (45.5%)
2022	53	24 (45.3%)
2023	44	21 (47.7%)
2024 (May)	17	7 (41.1%)
2024 (Nov)	15	3 (20.0%)
2025 (April)	12	4 (33.3%)
2025 (Nov)	16	7 (43.7%)
2026 (April)	14	4 (28.6%)

Both a challenge and an opportunity — The College's task is to decide which one it is prepared to build, and then to do the harder work of actually building it.

Section #1 of 6

GENERAL SURGERY AT A CROSSROADS: RENEWAL, RELEVANCE & THE ROAD AHEAD



Dr Duminda Ariyaratne

Chairman, Specialty Board in General Surgery, Post Graduate Institute of Medicine.

Immediate Past president, College of Surgeons

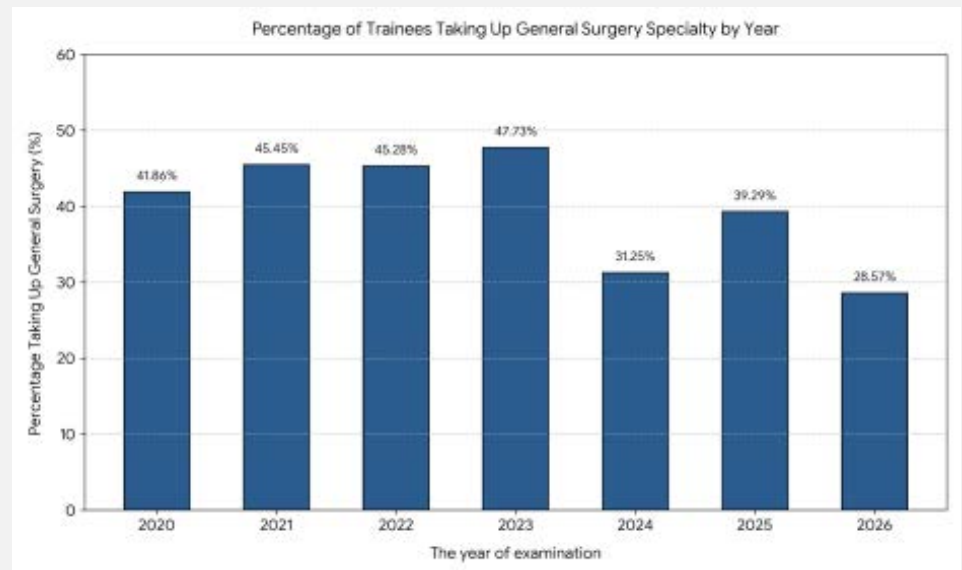
General Surgery has historically been regarded as the bedrock of surgical practice. The general surgeon continues to be the clinician uniquely equipped to provide comprehensive surgical care across a broad spectrum of conditions—particularly when the diagnosis is uncertain, the patient is critically ill, or urgent operative intervention is required.

However, General Surgery is now at an important crossroads. Across the world—including Sri Lanka, Asia, North America, Europe and Australasia—there is growing concern about the declining attractiveness of General Surgery as a lifelong career among postgraduate trainees. Increasing numbers of young surgeons are choosing organ-based or highly focused surgical specialties, while

fewer appear willing to commit themselves to the broad and demanding career of the general surgeon.

Selection of general surgery by the post MD higher surgical trainees given below:

Across the world—including Sri Lanka, Asia, North America, Europe and Australasia—there is growing concern about the declining attractiveness of General Surgery as a lifelong career among postgraduate trainees.



This trend should not simply be viewed as a failure to attract trainees. Rather, it should prompt us to examine how General Surgery is practiced, how surgeons are trained

and supported, and how the specialty can evolve to meet the expectations of the next generation.

Why are trainees turning away from General Surgery?

There are several reasons for this change in perception.

General Surgery remains one of the most demanding surgical disciplines. General surgeons frequently become the first port of call for complex, acutely ill and undifferentiated patients. They carry a disproportionately high burden of unscheduled and middle-of-the-night emergency work, often in contrast to subspecialties where elective daytime operating constitutes a greater proportion of clinical practice.

The cumulative effect of emergency workload, long working hours, and inadequate opportunities for recovery can result in exhaustion and burnout. More importantly, a heavy emergency commitment may leave insufficient time for general surgeons to develop expertise in complex elective surgery, academic work, research and teaching.

There is also a geographical dimension to the problem. Young general surgeons are often appointed to peripheral hospitals where infrastructure, staffing and other resources may be limited. They may have to provide a comprehensive emergency service with relatively little support, while simultaneously being separated from the academic and professional environment of major centers. The professional and psychological burden of working in such circumstances should not be underestimated.

Another concern among trainees is the perceived shrinking scope of General Surgery. As subspecialists increasingly assume responsibility for elective organ-specific procedures in both the public and private sectors, trainees may question what

will remain within the future domain of the general surgeon.

These concerns are genuine and they also provide an opportunity for renewal.

General Surgery must evolve—not disappear

The answer is not to resist sub specialization. Modern surgery has rightly evolved towards greater specialization, and this has undoubtedly improved patient care. Instead, we need to redefine the role of the modern general surgeon.

The general surgeon of the future should be a highly skilled emergency surgeon and a competent elective surgeon with a defined area of special interest. Sri Lanka has already taken important steps towards this model.

PGIM: Creating the modern general surgeon

The introduction of the Special Interest Scheme by the PGIM for General Surgical trainees in 2012 was an important milestone. It recognized that the modern general surgeon needs both breadth and depth of expertise.

The scheme has enabled trainees to develop a particular area of special interest while retaining the essential competencies required of a general surgeon. It has therefore helped create the concept of the surgeon who can “serve as a generalist at night and a specialist during the daytime.”

The scheme has progressed considerably, with an increasing number of special-interest trainers becoming available to mentor trainees.

The answer is not to resist sub specialization.

Modern surgery has rightly evolved towards greater specialization, and this has undoubtedly improved patient care.

Recent modifications have also provided greater flexibility. Although senior trainees identify their preferred special interest early in their training, they now have the advantage of declaring their final area of special interest at the Pre-Board Certification Assessment (PBCA). This provides an important period of reflection during which trainees can experience different aspects of surgery before making the final decision in choosing their career interest. This flexibility should be encouraged and continuously refined.

The Specialty Board in General Surgery has also undertaken important work towards developing and updating both pre-MD and post-MD curricula. The aim should be to ensure that Sri Lankan surgical training remains contemporary, competency-based and comparable with international standards, while still responding to the unique needs of our healthcare system.

The proposed development of a Transplant Surgery curriculum is another exciting opportunity. General surgical trainees will be able to opt for a special interest in organ

specific transplant surgery soon, while contributing to their national service.

The Ministry of Health: Making General Surgery sustainable

Training alone cannot solve the problem.

The working environment in which general surgeons practice must also change.

One of the most important challenges facing general surgeons, particularly in peripheral hospitals, is the heavy and often unpredictable emergency workload. This leaves little opportunity to develop expertise in a particular area of interest or to achieve a sustainable professional and personal balance. A more rational organization of emergency surgical services, through regional clusters of hospitals and coordinated emergency-take systems, could distribute this workload more equitably, improve the continuity and quality of emergency care, and make more effective use of the available surgical workforce.

Importantly, such a hub-and-spoke model could also provide the structural foundation for revitalizing general surgery through a meaningful special-interest scheme for surgeons in peripheral hospitals. Rather than expecting every surgeon to provide the entire spectrum of increasingly complex surgical procedures, individual surgeons could develop advanced expertise in defined areas such as upper gastrointestinal, colorectal, hepatopancreatobiliary (HPB), breast and endocrine surgery, emergency surgery, or, where appropriate, transplant surgery. This approach would preserve the versatility and generalist ethos of general surgery while providing surgeons with a clearer professional identity, opportunities for continuing skills development, academic engagement, and more structured career progression.

However, the success of this model depends on appropriate support from the Ministry of Health. Without such service reorganization, the special-interest scheme risks remaining largely aspirational and is unlikely to produce its intended benefits in the peripheral hospital setting.



One of the most important challenges facing general surgeons, particularly in peripheral hospitals, is the heavy and often unpredictable emergency workload.

In high-volume centres, consideration could also be given to developing dedicated Emergency Surgery and Trauma Surgery services, as has occurred in many healthcare systems internationally. Such services could provide specialist care for the severely injured and critically ill patient while allowing general surgeons to maintain and develop their elective areas of expertise.

Surgeons working in resource-limited and geographically isolated institutions should have appropriate infrastructure, accommodation, staffing, equipment, and professional support. Consideration should also be given to appropriate incentives or special allowances for those serving in particularly difficult stations.

If we want young surgeons to serve outside major cities, we must make peripheral surgical practice professionally rewarding rather than professionally isolating.

The College of Surgeons of Sri Lanka: General surgeons are the torchbearers

The College of Surgeons of Sri Lanka has a particularly important role to play in this transformation.

The College should increasingly become a lifelong professional development partner for every general surgeon—from the beginning of postgraduate training to the end of their professional career.

A modern general surgeon should have opportunities for:

- Continuous surgical skills development;
- Advanced minimally invasive surgery training including exposure to robotic and emerging technologies;
- International fellowships and professional exchange;
- Mentorship and career development;
- Research and academic collaboration;
- Leadership and management training;
- Post-fellowship subspecialty and special-interest development.

The College already supports general surgeons through workshops, conferences, skills programs and other educational activities. These initiatives should be expanded and taken closer to surgeons working throughout the country.

The relationship must be reciprocal. General surgeons have traditionally contributed enormously to the activities of the College on a voluntary basis. This partnership should be strengthened,

targeting colleagues who provide surgical services around the clock in peripheral and underserved areas.

The recently established Intercollegiate Advocacy Committee aimed at strengthening collaboration with Anaesthetists and Obstetricians & Gynaecologists in addressing broader issues affecting surgical service delivery.

The General Surgery Specialty Examination, initiated by the College in collaboration with the Royal College of Physicians and Surgeons of Glasgow, represents another important development. The opportunity to obtain an internationally recognised FRCS (Glasgow) qualification can enhance professional development and may facilitate access to overseas training and fellowship opportunities. In time, such programmes should also evolve towards structured post-fellowship upskilling, allowing practising general surgeons to acquire advanced competencies throughout their careers.

A National Surgical Skills and Simulation Academy

Perhaps one of the most transformative initiatives would be the establishment of a state-of-the-art National Surgical Skills and Simulation Academy.

Surgical training is changing rapidly. A national facility could provide a common platform for trainees and practising surgeons to develop and maintain skills in laparoscopic, robotic and conventional surgery. It could also serve as a centre for faculty development, assessment, research and international collaboration.

Such an ambitious project will inevitably require substantial investment. Strategic partnerships with credible external organisations, industry and philanthropic

institutions could help make this vision a reality.

AGSSL: Awakening the 'sleeping giant'

The Association of General Surgeons of Sri Lanka (AGSSL) has the potential to become a powerful advocate for the specialty.

Much has already been achieved by the Association, but the changing landscape of General Surgery demands an even more proactive role.

The AGSSL should become a strong platform for:

- Continuing professional development;
- Professional welfare and wellbeing;
- Mentorship of younger surgeons;
- Advocacy for appropriate working conditions;
- Engagement with the Ministry of Health on surgical workforce and service-delivery issues;
- Development of guidelines and standards for General Surgery; and
- Strengthening professional and academic networks among general surgeons.

However, an association is only as strong as the participation of its members. General surgeons themselves must take ownership of the future of their specialty and actively engage with the AGSSL.

Renewing general surgery- Inspiring the next generation

The challenge before us is not simply to persuade more trainees to choose General Surgery. It is to create a specialty that deserves to be chosen.

We must therefore move away from the perception of the general surgeon as the



The College of Surgeons of Sri Lanka, the Association of General Surgeons and the Ministry of Health, PGIM each have an important role to play.

person who is simply available to deal with whatever surgical problem nobody else wants to manage. Instead, we should promote the general surgeon as the ultimate surgical problem-solver—a surgeon with broad clinical competence, advanced emergency skills and the opportunity to develop genuine expertise in a chosen area of special interest.

General Surgery should not be seen as the competitor of surgical subspecialties. It is their foundation.

The College of Surgeons of Sri Lanka, the Association of General Surgeons and the Ministry of Health, PGIM each have an important role to play. But ultimately, the future of General Surgery belongs to all of us.

Our task is not to preserve General Surgery as it was. Our task is to reinvent it for the surgeon—and the patient—of tomorrow.

General Surgery has a future. We must now make that future worth choosing.

Section #1 of 6

RETHINKING THE GENERAL SURGEON: A SRI LANKAN BLUEPRINT FOR BALANCED SURGICAL CARE



Prof Ranil Fernando

*Emeritus Professor of Surgery University of Kelaniya, Consultant Surgeon
Past President College of Surgeons*

Introduction

Surgery is the art and science of healing using manual skills based on best available evidence. The word surgery evolved from the Greek *kheirourgia*—*kheir* meaning hand and *ergon* meaning work. The essence of the surgical craft remains unchanged as the surgeon employs manual skills to treat patients. From humble beginnings of treating wounds, injuries, fractures, and abscesses, many advances over the years have made surgery a precise art and science. In recent decades, with the introduction of advanced technology including endoscopes and robots, the landscape of surgery has changed greatly. Specialization and super-specialization have become the norm, yet the role of the General Surgeon remains ill-defined. In Sri Lanka, where the free health service places many constraints on resources, providing best and equitable surgical care adds another important dimension. Cost-effectiveness is a vital consideration. While the role of the General Surgeon needs clearer definition globally, in the Sri Lankan context it is essential to have a definition and role best suited to our health system. Lessons from more advanced health systems must be considered before making decisions. Hence defining the identity of

the General Surgeon in Sri Lanka is both a challenge and an opportunity.

The Challenges

Challenges in Training

Training a surgeon well is always

While the role of the General Surgeon needs clearer definition globally, in the Sri Lankan context it is essential to have a definition and role best suited to our health system. Lessons from more advanced health systems must be considered before making decisions.

challenging. In the era of open surgery, the apprenticeship model provided necessary hand skills and exposure, though some trainees attempted procedures beyond their skill level. The current training programme is robust and better supervised, but the role of open surgery has diminished. Endoscopic or robotic surgery is often depicted as ideal. Yet when complications arise during these procedures, open surgery is advocated to rescue the situation—a paradox that emphasizes that open surgery remains essential. Open surgical techniques must be mastered by the modern General Surgeon, as increasing use of endoscopic and robotic surgery will create situations where open surgery is required to overcome difficulties. Unless the General Surgeon is well versed in open surgery, a dangerous situation may arise. With increasing use of scopes, training in open surgery has become a difficult dilemma. Skills labs, videos, and simulators cannot match real exposure during live surgery. If all are super-specialists, who will train a General Surgeon? This question must be addressed by the surgical community and policy makers.

It is clear that General Surgeons are a much-needed species even in the era of AI and advanced technology. They must be

well versed both in endoscopic/robotic techniques and well-grounded in open surgery—a major challenge that requires rigorous supervised training. When training a super-specialist, the emphasis is not on providing day-to-day surgical requirements, making such a specialist less equipped for on-call commitments and trauma. Hence the need to train General Surgeons with special interests who will function as the workhorses of the healthcare system, alongside specialists who will deal with complex surgical problems. The urgent need is to combine the two schemes where the identity, dignity, and professional satisfaction of both groups is maintained. This requires a complete rethink of the organization of surgical services and better coordination between the PGIM and the Ministry of Health.

Challenges in Practice and Providing Equitable Surgical Care
Technology has provided many advances in surgical care, but new equipment is expensive and not readily available in a free healthcare system. Cost-effectiveness has not been adequately assessed. Yet a modern General Surgeon must be a highly trained

specialist who manages a wide range of surgical conditions—a challenge in both training and practice due to financial constraints. This also means a modern General Surgeon cannot be a “head to toe” operator of the bygone era. He or she must be well trained in the basics of surgical craft, able to deal with common surgical

problems, while mastering a few areas incorporating all advances to provide the best care.

With this concept, the PGIM introduced a scheme of training General Surgeons with a special interest. While the concept was sound, the mismatch between academic objectives and service requirements has cast doubts. The burden of workload and hospital organization did not permit the General Surgeon with a special interest to practice meaningfully. Data collection that would have empowered them was not a reality, and the need for a special interest became questionable. On the other hand, a super-specialist is not best equipped to undertake general surgical problems or deal with trauma while on call. This dichotomous situation has been the experience in Sri Lanka. It is clear that to provide the best patient care, a rethink of the whole system is needed. The role of the General Surgeon must be well defined and cannot be confined to mundane matters like incision and drainage, hernias, and hydroceles, while being on call for the rest of a professional life, especially in major hospitals. A team of General Surgeons and Specialist Surgeons must be considered,

**In truth,
the need in Sri Lanka
— especially in the
major part of the
hospital system—is
for a General Surgeon
able to deal with most
surgical problems, yet
also expected to be a
specialist in certain areas.**



where on-call commitment and surgical workload are shared, providing the best patient care.

