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THE CORPORATISATION OF GENERAL PRACTICE.

PROFESSIONALISM AND ETHICS.

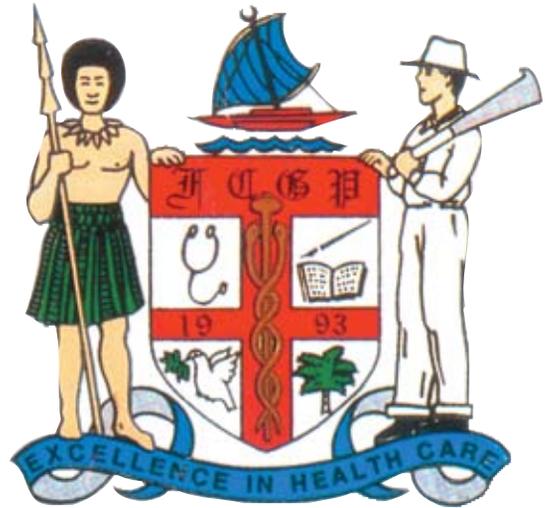
THE FIVE STAR FAMILY PHYSICIAN.

HEALTH ECONOMICS.

STRESS-INDUCED ILLNESSES ARE GROWING.

THE CHILDREN'S HEART FOUNDATION.

CODE OF ETHICS.



Theme: The Corporatisation of General Practice.

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CONTENTS

EDITORIAL

THE CORPURATIZATION OF GENERAL PRACTICE..... 4
Neil Sharma, Suva

MEDICO-POLITICAL COLUMN

PROFESSIONALISM AND ETHICS..... 5
Zorayda E. Leopando, Manila

INVITED REVIEW 3.1

FIVE STAR FAMILY PHYSICIAN..... 9
Zorayda E. Leopando, Manila

INVITED REVIEW 3.2

HEALTH ECONOMICS

CORPORATISATION: PART OF THE SOLUTION OR PART OF THE PROBLEM? 12
Keshwa Reddy, Suva

THE STRUCTURE OF SUFFERING..... 15
Rajeshwar Sharma, Suva

STRESS-INDUCED ILLNESSES ARE GROWING..... 18
Sunila Karan, Nadi

SPECIFIC APPLICATIONS OF COUNSELLING SKILLS BY HOSPITAL STAFF IN ANY HEALTH-CARE SETTINGS..... 20
Sunila Karan, Nadi

AN AUDIT ON PAIN MANAGEMENT..... 22
Shanita Sen, Suva

SPECIAL REPORT

IN SEARCH OF THE ELUSIVE "EXTRA" GP DOLLAR..... 24
Abdul Wahid Khan, Suva

THE CHILDREN'S HEART FOUNDATION..... 25
Abdul Wahid Khan, Suva

CODE OF ETHICS..... 26
Rosemary Mitchell, Suva

THE PROCESS OF SELF AUDIT. ESTABLISHING STANDARDS..... 26
Rosemary Mitchell, Suva

Obituary Dr S Lomani..... 29

Medwatch 30

EDITORIAL

THE CORPORATISATION OF GENERAL PRACTICE.

Traditionally the general practitioner was an independent operator who was community based and primary-care was the order of the day. The care was very much patient centred and the patients financial status was given great consideration. With increased workloads and greater client demands, group practises developed to maintain healthcare continuity when the family physician needed time out for various reasons. The entry of managed care offloaded some of the administrative and day to day management of practises. However those trained in the areas of administration and management took away some of the clinical autonomy from the clinicians under the pretext of optimisation of health delivery economics.

We have witnessed the arrival of Corporatisation of family medicine in Fiji with the arrival of Suva Private Hospital. Akin to developments in USA and Australia where larger group practises have been sold to Large Corporate structures where patient centeredness is rapidly sliding unless satisfactory health insurance schemes and cash is paid upfront. Newer practitioners in the private sector need to focus on patient centeredness, once again.

Ethics and professionalism needs to be addressed on a regular basis. Without a code of professional conduct any profession will flounder and variety of practises possibly detrimental to patient care will arise. Standards of practise must be reviewed and implemented.

The Fiji Medical Council has only recently asked the Fiji College of General Practitioners to be part of their activities and the initial impression is that there is much undone to date in the areas of guidance, mediation, policing, implementation and reprimand. The College has on its own steam set in motion a system of voluntary accreditation and provided continuing professional developmental exercises to this end. As the exercises are without statutory regulation the attendances are short of expectations to the few working to raise standards

and ethics. Corporate/practise allegiance appears to override patient centeredness.

The net result is of over servicing to keep the systems afloat and financially viable in an economic time when The GDP is practically zero rated. The College can only caution members and non-members to their ethical and professional responsibilities. The importance of the primary care providers in the community and the secondary healthcare providers can be optimised.

The importance of prescribing using generics and practising medicine with the patient at the centre stage without corporate interference would be ideal.

We must not forget however that many individuals are awed with current and developing technologies and will ask for MRI's for every headache or tummy ache.

With all the litigation risks some practitioners give in to quickly especially when the till is filling.

This journal presents issues of Professionalism and invited reviews on the Five Star Doctor by none other the Professor Leopando of WONCA. We also present a thought provoking piece on Health Economics by upcoming economist Keshwa Reddy. Our president explores the issue further in a special report: In search of the "extra" elusive G P dollar. Finally we have the chairperson of our Standards committee submitting a code of ethics and The Process of Self Audit with a view to establishing standards in primary care. Even our Med Watch columnist has a few anecdotes on professionalism and ethics. We welcome Shanita Sen's audit on Pain management.

This issue is not complete without mention of our regular contributors Rajeshwar Sharma and Sunila Karan. We bid farewell to our long term member and colleague Dr Lomani. "Ni sa moce, vuniwai.

Neil Sharma.
Editor in Chief
March 2008

PROFESSIONALISM DOES NOT ONLY HAVE FEET. IT ALSO HAS GILLS AND WINGS.

The Medical Profession

The medical profession is characterized by a strong commitment to the well being of patients, high ethical conduct, mastery of ever expanding body of knowledge and skills and high level of autonomy.

There are three major features of the medical profession.

