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GUEST EDITORIAL

MENTAL HEALTH SERVICES IN FIJI AND THE WAY FORWARD

Dr Odille Chang, Acting Medical Superintendent, St Giles Hospital

Mental health services in Fiji have had a long and interesting history. From its beginnings, in 1884, as a single ward catering to the mentally ill expatriate population it has evolved into a 136-bed psychiatric facility with links to the community through a well-established public health system. However, there is a need to further expand mental health care services and development.

One of the biggest hurdles facing mental health development in Fiji is the stigma associated not only with mental illness but also with St. Giles Hospital itself.

This stigma has fostered a very tragic catch-22 scenario whereby people are reluctant to seek assistance for mental health problems while their conditions worsen, sometimes resulting in them being brought to St. Giles Hospital forcibly, adding again to the stigma associated with being mentally unwell.

Also associated with the stigma surrounding mental illness are the many misconceptions, myths and traditional beliefs linked to the development of mental illness which prevent people from seeking appropriate assistance and turning to alternative means of treatment.

There is a dire need to educate the public and promote community awareness on mental health issues.

Other challenges include the limited resources available, both financial and human; the lack of trained mental health professionals and allied mental health professionals; limited community mental health and psychosocial rehabilitative services; archaic infrastructure and the need for new legislation which is in line with the modern day practice of psychiatry.

However, this is not to say that Fiji's mental health services have not continued to develop and evolve despite the challenges and shortcomings.

An expansion of community mental health services in the Western and Northern divisions of the country has been funded for the period 2006-2008 from the Fiji Health Sector Improvement Program (FHSIP).

This is being achieved through the provision of Mental Health Project Officers in those divisions to promote and advocate for mental health in the community and through capacity building and training of public health nurses in mental health. This has been boosted by the allocation of additional funds for a divisional Mental Health Project Officer in the CentEast division in 2007.

The Fiji School of Nursing has just started its first post-basic nursing program in mental health, which started on September 25, 2006.

The formation of the National Committee on the Prevention of Suicide (NCOPS) in 2001 to address the issue of suicidal behaviour has also been another milestone in the evolution of mental health services in Fiji.

Also, after a long delay, a review of the current mental health legislation has commenced in the last quarter of 2006.

This is a very important event as that legislation, along with the current mental health plan will form the basis of and provide direction for the further development of mental health care in Fiji.

Community psychosocial rehabilitation services are also being improved with FHSIP is providing funds for a bakery for the Hospital's Day Care Centre and the Leadership Fiji 2006 Team raising $50,000 towards the renovations an unused ward as the new site for the Day Care Centre.

Fiji is also a participating in two regional initiatives: the START (Suicide Trends in At-Risk Countries and Territories) study, a WHO study on suicide behaviour in the western pacific region; and is a member of the newly formed Pacific Island Mental Health Network (PIMH Net) which will be officially launched in April 2007.

So, for a small developing country like Fiji, what is the way forward for mental health? With limited resources and competing health needs, which are seemingly more urgent, how do we progress?

I would like to reiterate that there is a fundamental need in the wider community for greater awareness of the importance of mental health and need for greater understanding of mental illness.

It is unfortunate that through lack of knowledge and awareness, we have treated mental health as a luxury item that we can do without, rather than as the vital basic necessity it is and often do not realize its importance or value until it is no longer there: be it through having to nurse a parent with dementia, or care for an intellectually disabled child or having experienced an episode of depression.

There must also be a commitment to improve the delivery of mental health care services through its integration with primary health care.

Advocacy and promotion of mental health should be strengthened through the development and implementation of policies and legislation, not only in the realm of health, but

in other spheres such as education, housing, social welfare and employment opportunities, that will positively impact on the mentally ill and mental health care services.

Mental health must be made a priority and the realization of its importance in every aspect of our lives needs to be recognized and transformed to legislative and political commitment and funding.

However, we cannot depend solely on government to supply all our needs. We must also involve our communities and establish services and programs that will allow mental health care consumers to access help where they live in the least restrictive environment and without fear of stigmatization. There is a need to promote partnerships with the private sector to address shortcomings in the current delivery of mental health care (e.g. drug rehabilitation facilities, psychiatric respite and residential facilities, advocacy, mental health awareness, support groups, etc.). Consumers of mental health services should also be empowered and be given the opportunity to actively participate in the development of legislation, services, plans and policies related to mental health.

As a developing country with limited resources available, it is important to make use of the resources accessible at present. Mental health should be integrated into the general medical and public health arenas. Medical and nursing personnel, in both the private and public sectors, should be adequately trained to care and manage consumers with mental health concerns and community psychosocial rehabilitative and support systems in place.

I envisage a future where people with mental health concerns can be assessed and managed in their communities at their local health centers and hospitals; that St. Giles Hospital will cease to exist in its current form and be a much smaller psychiatric facility attending to subspecialties in the field; with mental health care supported by a private sector based Mental Health Fund; and that the stigma attached to mental ill health and its treatment will be a thing of the past…. does it sound too imaginative and far-fetched?

Probably. But with mental health one has to be visionary and ever hopeful that the value of mental health and the moral obligation we have to addressing mental health issues will one day be recognized.

Because we must remember: "There is no health without mental health".

MEDICO-POLITICAL COLUMN

ARE DOCTORS FEES TOO HIGH?

Dr Neil Sharma, Suva

An article in the F/T of Wednesday, 14 Th March alludes to the fact that private doctors are charging an exorbitant fee. This is an interesting avenue to explore. Rightly so, our vibrant Chief Executive at the Consumer Council has pressed the right button to research this topic.

The issues she raised in her press release happen to scratch only the surface of deep seated series of anomalies in the healthcare system which needs comprehensive review by all stakeholders. These stakeholders include the consumers, civil society, legislators and all relevant healthcare providers including the Fiji College of General Practitioners.

The Fiji College of General Practitioners

The Fiji College of General Practitioners was formed fifteen years ago to develop a forum where ongoing education to Practitioners would be provided, initially by voluntary agreement and later by statutes. This was a progressive move as unfortunately, registration of practitioners is life long once granted in Fiji, due to archaic laws.

This is contrary to our developed neighbors where continuous upgrade of knowledge, skills and application is necessary. Continuous assessment is necessary in view of advancing technology and science. Re-accreditation is maintained on the basis of continuing education on a regular basis by organizations akin to the College.

Most developed countries require 50 hours of professional interaction/annually to maintain accreditation/registration. The College of General Practice has been lobbying for a three yearly re-accreditation system all these years without success.

The Statutes have been delayed as a direct result of political upheavals since 1987, 2000 and 2006.The voluntary system is running on thin ice as bulk of the members of the profession remain ambient to change and continually fail to attend professional meetings.

The College was given due recognition by the Ministry of Health and eventually this year has its first direct membership to the supreme, Fiji Medical Council.

Over this period of time the College has conducted regular workshops, mini-seminars, conferences, journal clubs and established Peer Review groups throughout the country. The thrust on-going professional education continues through its quarterly journal, the Fiji General Practitioner and its newsletters.