In truth, the need in Sri Lanka—especially in the major part of the hospital system—is for a General Surgeon able to deal with most surgical problems, yet also expected to be a specialist in certain areas. When a surgeon functions as a General Surgeon

A General Surgeon in the state sector must take these matters into consideration and provide cost-effective surgical care. The General Surgeon must make a special effort to retain skills in the special area of interest and not become deskilled towards the end of their career.

over time, he or she may become deskilled in the special skills acquired during training. Hence the need for a team effort giving due recognition to the General Surgeon who provides the major part of surgical care.

While advances in surgery have been facilitated by newer equipment, non-availability of such facilities due to financial constraints means providing equitable care even in teaching hospitals is unrealistic, with little hope in peripheral hospitals. A General Surgeon in the state sector must take these matters into consideration and

provide cost-effective surgical care. The General Surgeon must make a special effort to retain skills in the special area of interest and not become deskilled towards the end of their career. This requires conscious effort, collaboration with colleagues, and an organized referral system. The need for Generalists rather than specialists or super-specialists is borne out by the need to provide equity in surgical care. This is both a challenge and an opportunity for the modern General Surgeon.

Challenges Posed by Super-Specialization

Super-specialization entails longer training and means such a specialist will not be available to the majority of patients, having to practice in specialized centres which may not be cost-effective, as the cost of specialized care has been shown to be higher. Some doubts have also been expressed about the holistic nature of care in super-specialization. The main advantage is expert care for very complex problems. This points to the need for a system of centres of excellence with super-specialization, while the majority of surgical care is provided by generalists with a well-organized referral system forming the link. Such a system will be effective even in a resource-limited healthcare system, re-emphasizing the essential role of the General Surgeon.

Opportunities

The Surgeon of the modern era must be an “all-rounder”—first and foremost a good clinician. Endoscopic and laparoscopic skills, with or without robotics, are essential. In addition, the modern surgeon must be well versed in applications of AI in surgical care and able to make full use of these facilities to enhance patient care and procedures. AI-driven applications can make surgical procedures safer and even minimize mundane activities like hand tremors. While manual skills and visual recognition of vital anatomy remain the cornerstone of surgical operations,

modern amenities act as valuable adjuncts enhancing care.

There is no doubt that rigorous training in Sri Lanka produces surgeons of the highest calibre who can excel in any global environment. The current era offers these surgeons an excellent opportunity to hone skills with AI and technology. Sri Lanka is well positioned to develop a surgical care system where General Surgeons undertake the bulk of care, with a few centres of excellence dealing with very complex problems through a well-organized referral system. This model, developed with foresight, can provide a roadmap for South Asia and perhaps the rest of the globe. Sri Lanka must not fall into a system where who drains an abscess or who does initial trauma management becomes a vexing problem, as experienced in some countries where over-specialization has taken place. With the existing state healthcare and hospital system, it will be the General

In addition, the modern surgeon must be well versed in applications of AI in surgical care and able to make full use of these facilities to enhance patient care and procedures. AI-driven applications can make surgical procedures safer and even minimize mundane activities like hand tremors.

Surgeon who performs the bulk of surgical management. They must arm themselves with all appropriate skills including a special area of interest, and be in a position to offer the best surgical care. Constant updating of knowledge, participating in workshops, and literary contributions are essential to this process.

Concluding Remarks

The debate about the best way to provide surgical services will go on, and necessarily so, as paradigms change with time. When deciding what is best, each country must be cognizant of all factors involved—advancing knowledge, academic needs of surgeons, global trends, changing patient demands, and most importantly cost-effectiveness and equity.

With the current state-funded healthcare system in Sri Lanka, where the majority of patients seek surgical care, the General Surgeon has an important role to play with many challenges to overcome. Selection of a special area of interest will empower General Surgeons and provide additional impetus to excel academically. While challenges exist, the current era provides excellent opportunities to develop a system where the bulk of surgery is done by General Surgeons, forming teams with specialists to provide on-call services and deal with complex problems through an organized referral system. The initial important step is to rethink and reorganize surgical care services in the country to provide the best patient care first, while ensuring the professional dignity and satisfaction of all surgeons concerned. The need in Sri Lanka is for a combination of General Surgeons with a special interest and super-specialists. Sri Lanka, with its competent manpower and academic abilities, is well positioned to set standards for the surgical community of the region and perhaps the world.



Section #3 of 6

THE EVOLVING ROLE OF THE GENERAL SURGEON IN SRI LANKA: A REAPPRAISAL AFTER 14 YEARS

Dr. A.S.K. Banagala

MS(Col), FRCSI, Dip.in Laparoscopic Surgery(Strasbourg).

Board Certified Consultant Surgeon, National Hospital of Sri Lanka



General surgery is the oldest surgical specialty in Sri Lanka. Development of other surgical specialties closely followed similar developments in the United Kingdom and the commonwealth for good reasons.

The scope of General surgery narrowed down over time and access to specialised surgical units improved due to the modernisation of transport, information, and health related technologies.

However, most of the emergency surgical work continued to be managed by General surgeons, as of 2006, and the seniority based promotion of General surgeons to the Teaching hospitals continued too.

General Surgeons who performed a wide array of procedures in the DGHs, found themselves to be redundant in Teaching hospitals because of the redistribution of case load and case mix with the specialised surgical units. The Association of General Surgeons of Sri Lanka recognized this and with the sanction of the PGIM and Ministry of Health initiated the training and Board certification of General surgeons with special interests.

**The
contemporary
and future
service needs
should be
defined and
solutions
found,
taking in to account
the demographic
changes anticipated,
and ways of working
within the available
finances**

These General Surgeons with special interests were expected to handle a wide spectrum of conditions in the periphery and take up specialised areas of General surgery as they migrate to teaching hospitals. This concept requires general surgeons to work hard towards their goal, and also requires the MOH and PGIM to commit themselves to facilitate this transformation.

There are both challenges and opportunities, when the going gets tough, the tough gets going. The working hours directive and concept of work life balance also needs to be taken in to account in finding way forward.

However, the ground realities are different, and since the inception of new Curriculum and syllabus in 2012, we have seen some successes and failures too.

After 14 years, I believe there needs to be a reappraisal of this subject involving CSSL, AGSSL, MOH, and PGIM. The contemporary and future service needs should be defined and solutions found, taking in to account the demographic changes anticipated, and ways of working within the available finances

Section #4 of 6

THE EVOLVING GENERAL SURGEON: FROM JACK-OF-ALL-TRADES TO SPECIALIST CLINICIAN



Dr Manjula Pathirana

*Consultant General Surgeon with special interest in Upper GI surgery, NHLS
(first batch of special interest trainees)*

General surgeons continue to be the backbone of surgical services in Sri Lanka. Their round-the-clock availability, unwavering commitment, and broad clinical expertise have enabled the country to maintain surgical standards comparable to those of many developed nations. However, the traditional identity of the general surgeon is undergoing a significant transformation. Rather than performing the full spectrum of surgical procedures, today's general surgeons are increasingly developing areas of special interest while continuing to provide comprehensive emergency surgical care.

Why General Surgery Remains Essential for Sri Lanka

Safe emergency surgery is not merely a healthcare service—it is a fundamental public necessity. Access to timely and quality emergency surgical care is a right of every citizen and a responsibility of the government.

General surgeons are indispensable in delivering this service. They provide emergency care across all age groups, from neonates to the elderly, and manage a wide range of conditions, including road traffic injuries, animal attacks such as dog bites, crocodile, leopard, and wild elephant injuries, acute abdominal emergencies, and life-threatening surgical conditions. They

also perform complex cancer surgeries and remain the frontline specialists available during nights, weekends, and public holidays.

While emergency surgery demands a broad range of competencies, elective and complex surgical procedures increasingly require subspecialized expertise to achieve the highest standards of patient safety and clinical outcomes.

However, the traditional identity of the general surgeon is undergoing a significant transformation.

From Generalist to Specialist General Surgeon

Recognizing global trends in surgical practice, the Postgraduate Institute of Medicine (PGIM) introduced the Area of Special Interest training pathway in 2012. This initiative marked a significant shift toward subspecialization while ensuring that all surgeons retained competence in emergency general surgery.

Surgeons trained under this system have acquired advanced skills in specific fields, setting new benchmarks for surgical

practice in Sri Lanka. For example:

- Surgeons with an interest in Upper Gastrointestinal (UGI) Surgery now perform advanced procedures, including bariatric surgery.
- Those specializing in Hepato-Pancreato-Biliary (HPB) Surgery undertake highly complex liver, pancreatic, and biliary procedures, with some also performing liver transplantation.

Subspecialization has therefore become increasingly important not only for improving patient outcomes but also for professional development, academic advancement, research opportunities, and international recognition.

Challenges of the Changing Identity

Despite these advances, several challenges remain.

The scope of traditional general surgery continues to narrow as more procedures become the domain of subspecialists. Furthermore, many anatomical regions are now shared with other specialties, reducing the exclusive practice areas previously associated with general surgery.

At the same time, undergraduate and postgraduate surgical training in Sri Lanka continues to be largely structured around conventional general surgery. As surgical practice evolves, there is a growing need to revisit training curricula to better integrate subspecialty exposure while preserving the broad-based competencies required for emergency surgical care.

Another important challenge is ensuring equitable access to specialized surgical services. While tertiary hospitals increasingly offer subspecialty care, many peripheral hospitals continue to depend heavily on broadly trained general surgeons.

At the same time, undergraduate and postgraduate surgical training in Sri Lanka continues to be largely structured around conventional general surgery.

Maintaining this balance is essential to ensure that patients throughout the country receive timely, high-quality surgical care.

Conclusion

The identity of the Sri Lankan general surgeon is evolving from the traditional “jack-of-all-trades” to a highly skilled clinician with both comprehensive emergency surgical capabilities and advanced expertise in a chosen subspecialty. This evolution should be viewed not as a threat, but as an opportunity to strengthen surgical services, improve patient outcomes, and align Sri Lanka with international standards of surgical practice. The future of general surgery in Sri Lanka lies in striking the right balance between maintaining broad emergency competence and fostering subspecialized excellence, while ensuring equitable access to high-quality surgical care for every citizen.



Section #5 of 6

THE PERIPHERAL GENERAL SURGEON IN SRI LANKA



Dr. Rifzan Jameel

*Consultant Surgeon with Special interest in HPB
BH Akkaraipattu*

When we talk about the evolving identity of the general surgeon in Sri Lanka, the perspective really depends on where you are standing. From my position at a Base Hospital in Akkaraipattu in the Eastern Province—with a special interest in Hepato-Pancreatico-Biliary surgery—I see a reality that is quite different from what might be discussed in Colombo. And I think it is worth putting that perspective out there, not to complain, but to have an honest conversation about where we are headed.

Life in a peripheral single-man station is demanding in ways that are hard to appreciate unless you have lived it. The daily volume of admissions is high, and there is no real separation between work and personal time. Even on weekends, you remain responsible for your unit. Cover arrangements, when they exist, are often virtual rather than physical—which is helpful but not the same as having someone on the ground. Because the catchment population is large, transfers to urban centres take time and coordination, and that adds another layer of complexity to patient care. Resources are another significant factor. Equipment is often second-hand, and support services like anaesthesia, radiology, and histopathology are limited. Leave is difficult to arrange in a single-man setup, which in turn affects one's ability to attend CME, CPD, and conferences—most of which are held in Colombo or other

Resources are another significant factor. Equipment is often second-hand, and support services like anaesthesia, radiology, and histopathology are limited.

major cities. These are practical constraints that can affect both morale and professional development. It is not surprising that some surgeons, especially early in their careers, choose to leave the public sector or even the country.

The situation in a larger hospital—a DGH, PGH, or Teaching Hospital—comes with its own set of challenges. Admissions are distributed, and resources are more available. However, sharing theatre space with multiple subspecialties can be a source of friction. Another recurring issue is the tendency for general surgical wards to become the default destination for patients that other teams prefer not to manage. For example, a head injury patient may be assessed by the neurosurgery team and deemed not to need acute surgical intervention.

That is a perfectly reasonable clinical decision. The difficulty arises when the responsibility for communicating that decision to the family—and for ongoing ward care—falls entirely on the general surgical team. This is not about refusing to look after patients, but about clearer lines of communication and ownership. If a patient has a pathology that clearly falls under a subspecialty, it would be more appropriate for that team to remain involved, even if only in a supervisory or consultative capacity. The current pattern, while perhaps born out of necessity, does create inefficiencies and adds to the workload of an already busy unit.

Perhaps the most important point to consider is how we support our junior

They step into roles with significant responsibility, often with limited infrastructure and support. This can be a steep and discouraging learning curve. Over time, the cumulative effect of these challenges— isolation, resource limitations, and restricted access to professional development—can lead to burnout and attrition. We have seen examples of this in recent years, and it is a trend worth paying attention to.

So, is this evolving identity a challenge or an opportunity? I would argue it is both. The challenges are real and systemic. They affect recruitment, retention, and the quality of patient care. But the opportunity lies in recognising the unique value of the general surgeon. We are not simply a fallback option or a gateway to subspecialisation.

Our training equips us to manage a broad spectrum of conditions, often in settings where no one else is available to step in. That is a strength that deserves recognition and support.

What we need is a practical path forward. Better locum relief systems to allow for leave and training. Fairer allocation of theatre time and resources across specialties. Clearer protocols for shared care and communication between teams. And perhaps most importantly, a genuine appreciation at the institutional level for the role that peripheral general surgeons play in the healthcare system. If we can address these issues, we can turn this moment of transition into a positive one—not just for surgeons, but for the patients and communities we serve.

Perhaps the most important point to consider is how we support our junior colleagues.

Many general surgeons begin their careers in a station far from home, immediately after completing training.

colleagues. Many general surgeons begin their careers in a station far from home, immediately after completing training.



Section #6 of 6

THE EDITORIAL FROM A TRAINEES PERSPECTIVE

Dr. Ravindran Dhanushkar

a graduate of the University of Peradeniya, currently serving as a second-year Surgical Registrar in Sri Lanka.



There was a time, not so long ago, when a surgeon in this country did whatever the situation demanded, with whatever the shelf offered. He was multifaceted; dynamic and adopted to whatever that's on demand-a Swiss army knife to be precise. A perforated duodenal ulcer, an obstructed hernia, a ruptured spleen, a large extradural hematoma, a difficult breech delivery at 3 a.m, because the obstetrician was two hours away- all of it fell to one pair of hands. Often those hands worked without the instrument they actually needed, improvising with what was available. That Surgeon was not a jack of all trades by choice. He was one by necessity, and the system ran on that necessity for decades. I'd call him the generalist.

That world is disappearing, and mostly for good reason. Yes, I meant mostly. Surgery has fragmented into hepatobiliary, colorectal, endocrine, breast, upper GI, surgical oncology - each with its own body of evidence, its own outcome data, its own case-volume thresholds below which results are simply worse. A patient with rectal cancer today deserves a surgeon who does rectal cancers often, not one who does them occasionally in between other cases. Nobody seriously argues against that anymore. The question is not whether sub-specialisation improves outcomes - it does - but whether Sri Lanka, particularly its state sector, has the number of specialists, the case volume, and the infrastructure to make

A perforated duodenal ulcer, an obstructed hernia, a ruptured spleen, a large extradural hematoma, a difficult breech delivery at 3 a.m, because the obstetrician was two hours away-
All of it fell to one pair of hands.

sub-specialisation the default model of care rather than the exception confined to a handful of National & Teaching hospitals.

***Practice more, specialize less
-is that actually an option?***

Walk into most base hospitals and district general hospitals, and the surgeon on call

that night is still, functionally, a generalist. He or she will see the acute abdomen, the trauma, the obstructed hernia, the incidental thyroid nodule, and the perianal abscess, often in the same shift. There is no hepatobiliary surgeon to hand the difficult gallbladder to at 2 a.m. If we insist that only the subspecialist should touch these cases, we are not raising the standard of care for the majority of the country- we are simply removing care from reach for patients who cannot travel to Colombo, Kandy, or Galle. Moreover, it'll complicate and delay service provision. So, the honest answer is that Sri Lanka currently needs both models running in parallel: subspecialist units in the tertiary centres, and a well-trained, broadly competent general surgeon holding the line everywhere else. But who goes to whom? That's the question that we have not found the answer to, at least yet.

Aspiring to higher standards; where do we stand?

There is a real temptation to want to offer everything that is technically possible-laparoscopic and robotic platforms, complex reconstructive options, the full spectrum available in better-resourced systems. Offering a service and sustaining it are two different things. A unit that performs an advanced procedure twice a

There is no hepatobiliary surgeon to hand the difficult gallbladder to at 2 a.m.

year is not practising advanced surgery; it is taking on advanced risk without the case volume that makes such surgery safe. Clinical governance has to mean more than credentialing a surgeon to do a procedure- it has to mean an honest institutional audit of whether the volume, the backup, and the after-hours cover exist to support that process long-term.

Whose territory is it, anyway?