1. Ethics of service is characterized by values of compassion, beneficence, respect for person and justice.
2. Clinical autonomy. Medicine is a highly complex art and science and through lengthy training and experience, physicians become experts and healers. Whereas patients have the right to decide which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.
3. Self regulation: Physicians have traditionally been granted privilege by society. It includes the control of entrance into the profession by establishing educational standards and setting examinations, licensing, and the establishment of ongoing review of standards of medical practice. In return, physicians are expected to hold each other accountable for their behavior and for outcomes they achieved on behalf of the patients.

Dr. Donald Irvine, President of General Medical Council of the United Kingdom cited three pillars, which constitute the basis of our independence as professionals.

1. Expertise derived from a body of knowledge and skills whose utility is constantly invigorated by the results of research.
2. Ethical behavior, which flows from unique combination of values and standards.
3. Service, which embodies our vocation- a commitment to put patients first.

Professional responsibilities

The practice of medicine entails a set of professional responsibilities to which we are committed to carry out.

Professional competence refers to commitment to lifelong learning, maintenance of medical knowledge and skills necessary for

the provision of quality care.

Honesty with patients is ensured through complete and honest information on treatment so that patients can be empowered to make health decisions. Appropriate patient confidentiality safeguards are needed to gain trust and confidence of patients. However, commitment to confidentiality must occasionally yield to overriding considerations in the public interest as in the issue of contact tracing and their treatment as part of management of sexually transmitted infection.

Maintaining appropriate relations with patient is a must. Never exploit patients for any sexual advantage, personal financial gain or other private purpose..

Improving quality of care: Specialty Board certification, Accreditation of training programs, Quality Assurance activities, peer review are examples of activities related to improvement of quality

Improving access to care is an equity issue. It entails the promotion of public health and preventive medicine, as well as public advocacy. Our family wellness program, a recognized priority area since 1995, is having difficulty taking off and this could have helped in improving access to care. Physicians should work to eliminate barriers to access based on education, laws, finance, geography and social discrimination.

A just distribution of finite resources refers to health care provided based on the wise and cost-effective management of limited clinical resources. Development of guidelines for cost-effective care is just one of the steps.

Scientific knowledge: Family Medicine, as an academic discipline and a clinical specialty, subscribes to the criteria for recognition as an academic discipline such as : integrity and appropriate use of scientific knowledge and technology; upholding scientific standards, promotion of research, creation of new knowledge and ensuring its appropriate use. Admittedly, our research base is still weak and that definitely calls for more sound research activities. New knowledge generated through research shall enhance the respectability of family medicine, making it equal to other disciplines.

Maintaining trust by managing conflict of interest: Disclosure is now the rule of the game.

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Whether you are conducting and reporting clinical trials, writing editorials or therapeutic guidelines or serving as editors of scientific journals, we have an obligation to recognize and disclose to general public any conflict of interest that arise in the course of our professional duties and activities. Disclosure on relationship with industry and opinion leaders. This importance is magnified when physicians are publicly promoting products owned or distributed by him/her.

Professional responsibilities: We work collaboratively to maximize patient care by being respectful of one another, participating in the processes of self-regulation and including remediation and discipline of members who have failed to meet professional standards. Our profession should define and organize standard setting process for current and future members.

Professionalism in medicine

Various professions are advocating for professionalism. For medicine, professionalism is our basis for contract with society. It refers to core values historically associated with our profession.

Its relationship to core value of family medicine

What are the core values in Family Medicine? Professor Cynthia Hac of the University of Wisconsin wrote about respect, compassion, intellectual integrity and integration. Respect for others builds trusting relationship. Compassion, although based on respect, goes on deeper level because it includes empathy and understanding. Critical thinking, acknowledging what we do not know, being self-reflective and lifelong learner manifests intellectual integrity.

Professor Ian Mc Whinney, a highly respected family physician in Europe, North America and Commonwealth of Nations from the University of Western Ontario, said accessibility, comprehensiveness, coordination and continuity are our core values.

How do we compare these values with the family medicine values set by PSTFM during its Workshop in 2003? We have a longer list, combining Hac and Mc Whinney's lists such that punctuality, honesty, integrity, initiative, resourcefulness, compassion, caring, humaneness. This does not mean we are more demanding, But rather, this is an indication that values and professionalism shall be taken in context such as location and culture play a part eg. Filipinos are always late, thus, punctuality was added. We have limited resources, thus, resourcefulness was added in Phillipines.

What is professionalism?

Professionalism implies adherence to a professional code of ethics. It is multidimensional too. When I searched the literature, there were more than 10,000 articles on medical professionalism. I selected 30 articles, finally choosing what is appropriate to our Asia-Pacific setting and to our discipline. We can even go to the extent of conceptualizing professionalism according to the phase of medical career.

What is very prominent in professionalism is placing the interest of patients above self. Our Medical Code of Ethics allows physicians to refuse patients when it can be harmful to their lives. It happened during the SARS scare when we pulled out our residents from RITM rotation, when we refuse to go to the mountains when invited to attend to some patients. When we got risking our lives, to attend to patients we can probably be called heroes, not professionals.

Professionalism is setting standards of competence and integrity. The Academy requires CME units to be retained as active members, has set competencies of family physicians, has mechanisms for certifying specialists and accrediting residency programs. Critical appraisal of journals, finding answers to our own questions about our patients are encouraged.

In our clinics and community, providing expert advise to patients, their families and community is professionalism.

What are the emerging themes in the discussion and promotion of professionalism?

Interpersonal professionalism encompasses contacts with patients and other members of the health care team. We shall adhere to the best interest of the patient; sensitive to the needs, feelings and wishes of the health care team; and have a big dose of respect for others. This is the essence of humanism.

Public professionalism relates to the demands society places on the medical profession. It deals with public trust. Paramount to public trust is ethical code which is even more stringent than legal code. An example of public professionalism is the use of clinical guidelines and blowing the whistle on poorly performing colleague.

Intrapersonal professionalism covers demands that have to be met to function effectively and adequately in the medical profession as an individual. It involves personal characteristics or behaviors like humility and critique. We doctors were trained to think highly of ourselves. Even the public used to think highly of doctors, thus encouraging arrogance. We should keep an open mind, keep learning and remain humble. We should also be able to accept criticism, look at things objectively and take steps to correct our shortcomings.

Fundamental principles

What then are the Fundamental principles in professionalism?

Principle of primary of patient welfare refers to dedication to serve the interest of the patient which contributes to the trust that is central to physician-patient relationship.

As physicians, we must respect patient autonomy, be honest with them so that they are empowered to make decision about their treatment.