The College has conducted several Office Based Research and pioneered Medical Writers, Peer Reviewers and Research Methodology workshops conducted by well renowned experts from the Asia- Pacific region. Recently the concept of developing a Standards Committee of the College was undertaken.

The idea is to educate the Practitioner in enhancing the status of Health delivery with specific regard to customer focus, improved clinical services delivery in an occupationally safe and comfortable clinical environment.

The strategists who founded the College have given great thought to the concept of a Consumer Watchdog Organization as is the case in the United Kingdom.

Consumer Council of Fiji

As an important consumer rights organization the Consumer Council of Fiji is correct in raising the issues with respect to suspect and questionable practices. Apart from the Ombudsman's office and the Fiji Medical Council, the Consumer Council of Fiji is suitably qualified to assist in advocacy issues for the client and/ or assist the aggrieved physician.

Moving to elaborate on some of the important issues raised by The Consumer Council of Fiji in their press release, we can only add that all stakeholders need to work in concert to move the issues forward. Tearing down each other will not improve Patient/client issues.

Young and inexperienced practitioners

There is no question that young and inexperienced practitioners can be harmful to safe practice. The College suggests that all new practitioners undertake vocational training in General practice as part of their affiliation into the College fraternity. Only four young practitioners are currently undertaking a vocational program run by the Fiji College / Monash University, Melbourne this semester. Several seasoned practitioners hold Masters and others diplomas and certificates for Monash University. The bulk has not moved.

A minimum fee schedule has been developed

A minimum fee schedule has been developed and consideration to rural areas has been factored in with variables adjusted in smaller townships and settlements. In view of individual variations in duration of consultation i.e. timings and durations, a sliding scale is in place to suit the financial and economic times and places.

Specialists have their own rates stated and good practices have a fee schedule on display on the notice board and/or reception counter for the information of the consumer.

Multi practice ownership

The question of private practitioners oper-

ating several practices is to be addressed with the Fiji Medical Council soon by individual members of the profession. A query in this matter has been raised. This is an issue which needs address as both options have advantages and risks. The public likewise needs to know if non medical persons can run practices too. A policy decision on this matter is awaited.

The Standard Committee of the College

The Standard Committee of the College is to address the issues of the physical location, occupational and safety of practice settings. Professionally the committee will need to address the features in the Clinic setting. These will include accessibility, patient and consultation areas, counseling staff, confidentiality of records and consultation, record keeping and methods in the Cold chain storage of vaccines and sterilization techniques. Issues on informed consent and choice are very relevant in this day and age and need to be adhered too.

Are Doctors fees too high?

Returning to the gist of the Consumer Councils major concern on cost, the private sector most definitively takes cognition of the balance between service delivery and costs to clientele as there is always competition from other practitioners down the road. There are unscrupulous elements in all professions and need to be weeded out. However we cannot cast all in the same stone. Interestingly there is a lot of philanthropy still around in the private sector. Unlike the government sector all practitioners in the private quarter are very aware of cost containment. It is the margin of profit which we need to consider taking into account time, energy, expertise, specialty and not forgetting the increasing medical costs and annual indemnity we pay. If we pay peanuts, the monkey business thrives.

Conclusion

The Consumer Council of Fiji has raised very pertinent issues close to the heart of Consumerism. The health delivery system cannot remain an ostrich and not work collectively through its Medical Council, College and Administrative hierarchy.

3.1 Invited review

Substance Abuse in Primary Health Care

Dr. Noere, Suva

Introduction

Substance Abuse is prevalent throughout the world and is a significant public health burden. According to the World Health Organisation, tobacco, alcohol and illicit drugs are among the top 20 risk factors for ill health. Tobacco is estimated to be responsible for 9% of all deaths and 4.1% of the global burden of all diseases. This is measured as the number of years spent living with a disease (Disability Adjusted Life Years - DALYs). Alcohol is responsible for 3.2% of deaths with 4.0% of DALYs. Illicit drugs (e.g, cocaine and heroin) are responsible for 0.4% of death and 0.8% DALYs.

In the Fiji Islands, the trend is similar where four main substances abused are marijuana, alcohol, kava/yaqona, and tobacco, have been identified. The massive usage of these psychoactive substances with direct links to biopsychosocial problems creates enormous burden on our already under resourced public health, criminal justice and social welfare system.

The table shows the results of the Global Youth Tobacco Survey by UNICEF and WHO in 1999 and follow up survey in 2004 by National Substance Abuse Advisory Council (NSAAC).

Substance	GYT Survey (1999)	NSAAC (2004)
Tobacco	32.6	43
Alcohol	40.3	51
Kava	51.9	61
Marijuana	12.8	13

2147 students were surveyed in 2004 in different secondary schools throughout the country. The figures show a general increase in secondary students for use of the substances.

The drug offences recorded by the Fiji Police Forces from 2000 to 2005 to September 2006 is as shown;

Year	2001	2002	2003	2004	2005	2006(Jan-September)
Against Drugs Ordinance/ Act	433	417	417	312	312	264

The drug refers only to marijuana and the figures do not show the exact figure for those who are actually abusing the drug. It does not differentiate between those caught abusing marijuana or those caught in possession only.

The Statistics compiled at St Giles in 2004 revealed a total of 982 patients seen at outpatient department diagnosed with a substance abuse disorder ,633 (64%) patients abused marijuana, 76 (7%) abused alcohol, 157 (16%) abused tobacco and 108 (11%) abused kava (grog). In 2005, a total of 612 patients seen with a substance abuse problem, 386 (63%) abused marijuana, 59 (9.6%) abused alcohol, 57 (9.3%) abused kava and 99 (16%) abused tobacco. From the data obtained more than 50% of patients abused marijuana.

Abuse of psychoactive substances continues to be a major issue in Fiji, therefore a lot of community awareness programs and education of secondary school students on different substances and health risks have been carried out by a lot of different organisations such as National Substance Abuse Advisory Council, Drug Squad of the Fiji Police Force, Non Governmental Organisation, different churches and other youth groups.

Discussions made with some of the organisations reflect a gap in the services for those who abuse or are dependent on psychoactive substances.

Approach in Primary Health Care Setting

Primary health care workers are the first contact for patients with substance abuse problems. They are in a unique position to identify and carry out appropriate interventions for different people. Screening for any substance abuse during initial contact at the clinic should be like any routine screening for blood pressure and random blood sugar. Many clinicians have different ways of screening their patients but the most important concept is to be able to differentiate, harmful use/abuse, intoxication, withdrawal and dependence.

Patients whose substance use is harzadous or harmful rather than serious dependence will generally benefit from a brief intervention. A brief intervention is considered to be any intervention that involves a minimum of professional time in an attempt to change drug use. Primary health care intervention can range from 5 minutes of brief advice to 15 – 30 minutes of brief counselling. This is a valuable tool for treatment of problematic or risky substance use. Strong evidence supports brief intervention to be low in cost, time efficient and effective with many levels of hazardous and harmful substance use. They are suitable for

use as a method of health promotion and disease prevention with primary care patients.

Patients with a more serious dependence problem can also receive a brief intervention to encourage them to accept more intensive treatment or referral to bigger hospitals like Colonial War Memorial Hospital, Lautoka Hospital or St Giles Hospital.