The hand is probably the cleanest example of a problem that runs through the whole specialty. A crush injury to the hand could reasonably go to orthopaedics, to plastics, or to a plastic surgeon with a declared interest in hand surgery- and in practice, which one it goes to often depends less on what is best for the patient and more on which department happens to be less busy, or which registrar picked up the referral call first on a midnight. This ambiguity is there across breast disease shared between general surgery and oncosurgery, across thyroid disease shared between general surgery and ENT, and you have a system where territorial lines are drawn by convention and personality rather than by any agreed protocol.

This is also seen in other specialties. For example, in the place where I work, the endocrinologist and the internal medicine specialist have a cutoff of 400 for glycemic control. Where if the patient's random blood sugar is less than 400 you refer to the medical unit and if it's more than 400 you refer to the endocrinologist.

Patients & healthcare systems absorb the cost of that ambiguity in the form of delayed referrals, duplicated investigations, and the occasional case that falls into the gap between two units, each assuming the other has it. This is precisely where clinical governance should be doing its job- not as a disciplinary mechanism after something goes wrong, but as a set of agreed referral pathways that exist before the patient ever arrives.

Are you competent enough? The medicolegal shadow.

As sub-specialisation becomes the expected standard, the general surgeon who

manages a complex case outside a formally recognized subspecialty is increasingly exposed if the outcome is poor- even when no subspecialist was realistically available. Litigation culture in Sri Lanka is still young compared to many countries, but it is growing, and defensive practice tends to follow parallelly. On the other hand when you practice something that's beyond your expertise, is there a formal feedback system to see whether things went alright?

A general surgeon who declines to manage a case for fear of liability, in a hospital where no one else can take it, leaves the patient with nothing. Would a Kumarihamy travel all the way down to NHSL from Udawalawe for a breast conservation surgery?

Impact on training

Surgical core training during the pre-MD period is shaped largely by caseload- by the sheer variety of cases a trainee is thrown into. Historically, registrars gravitated toward units where they handled the widest range of cases, because in surgery, the more you see, the more you learn. The evolving subspecialty landscape has disrupted this in ways that are only now becoming obvious. In major teaching hospitals, where every subspecialty exists under one roof, classic cases are increasingly redirected off to subspecialty clinics before the general surgical registrar ever sees them. A breast cancer patient walking into the OPD, for instance, is now routed straight to the onco-surgical clinic, which means the general surgical trainee in that same hospital may not encounter a breast cancer case at all, until a short subspecialty appointment, if then. Someone who wants to learn to swim can read a hundred and one books on "how to swim," and you know exactly what happens the first time he's actually put in the water. This isn't an exaggeration. It's already happening, in our own hospitals, as we speak.

Clinical governance has to mean more than credentialing a surgeon to do a procedure- it has to mean an honest institutional audit of whether the volume, the backup, and the after-hours cover exist to support that process long-term.

Litigation culture in Sri Lanka is still young compared to many countries, but it is growing, and defensive practice tends to follow parallelly.

On the other hand when you practice something that's beyond your expertise, is there a formal feedback system to see whether things went alright?

The Paradigm Shift

Worldwide, there's a clear trend of more trainees opting into subspecialty training compared to the past. We don't have Sri Lankan data to confirm it, but Sri Lanka appears to be turning the same way as the rest of the world. In my view, several things are pulling in that direction-work-life balance, the reluctance to be posted to remote stations, and, given the current economic climate, the fact that private practice is simply more viable in some subspecialties



than others. Most subspecialties, unlike general surgery, deal predominantly with elective cases, which leaves more room for the things you value outside hospital work.

But let's address the elephant in the room. Once postgraduate training is complete, a general surgeon can declare a special interest, provided he meets the requirements set by the Board of Study. In practice, though, only a handful of these surgeons ever get to actually practise what they've specialised in. Take a newly qualified general surgeon with a special interest in upper GI surgery: unless he secures a post in a university surgical unit, he'll still be doing general surgical on-calls in a peripheral hospital the moment he's board certified. Whether that surgeon is working anywhere near his full potential, given everything he's trained for, is a question we don't really have an answer to- because practically speaking, even if he wanted to use that training, the general surgical workload and the limited resources of a peripheral posting wouldn't let him do so. Perhaps it's this very ambiguity that steers trainees towards choosing a more viable subspecialty straight after their MD, rather than remaining in general surgery and declaring a special interest that may never translate into an actual change of practice.

Where this leaves us.

None of this argues against sub-specialisation- the evidence for it is too strong, and patients in reach of tertiary centres deserve it. What it argues for is a

The evolving subspecialty landscape has disrupted this in ways that are only now becoming obvious. In major teaching hospitals, where every subspecialty exists under one roof, classic cases are increasingly redirected off to subspecialty clinics before the general surgical registrar ever sees them.

tiered system, an agreed protocol on how it should be done. Therefore, general surgery is not a dying art, but it is the connective tissue that keeps the whole system standing while sub-specialisation catches up to the special needs.



THE PULSE



COLLEGE ACTIVITIES



ATLS

The college of Surgeons of Sri Lanka is the sole provider of the ATLS program in Sri Lanka. ATLS provides a systematic, safe and reliable method of training in the immediate management of severely injured patients.

2 intensive and interactive courses were conducted on March and May at the College of Surgeons, where 16 participants (Maximum accommodated) received comprehensive training in a range of skills essential for the immediate management of the trauma patient.

The course was conducted by an expert faculty of Surgeons and Anaesthetists and was led by country Chair Dr. Roshan Dassenaik and course director Dr. Mihira Bandara.



NTMC & ITCN

The 81st NTMC and ITCN were conducted on 20th and 23rd February; the 82nd NTMC was conducted on 19th -20th March; the 83rd NTMC and 40th ITCN were conducted on 26th -27th May; and the 84th NTMC and 41st ITCN were conducted on 25th -26th June at the College of Surgeons of Sri Lanka with the participation of over 55 medical officers for NTMC and over 60 nurses for ITCN per course.

The National Trauma Management Course has been designed based on the

guidance of the IATSIIC (International Association of Trauma Surgery and Intensive Care). In partnership with the College of Surgeons of Sri Lanka NTMC and ITCN have been guiding healthcare professionals of Sri Lanka to empower them in the initial management of trauma.

Course director Dr. Kamal Jayasuriya and his mentor Dr. Ranjith Ellawala, Global chair, NTMC, together with the panel of resource persons, continue to conduct successful courses.



Surgical Education and Training Sessions (SETS)

The College of Surgeons conducted five Surgical Education and Training sessions during the second and third quarters. The SETS is CPD-accredited training program conducted physically at the College of Surgeons Auditorium and is also transmitted live to Kandy, Peradeniya, Jaffna, Anuradhapura, Galle and Batticaloa. Despite the Main congress and pre-congress workshops, SETS coordinator Dr. Ranga Wickramarachchi, managed to keep the trainee education program running

extremely well attended, with 30-50 surgical registrars joining onsite.

The SETS on February was on LUTS where as March SETS was on HPB topics. The April SETS program was case case-based discussion on Paediatric Surgical topics, whilst a SETS program on Prostate Conditions was held in June. The August SETS program was conducted on Perioperative Preparation. All resource persons involved in these SETS programs are deeply appreciated.



Emergency Sonography for Trauma Care (ESTC)

The Course on Emergency Sonography for Trauma Care, organized by the College of Surgeons of Sri Lanka in collaboration with the Accident and Orthopedic Trauma Unit of the National Hospital of Sri Lanka, conducted 3 workshops in February, March and May 2026 at the Neurotrauma auditorium at NHSL.

The course aimed to provide a valuable learning experience as well as hands-on experience on eFAST, vascular access, vessel assessment, use of USS for fluid resuscitation, etc. Course coordinator Dr. Mihira Bandara, together with their faculty, conducted the successful workshop.



Blade and Bench Monthly (BBM): A Cross-Border Case Review

The College of Surgeons of Sri Lanka's Blade and Bench monthly webinar series continued to provide exceptional educational value from April to July 2026.

Held on the 3rd Tuesday of each month, these sessions brought together local and international expertise to discuss challenging surgical cases.

In April The series featured two compelling case presentations on Major Pancreatic Trauma and Abdominal

Catastrophe Following a Blast Injury, highlighting the management of complex surgical emergencies.

The May BBM shifted to vascular surgery with presentations on Critical Limb Ischemia and Acute Limb Ischemia Due to Saddle Embolism. June saw discussions on Breast Cancer, with insightful discussions on Invasive Lobular Breast Cancer and Gene-Positive Breast Cancer in a Young Woman. July the most recent session explored Acute Appendicitis with a

focus on its Unusual Presentations.

Each session was enriched by an expert panel, including local specialists alongside a team of experts from the USA, and was expertly moderated by Asst. Prof. Anushka Bagga. Dr. Kanchana Wijesinghe, Program Coordinator, together with the College extends its gratitude to all presenters, panelists, and participants for making this series a valuable platform for surgical education and collaboration.



Essential Surgical OSCE Stations for ERPM Preparation

The program provided a comprehensive overview of the ERPM OSCE format, covering its structure, scoring systems, and blueprinting for common emergency themes. Participants engaged in two intensive rounds of mock OSCEs conducted by a panel of examiners, followed by a structured feedback session that addressed key learning points and common pitfalls. Dr. Minoli Joesph, Coordinator of the program included interactive discussions on real-world surgical scenarios and a dedicated session on essential soft skills, such as communication, professional conduct, and stress management. The event concluded with closing remarks, having equipped candidates with the practical experience and clinical insights necessary for their upcoming examinations.



Basic Laparoscopy Skills Workshop

The Basic Laparoscopic Skills Workshop was conducted by Sri Lanka Minimal Access and Digital Surgeons in collaboration with College of Surgeons of Sri Lanka was held at College premises on 04/06/2026 to 05/06/2026. The course was mainly aimed towards surgical trainees.



Basic Surgical Skills Course for Medical Officers

To enhance the practical skills of medical officers, the College of Surgeons organized a series of one-day Basic Surgical Skills Courses across the island. This CPD-accredited program focuses on hands-on, practical training using wet tissues, allowing participants to practice critical techniques like skin suturing, knotting, anastomosis, and tendon repairs.

The course was successfully held at the following locations:

- Peradeniya: The series began on March 28th at the Skills Lab of the Faculty of Medicine, University of Peradeniya, in collaboration with the Department of Surgery, Peradeniya, and the Central chapter of the College of Surgeons.
- Negombo: May 2026
- Badulla: June 2026



Friendly Cricket Encounter

A Friendly cricket encounter between Surgeons and VOGs was held on 29/03/2026 at the CCC grounds. A unique event to foster collaboration and friendship between the two specialties. CSSL team won the match by 26 runs.



Wound Care Workshop

Wound care workshop for medical officers was held on 10/07/2026 at Base Hospital Homagama, in collaboration with the AGSSL

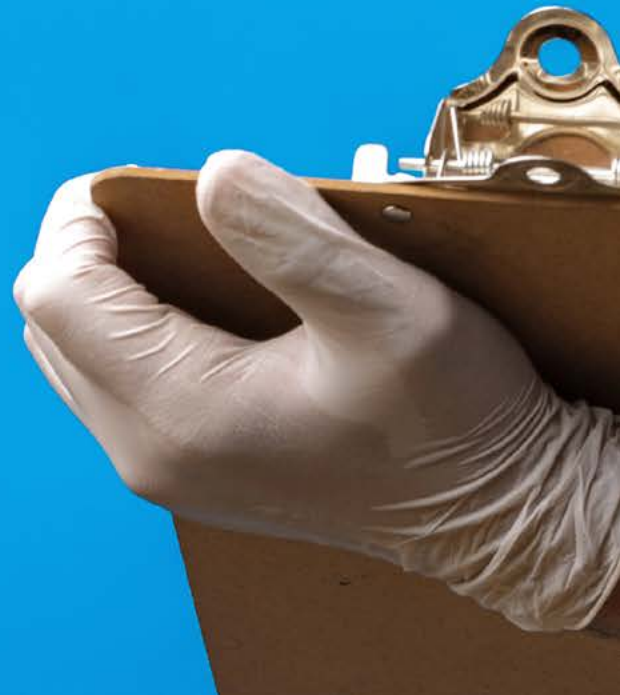


Peri-Operative Care Workshop For Nurses

Held in January with the collaboration of Kandy Society of Medicine



FEATURES & NEWS





Sri Lankan Society of Vascular Surgery

Vascular Surgery Coming of Age

In the history of any specialty, there comes an era when it stops asking to be taken seriously and simply owns it. For vascular surgery in Sri Lanka, the past few years have been the age of reckoning, an era where it blossomed and took ownership spreading its wings to different parts of the country. What was once a sideshow in the bigger scheme of General Surgery, now stands as a discipline with its own proper identity, its own international meeting, and its own place at the international circuit. It is a privilege, on behalf of the Sri Lanka Society for Vascular Surgery (SLSVS), to share something of that journey with the readership of Suture.

A flagship, and a record

In May 2026 we conducted SLSVS_26 — our flagship event and the largest vascular surgery conference ever held in this country. More than thirty overseas delegates joined us, travelling from every corner of the world to Colombo for three days of intensive academic knowledge sharing and networking. The significance lay not in scale for its own sake, but in what it made possible, bringing the world leaders in Vascular Surgery right to our doorstep. A meeting of that reach does not happen by accident, and I want to record my gratitude to the faculty, the organising committee, and the entire membership whose collective effort made it all possible.

The conference also marked the launch of Bloodlines, the official newsletter



of the SLSVS. The inaugural issue was presented to our chief guest, Professor Alun Davies.

The road to SLSVS_27

The turnaround after SLSVS_26 was quite quick. SLSVS_27 is scheduled for June 2027 at Cinnamon Life, Colombo, and it promises to be even larger and better still. Planning is already well underway and we extend a warm invitation to all our colleagues across the College of Surgeons — whatever your specialty — to join us. It will feature a full day of vascular emergencies

in general practice as a pre-congress workshop followed by two full days of intense analysis of all aspects in vascular surgery.

Taking our place in the world

Two developments this year have carried the SLSVS name well beyond our shores. The first is the publication of 'History and Evolution of Vascular Surgery in Sri Lanka; The Journey and Ongoing Challenge' as an editorial in the European Journal of Vascular and Endovascular Surgery — one of the

foremost vascular journals in the world. To have our national story published in that company is more than an honour; it is a permanent legacy for the next generation of vascular surgeon to follow. The second is our expanded role in the Asian Society of Vascular Surgery. This year a large SLSVS contingent will join the ASVS meeting in New Delhi, taking on a more prominent part in the regional dialogue than ever before. Sri Lanka will no longer be a mere spectator at the regional vascular event.

This year we also officially launched the Think Aorta campaign in Sri Lanka, becoming a formal part of the global movement. Aortic dissection remains one of the biggest catastrophes in emergency vascular care, with unacceptably high mortality if not recognized or acted

upon swiftly. Think Aorta exists to sharpen the index of suspicion among both clinicians and the general, and our aim over the coming year is to build it into a far more formidable presence across the country.

The real work: training and teaching

Podiums and publications matter, but a surgical specialty is built somewhere less visible — in the operating room. Our academic schedule this year reflects this with a packed calendar of events focusing on teaching and training in vascular trauma, cadaveric dissection, diabetic foot, and wound care. In January 2027 we will also conduct the second successive ‘Colombo Transplant

Surgery’ workshop, extending the same emphasis on training, teaching, and knowledge dissemination into vascular access and organ-transplantation. Every workshop we run, every trainee we equip, and every collaboration we build will ultimately be measured in limbs saved and lives preserved.

Looking ahead

This has been a defining period, but the Society’s ambitions are modest and practical: to widen training beyond the tertiary centres, to measure our outcomes, and to keep vascular surgery firmly woven into the wider surgical family of the College of Surgeons of Sri Lanka. There is plenty of work ahead and goals to be achieved, and we look forward to doing it together.



Sri Lanka Association of Minimal Access and Digital Surgeons

Activities during January to July 2026

The Sri Lanka Association of Minimal Access and Digestive Surgeons (SLAMADS) has continued to build on its momentum over the past several months, with a busy calendar of hands-on workshops, international webinars, and a growing membership base. The Association has kept its focus firmly on its founding mission – advancing minimally invasive surgery (MIS) and laparoscopic practice across Sri Lanka, and equipping the next generation of surgical trainees with the skills needed to deliver it safely and confidently.

Academic Activities and Workshops

Basic Laparoscopic Skills Workshop for Registrars

This mandatory pre-Part 2 course for surgical trainees was successfully conducted on 4th and 5th June 2026, with 30 registrars in attendance. The

course content was revised and the workshop was further strengthened by 20 new endo-trainers developed by Dr. K. L. Fernando, ten of which have been

handed over to the College of Surgeons' skills lab – a contribution for which the Council placed on record its special thanks to Dr. KL Fernando.

Basic Laparoscopy Workshop for Grade Medical Officers

The 5th workshop in this series was held at Teaching Hospital Kalutara on 3rd February 2026, organised by Dr. Sanjeev Samaranayake. A further workshop was conducted at Teaching Hospital

Jaffna on 25th June 2026, successfully combining didactic teaching with a live surgery demonstration. A subsequent workshop is being planned at the College of Surgeons towards the end of the year,

continuing SLAMADS' commitment to bringing basic laparoscopic skills training to medical officers island-wide, including at peripheral and provincial hospitals.