The last principle calls for physicians to promote social justice in the health care system, fair distribution of health care resources and elimination of discrimination in health care.

Need for professionalism

More than ever, there is an ever increasing need for professionalism because:

1. The focus of health care has changed from the health of the individual to comprehensive community-based care, health promotion, and preventive medicine
2. Explosion of knowledge makes it necessary to address our continuing professional development and apply evidence based medicine. Recertification by examination and practice review are now done in our sister organizations in the US, UK, Canada and Australia.
3. The physician lost decision-making monopoly not only due to the emergence of patient autonomy but also due to the multidisciplinary attendants at the bedside and advent of third party payers for health care.
4. The physician is now portrayed as a double agent, letting economic incentives dominate over the best interests of his/her patients. These have contributed to the erosion of public image of the doctors.

Professionalism and clinical transactions

The concept of healing as central to the physician's role is linked to a long tradition of compassionate care extending from ancient formulations of illness of our "babalonians", through Hippocratic naturalism and dawn of science in medicine to molecular biology and genetics.

The concept of professionalism implies a commitment not only to knowledge and compassion but also to progress, to expanding utility for the sick person and society.

Professionalism is expressed primarily in the clinical transaction, a patient-centered interaction that includes prominently the following components:

Competence is based on well-developed clinical skills and content of the clinical process applied with thoroughness and utilization of appropriate technologies.

Emphatic engagement includes a capac-

ity to communicate effectively and manage a patient-centered clinical transaction, with the needs of the patient as primary determinants of the scope, pace, and purpose of clinical events.

Reliability is timely access to the physician's thoughts and deed, helping patients go through the complexities of the health care system.

Dignity in all interactions is manifested by respect and affection for the sick, empathy, warmth and a wish to help, to be available and personally responsive to another's need.

Agency implies alliance, advocacy and commitment to the patient's priorities as primary factors in mobilizing and shaping the help provided. Not being able to do this because of any kind of pressure can lead to erosion of trust and confidence in the expectation that the needs.

A dual focus on illness and disease is embedded in Family Medicine. Disease as biological event and illness as human event encompass a variety of symptoms, discomforts, fears, inconveniences, and other social and psychological dislocation that characterizes being sick. We need to be sensitive as to when symptoms are based on stresses, anxieties, pressures, or maladaptations. In the same manner, we need to realize that disease maybe unaccompanied by illness.

Concern for quality manifested through valid application of clinical procedures categorized as : under-use, overuse, misuse of medications, laboratory and diagnostic procedures.

Challenges to medical professionalism

There are pressures which physicians experience resulting to diminished morale, changes in lifestyle and practice patterns. There are the challenges to medical professionalism

Resource restraints: Scarcity of resource, lack or inadequate access to Continuing Professional Development and inability of government to solve inadequacies for health care funds

Bureaucratic challenges: This happens with introduction of layers of management and policy directives between the physician and the patient. Changes in the system like devolution of health service to the local government, emergence of HMOs are examples.

Unprofessional conduct . There are some physicians not able to uphold values of the profession..

Commercialism Health care is a major industry where physicians play a major interest. Commercial interest may pressure physician to compromise their responsibilities to patients. Conflict of interest situation for physicians and medical associations are common especially when parties start talking about return of investment.

Consumerism. We strongly support the right of patients to make informed decisions about their medical care. With proliferation of health information and advertising in media and internet, there has to be a way by which we can lead our patients and the public to the accurate and relevant information.

Industrialization. Increased division and specialization affects continuity of care which is a very important ingredient in professionalism.

The situation in the Philippines

Here in the Philippines, the medical profession is challenged. During the 2005 Medical Summit of the PMA, some even say that the medical profession is a wounded profession. We are at the brink of a health crisis because of

1. **The mass exodus of doctors leaving the country mostly as nurses**
2. **Declining interest among young Filipinos to enter medicine as a career**
3. **Continuing threat of medical malpractice legislation.**
4. **Deteriorating public image of physicians.**

Conclusion:

Professionalism has been identified as an important learning outcome in medical education. It is not taught but rather, it is passively caught by students who imbibe the values and behaviors modeled by teachers and senior clinicians.

There is no profession from which greater

purity of character and a higher standard of moral excellence are required than the medical profession.”

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3.1 REVIEW ARTICLES

FIVE STAR FAMILY PHYSICIAN.

Patients and families are familiar with family doctors, their doctors of choice whom they consult for most problems. These same doctors almost disappeared with the advent of specialization and sub specialization. Care became fragmented but eventually, a need for a personal physician who is an expert on the person and who provides personalized care was resurrected as a trained family physician. Truly, the family physicians plays important roles in health care.

In the 1960's, Dr. Antonio G. Sison, former Dean of the University of the Philippines College of Medicine and former director of the Philippine General Hospital was awarded the title of President of then Philippine Academy of Family Physicians and in one of his messages to the members in 1970, he wrote about the function of a family doctor as less that of a healer and more that of a conservator of health, coordinator and integrator. He harmonizes and evaluates opinions of the various specialists for the good of the patient. His broad knowledge and psychological insight make him understand the totality of the patient as a person.

In the 1970s, Dr Ramon R. Angeles, the founding President of the Philippine Academy of Family Physicians described the family physician as " Health Protector for the Filipino Family "

In 1991, the World Organization of Family Doctors (WONCA) defined family physician as the physician primarily responsible for providing comprehensive health care to every individual seeking medical care, and arranging for other health professional to provide services when necessary. This is very evident in countries with strong National Health Service like the United Kingdom and Cuba where the citizens are registered with their own physicians. He is a generalist who accepts everyone seeking care. Patients he sees are undifferentiated, not bounded by age, sex, disease entity. The family physician care for the individual in the context of the family and the family in the context of community, irrespective of race, culture or social class. Clinical care is provided with competence, taking into consideration the various social, economic and cultural factors affecting health and disease.

Five star doctor, the evolution:

In 1992, Charles Boelen, then Head of Human Resource Office of the World Health Organization raised the need to have five star doctors who perform the roles of care provider, team member, manager, communicator and decision maker. The roles have been

modified in 2000 into:

Care provider: considers the patient holistically as an individual and as an integral part of a family and community; provides high quality, comprehensive, continuous and personalized care within a long-term trusting relationship.

Decision maker: makes scientifically sound judgments about investigations, treatments and use of technologies that take into account the patients' wishes, ethical values, cost-effective considerations and the best possible care for the patients.