FRAMES – The Current Model

There are six therapeutic elements which are common to a successful brief intervention.

Feedback – feedback from your clinical assessment is a key component of brief intervention, generally following a thorough assessment of the drug use and related problems.

Responsibility – emphasize the person's responsibility in regards to substance use and at the same time providing information to help them make good choices.

Advice – provide clear practical advice creating a link between the person's current pattern of drug use and the associated risks and harms.

Menu of alternative change options– offer a range of behaviour change strategies and intervention options. The patient is able to choose the strategy most suitable for him/her which will be helpful.

Some examples for patients to choose from;

- Keeping a diary of substance use (where, when, how much, who with, why)
- Identifying other activities like hobbies, sports, gymnasium, farming and others to replace substance use
- Identify high risk situations and develop strategies to avoid them
- Put aside money they would normally spend on substance for something else
- Provide written information, or about other groups or counsellors if available.

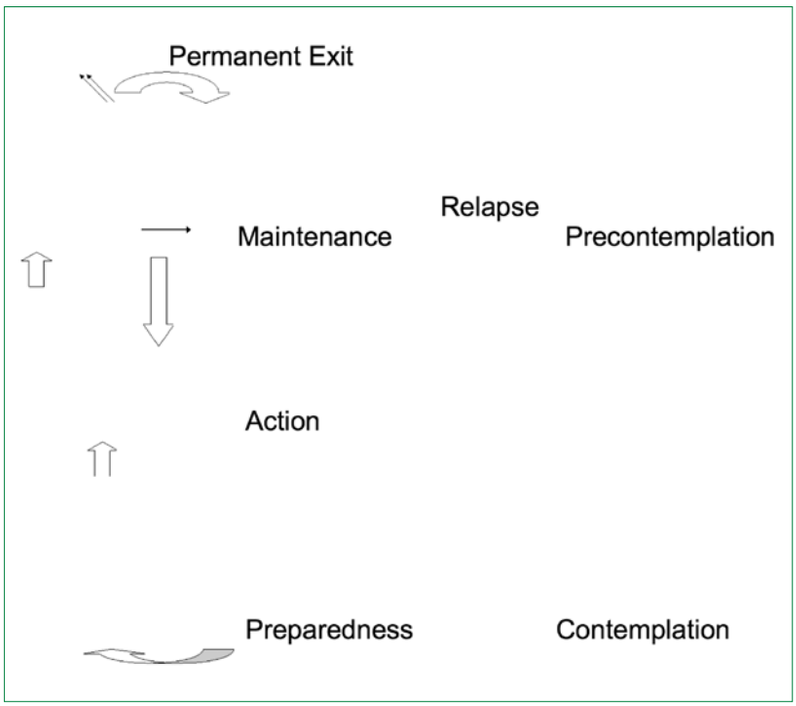
Empathy – the clinician must express warm, understanding and non judgemental empathy and support.

Self efficacy – to encourage patients' confidence that they are likely to make changes in their behaviour towards their substance abuse.

Motivational Interviewing.

This is an important tool to encourage motivation to change which is defined as a client centred, directive method aimed at helping people to explore and resolve their ambivalence about their substance use and more through the stages of change as written by Miller and Rollnick (2002).

Model of change is as shown.



Pre contemplation – Patients in this stage may not know or accept that their substance use is risky or problematic. Simply providing information on the risks of substance use may encourage them to recognise these risks and to think about cutting down or stopping.

Contemplation – Patients are likely to be ambivalent about their substance use. They are aware of the advantages and disadvantages of their current drug use. The focus here is to provide information about their substance related risks and advice them to cut down or stop. This aims to encourage them to find and talk about their own reasons to cut down or stop their substance use.

Preparedness – This stage relates to the determination and preparedness of the patient to change.

Action – Patients in this stage have made the decision about changing their behaviour. Interventions include, negotiating aims and goals for changing ones behaviour

- strategies for the patient to help them cut down or stop their drug use.
- assist them to identify situations where they might be at risk of relapse.
- discuss with the patient about their plans to reduce or stop substance use.

We must keep in mind that patients in this stage are likely to continue feeling ambivalent about their substance use therefore, they need encouragement and support to maintain their decision.

Maintenance – The patient is maintaining the behaviour changes that have been made. Long term success means remaining in this

stage. Primary care workers need to affirm their good job and encourage them to continue. Clinicians can also assist by providing praise for successes and reinforce their strategies for avoiding situation where they are at risk of relapse.

Relapse – This is a normal part of the recovery process where most patients who try to make changes in their substance use behaviours will go back to their substance use. However, this should be expected but the challenge is to quickly resume to the change process.

Most patients' change in the substance use goes in a vicious circle until they are eventually successful and escape through the permanent exit of maintenance.

Principles of Motivational Interviewing

The four main principles are as follows;

Express Empathy – Understand the patients' experience communicated in a warm and non judgemental manner. Avoid labels like alcoholic or drug addict.

Develop Discrepancy – Clinician's task is to allow the patients to see the difference or discrepancy between their current substance use, related problems and the way .they would like their life to be.

Roll with Resistance (avoid argument). Avoid provoking resistance but instead the clinician must reframe or do reflection.

Support Self Efficacy - Evoke the patients' belief in the ability to succeed at a task undertaken.

Specific skills in Motivational Interviewing.

The skills are known by the acronym, OARS.

Open ended questions – Questions that cannot be answered with 'yes or no'

Affirmation – Expression of appreciation for who the client is.

Reflective listening – Repeating or rephrasing without adding meaning or emphasis.

Summarising – To summarise what has been discussed.

Another additional skill which is used in motivational interviewing is change talk. This is a strategy that aims to help the patient resolving ambivalence and to enable the patient to present the arguments for change.

Motivation for Change, (Ready, Willing, Able)

For people to actually change their behaviour they need to be ready, willing and able to change. These three basic components, ready, willing and able, always work together in order to change a patient's behaviour.

Conclusion.

Appropriate approaches to substance abuse in Primary Health Care where screening for problematic substance use, using FRAMES techniques and integrating motivational interviewing strategies in the brief interventions as already discussed will benefit the individual, the family and community at large. These provide opportunity for educating people about the risks of substance use, promoting health and improving the health of the general population. Screening and brief intervention is a cost effective method to reduce the burden of disease due to substance use at population level.

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NEXT ISSUE:

Emerging infections

Vol 15, No 3 September 2007.

3.2 Invited review.

DEPRESSION AND ANXIETY – A G.P PERSPECTIVE

Dr Neil Sharma. Suva

Depression and anxiety are very common medical conditions in the community. Unfortunately fewer than 50% of cases present to their doctors for a wide variety of reasons. A lesser number agree to undertake medical management to full remission. Delayed diagnosis, implementation of care and follow-up result in many complications such chronic courses in the anxiety and depressive states including self harm, suicide.

All this translates into much distress for the patient and their immediate kin.

RECOGNIZING THE PATIENT WITH DEPRESSION

The recognition of patients at risk for depression is an extraordinarily important responsibility.

There is a genetic susceptibility to such conditions and then there are environmental predisposing factors which contribute in various shades in the individual case.