Asia Pacific Hernia Society – Hernia Essentials Workshop

In collaboration with the Asia Pacific Hernia Society, SLAMADS conducted the "Hernia Essentials for Trainees" workshop on 6th–7th March 2026. The workshop was very well received, and the Council hopes to establish it as an annual

fixture on the SLAMADS calendar. Professor Bawantha Gamage and Dr. Chathuranga Keppetiyagama continue to bring great pride to SLAMADS and Sri Lanka by serving as the Sri Lankan

Governors on the Executive Committee of the Endoscopic and Laparoscopic Surgeons of Asia (ELSA), representing the country on this prestigious international body.

Monthly Live Webinars

SLAMADS continued its well-attended series of live webinars, bringing local and internationally renowned faculty directly to Sri Lankan surgeons and trainees. Building on this, the Council has also launched a new series of webinars run in international collaboration with ALSGBI, AMASI and KSERS, beginning with ALSGBI, to further widen the range of expertise accessible to the local surgical community.

Month	Speaker	Topic
January 2026	Dr Thavam Chenthan Thambi-Pillai	Robotic Whipple's Procedure
April 2026	Dr Roy Patenkar (India)	Advances in minimally invasive & laparoscopic surgery
May 2026	Dr Rohan Ariyaratnam (Australia)	Minimally invasive surgical practice
June 2026	Prof. Seow-En Isaac (Singapore)	NOTES (Natural Orifice Specimen Extraction) for colorectal surgery specimen removal
July 2026	Dr Ng Jin Lia (Singapore)	D2 vs D3 Right Hemicolectomy

Membership Growth

SLAMADS membership has continued to expand steadily over the period, rising from 149 members in January 2026 to 159 members by July 2026. The Association’s training fund has

continued to grow over the period, boosted by earnings from the SHO training programme, which are regularly deposited into the fund. The Association’s training fund has

continued to grow steadily over the period, boosted by earnings from the SHO training programme, which are regularly deposited into the fund. The SLAMADS website has been updated.

Looking Ahead

With growing membership, an expanding international network, and a packed programme of workshops and webinars, SLAMADS remains firmly

committed to strengthening minimally invasive surgery and laparoscopic practice across Sri Lanka – particularly in resource-limited and peripheral settings

– and to ensuring that Sri Lankan surgical trainees have every opportunity to acquire these skills to a world-class standard.



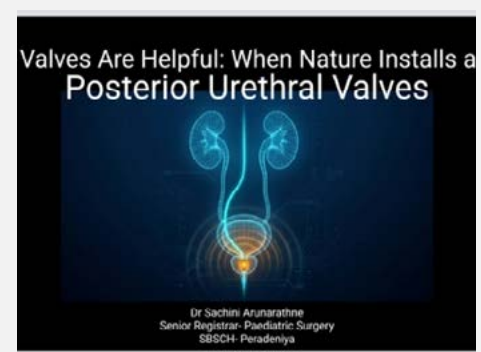
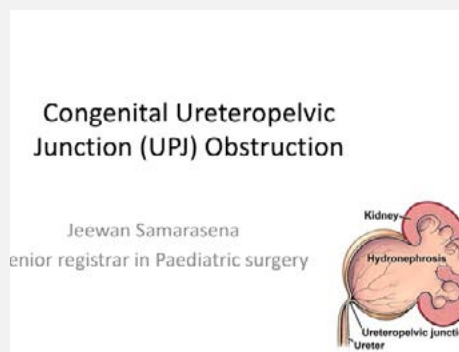
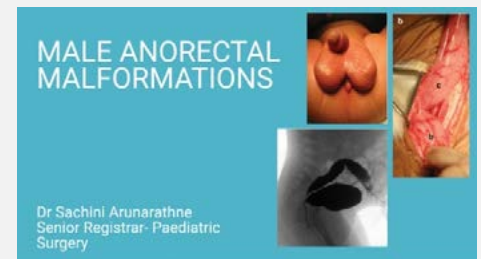
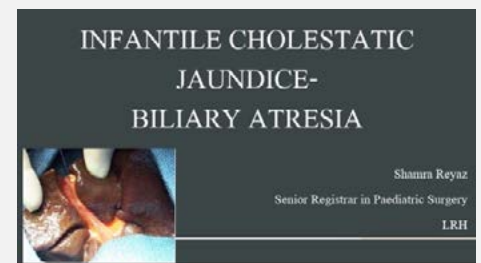
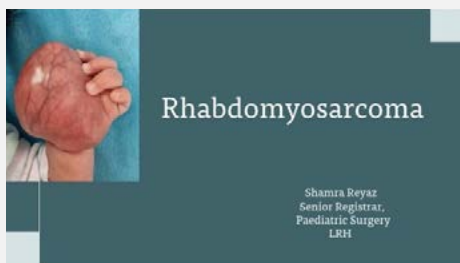
Sri Lanka Association of Paediatric Surgeons

SLAPS Online Journal Club

The Online Journal Club commenced during October 2025 and conducted twice a month continues to improve knowledge & presentation skills of

Senior Registrars. This platform help to improve the skills on the critical analysis of reputed journal articles by the presenting SRs and help to incorporate

the experience of senior surgeons in to their practice during the discussions. Eight presentations have been made since February 2026



SLAPS Online Forum for discussion of case reports

Online Forum for discussion of rare and challenging case reports continued to upgrade knowledge of all participants and facilitated sharing of experience of senior colleagues. The spectrum of management options and outcomes on selected surgical pathologies

SLAPS Paed surgery workshop at Jaffna Regional sessions

Workshop on common paediatric surgical conditions was conducted by a team of paediatric surgeons from SLAPS at this year's CSSL Regional sessions at Jaffna with the participation of more than 120 medical officers and nurses. Comprehensive education of the attendees on common paediatric surgical conditions was made during this interactive session.



FROM THE PROVINCES

Central Chapter

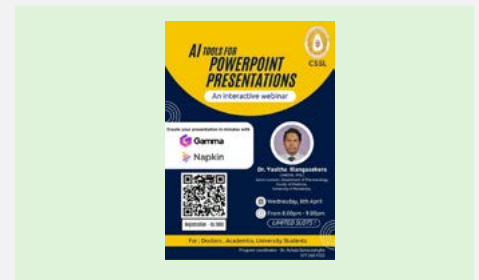
Executive council

- President - Vajira Jayasinghe
- Secretary - Achala Samarasinghe
- Secretary - Pulasthi Kanchana
- Treasurer - Sunanda Handiwaththage
- Editor - Kaushika Gunasekara

AI Tools for PowerPoint Presentations

The Central Chapter of the College of Surgeons of Sri Lanka organized an interactive webinar on AI Tools for PowerPoint Presentations, held on Wednesday, 8th April, from 8.00pm to 9.00pm. The session was conducted by Dr. Yasitha Illangasekera (MBChB, PhD), Senior Lecturer, Department of

Pharmacology, Faculty of Medicine, University of Peradeniya, and covered how tools such as Gamma and Napkin can be used to create presentations within minutes. Open to doctors, academics, and university students, the webinar was coordinated by Dr. Achala Samarasinghe.



Cognitive Bias

The Central Chapter of the College of Surgeons of Sri Lanka organized a lecture on Cognitive Bias, held on Friday, 24th July 2026, at 7.30pm at The Grand Kandyan Hotel, Kandy. The session was delivered by Dr. Air Vice Marshal Manoj Keppetipola (MSc, MBA, MDS, BA Defence Hons, Chartered FCIPM, FITD(SL), ndc, psc, Sworn Translator), and was followed by a fellowship dinner for all members. The event was coordinated by Dr. Vajira Jayasinghe.



Northern Chapter

Executive council

- President - Dr. P. Srigrishna • Secretary - Dr. S. Vinojan • Treasurer- Dr. S. Matheivaanan • Editor - Dr. V. Thushyanthan
- Council members - Prof S Gobyshangar, Dr. S. Sashikaran, Dr. R. Vaheesan, Dr. S. Selvaganesh, Dr. A. Thileepkumar
Dr P Sivamayuran, Dr N Shivashangar, Dr. M. Ranjithatharsini, Dr. S. Lavanya

The College of Surgeons of Sri Lanka – Northern Chapter continued to build on its strong academic tradition throughout 2026, conducting a wide-ranging programme of workshops, hands-on courses and scientific meetings for surgical trainees, consultants, doctors and nurses across the Northern Province. From basic research methodology and wound care to advanced laparoscopic and endoscopic spine surgery, the Chapter's calendar reflected its continuing commitment to surgical education, skills training and collaboration with national and international faculty. The year's activities culminated in the Inauguration Ceremony of the Northern Chapter's Scientific Session 2026, held in Jaffna.

Wound Care Workshop 2026

The Northern Chapter conducted a Wound Care Workshop on 14th May 2026 from 8.00 a.m. to 2.00 p.m. at the District General Hospital, Kilinochchi, under the theme “Better Wound Care, Better Patient Outcomes.” The workshop was targeted at both doctors and nurses, reflecting the Chapter's continued emphasis on multidisciplinary training. The programme was supported

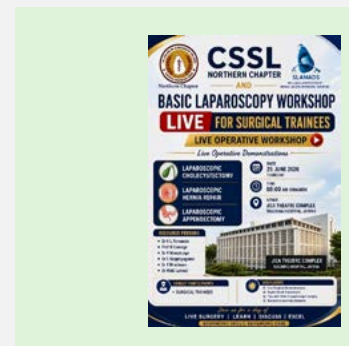
by a large panel of resource persons, including Dr. P. Srigrishna, Dr. S. Matheivaanan, Dr. S. Selvaganesh, Dr. T. Ambalavaanar, Dr. A. Nishanthan, Dr. Kawindi Dharmasiri, Dr. Lakdini Fernando, Dr. V. Koculen and Dr. K. Pratheep, who together delivered a comprehensive, practically oriented session on modern wound management.



Basic Laparoscopy Workshop - Live Operative Demonstrations for Surgical Trainees

In collaboration with the Sri Lanka Association of Minimal Access and Digital Surgeons (SLAMADS), the Northern Chapter organized a Basic Laparoscopy Workshop with live operative demonstrations for surgical trainees on 25th June 2026, from 8.00 a.m. onwards, at the JICA Theatre Complex, Teaching Hospital, Jaffna. The workshop featured live

demonstrations of laparoscopic cholecystectomy, laparoscopic hernia repair and laparoscopic appendectomy, together with expert panel discussions, tips and tricks in laparoscopic surgery, and interactive learning sessions. The resource persons were Dr. K. L. Fernando, Prof. B. Gamage, Dr. R. Manatunge, Dr. C. Kepptiyagame, Dr. T. Bhishman and Dr. M. A. C. Lakmal.



Inauguration Ceremony - Scientific Session 2026

The Northern Chapter's academic year was crowned by the Inauguration Ceremony of the Scientific Session 2026, held on 25th June at the North Gate Hotel, Jaffna. The ceremony brought together the Chapter's office bearers, past presidents and members for an evening celebrating the Chapter's achievements over the year.



Neonatal & Paediatric Surgical Care - “What Not to Be Missed!”

On 27th June 2026, the Northern Chapter held a dedicated scientific programme on Neonatal and Paediatric Surgical Care, themed “What Not to Be Missed!”, at the Exam Hall of the Clinical and Training Research Block, Faculty of Medicine, University of Jaffna, from 8.00 a.m. to 2.00 p.m. The scientific programme covered eleven topics spanning the full spectrum of neonatal and paediatric surgical care, including integrated perinatal care for surgically correctable fetal anomalies, early recognition and stabilisation of neonatal surgical conditions, identification of the

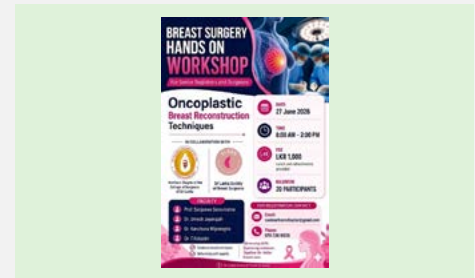
critically ill child, distinguishing surgical from medical acute abdomen in children, paediatric groin swellings and testicular disorders, paediatric urology for the general clinician, post-operative renal complications, management of foreign body ingestion, constipation in children, and stoma care in children. The faculty comprised Dr. R. Thuvarathepan, Dr. Ranjitharsini, Dr. S. Nithhiyaruban, Dr. T. Rajeevan, Dr. Arulmoli, Dr. Janath, Dr. B. Sayanthan, Dr. Tharanga Gamage, Dr. S. Jasinth, Dr. Nipun Wickramasekara, Dr. Nuwanthika Karunaratne and Ms. R. L. Chandralekha.



Breast Surgery Hands-On Workshop - Oncoplastic Breast Reconstruction Techniques

The Northern Chapter, in collaboration with the Sri Lanka Society of Breast Surgeons, conducted a hands-on workshop on Oncoplastic Breast Reconstruction Techniques for senior registrars and surgeons on 27th June 2026, from 8.00 a.m. to 2.00 p.m. The workshop was limited to

20 participants to ensure a focused, evidence-based training experience with ample opportunity for networking with experts. The faculty for the workshop included Prof. Sanjeeva Seneviratne, Dr. Umesh Jayarajah, Dr. Kanchana Wijesinghe and Dr. T. Kokulan.



Basic Research Workshop - “Clinical Research Made Simple: From Concept to Publication”

As a post-congress workshop of the Regional Scientific Meeting 2026, the Northern Chapter organised a Basic Research Workshop titled “Clinical Research Made Simple: From Concept to Publication.” The workshop was held on 28th June 2026 from 8.00 a.m. to 5.00 p.m. at the Auditorium of the Clinical and Training Research Block, near the Clinical Complex of Teaching Hospital, Jaffna. The session, capped at 24 participants to preserve a practical, hands-on learning experience, was conducted on a first-come-first-served basis and guided by resource persons Dr. Umesh Jayarajah and Prof. Sanjeeva Seneviratne, taking attendees through the entire research journey from concept development to eventual publication.



Endoscopic Spine Surgery Workshop

Under the theme “Advancing Precision. Enhancing Outcomes. Shaping the Future of Spine Surgery,” the Northern Chapter conducted an Endoscopic Spine Surgery Workshop on 8th July 2026, from 8.00 a.m. onwards, at the JICA Theatre Complex. The workshop was conducted by Dr. P. Keerthivaasan, Consultant Orthopaedic Surgeon at Kauvery Hospital, Chennai, who shared his expertise in endoscopic spine surgical techniques with surgical trainees and consultants from the region.



UVA Chapter

Executive council

- President - Dr. Kelum Chathuranga Vidana Gamage • Vice president - Dr. Wasula Sampath Rathnaweera
- Secretary - Dr. Palitha Rajapaksha • Treasurer - Dr. Chamikara Palkumbura • Editor - Dr. Lakshman Bandara
- Editor - Dr. M. R. I. Weerasekara
- Council members - Dr. Himali Wijegunasekara, Prof. Muditha Vidanapathirana, Dr. Achini Wijesinghe, Dr. Thathsarani Vithana Pathirana, Dr. B. S. C. S. Jothirathna, Dr. M. Chenturan, Dr. Kolitha Wijayawardane, Dr. Bandusiri Rathnayake, Dr. S. R. Galappaththi, Dr. Dasitha Rathnayaka, Dr. Thilar Nawindra, Dr. Shantha Ekanayaka, Dr. Samitha Munaweera, Dr. Akila Rathnayaka, Dr. Prageeth Dissanayake, Dr. Dilanka Liyange, Dr. Saman Fernando, and Dr. Prabhath Kavinde.

The UVA Clinical Society (Uva Chapter) successfully conducted a series of educational workshops and clinical training programmes throughout 2026, reaffirming its commitment to advancing surgical education and strengthening the clinical competencies of medical officers within the Uva Province. These programmes were organized with assistance of the CSSL Uva Chapter Coordinator, Dr. Duminda Dissanayake, with the dedicated efforts of the Executive Council and Council Members of the Uva Clinical Society.

Basic Surgical Skills Workshop

On 18 June 2026, the Uva Clinical Society, in collaboration with the College of Surgeons of Sri Lanka, conducted the Basic Surgical Skills Workshop for medical officers at the Faculty of

Medicine, Uva Wellssa University. The workshop focused on fundamental surgical techniques through expert-led demonstrations and intensive hands-on training. Participants gained

practical experience in essential surgical skills, including suturing and knot-tying techniques, providing a strong foundation for safe surgical practice.

Orthopaedic Skills Training Programme - Splint & Cast Application Workshop

In partnership with the Department of Orthopaedics, Teaching Hospital Badulla, the Society organized two successful Splint and Cast Application Workshops. The first programme was

held at Mahiyanganaya Base Hospital on 3 June 2026, followed by a second workshop at Diyatalawa Base Hospital on 30 June 2026. These workshops emphasized the principles of splint

application, cast techniques, practical immobilization skills, and evidence-based orthopaedic management, enabling participants to develop confidence in managing musculoskeletal injuries.