Manager: works harmoniously with individuals and organisations both within and outside health system to meet the needs of individual patients and communities, making appropriate use of available health data.

Communicator: promotes healthy lifestyle by effective explanation and Advocacy, thereby empowering individuals and groups to enhance and protect their health.

Community leader: having won the trust of the people among whom he or she works, can reconcile individual and community health requirements, advise citizen groups and initiate action on behalf of the community.

In 1994, the Department of Health and the Association of Philippine Medical Colleges conducted a series of workshop defining the most appropriate roles of a five star Filipino doctor and roles identified where: health care provider, teacher researcher, leader/manager, and social mobilizer. It was only in 2003 when the Commission of Higher Education strengthened the medical curriculum by validating these roles for medical graduates. The roles became the basis for the core curriculum in medicine.

Roles of family physicians

The functions of family doctors in a primary health care team were identified as effective clinicians and providers of health care services, leader/manager/ supervisor of care and coordinator of care. Family practice activities around the world indicated that family physicians practice primarily in the community, providing care to children and adults of both sexes, The scope is broad, including knowledge or practice in various clinical medicines including preventive medicine, providing office practice, emergency care, home visits, after hours coverage, nursing home care and hospital care. Procedures commonly performed are: individual preventive services,

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office diagnostic procedures, office surgical procedures, control of laboratory testing, supervision of other health workers, preventive services to communities.

In Canada, the roles of family physicians are guided by the principles of family medicine and they have been identified as :

1. Medical Expert : The family physician is an effective clinician who arranges practice to maximize the ability to provide patient care, meets responsibilities related to “on call”, assesses and applies guidelines to maximize patient benefit, maintains knowledge of current literature and practice in the context of best evidence and actively communicates and collaborates with other health care professionals to ensure a team approach to patient care
2. Collaborator, manager. The family physician is community based who understands physicians responsibility to professional organization and to colleagues and health service organizations, health needs of the community and the impact on the profession and on patients and alternate models of health care delivery. He/ she is familiar with health care reform issues and their impact on the profession and on patients.
3. Health advocate, scholar, professional. The family physician is a resource to a defined practice population who uses information technology effectively, maintains medical record in keeping with CPSM guidelines, has working knowledge of the statements and guidelines that apply to family medicine practice, understands and applies the role of the physician as advocate, able to apply research findings to clinical practice

in a way that benefits the patient and the community, participates in research that will benefit the community, the practice population and the profession and take ownership of practice-based medicine.

4. Communicator. The doctor-patient relationship is central to the role of the family physicians. Thus, the family physician understands confidentiality and scope of practice and personal limitations, provides continuity of care and models patient-centeredness

The Filipino Family Physician

The Filipino family physicians provide care in the clinic, homes of patients, workplace, school, hospital to patients at the various stages of life and families at the various stages of the family life cycle.

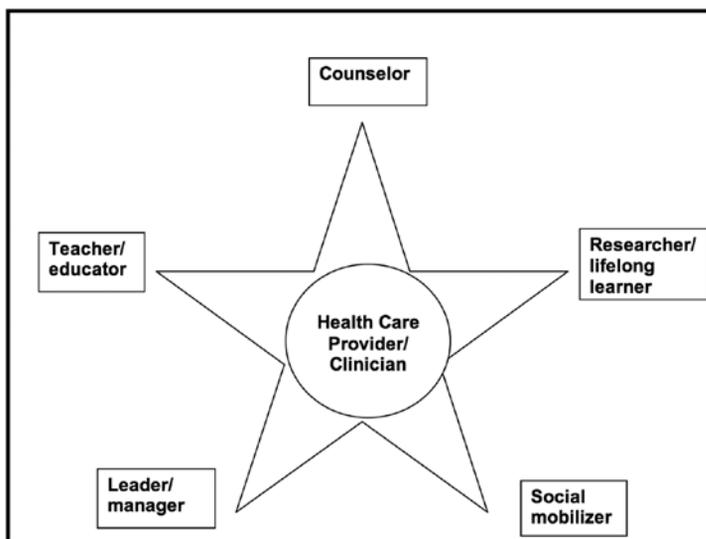
In 1998, the Department of Family Medicine of the College of Medicine and Philippine General Hospital, University of the Philippines Manila reviewed its residency training program and agreed that family medicine graduates shall have the following roles: Health care provider, Counselor, Teacher/educator, Researcher/Lifelong learner, Leader/manager/Social mobilizer. There are the same roles the Philippine Academy of Family Physicians adopted when it reviewed the competencies of family physicians. In the 2005 Planning Workshop of the PAFP, Dr. Josefina Isidro suggested a revision on the format of the five star family physician by making being a health care provider a central to the family practice. That of **Figure 1**.

As Health Care Provider, the family physicians are the Entry to the health system as primary care/ first contact physicians. They see patients with undifferentiated problems; provides continuing, comprehensive, cost-effective and of high quality. They know their limitation and refer patients appropriately through prompt and appropriate referral. The care that they give is patient-centered, family-focused and community-oriented

As counselor, they apply active listening skills, empathize with patients and families, provide alternatives and clarify issues, reassure patients and families, counsel and give support.

As educator of patients and families, they promote healthy lifestyles by effective explanation and advocacy, thereby empowering individuals and groups to enhance and protect their health; they disseminate information to patients and families and they provide professional knowledge and skills that are community and family centered. As teacher to students and residents, they act as role models for students and residents, train and teach students and residents in family medicine. They also

Figure 1: The Five star family physician



act as tutor/facilitator in Quality Assurance circles and practice based trainees.

As researcher, they document experiences and conducts researches in practice, appraise and apply research to clinical decision making, manage information about patient and the community through record keeping, reporting, analysis of health statistics and data; practice evidence based approach to care and analytical in the use of Clinical practice guidelines. As lifelong learner, they commit themselves to continuing professional development by being using computer and electronic technology, by practicing quality assurance, updating their practice, knowledge and skills through journal reading, attending conferences, surfing the internet and maintaining a practice portfolio.

As community leader, they establish a trusting relationship with the people among whom they work, can reconcile individual and community health requirements, advise citizen groups, and initiate action on behalf of the community. As manager, they work harmoniously with individuals and organizations both within and outside the health system to meet the needs of individual patients and communities and they make appropriate use of available health data.