Obtaining the patient's family history is crucial. The patient's personal history of depression is also important, since a previous episode increases an individual's risk for a subsequent episode.

Women are approximately twice as likely as men to develop depression. Although the reasons for the difference in gender susceptibility are unclear, there is evidence to suggest that the increased incidence is related to hormonal factors, stress, and lifestyle. Life stressors are important risk factors for the development of depression; individuals who have experienced adverse childhood experiences, including childhood trauma, neglect, sexual and/or physical abuses, and parental loss at an early age, are at increased risk for developing depression.

A number of other psychiatric and medical disorders increase the risk for depression, with anxiety disorders prominent among them. Alcoholism and other forms of substance abuse are associated with an increased risk for depression; many patients undoubtedly use alcohol and drugs as a means of self-medication for depressive symptoms. There are medical disorders with high rates of co morbid depression, including Parkinson's disease, Alzheimer's disease, cardiovascular disorders, pancreatic cancer, and a variety of other malignancies. One quarter of women with breast cancer experience major depression.

DEPRESSION AND REPRODUCTIVE ISSUES

Postpartum depression, for example, has an overall prevalence of 10%. Certain subgroups are at even greater risk. Over 25% of adolescents who give birth, particularly single mothers, have a risk of developing postpartum depression. This condition is associated with an increased risk for suicide. Obstetricians, with whom new mothers are most likely to have contact after delivery, are likely to focus on issues such as episiotomy healing and breastfeeding at the first postpartum visit and therefore may not inquire about symptoms of depression. Besides being a risk factor for suicide, postpartum depression can impede mother-infant bonding. Deficits in this area can result in negative outcomes for the child, including an increased risk for anxiety and depression in adulthood. Depressive disorder also occurs in some women after spontaneous miscarriage.

Many of these women will not actively seek treatment for their symptoms; therefore, it is the responsibility of all concerned to be aware of such outcomes.

WHEN THE COMPLAINT IS SOMATIC

Many individuals present with somatic or bodily complaints when they are stressed, anxious or depressed. Too many doctors are misled into believing that the signs are of the body rather then of the mind or spirit.

Short consultation times, busy clinics, overworked doctors, hesitant patients with soft complaints who may find the medical environment threatening opt to internalise their concerns. On the other hand" difficult" patients sometimes receive the wrong end of the ruler for their lists of complaints or demonstrating the brown paper-bag full of medication for an unending list of unresolved symptoms.

When an individual has symptoms which do not abate with a second or third consultation then the next of kin need to consider a "mind over matter" diagnosis. The mental and spiritual health status must be given consideration.

FACILITATING DEPRESSION SCREENING

The following two simple questions are about as effective for initial screening:

1. Over the past few weeks, have you felt down, depressed, or hopeless?
2. Over the past few weeks, have you felt little interest in doing things?

If the response to either of these two questions is positive, further investigation is recommended.

SELECTING A TREATMENT

Treatment options for patients with mood disorders include psychotherapy, pharmacotherapy, combined psychotherapy and pharmacotherapy, and combination pharmacologic therapy.

1. PSYCHOTHERAPEUTIC OPTIONS

Of the available psychotherapeutic treatment options, cognitive-behavioural therapy (CBT), alone or in combination with pharmacotherapy, has the best evidence in its favour

2. THE PHARMACOLOGIC APPROACH

There is strong evidence for the efficacy of the SSRIs in treating depression and anxiety, but the serotonin- norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs) are effective as well. Costs are of concern in Fiji, when we consider medication choices.

GETTING TO REMISSION

Remission of symptoms is the established goal of acute-phase treatment

Chief among the barriers to remission are psychiatric and medical co morbidity, psychosocial stress, inherited vulnerability, and insufficient treatment intensity. Health-care practitioners cannot change factors such as inherited vulnerability and the ability to modify psychosocial stress is limited. Clinicians can, however, modify treatment intensity and some aspects of co morbid conditions, especially psychiatric ones.

Patients need to be educated and clinicians also need to match the patient's requests for treatment with the interventions that offer the best chances of recovery. Understanding patients' belief systems, cultural notions, and perceptions of their illness is essential. Attention to a patient's literacy level is crucial when distributing patient-education materials.

LONG-TERM APPROACHES

Depression and anxiety are chronic diseases requiring long-term follow-up and treatment. The clinical focus after the acute phase shifts to concerns for long-term care. Goals of long-term treatment of mood disorders include:

- Minimizing relapses and recurrences
- Progressing from response to remission
- Improving treatment adherence with antidepressant therapy and other medical and psychiatric treatments
- Minimizing and managing side effects of medications
- Slowing the progression of psychiatric and medical illnesses.

SUMMARY

Depression and anxiety are common in the community. They are frequently undiagnosed and are a source of morbidity and mortality. Both conditions increase the risk of suicide, increase the use of health-care resources, cause occupational impairment, and often become chronic. With increasing stress in modern day living, we need to support each other and assist in maintaining positive health in the community. A psychiatric condition can present in up to 20% of the population, in some form at some stage of their life.

ACCOUNTING FOR VAT AND ANNUAL RETURNS

Rajnita Bhan-Sharma, Nadi.

Two very important and required accounting procedures in a business is the preparation of VAT and annual income tax returns. It is essential for any medical organization to follow professional accounting standards (as discussed on the previous issue of the journal).

The Income Tax and VAT laws require that all businesses keep essential records to substantiate figures put in income tax and VAT returns. Apart from income tax and VAT requirements there are other reasons for keeping good accounting/ business records. These include monitoring the cash flow and profitability of the business and when one applies for loans for business related activities.

There are several types of business ownerships in the medical practice. The most common is the sole proprietor and then there are practice partnerships and also clinics that operate as companies. In the Pacific island setting, private medical practices are generally owned and managed by sole proprietor. It is the responsibility of the owner to supply the necessary funds to commence the business and in turn the business profit and loss is also sustained solely by the owner.

Despite the "accounting entity" concept the business is not a separate legal entity, although it is treated as a separate accounting entity. The debts of the business are the sole responsibility of the owner. In the eyes of law the owner has unlimited liability, thus the personal assets of the proprietor can be sold to meet the debts of the business. Therefore, it is advisable when commencing a practice, the owner decide whether to operate the business as an owner or to be a paid employee of the company. One of the advantages of being an employee is that a portion of the wages/ salaries is assigned as a compulsory saving in form of FNPF deduction, whereas the solo owner of the business often forgets to follow.

Whether you are an employee or operating a business income tax returns are usually filed annually at the end of each accounting period, though the accounting period for different business can differ according to the structure and size of the organization.

There is a set guidelines assigned by Fiji Islands Revenue and Customs Authority as to when and how the VAT and income tax returns are to be submitted. This is generally is determined by the income earning capacity of the organization.

Value-added tax (VAT) is defined as a percentage tax applied on the value of the commodity that is produced. For example, 12.5 % is the current rate of VAT that is applied on sale and purchases of goods and services.

VAT returns can be submitted on monthly, quarterly or annual basis.

Under the 1991 VAT Decree the any organization exceeding a taxable income of $100,000 per annum is required to prepare a monthly VAT returns. Also under the same Decree it is important that prior registration with FIRCA is necessary. After the VAT returns is completed it must be lodged with FIRCA and any tax to be paid must be done by the last day of the following month. Penalties apply for late lodgments of returns and late payments as well.