Wound Care Workshop

The Wound Care Workshop, conducted on 28 July 2026 at the New Auditorium, Teaching Hospital Badulla, was organized in collaboration with the Sri Lanka Society for Vascular Surgery (SLSVS). The programme

provided comprehensive updates on wound healing science, wound assessment, diabetic foot management, leg ulcers, infection control, antibiotic stewardship, compression therapy, offloading techniques, and advanced

wound care strategies. The workshop also featured expert panel discussions and live practical demonstrations, offering participants valuable insights into contemporary wound management practices.



Continuing Professional Development

As part of its ongoing educational initiatives, the Uva Clinical Society has also scheduled an upcoming session titled “Surgical Emergencies: A Practical Approach”, which will focus on the recognition, assessment, and management of common surgical emergencies encountered in clinical

practice. Through these high-quality educational activities, the UVA Clinical Society (Uva Chapter) continues to promote excellence in surgical education, encourage multidisciplinary collaboration, and enhance the clinical and practical skills of medical

professionals across the region. The Society remains committed to providing accessible, evidence-based training programmes that contribute to improved patient care and the continued professional development of healthcare practitioners in Sri Lanka.

Sabragamuwa Chapter

SLAMADS Basic Laparoscopic Skills Workshop for Grade Medical Officers

Under the umbrella of the College of Surgeons of Sri Lanka (CSSL), the Sri Lanka Association of Minimal Access and Digital Surgeons (SLAMADS) successfully conducted the Basic Laparoscopic Skills Workshop for Grade Medical Officers on 17 December

2025 at Teaching Hospital Ratnapura. The programme was organized as part of SLAMADS’ commitment to strengthening the knowledge and technical skills of medical officers while promoting the safe practice of minimal access surgery in Sri Lanka.

The workshop commenced with a comprehensive lecture series delivered by an experienced multidisciplinary faculty. The scientific programme covered the history of laparoscopic surgery, laparoscopic setup and camera handling, energy devices, instrument handling



and tissue dissection, intracorporeal knot tying and port closure, and the prevention and management of complications in laparoscopic surgery. These sessions provided participants with a solid theoretical foundation in the principles and practice of basic laparoscopic surgery.

The lectures were followed by an intensive hands-on training session using endoscopic trainers, allowing participants to develop essential psychomotor skills, hand-eye coordination, instrument handling, and intracorporeal suturing techniques under close faculty supervision. The practical component encouraged active participation and provided invaluable experience in a simulated environment before progressing to clinical practice.

The workshop attracted an excellent number of participants, with registrations reaching the planned capacity, reflecting the increasing demand for structured training in minimal access surgery among medical officers. Throughout the programme,

participants engaged enthusiastically with both the lectures and practical sessions, creating an interactive and productive learning environment.

Feedback received at the conclusion of the workshop was overwhelmingly positive. Participants particularly appreciated the high quality of the faculty, the well-structured scientific programme, and the opportunity for supervised hands-on practice. The workshop was widely regarded as educational, relevant, and highly beneficial to everyday surgical practice.

The success of this programme highlights SLAMADS' continued dedication to advancing surgical education through high-quality training initiatives under the umbrella of the College of Surgeons of Sri Lanka. By combining evidence-based lectures with practical simulation-based learning, the Association continues to support the professional development of medical officers and promote excellence in minimal access surgery across the country





INTERVIEWS / COMMENTARIES



BEYOND EVIDENCE-BASED MEDICINE:

BALANCING SCIENCE AND HUMANISM IN HEALTHCARE



Mandika Wijeyaratne
Emeritus Professor in Surgery, Colombo
Consultant Surgeon
Past President of College of Surgeons of Sri Lanka

I have practiced medicine since 1984, paying scant conscious attention to patient experience beyond demonstrable clinical outcomes. In the latter stages of my career, I have had more time for conscious reflection, which has resulted in the following article, among other more frivolous aspects of life.

● MEDICINE HAS ALWAYS HAD TWO SIDES

Medicine has always had two inseparable dimensions: science and art. Like the two sides of a coin, neither can exist meaningfully without the other.

Few would argue that the scientific revolution over the last few decades has been anything other than one of humanity's greatest achievements. Yet as scientific knowledge expanded has the human experience of illness and the art of addressing received equal attention?

Today, the challenge is no longer choosing between science and art. It is learning how to integrate both. Disease and illness are not identical. Disease describes biological

Yet as scientific knowledge expanded has the human experience of illness and the art of addressing received equal attention?

abnormality. Illness describes the patient's lived experience of that abnormality. A more fundamental question often remains unasked: How do physicians positively

influence the patient's experience of illness?

Two patients with identical pathology are likely to experience different levels of suffering. One adapts remarkably well; the other becomes overwhelmed by anxiety, uncertainty, and/or loss of identity. Laboratory results and imaging may appear identical, while their emotional and functional realities differ profoundly with immediate and compounding effects on their lives going forward. Medicine excels at treating disease. It is less systematic in addressing illness.

Perhaps this is the next frontier of clinical practice.

● WHY FEELINGS MATTER

Every illness produces more than physical symptoms. It disrupts the manufactured heuristic of certainty in our lives. It threatens independence. It creates fear of disability, pain, and death. It affects family relationships, employment, finances and future plans.

These experiences are not secondary to illness—they are part of illness.

How patients feel influences adherence to treatment, willingness to undergo procedures, trust in clinicians, recovery and overall quality of life. Emotional distress may amplify symptoms, as well as affect decision-making with what we might professionally classify as negative consequences. Despite this, medical education devotes relatively little structured discussion and exposure to understanding how patients

experience illness, or how clinicians can deliberately influence those experiences in therapeutic ways.

Empathy is encouraged, but is difficult to ‘train’ as a disciplined clinical skill. Understanding suffering should perhaps receive the same educational emphasis as understanding pathology.

● THE PARADOX OF PATIENT EXPECTATIONS

Patients often ask physicians to satisfy conflicting needs.

They want complete honesty but fear hearing bad news. They seek certainty while understanding that biology is inherently uncertain. They wish to participate in decision-making but frequently look to their doctor for guidance. They want realistic expectations without losing hope.

These contradictions are not signs of irrationality. They reflect the global human experience of vulnerability. The physician’s task is not simply to communicate information but to help patients navigate these competing emotional needs without compromising scientific integrity.

That is the art of medicine.



The physician’s task is not simply to communicate information but to help patients navigate...

● TRUTHFULNESS VS. BENEFICENCE:

When clinicians realize that emotional states dictate health outcomes, they encounter an immediate ethical dilemma: How do we address emotional vulnerability

without compromising scientific integrity and patient autonomy? Clinicians must navigate two fundamental principles

Evidence-based knowledge should never be altered. Its delivery, however, should be personalized.

● PERSONALISING ‘TRUTH’

Patients differ in education, health literacy, cultural background, religious beliefs, previous experiences, personality and coping styles – in short, their reality, or personal ‘truth’, of life. Some want every statistical detail. Others prefer only broad explanations. Some require time before discussing prognosis. Others wish to know everything immediately.

Some don’t know what they want. Some

may have what turns out to be a deleterious perception of what they want or don’t want to know. Providing identical information in identical language to every patient is neither compassionate nor effective. Good clinicians adapt their communication while preserving scientific accuracy. Equally important, difficult conversations should not end with diagnosis alone.

Patients should leave consultations understanding not only what has happened but also what happens next. Even when cure is impossible, there is always something meaningful that can be done, through consultation and/or clinical planning—relieving symptoms, preserving function, supporting families, maintaining dignity or planning future care.

● THE TRIAGE OF TRUTH: STRATEGIC SILENCE AND NON-CORRECTION

Clinicians often encounter patients and families who hold non-scientific societal-cultural beliefs about their health. Rather than correcting every inaccuracy, I suggest we “triage the truth”:

Fabricating medical information is unethical and unacceptable.

Misconceptions that directly threaten wellbeing or impair necessary treatments (e.g., special diets and alternative medicine

instead of colonoscopy for rectal bleeding) must be systematically corrected using clear, empathetic dialogue.

However, refraining from challenging a comforting, harmless narrative e.g., believing a Vitamin or a specific tea cures a viral cold or that a healed leg ulcer needs a special dressing preserves the therapeutic alliance, while disagreement risks breakdown of rapport and non-compliance with key instructions.

Fabricating medical information is unethical and unacceptable.

● CLINICAL UTILITY AND “MEDICAL THEATRE”

Patients often expect, or sometimes even request investigations and/or interventions as suggested by friends, relatives, and more recently, children who have migrated overseas, that have little or no scientific justification but appear psychologically reassuring. The situation is further worsened by prior advice from ignorant medical practitioners and AI chat-bots given the wrong prompts.

Examples include requests for imaging and sometimes invasive interventions for long-standing asymptomatic uncomplicated

They represent compassionate clinical tools that prioritize beneficence and non-maleficence alongside autonomy.

varicose veins in the elderly, non-disabling claudicants, uncomplicated atherosclerosis on extremity and carotid scans, and acute leg swelling from soft-tissue infections, to name a few. This presents an ever-growing ethical dilemma.

Guided by clinical judgment, non-correction of harmless myths, and intentional low-risk diagnostic procedures serve a vital function. They represent compassionate clinical tools that prioritize beneficence and non-maleficence alongside autonomy.

● “DIAGNOSTIC SEDATION” AND PLACEBO MECHANISMS

A previously healthy 35-year-old feeling unwell for two days and nothing on physical exam is most anxious and demands immediate concrete action: the clinician faces a common choice: Deliver a blunt reassurance, say no tests or drugs are required for now and say to return if symptoms don’t settle in a couple of days. In an era where patients have a choice in the way they are cared for, a more acceptable action plan would be to provide a structured, low-risk plan: rest, take 3 L of fluids daily, and two eggs daily usually serves as a psychological stabilizer.

Today I see healthcare is sliding more and more towards

Diagnostic Sedation:

Ordering routine blood tests, X-rays or ultrasounds—even when clinically redundant—to provide visual and physical evidence of health. This tangible feedback calms an overactive nervous system more effectively than verbal assurance.

Therapeutic Placeholders:

Recommending benign vitamins or dietary adjustments fulfill the patient’s expectation

of active care, and prevents them from pursuing risky self-medications.

Visual Care Cues:

Applying simple dressings to healed surgical wounds or offering detailed lifestyle routines provides patients with a sense of control and ongoing care.

Complementary Pathways:

Safe non-pharmacological routines (mind-body practices, holistic therapies) offer psychological structure, helping patients retain personal agency while undergoing rigorous medical protocols.

● THE ECONOMICS OF REASSURANCE

Reassurance is not free; it carries measurable financial, systemic, and temporal costs for patients and healthcare systems alike. From the patient's perspective, paying for a low-yield ultrasound or routine bloods can be a practical trade-off. They are not paying strictly for a diagnosis; they are paying for relief from acute anxiety. If a low-risk test alleviates days of distress, the patient considers it a worthwhile investment in their quality of life.

Clinical environments place high demands on physician time. Deescalating an anxious

patient without ordering tests requires substantial emotional energy, patience, advanced communication skills, and 15 to 30 minutes of focused dialogue.

Ordering a low-risk scan takes under a minute, satisfies immediate patient expectations, reduces conflict, and provides defensive documentation in litigious environments. Fee-for-service frameworks reimburse diagnostic procedures and physical tasks, not time spent in complex counselling, subtly incentivising technology over conversation.



Fee-for-service frameworks reimburse diagnostic procedures and physical tasks, not time spent in complex counselling..

● THE CRUX: ETHICAL USE OF REASSURANCE VIA TRANSPARENCY AND INFORMED PATIENT PREFERENCE

Rejecting every anxiety-driven request may preserve scientific purity but damage the therapeutic relationship. On the other hand, accepting such requests risks unnecessary investigations, incidental findings, increased healthcare costs, and the subsequent medicalisation of 'normal' life, and perpetuating this culture. Furthermore, the potential abuse and exploitation of the vulnerable is my real concern. Thus, medical theatre must



Physicians should clearly explain when a test or treatment is unlikely to provide meaningful clinical benefit,

remain safe, low-risk, intentional and above all, transparent. Physicians should clearly explain when a test or treatment is unlikely to provide meaningful clinical benefit, discuss possible harms, including incidental findings and unnecessary interventions, and clarify the financial implications. Following such disclosure, respecting informed patient preferences must be the only reason for such practices.

● TRUST IS MEDICINE'S GREATEST PRIVILEGE

Society has historically, and still does, endow physicians with extraordinary trust.

Patients disclose their deepest fears, accept invasive procedures, and make life-changing decisions based upon professional advice.

This privilege carries equally extraordinary responsibilities.

However, physicians are also human. They work under time pressures, financial constraints and institutional demands. They are not immune to personal or

collective ignorance, unconscious bias, or conflicts of interest.

The knowledge and communication skills that comfort patients can also be misused to justify unnecessary investigations, procedures, or treatments for personal gain.

The safeguards that must be selected for and cultivated in medical education and practice are honesty, transparency, accountability and professional self-reflection and regulation. The profession must continually examine its own behaviour to maintain

public trust rather than waiting for external regulation to do so.

Trust, once lost, is difficult to restore.



The knowledge and communication skills that comfort patients can also be misused...

THE SLAUS AIRLINE MODEL: A NEW FLIGHT PATH FOR EQUITABLE SURGICAL CARE

Dr Munipriya Willarachchi & Dr Hilary Fernando

Joint Secretaries

Sri Lanka Association of Urological Surgeons

12 July 2026 marked the beginning of a new culture in urology—and perhaps in surgery as a whole—in Sri Lanka. On that day, the Ministry of Health and the Directorate of Non-Communicable Diseases inaugurated the country's first National Referral Centre for Kidney Stone Disease at Base Hospital Meerigama, bringing to life a concept developed by the Sri Lanka Association of Urological Surgeons (SLAUS).

This was far more than the opening of a new hospital. It marked the launch of an entirely new model for delivering elective surgical care in Sri Lanka.

Long waiting times for kidney stone surgery are well recognised in Sri Lanka

and throughout much of Asia. Despite the equitable distribution of the country's limited number of consultant urologists across all provinces, the principal bottleneck has always been access to operating theatres rather than specialist expertise. At the same time, modern stone surgery equipment costs hundreds of millions of rupees, yet in many hospitals these expensive systems remain underutilised because of restricted theatre access.

It was against this background that SLAUS proposed the SLAUS Airline Model.

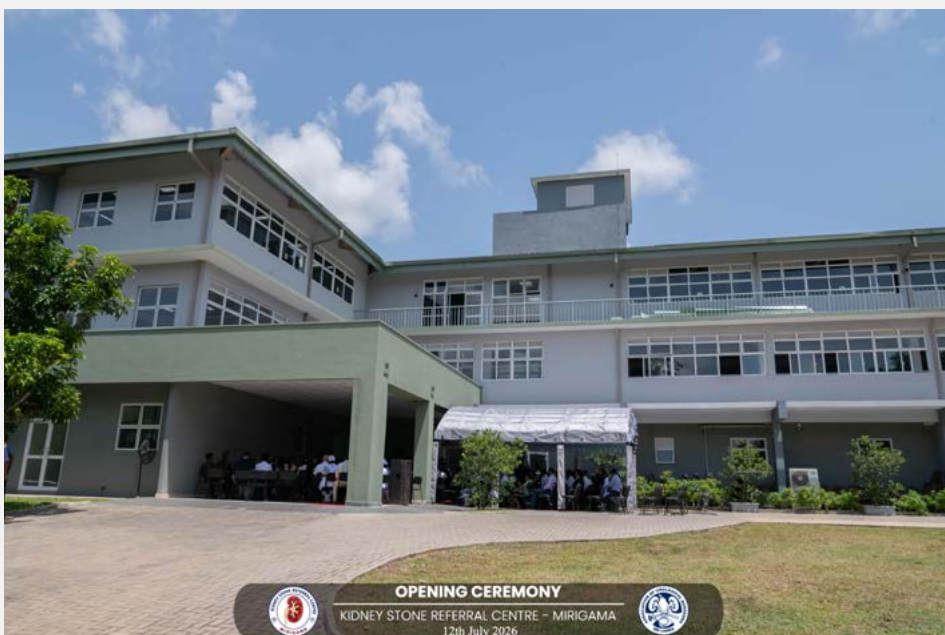
The concept is elegantly simple. Rather than duplicating highly specialised equipment in

every hospital, technology valued at over Rs. 300–400 million can be shared by a network of specialists who travel to a central facility, just as a single aircraft is utilised by many pilots to transport thousands of passengers.

It marked the launch
of an entirely new
model for delivering
elective
surgical care
in Sri Lanka.

The result is maximum utilisation of expensive technology, improved efficiency, greater productivity, and a far superior return on public investment.

Meerigama was selected because of its exceptional accessibility via the motorway, railway, and national road network. Equally important was the availability of a newly constructed hospital wing with modern operating theatres, creating a unique opportunity for rapid implementation within a matter of months.



Several other features distinguish this project. The shortage of trained nurses and technical staff, together with the cost of procuring modern endourological equipment, would ordinarily have delayed such an initiative for years. Instead, the project was driven by an extraordinary spirit of volunteerism and collaboration.