As social mobilizer, they lead or actively participate in health policy making, advocate for patient rights and safety, mobilize community towards worthy projects which will improve their quality of life, actively advocate among his colleagues quality health care development and progress

A study is being conducted by the PAFP to determine the capability of family physicians to perform the five star role, the amount of time spent in its role and the training necessary to enhance the performance of such responsibilities.

The World Organization of Family Doctors (Wonca) is a strong proponent of Five Star Doctor. It recognizes family physicians who has shown excellent contribution in health care and in improving health of families and communities. Recipient of awards are not only good clinicians but is also able to introduce innovations in health care, conduct and publish studies on comprehensive health care and has also significant contributions in medical education. Thus, in 2004, the International Award for Health Care or Five Star Doctor Award was introduced.

The second award was given in July 2007. The criteria considered by the selection com-

mittee/s will include the following.

- Impact on healthy care of individuals and community
- Contribution to regional / global development
- Community perspective and involvement
- Networking for the benefit of the community
- Innovative services
- Development of services in previously underserved / disadvantaged areas
- Demonstrated support of colleagues in another region / country / college
- Performance of academic work of quality and relevance including teaching and research
- Development of models which could be applied to other regions / areas

In addition, the awardee should best meet the criteria of the "5-star" health professional

- * Care provider
- * Decision maker
- * Communicator
- * Health Advisor and Community Leader
- * Team member

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3.2 REVIEW ARTICLES

HEALTH ECONOMICS: CORPORATISATION: PART OF THE SOLUTION OR PART OF THE PROBLEM?

Keshwa Reddy,
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“Health economics is concerned with the supply and demand of health care resources and the impact of health care resources on a population”

What is health economics?

The latter decades of the twentieth century saw an unprecedented growth in health care spending particularly in high and middle income countries (Getzen, 1997). Paralleling the growth in health care costs and the health sector's increasing share of Gross Domestic Product (GDP), was the rise and rise of the discipline of health economics. Today, health economics has permeated every aspect of health care from decisions on the most cost effective treatment for a particular disease to resource allocation decisions for national public health programs. From a health economist's perspective, many aspects of health and health care may be defined, analysed, evaluated and policy recommendations made by utilising economic methods. However, for the health practitioner and manager, a practical appreciation of the benefits and limitations of health economics will provide an alternative framework for understanding the forces that shape the health care delivery environment, and may lead to an improved, analytical and efficient approach to the allocation and utilisation of health resources at all levels of the health care sector.

Health economics is concerned with “the supply and demand of health care resources and the impact of health care resources on a population” (Anderson, 1998 p.733). Fundamentally, it is about the choices we make as a society in the use of scarce health care resources and the benefits obtained from those decisions (Clewer, 1998, p.i; Mooney, 1998, p3). Most health economists agree that the pioneering work of Kenneth Arrow in 1963 led to the development of health economics as a specialist field (Saviedoff 2004). The principal issues that occupied Arrow were the role of outcome uncertainty and asymmetry of information (between the doctor-supplier and the patient-demander) in health care and the consequent inefficiencies that allowed scope for non-market institutions and government intervention in health care (Arrow 1963). Technological change, the changing role of government and the dramatic increase in spending on health care has made the economics of the health care sector much more complicated than ever before. This is reflected in the health economics literature with a number of specialist journals currently devoted to the discipline and some 56,627 articles in medical publications since the 1960's, most of them concerned with health insurance, health policy or evaluation of health care interventions (<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=PubMed>

Pub Med literature search, National Library

of Medicine, accessed 06 February 2008)

The health economists 'toolbox'

Health Care Market

The principal 'tools' of the health economist belong to the categories of microeconomics and evaluation. The microeconomic theories of health capital, utility, insurance, supply and demand provide the basis for understanding the forces that shape the health care 'market' and form the framework of modern health care systems. For example, if one considers the number of changes that the Australian health care system has undergone since 1975, and not discounting the influence of equity, efforts to provide universal access to health care through Medibank and later Medicare are based primarily on economic theories of insurance which have been subjected to broad ideological differences in interpretation by different governments in the ensuing years. The subsequent argument persists to this day as to whether it is more beneficial to subsidise private health sector insurance than to divert funds into the public health care sector (McAuley, 2004). The questions remain as always, 'who benefits' and 'by how much'? Health economics provides one important part of the answer.

Delivery of Health Care

A number of aspects of health care delivery can be understood within the framework of microeconomics. For example, a study on the impact of lay media marketing of prescription-only medications by pharmaceutical companies on the utilisation of health care services identified the potential for reduced care for those with more serious conditions (t'Jong, 2004). This can be explained by economic models of competition, supply and demand as patients, encouraged by media advertising, seek medical care, perhaps unnecessarily, to the exclusion of other patients. One can readily identify how costs may spiral out of control with other patient's serious needs being unmet in an increasingly inefficient system (but one of increasing profits to the pharmaceutical company concerned). On one hand many health professionals might consider direct to consumer marketing unethical, but in an economic framework it is a potentially wasteful and destabilising influence.

Technical versus Allocative Efficiency

The economic concepts of technical efficiency (securing the best outputs or outcomes within set resources) and allocative efficiency, is a method of determining the efficient allocation of health care resources to the best pos-

sible combination for everyone (Hall, 1991). Both are required to achieve a state described in economics as Pareto optimal, a measure of the optimal distribution of resources such that it is “not possible to improve the welfare of one group without detracting from the welfare of others” (McQuire, 1988, p76-77; Folland, 2004, p. 562, 565). It remains a concern that at every level, globally, nationally and locally, we will struggle to attain such an optimal distribution of health care resources. Perhaps we must reconsider whether expensively trained and publicly subsidised medical practitioners should be allowed to develop specialist practices in administration of botulinum toxin (“botox”) injections to the well heeled or should their time and efforts be reallocated to meet more serious health needs in other areas? Should these private sector practitioners be required to provide different services to a public sector ‘in crisis’? The distinction between economics and equity blurs. The further question remains as to which authority makes such decisions or should the health care ‘market’ decide?

In this context, one can readily understand the role of government in securing (or attempting to secure) allocative efficiency of scarce resources through various regulatory and program initiatives. Such efforts include attempts to provide more diverse, affordable and accessible health care services (and reduce demand on expensive medical services) through the use of (less expensive) nurse practitioners to perform a range of primary health care tasks instead of general medical practitioners, a principle of substitution (Folland, 2004, p. 97-100). A randomised controlled trial found that nurse practitioners did not reduce doctors’ workloads (demand) but instead provided a wider range of services to the population (Laurant, 2004). In that study, nurse practitioners became supplements rather than substitutes of medical practitioner care. This finding should be compared with other studies that have found nurse practitioners may act as effective substitutes of aspects of medical care (Marsh 1995; Shum 2000). Regardless of the specific results of these studies, these principles should be incorporated into all future health service planning deliberations.