There are three main steps that should be followed when completing the VAT returns:

1. Total Output Tax is to be calculated. This is the tax sum that the business has charged on the sales income that has been generated during the taxable accounting period. This sum is derived by simply by dividing the total income by 9 or calculating the 12.5% of the total income. Also inclusive in this figure is the VAT charged on fringe benefits (example, the business vehicle), VAT on bad debts recovered, VAT on insurance indemnity payments received, VAT on assets retained at the time of ceasing to be registered, VAT on debit notes issued and credit notes received.
2. Total Input Tax is to be calculated. This is the taxable sum that is calculated from all the expenses that has been incurred during the accounting period. These are only those expenses that are incurred when running the business on a daily basis. It does not include any expenses that relates to the owners personal expenses. Even though as stated earlier that, by law the business and the owner are not separate legal entity the accounting entity overrides this statement. The Input tax does not include any personal drawing incurred by the owner. For example, water bills, VAT on Telecom bills, household expenses and loan repayments. Thus it is advisable to separate all business and personal expenses before calculating that VAT Input figure.

For those general practitioners who operate the practice from their residences should consider enquiring with the FIRCA office as to what percentage of the VAT for their personal drawing is included in the VAT returns. Generally FIRCA only allows from 50% to 75% of these expenses to VAT exclusive when claiming the returns. VAT input adjustments also include the VAT paid on Customs which is invoiced by the FIRCA office. Furthermore, VAT on bad debts written off, VAT on credit notes issued, VAT on debit notes received and VAT refundable due to a change in accounting basis can all be included when lodging claims for VAT returns. All this VAT figures can be totaled up to give the total input tax.

3. Finally when both total output tax and total input tax is calculated, tax is payable if the total Output Tax is higher than the total Input Tax. But when the total input tax is higher than the total Output tax there is a refund allowed to the business.

This is the final article in this series of "Accounting in General Practice" which I have presented to simplify accounting matters. I have covered "Accounting in General Practice" and all its statutory requirements followed by Accounting Standards. That article dealt with ethical and transparent practice standards including the design of a Standard Accounting Practice and finally this completes the essentials in preparation in the "Business returns".

CLINICAL AUDIT
RATIONAL USE OF ORAL CONTRACEPTIVES IN WOMEN AGED 16 - 45

Dr Mohini Goverdhan, Suva

INTRODUCTION

A clinical audit was carried out in our practice to assess the use of oral contraceptives and associated preventive activities.

The current recommendation is that the following parameters must be assessed at an initial contraception clinic:

- Age
- Sexual and medical history
- Obstetric and gynecological history
- Family medical history especially of any cardiovascular diseases in female members
- Social habits such as smoking.
- Weight
- Blood pressure
- Breast examination
- Pap smear

Any misconceptions or fears in the potential oral contraceptives [OC] users must be addressed and clarified on the first visit.

Follow up clinics at appropriate intervals should be carried out

To aim is to assess the following:

- How the woman is managing with the use of OCs.
  Whether she is facing any problems or has any queries or confusions.
- If she is having any side effects.
- Weight, blood pressure, breast examination and pap smears at appropriate intervals. This would ensure an early detection of any of the diseases to which OCs pose a risk.
- The woman's smoking history if she is a smoker.
- Any other risk behaviors or health conditions she may be having that could drastically affect the outcome of her OC use.

The audit was carried out accordingly.

METHOD

Any patient who presented, requesting a repeat of oral contraceptive pills was short listed for the audit. The records were then retrospectively scrutinized over the preceding 24 months.

Those patients who had attended the clinic for less than 24 months were disqualified from the audit. This group of patients was further selected and those falling in the age group of 16 years to 45 years were finally entered into the audit. A total number of 25 patients were included.

Each patient was screened for the following variables as outlined on the audit sheet:

i). Length of time on the OC

ii). Number of time the pill was changed

iii).The reason for change of pill

iv). Number of patients who were screened for smoking, pap smear, blood pressure and had breast examination done.

The results were tabulated and analyzed.

RESULTS

Total number of patients: 25

RESULTS

Total number of patients: 25

TABLE:

VARIABLE	DOCUMENTED CASES	TED CASES
Smoking		20
Cx Smear		21
Blood Pressure		23
Breast Examination		19

Duration of patients on Ocs

PERIOD	NUMBER
1 - 6 Months	5
7 - 12 Months	0
12 - 24 Months	13
> 24 Months	6

Frequency of Changes

NO. of CHANGES	NO. of PATIENTS
Nil	10
Once	11
Twice	4

Common Reasons for Change

REASONS	NO. of PATIENTS
Poor Compliance or Failed Contraception	12
Side Effects	2
Smoking	20
Cx Smear	21
Blood Pressure	23
Breast Examination	19
1 - 6 Months	5
7 - 12 Months	0
12 - 24 Months	13
> 24 Months	6
Nil	10
Once	11
Twice	4
Poor Compliance or Failed Contraception	12
Side Effects	2

DISCUSSION

The results indicate that a majority of the patients (52%) took OCs consistently for a period of 2 years. 24% took pills consistently for more than 2 years and 20% took it for a period of 6 months.

11 patients out of 25 changed the pill once in the 2 year period, and 4 out of 25 patients changed it twice, while 10 did not change their pill in the 2 year period.

The common reason for the change of pill was poor compliance or failed contraception.

Only 2 patients out of 25 changed their pill due to side effects.

Over 80%, of the patients were evaluated for blood pressure, cervical smear and smoking. 76% had breast examination undertaken.

Smoking, abnormal cervical smear and hypertension have a bearing on the outcome of pill users.

Some early studies have linked OC use with breast cancer*. Although the absolute risk is small on current dose schedules, it is impertinent to undertake an initial breast examination and subsequent follow up. Any mass or abnormal findings of breast tissue would need to be further assessed.

OCs usage may also increase risk to cardiovascular diseases especially in women with other risk factors such as a family history of hypertension, history of smoking cigarettes or hypertensive tendencies. Estrogen component of OC increases blood coagulability, and poses further risk of cardiovascular disease. Inadequate follow up of blood pressure and smoking would allow progression or symptoms of cardiovascular disease to progress unnoticed.

OCs use have been associated with an increased risk of cervical cancer.* The association between oral contraceptive use and cervical cancer may not be directly causal but of a casual nature. Infection with human papilloma virus, or sexual relationships patterns which can predispose one to additional risk to cancer of cervix may provide the linkages in the causation chain.

The most practical and probably cost effective means of following up on this risk association is by doing pap smears at regular intervals.

It was noted that the commonest reason for a switch of the OC was poor compliance and failed contraception.

The following were the areas of weaknesses:

Lack of knowledge on how to take the pill correctly.

Lack of understanding as to why OCs need to be taken daily and at the same time.

Lack of knowledge on what to do if they miss pills.

Lack of knowledge that certain medications taken concomitantly would reduce the efficacy of the pills.

Lack of knowledge that once they start the pills, they might not get instant protection.