Consultant urologists committed themselves to travelling from across the country to operate within the state health service. The complete endourology equipment required for the centre was generously pledged by renowned philanthropist Nahil Wijesuriya.

This project reminds us that the role of healthcare professionals extends beyond the operating theatre.

Further support came from Aslam Omar (Brandix), Asgi Akbarally (Akbar Brothers), Mano Sekaram (99X), DSI, together with numerous partners from the pharmaceutical and medical technology industries and many individual well-wishers.

The proposal, developed under the 2025–2026 SLAUS presidential theme “Equity Through Collaboration,” was rapidly embraced by the Directorate of Non-Communicable Diseases. Encouraged by the Hon. Minister of Health and strongly supported by the Secretary to the Ministry of Health, implementation proceeded at remarkable speed.

The enthusiasm generated was unprecedented. Within just 12 weeks, the centre commenced operations using volunteer nursing and technical staff, loaned equipment from industry and well-wishers



pending permanent procurement, and the collective commitment of the urological community. Designed ultimately to perform more than 1,000 major stone procedures annually, with two operating theatres and 30 beds, the project demonstrated what is possible when vision is matched by commitment. Few public healthcare initiatives of this scale have progressed from concept to clinical reality in such a remarkably short period.

Yet the true significance of the SLAUS Airline Model extends well beyond kidney stone disease. It offers a practical solution to one of the key challenges facing healthcare systems in developing countries: how to provide equitable access to expensive, high-technology healthcare without duplicating resources. The principles of centralisation, resource sharing, mobility of specialist teams, and maximum utilisation of technology are equally applicable to many other complex procedures burdened by long waiting lists.

The model provides a practical framework that can be adapted wherever expensive technology, limited operating capacity, and scarce human resources stand between patients and timely care.

For SLAUS, however, the greatest lesson lies elsewhere. This project reminds us that the role of healthcare professionals extends beyond the operating theatre. It is about leadership, innovation, advocacy, and service. Above all, it reflects the

extraordinary commitment of urological surgeons, nurses, and technicians, who volunteered their time and expertise purely in the interest of patient care; the willingness of the Ministry of Health to embrace a bold new solution; and the remarkable generosity of philanthropists, industry partners, and countless well-wishers who believed in a common vision.

The Meerigama project is therefore far more than a kidney stone centre. It is a practical demonstration that the SLAUS presidential theme, “Equity Through Collaboration,” is far more than a slogan—it is a philosophy capable of transforming healthcare. It demonstrates that collaboration can achieve what individual institutions often cannot. By bringing together professional leadership, government, philanthropy, industry, and volunteers behind a common purpose, barriers that once appeared insurmountable can be overcome.

The SLAUS Airline Model has now taken its maiden flight. If it continues to soar, it has the potential to redefine the delivery of high-technology elective surgery—not only for stone disease, but for many other services burdened by long waiting lists. More importantly, it offers a blueprint for healthcare systems across the developing world, proving that innovation need not always come from greater resources, but from using existing resources far more productively for the benefit of patients.



Womens Chapter

Interviewed by Dr. Shamra Reyaz

IN CONVERSATION WITH

DR MELANIE AMARASOORIYA,

Sri Lanka's first female Orthopaedic Surgeon.



First things first, are you the first and only female orthopaedic surgeon in Sri Lanka?!



Yes, still I am. But fortunately, now there are two trainees, one a senior registrar and a registrar in the system so I'm happy to note that there are others taking it up.



If you can just take us through briefly about your career path. Was it always medicine or were there other options for you? And what led you to surgery and orthopaedics?



I was never interested in biology or related subjects. Physics was my favorite subject and I wanted to be an engineer. So unfortunately, there was a bit of parental pressure so that I had to do medicine. I did well in school at Devi Balika, with an island rank. But it wasn't my first choice!

And then med school, again, I performed well. I decided I'm going to do surgery. Towards the end of my first year in General Surgery I became pregnant and scheduled my orthopaedic rotation right after delivery, thinking it was the least important! 6 weeks after delivery my appointment was with Dr Wasantha Perera and I just fell in love with Orthopaedics! I always had this regret thinking I couldn't do engineering subjects. And then when I started doing orthopedics, I was like, oh, wow, this is it!



So were you able to switch from general surgical to orthopedics right after that rotation?



Yes because I hadn't done much. I hadn't wasted any mandatory appointments.



Once you switched on to orthopedics, was your training all smooth sailing? Did you always feel like you belonged? Or did you swing between maybe I should have or not?



Honestly, I've never had that feeling. It was challenging. If you look at all the casualties, those days we did three day casualties, Saturday, Sunday, and Monday, sometimes on call for 48 hours in theater. I had an 8 week baby at home and my husband was overseas and I didn't have much family support. I had 2 nannies and it was extremely challenging but I loved it and found ways to get it done

My colleagues, they were super supportive. In a lot of other countries, it can be a difficult situation for women, but it was not the same here. I didn't take time off, I did all my on calls but my colleagues were like my brothers and I felt I had a family at work.



As a female trainee, and more so in your situation, you're literally breaking ground as probably the first trainee to be in orthopedics. Did you see an advantage or disadvantage?



I would never say you're at an advantage. If you worked in National Hospital Accident Service, at that time, there was no toilet for females, no changing room for female orthopaedic or surgical registrars.



I think all females in training will vehemently agree!



Everybody has a place to sleep and rest and, whereas the female resident who's up all night, has none.

Also important is the radiation exposure. Our lead aprons are old with no quality check done. Female surgeons are 4 times at more risk of breast cancer than the average woman as the aprons are not designed to protect the female. An orthopaedic drill is designed for the male with a larger glove size of 7.5 to 8, so it's not ergonomic at all. If your instruments match the size of your hand then it's easier to work.

Society in our culture is another expectation to bear with. You are expected to be a mother, to have a family, be more responsible about the. Gender roles don't change here, so you are never at an advantage. I always say you should never have to choose between your job and family, it should never happen. But in our training years, it's unfortunately a situation you face, prioritising one over the other.



Towards the end of my first year in General Surgery I became pregnant and scheduled my orthopaedic rotation right after delivery, thinking it was the least important! 6 weeks after delivery my appointment was with Dr Wasantha Perera and I just fell in love with Orthopaedics!



Do you feel that that would change in the near future, or that it has to change?



Yes, and I think it's changing. One thing is, there are more women in the field. When I was in my orthopaedic rotation, there was no clear cut document or rules about maternity leave. So when you have one person going through that, it all gets sorted. So with more people, change has to happen.

I think because the world in general is changing for better and more women are involved and there are more voices heard regarding radiation hazards, occupational health and safety, part time training etc. I'm still not sure whether we should promote part-time training, but countries like Australia do promote it if you have a young family. My point is people are so progressive now to facilitate women and young people, especially people not having to choose between one part of life or the other. So I'm happy to see that but you have to be cautious with change as well.



You mentioned you had a lot of support from people around you. Did you have any mentors to look up to, and how was the response to a female invading a previously all male domain?!



The first person I reached out to was Dr Wasantha Perera. I just went to him and saying I want to do orthopaedics, and he immediately said yes!

I'm not even sure whether he took it seriously! But he was very encouraging and supportive in the administrative part of switching from general surgery to orthopedics. I have honestly been very lucky with Dr Wasantha Perera, Dr Punchihewa, Dr Sooriyarachchi and Dr Pinto. I was Dr Pinto's Senior registrar and he saw hand surgery as a separate speciality and encouraged me to take it up.

One person who was really important to me is my post intern boss, Dr. Selvi Vettivelu, the ENT surgeon. She was the first woman surgeon I saw. And she helped me make my decision, motivated me and encouraged me. Most importantly, I saw a woman who had a family with two children, cooks dinner and then comes for the night ward round. She was a smart commanding surgeon in the theatre, but outside of it, was a normal traditional woman. Coming from a traditional family, that impressed on me that I could be both Dr Umaphathy was also someone who helped me immensely. Having these role models were very important.



What influenced you towards hand surgery?



I went to UK for my foreign training and I worked in an Upper Limb department mainly. I got a fellowship position in Upper Limb surgery and got an opportunity to work with one of the world's leading shoulder and elbow surgeons in the UK who introduced me to academia. That partly influenced me, and then my next rotation was in hands. So I got re-focused early in my career.

It's a niche thing, it's not orthopedic, it's not plastic, it's a separate sub-speciality. For example in Singapore and Finland, like, hands are done by like hand surgeons. They're not orthopedics or plastic surgeons. Because your skill set is very different. I thought this is a place that you can make a difference.. I did 2 fellowships from the UK in it.

We tend to forget the academic side, we don't do a lot of research, we don't represent, we don't go to conferences. That's one thing I did differently, if this helps someone to learn from it. The moment I finished my fellowship training I met a leading Orthopaedic surgeon from Australia in a conference and I said I want to come and work with you. His fellows are top surgeons from Europe and my CV couldn't compete and his fellowship spots were booked for the next 3 years. I told him I would come work with him somehow, so he took me in for six months. I worked 24/7, and it was stressful but he offered me a proper fellowship and a PHD. That changed my life. You have to do the work, prove yourself and when they know you are good they will give you the opportunity. I was exposed to the world arena by this one single mentor and it was a turning point in my career.



One person who was really important to me is my post intern boss, Dr. Selvi Vettivelu, the ENT surgeon. She was the first woman surgeon I saw. And she helped me make my decision, motivated me and encouraged me.



In terms of your practice, have you found a difference in the way patients perceive you?



I don't know whether I'm in a bubble! In Australia and UK, yes, I've seen it. I've seen girls complaining about it. And I probably firsthand felt it at times. When you're a brown-skinned woman, its inevitable. But in Sri Lanka I've never felt it. You go to accident service and reduce a dislocated ankle and everyone respects you the same way that they respect your male colleague.

Sri Lanka had the world's first prime minister so I think the Lankan mindset is geared to accept women leadership more than in other countries. A second thing is Sri Lankan women culturally are more nurturing and empathetic. I think that's seen as a positive quality here rather than a weakness. Whereas in a lot of developed countries, being ambitious and being assertive and being loud is known as leadership qualities. Sri Lankans respond more to empathy!

What have been your biggest challenges so far?

Managing family and work- life balance!

If I'm very honest, I do feel there are times that I should have been there for my son. I've just one son. And if I had two, I don't know how would I manage. Yes. So that's the hard truth.

That is my biggest challenge. I have always questioned, am I doing the right thing? I get busy with research, conferences, teaching, running a private practice and university roles. And I question, am I spending enough time with my son? Am I doing the right thing here? So you're always questioning your decisions and yeah, so I wouldn't say it's all hunky-dory.

It's challenging. There are difficult times.

Is there anything you do to sort of de-stress, take your mind off or, you know, just maybe a hobby that would, you know, give you a little bit time away from work and then the family responsibilities and all of that?

Not really. Because when you have so much on your plate. I don't know.

I would say manage stress. One thing I've learned very recently at a Leadership Summit was that you don't have to explain your choices or situation or life decisions. And I started practicing it, taking the decision that works best for you, not feeling bad about it or being judged by societal norms, or having to justify the same.

Also I think its important that you do something you are passionate about., I'm a university lecturer. Doing the administrative work in the university, the exams, paper marking, setting up papers, I'm not passionate about those. I spend a fair amount of time doing these. But you have to have fun thing where you GET your energy from and spend it on other areas. So I get my energy from operating, from journaling, from teaching future surgeons and going for conferences where I learn, the rest of the things like for one and a half hours and setting up for an exam, I spend energy on. So I think it's identifying your positives and negatives in life and balancing them out.

Any inspiring words for future trainees and possibly for females looking towards orthopaedics?

So number one, I would, I would like if we didn't have to talk about women in surgery. We had to talk about it because there are still barriers and medical students don't see the possibility. I didn't see myself becoming an orthopedic surgeon. If you don't see someone ahead of you do it, no one considers that possibility. But the ideal situation would be we don't have to talk about it. So our focus should be how good you are as a surgeon. And not as a female surgeon. How our patients are benefited, focusing on our mission than ourselves.

Don't expect things on a platter as a girl or as any trainee. Think about your patients and the next generation. I think that's where our focus should be.



Off — the — Scalpel

Dr. Chandima Amarasena
MS, FRCS, FRCSE, Consultant Cardiothoracic Surgeon



Tyger tyger burning bright,
In the forests in the night;
What immortal hand or eye'
Could fame thy fearful symmetry?

The Tyger – William Blake



This famous poem describes the beauty of the tiger. Easily the most beautiful and majestic of the big cats. Who once seen will put all other big cats to shame.

TIGER IN LITERATURE

Tigers have made multiple appearances in true stories as well as literature

True stories include those from colonial big game hunters such as Jim Corbett. Indian naturalist Valmik Thapar has written several books about Indian tigers

In fiction, who can forget the infamous Sher Khan, the quintessential villain in Kipling's "Jungle Book". There is the tiger Richard Parker in the more philosophical "Life of Pi" as well as Tigger in the "Winnie the Pooh" series.

My personal favourite is Hobbes in the cartoon series "Calvin and Hobbes".

THREATS

Tiger poaching is the primary threat. There is a multi-million-dollar illegal trade in tiger body parts primarily as a source for certain forms of traditional medicine, as well as for trophies. All parts of a tiger have a value going up to \$100,000/-. Every part of a tiger can be sold, including skin, teeth, bones, claws, etc. Despite the 1975 CITES convention banning the trade in tiger parts, the trade still continues. Another issue is human-tiger conflict due to the increasing agricultural encroachment of their habitat.

FAMOUS TIGERS

This was Machali (T16) a tigress from Ranthambore. Also known as the “Lady of the Lakes”, she was renowned for her longevity, fertility, and dominion over the lake area. She was the world’s most photographed tiger. She became famous after a battle with a 14-foot crocodile, which she killed. More than 50% of tigers from Ranthambore are from her lineage. Many documentaries were made about her.

Most Dangerous Tiger

This was the Champawat tiger. A female Bengal tiger responsible for an estimated 346 deaths in India and Nepal in the late 19th and early 20th centuries. This gives a whole new meaning to the term of the “female being the deadliest of the species”. Recognised by the Guinness Book as the world’s deadliest man-eating animal in history, she was shot by Jim Corbett in 1907. The book “No Beast So Fierce” is about her.

TIGER HUNTING

Tiger hunting has been popular since the days of the Mughal empire. During the era of the British Raj, flamboyant tiger hunts (shikara) were organised by the maharajahs and senior British colonial officers. Many flamboyant reports and pictures of such hunts are available. Some of these hunts were from the top of a trained elephants or from hides (machang). Most wealthy maharajas had custom modified Rolls Royce cars for tiger hunting.

When King George the 5th visited India in 1911, he carried out a mammoth hunting expedition lasting 11 days. The expedition killed 39 tigers, 11 rhinoceros, 4 bears, some leopards and several other animals. This is however overshadowed by some Maharajahs who had shot several hundred tigers. The record holder is late the Maharajah of Surguja, who holds the record at 1710 tigers killed.

TIGER FACTS



Scientific name: *Panthera tigris*



Largest of the cats; an apex predator.



Its black, white and gold stripes are unique like fingerprints — no two tigers have the same pattern.



These stripes help camouflage the tiger in tall grass, a technique known as disruptive colouration.



Primary prey such as deer and wild boar do not see the red-green spectrum well, so the tiger is well camouflaged in dappled sunlight.



Bright white spots behind the ears (ocelli) act like false eyes and also help guide cubs following the mother.



Adult males can weigh up to 300 kg and measure up to 3 metres from nose to tail; females are slightly smaller.



Tigers typically live 10–15 years in the wild.



Their canines can reach 6–8 cm; retractable claws can grow to 8–10 cm.



They have excellent eyesight, hearing and sense of smell.



Their powerful legs allow jumps up to 9 metres horizontally and 4.5 metres vertically.



Unlike many other cats, tigers love water and are strong swimmers; Sundarbans tigers are specially adapted to mangrove habitats.



Chandima Amarasekera



Chandima Amarasekera



TIGER SAFARI

— PAW CHECKLIST PAW —

WHERE TO SEE THE TIGER

India is the best place to see the tiger. There are a large number of national parks with tigers but some parks are better for tiger sightings. The best parks are Ranthambore, Bandhavgarh, Kanha and Tadoba. Parks with large areas of grassland are better for tiger sightings. Ranthambore is the most easily accessible, requiring a flight to Delhi and a 6-hour drive. In contrast, the other parks mentioned require a connecting flight and long drives. The prices for visiting also vary between parks.

DO YOUR HOMEWORK



A lot of people have gone on tiger safaris but haven't seen the tiger. Hence, planning is essential.



Plan well in advance. Park tickets are limited, and core zones get sold out fast. Plan at least 6–9 months in advance regarding the park bookings.



Pick the right park and the right zones. Some parks have a higher density of tigers and give you a better chance at sightings.



Pick the right season. Dry season is better as sightings are more frequent. Varies between parks.



Spend sufficient time. A minimum of 6 safaris. This means a 5–6 nights stay at the park.



Pick the right naturalist/guide or a company specialising in tiger safaris. A general travel agent will just book some random available zones.

RULES AND REGULATIONS



Indian parks have strict regulations, with approx. 2.5–3 hours per morning or evening.