The concepts of microeconomic theory are perhaps less familiar to the health practitioner than those of evaluation. While the former largely influence the funding and structure of health care systems, the latter address the question of what form of health care should be delivered. Health care evaluation in its simplest terms can be considered a comparison of the costs and consequences of the choices made in health care delivery (Drummond, 1997, p. 10). These choices are made at all levels of the health care system, whether they are decisions on whether to fund a mental health program instead of a maternal and child health program, or comparisons of the value or otherwise of several interventions in

treating a specific disorder.

Understanding Economic Evaluation Methods in Health Care

Quality Adjusted Life Year (QALY)

Thus, the health economic literature provides health planners and practitioners with intricately developed assessments of various interventions. These include cost minimisation studies, (the classic example being comparisons between different modes of delivering oxygen therapy), cost-effectiveness studies, which measure common outcomes such as years of life saved, cost utility studies, which measure outcomes in the Quality Adjusted Life Year (QALY), and cost benefit studies, which attempt to measure costs and consequences in monetary terms (Drummond 1997, p. 11-17; West 2004). Cost effectiveness studies in particular form a large part of the health economic literature but are limited by “inconsistent methodologies, low generalisability and an inability to assess the current mix of interventions” (Hutubessy 2002).

One example may suffice to demonstrate both the strengths and weaknesses of these methods. A study compared two methods of screening for colorectal cancer, determining that one method would lead to a mean increase in individual life expectancy of one week (Berchi, 2004). This was equated with an economic valuation of 2980 euros per year of life saved. While it is necessary to applaud the rigorous methodology that can determine the difference between two interventions down to one week of life, it is a warning for clinicians and others who must interpret these data that it is important to determine whether the clinical endpoints in such studies are clinically meaningful. Is a difference of one week of life or say, two mm Hg in blood pressure measurable, let alone clinically significant in the long term? Recent evidence suggests that many decision makers do not understand or are not qualified to interpret the results of health economic evaluations (Drummond 2003). This is especially relevant in a health care system where pharmaceutical costs are increasing with the potential to outstrip controls (Mather D, 2003). An informed approach to interpreting these studies is essential if health planners and practitioners are to choose wisely, whether it be which program to implement or which treatment option to provide.

Burden of Disease Studies (DALY)

On a broader scale, in the last twenty years the influence of health economics has been an important factor in the development of concepts of the burden of disease. A more complicated but significant improvement on previous simple measures of mortality as the driving force in determinants of health care provision and preventative programs, the concept of burden of disease, summarised in the Disability Adjusted Life Year (DALY) has revolutionised how we measure ‘health’ and

“Recent evidence suggests that many decision makers do not understand or are not qualified to interpret the results of health economic evaluations”

how we prioritise policy and resource allocation. A DALY combines the concepts of Years of Life Lost (YLL) due to premature mortality with Years of Life lived with Disability (YLD), the latter being weighted according to the severity of the condition (Mathers C, 1999, p.4). This is in keeping with health defined in terms of physical, social and mental well being and provides us with a measure that can be used in a fair comparative sense, removing the influence of advocacy groups on policy and prioritisation and allowing unbiased assessment of the cost-effectiveness of potential interventions (Mathers C, 2001, p. 9). Criticisms exist of the assumptions and value judgements involved in DALYs (Anand 1997). However, the burden of disease methodology combined with epidemiological knowledge has become increasingly accepted and has contributed towards a reappraisal of the challenges.

A simple example is the economic burden of tobacco related disease. The economic burden of cigarette smoking is enormous, influenced by the cost of illness from direct and passive exposure to tobacco smoke, lost employment and lost opportunities to provide health care to meet alternative needs. It accounts for "up to 15% of total healthcare costs in developed countries" with total cost estimates ranging from 0.4% of GDP in Australia up to 1.15% of GDP in the United States (Parrott, 2004). In Australia, tobacco smoking accounts for approximately 12% of the total disease burden for males and 7% for females. Tobacco control strategies include regulation, taxation, education and cessation programs of varying efficacy and cost effectiveness. It is these measures of cost effectiveness, expressed in cost per life year gained, that allows health planners to decide which program is likely to give the taxpayer the 'best bang for the buck'. Putting tobacco related illness in economic terms is a key driver of tobacco control efforts, especially when asking (economic-rationalist) governments to forego enormous tax revenues from tobacco sales.

Where to from here?

Health economists combine knowledge of the value and determinants of health with an understanding of the impact of economic principles of supply and demand, technical and allocative efficiency, on the provision of health care as part of a larger framework of a health care 'market'. Health economics is, of course, only part of the equation that must be considered in health care as notions of equity, moral value judgements and political advantage play an equally important role (Little 2003). However, this health care 'market' is subject to evaluation, planning, incentives, program development and interpretation by health planners, bureaucrats and politicians who may have more than health outcomes in mind and who may not even fully understand the limitations of studies on which they

base their decisions. A greater investment is required in educating the health professions, planners and bureaucracy about the intricacies of health economics in order that the arguments and allocations may be clearly defined and understood.

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3.3 OPINION COLUMN

THE STRUCTURE OF SUFFERING - CASE STUDY AND DISCUSSION

SM has been suffering from migraine for the past five years. *She has had intensive workup, including several consultations by the specialist. Despite her many medications, she continues to be in distress. In fact, her aches are getting worse. She presents to the family doctor frequently-sometimes even every other day. To the medic she is just another headache: both his and hers!*

Medical science, based on the foundation of pathological alterations, focuses on diseases. However, much to the dismay of all parties concerned, patients do not have pathologies occurring in isolation; but develop their own perceptual constructs to the changes to give rise to the concept of illness. Furthermore, existing as individuals-with physical, emotional, mental, spiritual, socio-cultural components-within their altering contexts, the clients do not just have medical ailments but are engulfed by other concerns as well. They have, in addition, their shortcomings that worsen their predicaments. The compounded composite can be labeled as suffering.