Counseling, follow up clinics, clarifying the fears and misconceptions of the women would help address these issues and thus would help reduce the failure rate.

Side effect to the OCs did not seem to be much of an issue with OC use. Though this audit is limited by its small size, other larger studies also have shown similar results*.

Although, the audit shows an above average coverage of the necessary parameters with OC use, there still is room for improvement.

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1. Weisberg, Edith, Hormonal Contraception, Session

2, Family Planning: Sexual &Reproductive Health, Monash University.

MEDICAL ASPECTS OF HEARING DEFICIENCY

Tom Shepherd - MACAud
shephear@keypoint.com.au

As an Australian Audiometrist visiting Fiji, the most noticeable factor in hearing care provision throughout the Fiji islands is the lack of infrastructure to support the hearing impaired.

This is not to say that the hospitals do not fulfil an excellent role with the limited resources they have to offer, and certainly not intended to belittle the wonderful standard of care offered by organisations such as Project Heaven however, the provision of hearing care throughout the Fiji Islands is concentrated within Suva with very little assistance available in outlying areas.

Simple tasks like locating dispensers of batteries and repair services to those who rely heavily on their hearing aids for communication within their business and private lives, can prove to be a monumental problem.

My role over the last eighteen months has been to fill the shoes of a man whom I greatly respect for his charitable work to the hearing impaired population of Fiji - Eric Heideman.

I have been fortunate to inherit the existing architecture of a hearing care system set in place by Eric over his twelve years of service.

Primarily working from Nadi and Suva, with visits to the Mission Hospital in Ba, the support provided by both the Medical centres in the two major towns and by the wonderful, caring ladies who represent the Ba Quota club, makes my visits to Fiji productive and rewarding.

In many cases, the patients attending my clinics have arrived without a medical referral, but when prompted, offer sometimes surprising accounts of lengthy episodes of middle ear infection with recurrent discharge accepted as a simple inconvenience.

I believe the ability to access ENT specialists has improved over the years and I have had the pleasure of meeting Dr Murray Grieg who visits from New Zealand on a regular basis. His endeavours have been assisted by the staff at Suva Private Hospital, in particular, Dr Su Hong.

In my practice on the Sunshine Coast in Australia, we work closely with a government body called the Office of Hearing Services (OHS) - a federally funded organisation that contracts hearing care services to qualified Audiologists and Audiometrists - providing comprehensive hearing assessments and appropriate instrumentation where required.

Rigid protocols are in place to ensure medically referrable conditions are dealt with in a timely manner - involving ENT specialists where required.

For example, any patient suffering unilateral tinnitus or sudden onset tinnitus / hearing loss, is immediately flagged for referral. The potential for an early diagnosis of an acoustic neuroma is reliant on the expertise of the clinician conducting hearing evaluations.

Other factors such as fluctuating hearing loss, pain or numbness around the pinna and asymmetry of the audiogram, are all part of the battery of warning signs for clinicians to observe and notate for referral back to the GP.

Rotational vertigo, 'roaring' tinnitus and a sensori-neural hearing loss may indicate Meniere's syndrome, another common condition sometimes initially detected by the hearing clinician.

Whilst working in Fiji, I have noticed a higher percentage of untreated middle ear infections with resultant, and substantial, perforations of the TMs.

Obviously not a reflection on the attentiveness of the medical fraternity, more so an acceptance from the people who endure these problems as a 'normal' aspect of living in a tropical environment. Many advise me that they have not yet consulted a GP - but arrive in the hope that a hearing aid will overcome the problem.

The provision of an audiogram to the referring GP is a normal part of the process, generally encompassing air conduction, bone conduction and speech intelligibility scores, and sometimes, also accompanied by the results of tympanometry testing which may include ipsi and / or contra lateral reflexes.

In all cases, these results should be explained in order to remove the jargon that accompanies any profession. I have no doubt that the interactivity of these tests would be more confusing than of assistance should an accompanying explanation not be provided.

I have personally sent quite a few assessment results to GPs throughout Fiji who have utilised my services in the past - and it is important to provide an assurance that the patient has been given the most appropriate form of treatment once the referred patient has been consulted and a rehabilitation program commenced.

In the majority of cases, a hearing aid will overcome the majority of hearing difficulties in both sensori-neural and conductive hearing loss cases, but there is always a percentage that may benefit from further medical intervention rather than simply providing an aid.

Ongoing developments in techniques for prosthetic ossicular replacements, tympanoplasty and treatments for cholesteotoma, have offered hope for many.

The advances in technology associated with digital processing used in modern hearing aids enables provision of hearing assistance for even the most difficult of sensori-neural losses - the noise induced loss.

This particular type of hearing loss is very specific in the range of frequencies affected, generally targeting the range above 4KHz for those who have experienced limited noise exposure. People with this type of loss generally complain of a lack of clarity with speech - they can hear the deep sounds easily, but are unable to discern the high pitched sounds in speech that are so important for discrimination between words of similar enunciation - for example, "this / these".

Interesting to note that hearing evaluations on those who have worked in heavy noise environments for many years duration (boilermakers, sheet metal workers, etc), result in audiograms that show severe / profound loss across the entire frequency range - not just specific high frequency loss.

Even in my relatively short time of fourteen years in the hearing care industry, I have heard stories of clients being told by their GP that a hearing aid is unlikely to help them because they have a sensori-neural hearing loss, or 'nerve deafness' as some still call it.

I guess the theory must be that if the cochlea has been subjected to various means of destruction - viral, noise, ageing... there is no way of 'fixing' the problem.

In almost every case of sensori-neural loss, the provision of a hearing aid will offer substantial benefit - not offering a complete restoration of the hearing function, but certainly offering a benefit that in some cases, will make the difference between keeping a patient in the workforce; enhancing domestic harmony; even allowing a child to complete their schooling.

The advances in hearing aid technology seem to be coming at a faster rate every year - the latest being an aid that offers virtually no feedback (the annoying 'whistling' noise heard from generally ill-fitting hearing aids).

And advances continue at a seemingly exponential rate...

May I be so bold as to extend the availability of my services to the GPs of Fiji through this article.

Please contact me via email shephear@keypoint.com.au should you require additional information.

My thanks to Dr Neil Sharma who has given me this opportunity to talk to you through the pages of your professional magazine - a very high quality magazine if I may say so, Neil!

Bula Vinaka,

CME

A 26 year old woman presents with complaints of lethargy, tiredness, and breathlessness. Her FBC report is as follows:

			Reference
Hb	57	g/L	(130-180)
WCC	6.0	x109 /L	(3.7-9.5)
Platelets	202	x 109 /L	(150-400)
RCC	3.52	x1012 / L	(4.30-5.70)
PCV	0.17	L/L	(0.40-0.54)
MCV	65	fL	(82.0-98.0)
MCH	19.1	pg	(27.0-32.0)
MCHC	278	g/L	(300-350)
RDW	23.1	fL	(9.0-15.0)

White cell Differential					
Neutrophil	61.7	%	2.5	$x10^9$/L	(2.0-8.0)
Lymphocytes	28.3	%	1.2	$x10^9$/L	(1.0-4.0)
Monocyte	6.4	%	0.3	$x10^9$/L	(0.2-1.0)
Eosinophils	3.6	%	0.1	$x10^9$/L	(0.0-0.5)
Basophils	0.0	%	0.0	x109/L	(0.0-0.1)

Q1) What type of anaemia does this lady have?
Q2) Name 2 common causes of this type of anaemia?
Q3) What other single test will clinch the diagnosis?