Parks are divided into core zones and peripheral zones. Sightings are better in core zones. Usually there are 10 zones. 5 core zones and 5 peripheral zones. Only a limited number of tickets are issued per zone. Hence core zones sell out months in advance.



2 types of vehicles are used. The vehicles have no roofs.



Maruti Gypsy. Will accommodate 4 persons comfortably and 6 slender people but that is a tight fit. 4 persons per jeep is better if you want to take good photographs. Bigger groups can rent multiple jeeps. Note that a full-grown tiger can be as tall as the jeep! This is the best option as these vehicles can manoeuvre down small roads.



Open-top Canter trucks. Cheaper but more cumbersome. Not available in all parks. Carries about 25 people. Cannot travel along some of the narrower roads.

CLOTHES AND ACCESSORIES



Earth-coloured clothes are best. Long-sleeved tops are better as it can get very hot and the sun will burn. A wide-brimmed hat is essential. Also sun lotion. Carry adequate water.



Indian parks are very dusty; wear a mask or a neck gaiter. Carry a protective cover for your camera equipment.



It is very cold in the mornings and evenings; it is important to carry warm clothes, a scarf and gloves. It is a good idea to take along a lightweight jacket.



Use the technique called layering (multiple layers of clothing over each other that you peel off as it becomes warmer).



Carry plenty of water.



Binoculars are useful. A good camera with at least a 400 zoom. Some parks charge a camera fee.



Indian parks have now banned cellphones in the parks.



A TYPICAL SAFARI



Book a hotel close to the relevant entrances. Hotels range from 1-star to 5-star, and most usually operate on a full-board basis. Except for breakfast, only Indian cuisine is usually available.



If you are travelling with a large SL group, you can ask the hotel to spice up some dishes to SL taste.



Alternatively, you can take some vacuum-packed SL foods.



If you enjoy a drink in the evening, buy your alcohol at the duty-free shop, as liquor is expensive outside.



Get up early and usually leave the hotel by 5 o'clock. The park opens at 6 o'clock. There are long queues, so get there early.



IMPORTANT



Carry your passport, as it will be checked.



A safari lasts 2.5 to 3 hours.



Return for a late breakfast and a nap.



Leave the hotel after a late lunch by 2.30 pm for the evening safari.



Don't concentrate only on the tiger. Indian parks have a large amount of wildlife, including deer (chital), bears, antelopes, nilgai, gaur, barasingha, and more. Some parks have Indian wild dogs. If you are lucky, you may even see a leopard. Leopards in India are rather shy, as they are not the apex predator.



India is a mecca for bird lovers with an astounding variety of birds. Bird watchers should invest in a book on Indian birds.



RANTHAMBORE



This is the most accessible park in my opinion; it takes less time to get there, hence more time in the park. But this is also one of the biggest parks, and you have to drive around to catch a tiger.



Bandhavgarh is small and has a high density of tigers, but it also has large crowds. Tala Zone is the best. In Tadoba, the Moharli Zone is the best.



With Ranthambore, one can extend the stay on the way back and visit Jaipur, Agra, Fatehpur Sikri, Delhi sights, and more. This is the most popular Indian trip among foreigners — the Golden Triangle circuit.



For bird lovers, you can combine Ranthambore with Keoladeo Ghana (Bharatpur) National Park. This very small NP is a heaven for birds. No vehicles are allowed, and you have to use an electric 3-wheeler.

EXPLORE

MY CONTACT

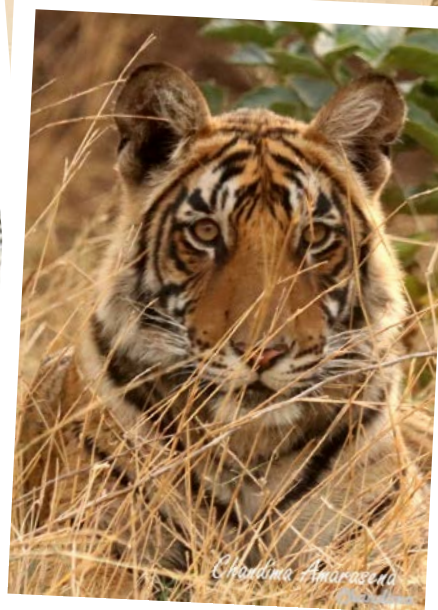
This naturalist/guide is the person I use when I visit Ranthambore. He is very reliable. He will handle everything from transport from Delhi airport to Hotel bookings, jeeps, and, most importantly, park bookings. You pay him an advance by money transfer and the remainder on arrival. You only have to book your flight. He can also arrange visits to adjacent parks.

Name – Mr Ramdan Meena **Contact** – WhatsApp no: +91 98288 09223





Chandima Amaraseena



Chandima Amaraseena



Chandima Amaraseena



Interesting Facts

DID YOU KNOW

THE CODE OF HAMMURABI?

The segment is contributed to the SUTURE by
Dr. Shamra Reyaz,
Senior Registrar in Paediatric Surgery

The Code of Hammurabi is one of the earliest known comprehensive legal texts composed in the Babylonian era, circa 1753. Commissioned by King Hammurabi (1795-1750), a great military commander, it set out 282 laws and punishments for Mesopotamian society. Arranged in order, it was carved in cuneiform script upon a black basalt steel monument 8 feet high, clearly intended to be demonstrated in public view. Addressed to the Gods, it is filled with prayers cursing whoever who neglects the law and shows the King receiving the laws from the Sun God Shamash, proclaiming the divine nature of these laws.

In addition to covering topics such as trade, theft, family life, worker wages, it set out specific regulations for surgical services as well, establishing both patient rights and physician compensation together. Compensation for surgery was linked to the outcome of the procedure, which required meticulous record keeping for the same. Punishments were very much in flavour of draconian justice, where

the concept of 'an eye for an eye' was widespread. However they also were moderated according to the social class

of the patient, with severe repercussions mandated if the victim were a nobleman and lesser so if it were a slave.

Articles 215-223 set down the payment system as detailed below (translated as written). It is of note that surgeries were referred to as 'those performed with a bronze lancet' indicating the instruments used at the time.

- 215. If a physician makes a large incision with a bronze stylet and cures it, or if he opens a tumor (over the eye) with an operating knife, and saves the eye, he shall receive ten shekels in money.
- 216. If the patient be a freed man, he receives five shekels.
- 217. If he be the slave of some one, his owner shall give the physician two shekels.
- 221. If a physician heals the broken bone or diseased soft part of a man, the patient shall pay the physician five shekels in money.
- 222. If he were a freed man he shall pay three shekels.
- 223. If he were a slave his owner shall pay the physician two shekels.

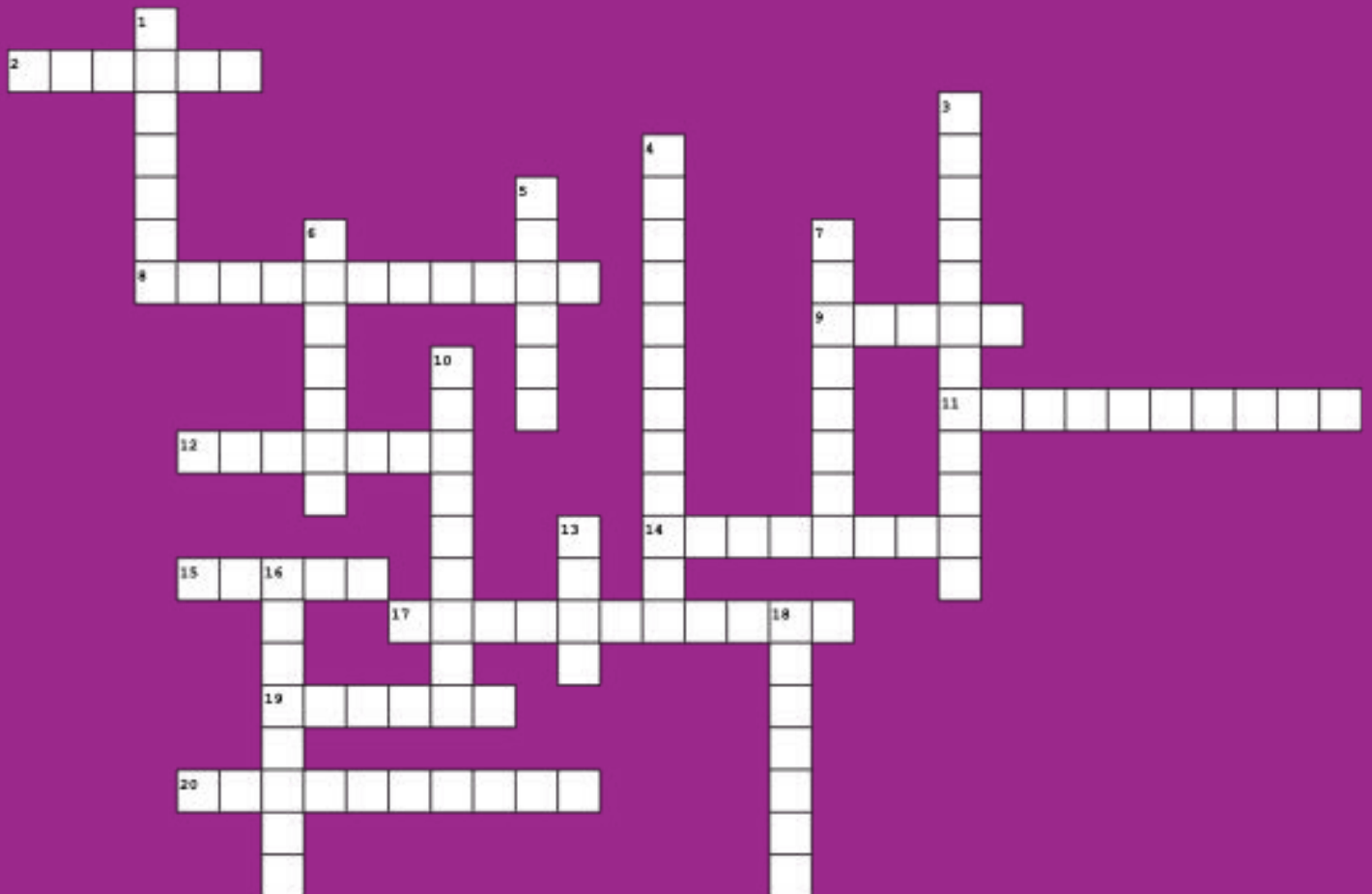
The fees are heavy for the time but they came at a cost. The responsibility for unsuccessful surgeries was severe:

- 218. If a physician make a large incision with the stylet, and kill him, or open a tumor with the operating knife, and cut out the eye, his hands shall be cut off.
- 219. If a physician make a large incision in the slave of a freed man, and kill him, he shall replace the slave with another slave.
- 20. If he had opened a tumor with the operating knife, and put out his eye, he shall pay half his value.

The monument was discovered in the Elamite king Shutruk-Nahhunte in the 12th century BC. It is currently on display at the Louvre Museum in France. Archaeologists. It had been taken by



THE SURGEONS' CROSSWORD



Across

2. Needle entry for laparoscopy
3. Removal of constricting burns
4. Solution of potassium iodide and iodine in water
5. Important in preventing musculoskeletal disorders in surgeons 6. catheter used by vascular surgeons
7. Indian father of plastic surgery in BC times who described facial flaps 8. knife used in harvesting skin graft
9. Polish pathologist after which spinal radicular artery is named after 10. peritonsillar abscess
11. Radio frequency lesioning of facet joint pain

Down

1. Syndrome involving buttock claudication
2. Hair causing obstruction in GIT
3. Literally “street of stones”
4. Pioneer of technique used in duodenal atresia
5. Air flow in theatre
6. Parasitic disease transmitted by female sandfly bite
7. Fibroepithelial neoplasm of breast
8. Historical method of classification of colorectal ca
9. Instrument that shares its name with an insect
10. Method used in bowel anastomosis to increase circumference





Letters to the

EDITORS

Robotic Surgery

Dr. Nuwan D. Premachandra

*Consultant Urological Surgeon, Colombo South
Teaching Hospital, Sri Lanka*

When you hear “ROBOTIC SURGERY” everyone thinks it’s a ROBOT doing the surgery. But “No” the surgery will be performed by an expert laparoscopic surgeon. And the need of an expert surgeon is still there, actually sometimes we need 2 surgeons for a surgery.

Everyone knows that minimally invasive surgery, Laparoscopic surgery is superior to the conventional open surgery due to many reasons such as early recovery, less post operative pain, early discharge and less blood transfusion. There are additional advantages of Laparoscopic surgery depending on the type and the organs involved in the surgery. Robotic Surgery is the more refined and precise latest upgrade of Laparoscopic surgery.

The Robot consist of the patient Operation Platform, the Surgeon Console and the Image / Processing Trolley. The Operation Platform has the Multi-Arm Robotic manipulators which gives the scaffolding and gross movements for the surgical end effectors such as scissors, graspers and dissecting instruments.

This latest technology in Medical / Surgical field enables the surgeon to perform the surgery with a very few tiny incisions (without big incisions made for conventional open surgery) with more precision. One of the main advantages is the suturing with Robotic Arms; it has become extremely easy to suture with robotic arms than



One of the main advantages is the suturing with Robotic Arms; it has become extremely easy to suture with robotic arms than Laparoscopic instruments



Laparoscopic instruments. The instruments used with Robotic Arms are very flexible, just like the wrist of and skilled surgeon. This flexibility and maneuverability of the instruments in the Robotic arms are the main features that makes the operating easier than Laparoscopic surgery.

These fine and flexible instruments in Robotic arms have made it easy to operate in very small places and perform very meticulous dissection. For example, dissection around the prostate during a Radical Prostatectomy has become more precise and easier with these instruments. Controlling the blood vessels around the prostate and dissecting the prostate from the bladder has become very meticulous with these. At the same time the blood loss will be less and clearance of the cancer has



Picture - The Operation Platform

become better. The frequently described consequences such as urine incontinence and erectile dysfunction rates have gone down markedly due to more precise dissection.

The “Surgeon Console” is the other feature which makes a huge difference from laparoscopic surgery. In laparoscopic surgery the Surgeon must stand next to the patient. And sometimes the surgeon faces lot of difficulties due to the ergonomics of the theatre bed and the instruments. These difficulties become worse when the surgical procedure takes more time and when the area of dissection is confined and small. The Surgeon Console has very successfully eliminated the ergonomic limitations that we face when doing laparoscopic surgery. The visual field, arm rest and control arms height can be adjusted according to the operator needs.

The console has a 3D view with a considerable free moving space for the operator’s head. The 3D vision gives a very good perception of the depth of the structures as well. The visual magnification of the structures makes it easy to identify the important structures and makes dissection easier than laparoscopy.

The other advantage of the Surgeon



Picture 02 - Use of the flexible instruments to suture a bladder

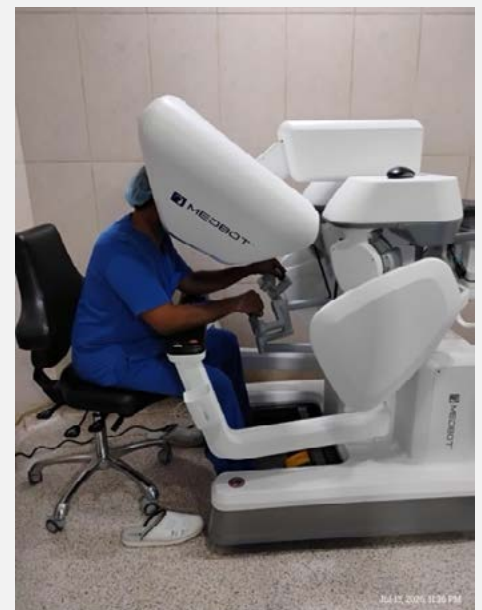
Console is the ability to operate from even far away from the patient. This had been enabled by Telerobotics where the Surgeon Console is connected to the Robot via 5G network.

After anaesthesia, cleaning and draping the patient, the first step in Robotic surgery is to Dock the Robot arms. This step has to be planned thoroughly for the Robot Arms and the instruments to function properly. The Robot Arms should be placed within the ideal distance from the targeted area of the operation. After Docking the Surgeon can move to the Surgeon Console to perform the surgery. However, there should be a very reliable assistant to help with steps such as suction, applying clips and Hem-O-Locks and loading the needle for suturing. After completing the surgery removal of the instruments and the ports will be similar to Laparoscopic Surgery.

The advantage of Robotic Surgery over Laparoscopic surgery will be more for surgeries which needs long operation hours,

where the surgical space is very limited and where suturing is needed. There is a time-tested advantage when performing Radical Prostatectomy and Partial Nephrectomy using Robotic Surgery. When using the Robotic instruments, definitely there is an additional cost over the standard Laparoscopic Surgery. For the Robotic surgery to become cost effective it should be used to perform advanced Laparoscopic Surgeries. With time, availability and more experience with the Robotic applications it will become more cost-effective.

The advantage of Robotic Surgery over Laparoscopic surgery will be more for surgeries which needs long operation hours, where the surgical space is very limited and where suturing is needed.