However, dealing with suffering using the existing medical model can be abstruse-for all parties concerned. Holistic philosophy is ideal but in practice, without a simplified structural approach, such modeling can become confusing, as the practitioner may not be able to employ an effectual *modus operandi*. Thus, there is a need for a pragmatic paradigm that not only caters for all the aspects, but also is also suitably configured and is effortless to apply. This article proposes such an all-inclusive user-friendly problem complex model.

The structural representation of suffering is portrayed in fig. 01. The model reveals three major areas: the generic problem, stress responses, and deficiencies. The stress response is further divided into reflexive and augmentative tensions. The entire problem complex, illustrating the integral integration of psychosomatic facets, is constructed within the minds of the clients to give rise to the individualized torment.

When we review SM's migraine, we note that she has a definite generic problem: the chronic headaches. Indeed all clients present with difficulties that we can identify as the generic problem. This is an all-encompassing term that includes predominantly physical pathologies-such as acute myocardial infarction-and the primarily psychological disorders-such as depression-as well as all the other types in between. For sufferers in general, we do not have to limit the generic problem to a medical one. They can have other difficulties such as personal issues, relationship concerns, financial woes, and a whole host of never-ending human headaches.

Now these generic problems, no doubt, will reflexively activate the neuro-hormonal stress responses to give rise to mental and bodily stress reactions. As a result, the affected will have a variety of reactions such as intense emotions, negative thoughts, perceptual distortions, and physiological alterations. For example, SM feels frustrated, depressed, angry, and afraid-in vacillating levels at different times. She thinks that she has a brain tumor; and she perceives her whole life as a hopeless one. She feels hot and cold at odd times.

The reflex stress induces a deluge of distressing memories. The mind and all its components follow a distinct pattern-the principle of hologram: contact a small part and the whole hologram will be instantly recalled, together with all the closely associated memories (Sharma, 2003). Simply put, recall of any part of a memory will retrieve the entire past event together with the associated pain and emotions as well as recollections of similar nature. Thus, the reflex stress response will bring on the mental processes from the clients' past traumatic experiences, as all these are holographically stored in the memory.

For example, SM's past injuries as a result of long-standing domestic violence, damages from a fall five years previously, separation from spouse six months earlier, and death of her mother from cervical cancer four months prior, get retrieved-with or without her awareness-in accordance to the principle of hologram. Naturally, the controlling pathways antagonize the retrieval of these recollections. If, however, the modulators were ineffectual, the tormenting memories would magnify her suffering.

In addition, stimuli from the clients' ongoing issues eventually end up in their minds. They also follow the principle of hologram. Accordingly, these coexisting conditions compound to intensify the stress responses. If they are not regulated, the patients are likely to experience tremendous stress that, besides affecting their entire beings, will amalgamate to the generic problem to exacerbate the suffering significantly. Thus, SM's mid-life developmental alterations, financial woes, her child's poor academic performance, pressure from friends to start dating, and other contemporaneous concerns add to her stressors and make her agony worse.

At the same time, the clients also lack in skills, resourcefulness, techniques, virtues, and other coping devices. These, together with other deficiencies, aggravate the anguish. SM's low self-esteem, paucity of stress management techniques and other coping skills exacerbate her migraines. The shortcomings may not

Rajeshwar Sharma., Suva.

be restricted to the patients, moreover. This model also entails the health care giver's inadequacies as well.

In the clinical set up, where the cases are diverse, the actual proportions will differ, of course. In acute situations-for example, in a motor vehicle accident, gastric ulcer perforation, ruptured ectopic pregnancy, and the like-the generic problem together with its reflex stress reaction will constitute the major part of the suffering complex as the other aspects are pushed into the background. In contrast, in the circumstances in which the psychosomatic factors predominate, the prominence will be on the past traumatic experiences, the ongoing issues, and the deficiencies. The bulk of the cases, nevertheless, lie within the spectrum encompassed by these two extremes.

This problem complex model is based on three important premises. First, all patients are undergoing stress reaction. This stress is not limited to psychological manifestation, but includes involvement of somatic neuro-humoral activation (Englert, 2004). Some of these processes may not be in awareness. That is, even if the clients do not complain of any stress related symptoms and/ or deny feeling uptight, all patients are to be considered to be going through stress until proven otherwise.

The second foundation involves the existence of deficiencies in all the concerned parties-including the medical arrangement. Again, the sufferers-and the providers-may not readily admit the flaws; they may even get upset on being given the insight of their shortcomings. However, this is an important aspect of the entire management because if this part is not remedied the patients will continue to suffer.

The final premise is that all processes-physical as well as psychological-eventually end up in the memory that itself is holographically orchestrated. The mind is made up of amplified electromagnetic waves. These very intense phased waves produce a very strong bond for the various components to create the suffering gestalt. They are also important in therapy, as breaking up of the bond - by dealing with negative emotions, irrational thoughts, perceptual distortions, and distress in general- will result in disintegration of the complex to enable easier management of the separated components.

With a structured holistic approach provided by this model, patient management can become easier. To begin with, the generic problem is dealt with in conventional problem solving manner. If the solution is a straightforward one, then the suffering complex disintegrates almost instantly. The reflex stress reaction may require tendering, nevertheless.

On the other hand, if a speedy solution

cannot be easily found-like SM's chronic headaches-the suffering complex would show a high degree of resistance. In these cases, the therapeutic emphasis needs to be on the past traumatic memories, ongoing issues and client deficiencies. Here, the philosophy that if a rapid cure cannot be discovered then the complex is pounced upon to shrink it as much as possible, needs to be applied. This would significantly diminish the client's anguish. In certain situations, this approach may even lead to complete destruction of the construct: spontaneous healing eventuates-thus explaining the mechanism of miraculous cures.

This structured suffering approach can make complicated cases easier to manage. Take the example of a fifty-three year old patient's five-week history of right shoulder pain. All the investigations were within normal limits. The pain did not get better with the conventional treatment and she ended up doctor shopping. Finally, when the suffering model was applied, it was discovered that her ongoing issue was the key to the persistence of her problem construct.

With her background of being a widow, and dependent on her only son, she became worried when he was about to migrate overseas. Her anxieties of an unknown future transformed into physical manifestation of chronic non-responding shoulder pain. This was aggravated by her lack of life skills. When these two features were addressed, her suffering construct disintegrated and her shoulder pain disappeared.