E-mail your answers to Dr Maria Chung Harrison for your CME points.

This quiz is compliments of Mr. Arvin Chand of Austec Lab, Suva

REPORT

PRIMARY CARE IN THE ASIA PACIFIC: MAKING IT SURVIVE

{Reprint Courtesy of Asia Pacific Journal of Family Medicine Volume 5 Issue 2,2006.}

Introduction

Thomas Bodenheimer, giving a perspective on primary care in America in the New England Journal of Medicine in August this year said that the American College of Physicians recently warned that "primary care, the backbone of the nation's health care system, is at grave risk of collapse'.1 This is a message that is applicable to countries around the globe. Primary care in the Asia Pacific is no exception.

Should primary care survive?

This is an important question to ask of ourselves and others. Employers and insurers, public and private, may reap a return on investment by fostering a more effective primary care sector that will reduce health care costs.1 The public will benefit from microsystem improvement by having more meaningful interpersonal relationships with their primary care providers.

Even organ specialists might recognize that they would suffer if primary care were to disappear. They will be forced to have to take on the tasks to co-ordinate care and confront psychosocial issues in patients with multiple acute and chronic conditions, rather than focusing on diagnosing and managing specific diseases within their scope of expertise.1

Formula for survival

Primary care should therefore try to survive. The formula to make it survive has to be a macro and micro set of strategies. It has to be from a patient, a professional, and also a systems perspective. Bohenheimer observes that fixing primary care requires actions on the part of primary care practices (microsystem improvement) and the larger health care system (macrosystem reform).

Microsystem improvement

Microsystem improvement is the capacity-building of each practitioner in his ability to communicate, explain, and convince the patient of the need for paying for performance so that the provider can begin to have the time and resources to deliver what the patients need to be kept in better health. Vocational training regarding the know-how of good care, safe care and mindset change of being able to make a difference, is needed.

Macrosystem reform

Macrosystem reform is more tricky, but necessary. The standard of health care delivered is precisely what the system allows practitioners to do. Reform is needed to promote the preventive focus, the concept of unity for health, and safe outcomes.

What Asia Pacific countries can do?

There are many things that Asia Pacific countries can do to make primary care survive and even thrive. What will happen will of course depend on the prevailing leadership.

Evidence is necessary and that means research

Barbara Starfield showed that countries with greater emphasis on primary care spent less on health care and have better outcomes. In her cross-sectional study of 10 industrialized countries in the later 1980s and early 1990s, concluded that there was general concordance for primary care, the health indicators, and the satisfaction-expense ratio in nine of the 10 countries. Ratings for the US were low on all three measures. West Germany also had low ratings. In contrast, Canada, Sweden, and the Netherlands had generally high ratings for all three measures. The lack of concordance in the ratings in the UK may be a result of relatively low expenditures for other social services and public education in that country.

Starting with prevention

Into the 21st century, it is necessary for Asia Pacific countries to continue to demonstrate that the presence of primary care will make a difference. Such information will strengthen the belief about cost effectiveness of primary care to patients, politicians, and practitioners themselves. This can be patient education programs like stopping smoking, targeting blood pressure control, or or avoiding complications via diabetes control. Even people with one stroke, one heart attack, or an admission for poorly controlled asthma, can be helped to prevent future episodes. The list of preventive care, primary or even tertiary, can go on.

Documentation of such interventions will prove beyond doubt the importance of prevention and reduction of health care costs. This is where practice-based research projects come in. And one can collaborate across countries to document such interventions. We can work collaboratively on case control studies on prevention in primary care - one arm documenting the outcome of usual care, and the other arm documenting primary care interventions in preventive care.

In rich and poor countries alike in the Asia Pacific region, prevention can be made to work to show the difference between its use

and its non-use. And paramedical staff can provide the manpower substitution if there are no doctors.

The starting point will be the convergence of belief in the four Ps (patients, profession, politicians and policy makers and the press); that prevention is cost-effective but also requires resources and commitment to be ploughed into it to achieve results. All need to believe that prevention can be more effective and cost-saving than care after the disease has struck. We must see how to make the first step.

Towards unity for health

Health care today is fragmented into silos: the hospital, the community hospital, the primary care clinic, and the nursing home. Primary care doctors can begin the initiative to link the different sectors together through the spread of the vision of unity for health. Easier said than done, but we can always take the first step to link people and facilities together.

Developing family medicine capability

Family medicine is the discipline that promotes personal, primary, continuing, comprehensive care of the individual in the context of family and community. Much thought, experience and paradigm have gone into the discipline to help its practitioners practice more effective primary care and beyond. Isn't experience enough? Experience is important but not enough. We need to recognize that family medicine capability = GP experience + vocational training. Countries in the Asia Pacific region are now developing vocational training programmes for GPs to build capacity to be FPs (family physicians). Primary care survival will be more assured if its practitioners have a means to build capacity to treat more than cough and cold.

Working towards paying for performance

Paying for performance in the long run will be the way to go to sustain primary care and keep it alive. The patient needs to be convinced that paying the primary care doctor his due consultation fee keeps him alive. More importantly, it also keeps the patient alive by saving him from complications of chronic diseases, and also prevents many diseases from even occurring. The money he or she pays the primary care doctor may be more than before, but think of the savings from prevented morbidity and mortality. Employers, governments, and insurance funders need to recognize the long-term savings and be generous enough to pay primary care providers for their performance in keeping patients in total good health.

Conclusion

Primary care should be able to survive so long as every primary care practitioner is committed to keep the patient alive and thriving. This requires attention to the set of strategies in microsystem improvement and macrosystem reform. For a start, primary care providers can consider: starting with prevention, towards unity for health, developing family medicine capability, and working towards paying for performance. There is also a need to undertake relevant research to provide evidence in support of strategies of improvement.

Associate Professor Goh Lee Gan
Regional President
WONCA Asia Pacific Region

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2 Starfield B. Primary care and health. A cross-national comparison. JAMA 1991; 266: 2268-71.