Reflections on the First Robotic Cholecystectomy in Sri Lanka:

A Personal Perspective

Dr Chathura Karunatileke
Consultant General Surgeon MD, MRCS

Performing the first robotic cholecystectomy in Sri Lanka was a defining moment in my surgical career and, I believe, an important milestone in the evolution of minimally invasive surgery in our country. Although every surgical innovation begins with technology, its true value lies in the opportunities it creates to improve patient care and advance surgical practice.

This achievement was made possible by years of experience in open and laparoscopic surgery, followed by dedicated training in robotic surgery. Transitioning to the robotic platform required adapting to a different way of operating—mastering three-dimensional visualisation, wristed instrumentation, ergonomic console control, and the close coordination needed between the console surgeon, bedside assistant, anesthetic team, and theatre staff. In many ways, this experience reinforced the understanding that robotic surgery is not simply an extension of laparoscopy, but a distinct surgical discipline in its own right.

With that foundation in place, our inaugural robotic cholecystectomy was approached with meticulous planning. Patient selection was deliberate, equipment was carefully checked, and the entire operating theatre team took part in detailed preoperative discussions and simulation. This shared preparation was instrumental in ensuring that the procedure was carried out smoothly and safely.

The operation itself highlighted several strengths of robotic technology. The enhanced three-dimensional magnified vision and superior instrument articulation allowed precise dissection within Calot's triangle. The stability of the camera platform, together with improved ergonomics, supported controlled tissue handling and confident identification of critical anatomical structures. Even with the additional steps required for robotic docking, the procedure progressed efficiently and was completed without complications.

Beyond the technical success, this experience underscored the importance of multidisciplinary collaboration. The commitment of the operating theatre nurses, anesthetic team, biomedical engineers, technical support personnel, hospital administration, and industry partners was essential in making this milestone possible. Introducing a new surgical platform is never the achievement of one individual alone; it reflects the combined effort of an entire team united by a shared commitment to innovation and patient safety.

Being the first to perform a robotic cholecystectomy in Sri Lanka carries both pride and responsibility. It establishes a foundation for future robotic procedures, encourages the development of structured training programs, and contributes to



building local expertise. As robotic surgery expands into more complex general surgical procedures, maintaining rigorous standards of patient selection, training, governance, and outcome evaluation will be essential.

Looking ahead, I believe robotic surgery will play an increasingly important role in Sri Lanka, particularly in advanced gastrointestinal, hepatobiliary, colorectal, endocrine, and bariatric surgery. However, the technology should not replace sound surgical judgment; rather, it should complement it by providing surgeons with enhanced precision and dexterity when appropriate.

This first robotic cholecystectomy marks not the culmination of a journey, but its beginning. It symbolizes our commitment to embracing innovation while maintaining the highest standards of patient care. I hope this experience inspires other surgeons to pursue robotic training, contribute to the growth of robotic surgery in Sri Lanka, and continue advancing the field through collaboration, education, and research.

SCRUB IN

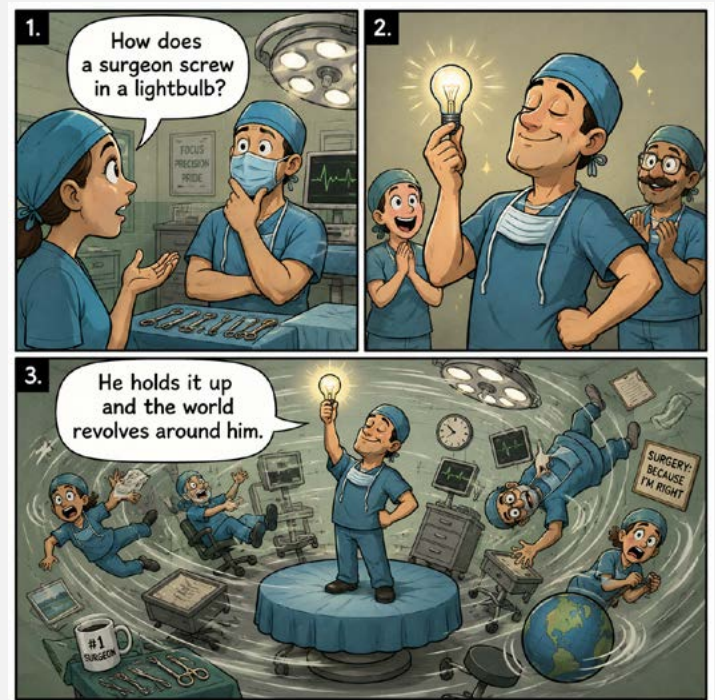
for laughs



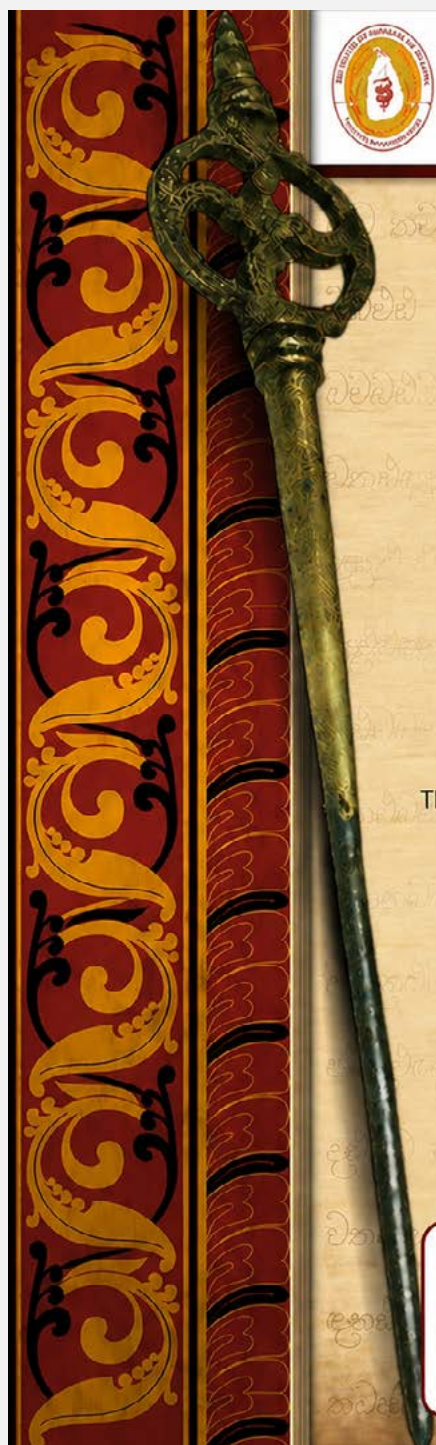
The segment is contributed to the SUTURE by Dr. Deshan Gomez, Senior Registrar in Urology







Announcements







SAVE 03rd – 05th
THE DATE SEPTEMBER
2026

SRI LANKA SURGICAL CONGRESS 2026

"Shaping tomorrow's Surgeon through Academia,
Integrity and Accountability"

The College of Surgeons of Sri Lanka

in Collaboration with

The Royal College of Surgeons of Edinburgh & The South Asian Surgical Care Society &
TRAUMA DAY in collaboration with ACT, IATSIC & ISS

at the
Cinnamon
 GRAND
 COLOMBO

**Registration
Now open**



FOR MORE
DETAILS

The College of Surgeons of Sri Lanka
 No. 6, Independence Avenue,
 Colombo 7
 Tel/Fax: +94 112 682 290/ 2 699 884
 srilankasurgicalcongress@gmail.com
 www.surgeonalk



Sri Lanka Surgical Congress 2026

'Inclusivity, Equity, Sustainability'

The College of Surgeons of Sri Lanka



Post - Congress Workshops

Integrated Breast intervention workshop: Live interventional ra- diology and surgery

21st September 10:00 AM



Old Auditorium National
Cancer Institute
Maharagama

Registration Fee: Consultant Rs. 3000
Trainee Rs.1500

Coordinator: Dr Minoli Joseph

Breast Imaging Workshop for Surgeons

5th October 8:00 AM



Lecture Hall
Department of Surgery
NHSL

Registration Fee: Rs. 4000

Coordinator:

5th October 8:00 AM



CSSL Auditorium

Registration Fee: Consultant Rs 2500/=

Trainees Rs.1000/=

Coordinator: Dr Sumana Handagala

01st & 02nd
November 8:00 AM



CSSL Auditorium

Registration Fee: Doctors Rs. 1500/=

Other medical staff Rs. 1000/=

Coordinator: Dr Nirmal Marasinghe

For Registration



The College of Surgeons of Sri Lanka

No. 6, Independence Avenue
Colombo 7

Tel / Fax :+94112682290 / 2699884

Email : srilankasurgicalcon-
gress@gmail.com

www.surgeons.lk



Sri Lanka Surgical Congress 2026

"Inclusivity, Equity, Sustainability"

The College of Surgeons of Sri Lanka



Pre- Congress Workshops

The Colombo Wound Meeting

10th July 7:30 AM
CSSL Auditorium

Registration Fee: Doctors—Rs 4500
Nurses—Rs 3500
Coordinator: Dr Yasas Abeywickrama

Decision Making in Major Trauma

DMMT
23rd, 24th & 25th July 8:00 AM
CSSL Auditorium

Registration Fee: Consultants—Rs 20000
Trainees—Rs 15000
Separate registration for 'Cadaveric dissection' module—Rs 10000
Coordinator: Dr Kamal Jayasuriya

Photography for Health Care

Professionals
31st July 9:00 AM
CSSL Auditorium

Registration Fee: Rs 5000
Coordinator: Dr Yasas Abeywickrama

For Registration



Hand Surgery

6th August 8:00 AM
CSSL Auditorium

Registration: Consultants Rs 3000
Reg/SR/MO—Rs 2000
Nurses/ occupational therapist Rs 1500
Students (Nursing/ occupational therapist)—Rs 500
Coordinator: Dr Jeewan

Initial Trauma Care for Nurses (ITCN)

7th August 8:00 AM
CSSL Auditorium

Registration Fee: Rs 1500
Coordinator: Dr Kamal Jayasuriya

National Trauma Management Course (NTMC)

7th & 8th August 8:00 AM
CSSL Auditorium

Registration Fee: Consultants—Rs 25000/=
Reg/MO/Pre-interns—Rs 20000/=
Observers—Rs 10000/=
Foreign Participants—USD 200
Coordinator: Dr Kamal Jayasuriya

Paediatric Stoma Care Workshop for Nurses

17th August 8:30 AM
New Auditorium, LRH

Registration Fee: Rs 1000
Coordinators: Dr. Ravibindu

Endo Excel-Mastering Core Endoscopy Skills

20th August 8:00 AM
Endoscopy suite CSH Kalubowila

Registration Fee: Rs 1000
Coordinator: Dr Isuru Upanishad

Robotic Surgery Workshop

20th August 8:00 AM
Kings Hospital

Registration Fee: Consultants—Rs 2500
Trainees—Rs 1000
Coordinator: Dr. Bawantha Gamage

Laparoscopic Hernia Workshop

21st August 9:00 AM
Teaching Hospital Kurunegala

Registration Fee: Rs 2000
Coordinator: Dickson Wickramaratne

Cadaveric Vascular Exposure

24th August 8:30 AM
Department of Anatomy of Faculty of medicine Ragama

Registration Fee: Rs. 5000/=
Coordinator: Dr. Aruna Weerasinghe

Skills Training in Trauma for Nurses (STTN)

31st August 8:00 AM
NHSL, Neurotrauma Auditorium

Registration Fee: Nurses Rs: 2000/=
Coordinator: Dr Mihira Bandara

Emergency Sonography for Trauma Care (ESTC)

1st September 8:00 AM
NHSL, Accident service auditorium

Registration Fee: Rs. 5000/=
Coordinator: Dr Mihira Bandara

THE GLOBAL DOCTOR

Research, Residency & Global Opportunities Masterclass
Expand Your Career Beyond Borders

1st September 1:00 PM
SLMA Auditorium

Registration Fee: Rs. 500/-
Coordinator: Prof. Dakshitha Wickramasinghe

Optimizing Cytoreductive Surgery and HIPEC/PIPEC from Patient Selection to Perioperative Management

1st September 9:00 AM
Kothalawala Defence University

Registration Fee: Consultant Rs: 2000/-
Trainee Rs: 1000/-
Coordinator: Dr Dulantha De Silva

WORKSHOP ON BARIATRIC SURGERY

1st September 8:30 AM
NHSL

Registration Fee: Consultant Rs 3000
Other Participant Rs 2000
Coordinator: Dr. Vihanga Wickramasinghe

Laser in Benign Proctology

7th September 8:30 AM
University Surgical unit Auditorium NHSL

Registration Fee: Rs 5000
Coordinator: Dr. Mihira Bandara

SLMADS- Elsa Live Operating Workshop

2nd September 9:30 AM
CSSL Auditorium

Registration Fee: Consultant Rs 2000
Other Participant Rs 1000
Coordinator: Dr. Chathuranga

The College of Surgeons of Sri Lanka
No. 6, Independence Avenue
Colombo 7
Tel / Fax : +94112682290 / 2699884
Email :
srilankasurgicalcongress@gmail.com
www.surgeons.lk



A Tribute To A Great Surgeon

Dr Ranjith De Silva

(1937 – 2026)



The passing of Dr. B. G. R. (Ranjith) De Silva marks the end of an era in Sri Lankan surgery. His departure is not merely the loss of an eminent surgeon but the loss of a teacher, mentor, role model and a gentleman par excellence, whose life exemplified the noblest ideals of the medical profession.

We had the privilege of serving under him as surgical registrars in Wards 23 and 29 of the National Hospital of Sri Lanka (NHSL) in 1994. Looking back more than three decades, we realize how fortunate we were to have been trained under one of the finest surgeons this country has ever produced. Many of the young doctors who stood beside him during those years have themselves become leading academics and medical specialists. Their achievements bear testimony to the quality of the teacher who shaped them.

Dr. De Silva possessed a rare combination of exceptional clinical judgment and remarkable surgical dexterity. His diagnostic skills were legendary. He belonged to a generation of surgeons who relied first and foremost on meticulous history-taking and careful physical examination. Long before sophisticated investigations became commonplace, he could arrive at an accurate diagnosis through disciplined clinical reasoning. His operations reflected the same precision, confidence and elegance.

What distinguished him even more was his unwavering professionalism. Punctuality was non-negotiable. Ward rounds commenced promptly at 7.00 a.m., even on operating theatre days. Every patient was seen, every clinical detail reviewed and every trainee expected to be prepared. Those ward rounds were not merely patient reviews; they were masterclasses in clinical medicine, surgery and professional ethics.

Despite his towering reputation, Dr De Silva remained a remarkably humble and approachable individual. He treated everyone—from patients and nurses to junior doctors and support staff—with courtesy and respect. He neither sought admiration nor tolerated flattery. His authority stemmed not from his position but from his integrity, knowledge and example.



His compassion for patients was genuine and deeply rooted. At a time when private practice was considered a natural extension of a consultant's career, he consciously chose not to engage in it. Instead, he devoted himself entirely to public service. Throughout his distinguished career, he served the people of Sri Lanka with dedication in Anuradhapura, Galle, Gampaha, Ragama and finally at the then General Hospital in Colombo (the current NHSL). Thousands of patients, particularly those from disadvantaged backgrounds, benefited from his knowledge, skill and kindness.

Outside the operating theatre, he was equally accomplished. An outstanding sportsman, he captained the cricket team of Royal College, Colombo, and later that of the then University of Ceylon. His sporting achievements reflected the same qualities that defined his surgical career: discipline, leadership, humility and commitment to excellence.

For those of us who trained under him, the lessons extended far beyond surgery. He taught us that technical competence without compassion is incomplete; that humility enhances greatness; that punctuality reflects respect for patients; and that service to society is the highest calling of a doctor.

Today, when medicine faces unprecedented technological advances and changing healthcare landscapes, the values embodied by Dr Ranjith De Silva remain timeless. His legacy lives on not only in the countless lives he saved, but also in the generations of surgeons and physicians he inspired. Every doctor who strives to place the patient first, uphold the highest ethical standards and pursue excellence with humility is, knowingly or unknowingly, carrying forward a part of his legacy.

Sri Lanka has lost a surgical giant. His students have lost a revered teacher. His colleagues have lost an exemplary professional. The nation has lost a gentleman whose life demonstrated that true greatness lies not only in extraordinary ability, but also in simplicity, integrity and selfless service.

May he attain the supreme bliss of Nibbāna.

Satish K Goonesinghe

Sunil R Wijayasinghe

(Former surgical registrars trained under the late Dr. B.G.R. De Silva)

Originally published in the Sunday Times – 12th July 2026

SPONSOR

+ IODOSORB[◇] Cadexomer Iodine Dressing/Ointment/Powder

IODOSORB Range promotes wound bed preparation by removing barriers to healing¹⁻⁸



Smith+Nephew

IODOSORB[◇]
Cadexomer Iodine Range

www.smith-nephew.com

Indications

- IODOSORB[◇] Range is indicated for the topical treatment of chronic exuding wounds
- IODOSORB Range can be used under compression therapy



SUTURE