LETTERS TO THE EDITOR

• Dear Sir,

Depression in primary care

Depression is very common. One in five people will experience depression in their lives. On the other hand, nearly 80% of individuals will visit their family doctor at least once a year. It is the family doctors and their teams who are often the first point of contact for people with depressive illness. They are confronted endlessly by the challenge of depression and related mental health problems in their patients.2 The primary care team often has the potentially precious advantage of knowing the ongoing psychological and social dynamics of the family background. International studies also reported positive outcomes of psychological care by primary care doctors. For instance, Williams et al. found that a substantial proportion of primary care physicians report diagnostic and treatment approaches that are consistent with high-quality care in the US.3 Harman et al. also found that family physicians are more likely than internists to record a depression diagnosis.4 Family doctors therefore have a pivotal role in the management of their patients' mental health conditions.5

Because of social and cultural differences, the awareness and presentation of depression may vary among different nationalities and ethnic groups. In the Asia Pacific region, it is likely that, for example, an Australian patient may be more prepared to present mood symptoms to their family doctor than a Chinese patient. The implication is that family doctors would need to be sensitive to the varying presentations of their patients. Furthermore, it has been reported that 64% of Australian family doctors had found patients felt uncomfortable being referred to psychiatrists, probably relating to the stigma of psychiatric care.6 This highlights the need to acquire the appropriate skills by family doctors to look after their patients with psychological problems in the community, and to work closely with other healthcare professionals. There are various examples around the world that such collaborative mental healthcare is being pursued, for example, the Canadian Collaborative Mental Health Initiative7 and beyondblue: the national depression initiative in Australia.8

The World Health Organization has predicted that depression will become the second most important cause of disability worldwide by 2020.9 And yet it is generally accepted that less than half of all cases of depression are detected by their doctors.10 There is therefore a clear message that doctors would need to do better to combat the depression 'epidemic'. Training will help. However, in order to improve the quality of care for depressive patients, community awareness, government support and collaboration among healthcare professionals are needed. It is to start now.

Tai Pong LAM
Reference on request with editor.

Reprint courtesy of Asia Pacific Journal of Family Medicine Volume 5 Issue 2

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19 April 2007

Pharmaceutical matters

• Dear Sir

Re: With reference to G.P.Vol 15 No 1 March 2007 Med-Watch P20 Point 6 I respond as follows.

Like doctors, pharmacists are also very much concerned about the quality, safety and efficacy of medicines which we sell to our patients as we also owe a duty of care to them.

I could not find any product on the market with "paracetamol/indomethacin" combination. I believe you are, probably, referring to "paracetamol/ibuprofen" combination under the brand name of "selfcare" distributed by Budget Pharmacy.

The only reason I did not come back to you was that when I had a look at the "paracetamol/ibuprofen" combination dosages, as stated on the package and the label, I did not think the dosages were at toxic levels. For example, let us consider the formulations in question.

(1) Stoppain Tablets:

In this formulation each tablet contains paracetamol 5OOmg and ibuprofen 400mg. The dosage statedis "one tablet twice or three times daily". Thus, in a day the maximum dose the patient will take would be 1 .5g of paracetamol and 1 .2g of ibuprofen.

In the U.K, the maximum adult dose of ibuprofen is 2.4g daily in divided doses, whereas, in the U.S.A the maximum adult dose is 3.2g daily in divided doses.

The maximum adult dose of paracetamol is 4g in divided doses in 24 hours.

The patient is, therefore, taking below the maximum dosages Of each ingredient and this will not result in toxic levels. Perhaps, this clarifies the issue on this formulation.

(2) Stoppain Syrup:

In this formulation, each 5ml contains paracetamol 162.5mg and ibuprofen 100mg.

Let us consider the dosage for one-year-old child (10kg). The dosage stated is 2.5m1 three times a day. The child will be taking 243.75mg of paracetamol and 150mg of ibuprofen. (If the child was taking the medicine four times daily, he/she would be taking 325mg of paracetamol and 2 00mg of ibuprofen daily).

The maximum dose for one year old child (10kg) for paracetamol is 480mg in 24 hours in divided doses and higher in severe cases (BNF for Children 2006). The revised dosage of paracetamol on the package of "Panadol brand-for a one-year child is-576mgs in 4 doses in 24 hours.

The dose of ibuprofen for one-year child wt. lOkg (BNF for Children 2006) is 100mg three times daily; in severe conditions up to 30mg/kg daily in 3-4 divided doses i.e. up to 300mg.

As in the case of the tablet formulation, the patient in this formulation is also taking dosage below the maximum dosages of each ingredient and this will also not result in toxic levels.

I hope this clarifies the issue but, please, feel free to contact me for any further clarification. My

endeavour is to get both the professions to work together so that we can deliver nothing less than the best for the patients.

I agree with your comments, on the phone, regarding the quality of the local sales representatives and have since spoken to the distributor in question. Like you, I would also like to see quality reps and in this, respect I would suggest that doctors comment direct to the distributors in question for fast improvement. Nevertheless, as stated above, you are at your liberty to contact me any time you may wish.

Yours sincerely,
Pushp Chand
President: Fiji Pharmaceutical Society.

Editorial comments,

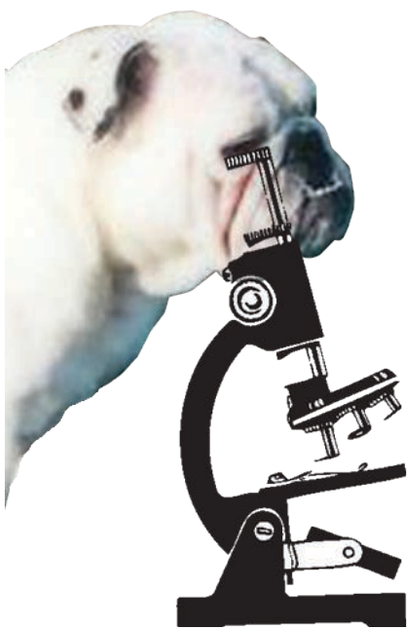
Thank you for your response. I think you have made your point on toxicity as a single agent in use clearly. The questions being raised is that of the need for unnecessary polypharmacy and uncertain toxicity from combined therapy.

What is the evidence that these two agents combined, are really necessary to treat simple pyrexia or act as an analgesic agent? Can the patient not use a single agent and achieve the same result? It would be a lot more cost effective and pharmacologically safer.

What evidence is currently present that we may not, be doing potentially more harm then good by using polypharmacy (a simple analgesic and combining it with another NSAID for a patient), on either someone with a compromised gut and/or a child with this combination? If not toxicity, then side effects can surely intervene. Remember a child is not a miniature adult.

Our pharmacology gurus taught us that we need to write scripts with chemical names and the cheapest approved generic utilised unless specific originator agents were needed. The mumbo -jumbo alchemistry needs to provide evidence in this day and age. I trust the Pharmacy Society will look at all these agents with a broader patient oriented perspective rather then a commercial one only. There are several other items being flogged by the "big three" pharmaceutical wholesalers, which need your society's microscope.

Neil Sharma.



MED-WATCH

• Pilferage from the Govt. Pharmacy is a real issue. A pharmacy hand from the Bulk Purchase section was selling Advantage glucostix at $15/box to a community pharmacist in Suva when his regular community pharmacist was abroad on a buying spree. That is another reason why the National Pharmacy is stock taking almost regularly!

• Beware of some unscrupulous part timers from the School of Medicine , running General Practises in the Nausori corridor without Council licences, registration with Vat and FIRCA authorities. The Fiji Medical Council has been notified but are pussy footing to date. The two mentioned staff members are blurry eyed and forgetful in the morning sessions when supervising students at the school. One was even seen receiving money from a patient at their base establishment at Tamavua for a previous night call from their shared office in Nasinu. Ring any bells?

• Do you have an evidence based approach to your client's management? What do you recommend for patients needing bronchodilators? Will it be salbutamol or will you use an aerosol steroid? Watch this column for a small study and literature search in the next issue.

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