Likewise, RP's difficult to manage dysmenorrhoea responded to the suffering model approach as it was revealed that her pains were closely associated with her bereavement from her grandmother's death six months previously. JN had tinnitus but intensive work up by the specialist was not fruitful. Without an explicit pathology, the conventional approach had nothing to offer besides placebo therapy. However, the problem complex paradigm helped reduce his stress reaction, addressed his two-year prior ear injury, allowed him to deal with his ongoing issues of legal concerns, and helped him learn stress management skills. These led to reduction of his agony. Interestingly, after a few weeks his tinnitus vanished.

Emotional problems can also be managed using this suffering paradigm. For instance, if anger problem is viewed with the percept that the affected is suffering from within, the paradigm can be used to dig up the past traumas, identify the ongoing stressors, and discover the skills needed. These can be dealt with; the necessary adroitness taught for enduring rage restraint. Other emotionally charged problems can be handled likewise.

Thus, this suffering approach can be applied

to all cases. It provides a holistic method that is systematically structured. Besides enabling provision of optimal care, it also facilitates the primary providers to address their own deficiencies; and to utilize other helpers such as specialists, counselors, and the like, if necessary.

To sum, patients do not just have pathological alterations but compose their own perceptual constructs to the pathologies. Moreover, they have simultaneous non-medical concerns as well. Generic problems give rise to reflective stress responses that induce augmentations from past traumatic experiences and ongoing issues. If not modulated, these stressors create havoc and worsen the torment. Finally, the deficiencies of clients as well as the practitioners' intensify the suffering. The resultant suffering complex can be used to provide a systematic approach to holistic care.

STRUCTURE OF SUFFERING: THE PROBLEM COMPLEX MODEL

Generic problem	Stress Responses			Deficiencies * Strengths/ Limitations * Skills/Techniques * Client & Helper factors
	Reflex stress	Past traumatic experiences	Ongoing issues	

Fig. 01: A systematic representation of suffering based on the baser-hologram theory of brain function. The model enables all past, present, and future - medical and non-medical- problems to be addressed in a holistic but organized manner. The painful memories, all coexisting, together with the clients' as well as the practitioners' shortcomings, become more prominent in difficult situations.

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NEXT ISSUE:

A potpurri of Family Medicine practices

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3.4 REVIEW

STRESS-INDUCED ILLNESSES ARE GROWING.

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At moments of discomfort and convenience stress is not a problem, but when challenge and controversy stare us in the face, the way in which we react, physically, emotionally, and spiritually, is the measure of our success in dealing with stress. Stress is a part of everyday life, and our bodies' responses to stressful stimuli have always played a key role in mankind's survival.

The "Fight or Flight" response which prepares our bodies for instant reaction at times of danger, and which our bodies produce without conscious effort or command, is the root cause of all the problems associated with our growing inability to cope with the stresses produced in our fast paced lifestyles. This remarkable ability to react instantly to challenge becomes counterproductive when it is impossible to choose either "Fight" or "Flight", when the only option is to 'grin and bear it', and "move on"-all expressions which betray the emotions.

Many people are ill-equipped to deal with excessive stresses, and stress-induced illness is growing to epidemic proportions. Heart attacks, high blood pressure, insomnia, PMT, menopausal problems, sexual disorders, skin complaints, digestive and bowel disturbances, asthma, migraine, and arthritis can all be directly linked to, or caused by, poor coping with stress.

The idea that these stress-related disasters are exclusively province of the high-powered executive is just not true. No one is immune to this plague, and it is found on the factory floor, in the boardroom, at the kitchen sink, in the elderly and in the young.

Whilst attitude to the overstressed patient are thankfully beginning to change, the orthodox medical approach frequently fails to recognize or deal with the root of the problem. The symptoms are treated but not the patient. The physician may not recognize the effects that the patient's mental state are having on his or her body, whilst the psychiatrist may well ignore physical disease and concentrate on the patient's mental problems. The epidemic of stress disorders is only equaled by the pandemic of prescriptions for antidepressant and tranquillizing drugs and the consequent dependence on these by many.

Sweeping the dirt of stress under the pharmacological carpet with behavior-modifying drugs is not the solution for the vast majority of people. There is no better example of the need for a holistic approach to health than in this field of stress disorders. There is no single answer to dealing with the vast range of problems stress producers, but the most important steps that any of us take along the

road to coping with stress are to recognize it, to understand it, to use "good" stress to our advantage, to deal with "bad" stress, to avoid the "ugly" stress, to cope with stress in our family, work, social and environmental situations and, above all, to help ourselves.

Before you can cope with stress effectively, you must become aware of your own stress responses.

This is not as straightforward as it sounds. The effects of stress are insidious and we often fail to notice them. Both the mind and body have a tremendous capacity for adaptation. The more readily we appear to adapt to the pressures around us, the greater the temptation to drive ourselves harder, beyond our capabilities. Stress distorts our perception, so that we do not notice that this is happening. If we allow the process to continue the result can be fatigue, exhaustion, and even, eventually, collapse. The more stressed that we are, the less chance we have of realizing it, so it is vital to make ourselves aware of our stress responses.

Signals of Tension

The human body is superbly equipped to deal with stress - but only up to a certain level. If your adaptive resources have overworked and exhausted your body ceases to function smoothly. Symptoms may arise individually in various combinations. Chronic stomach upsets, headaches, skin rashes, back-pain, irregular breathing patterns, and sleeplessness, are common early indications that we are pushing ourselves too hard. Psychological symptoms tend to creep up on us more slowly and may be less easy to identify. Behavior is a prime giveaway of tension. Less noticeable to ourselves, it is those who are close to us who may be the first to read these behavioral signals. Erratic, uncharacteristic behavior and mood swings often have their origin in tension. Take all these signals seriously - ignoring them can make them get worse.

Physical Signals

The body transmits stress through many channels. Unconscious, nerves reflexes lead to overt physical stress signals. Many of these are lifetime habits acquired during childhood. But we may be more prone to them under stress. More serious signals come in the form of physical stress-related illnesses. These vary according to which organ or system is the weakest link to our physiological make-up.

The human body registers stress in a number of places, especially on the head and feet. Habitually, touching the hair, ears, or nose, grinding the teeth, and biting the lips are common

signals, as are foot tapping and turning.

Mood Signals

Stress affects our moods in a variety of ways. Some mood changes take place on the surface, while others are deeper and more pervasive. Irritability and impatience are hyperactive states, relatively superficial manifestations of underlying anxiety and aggression. Restlessness and frustrations, if persistent, can be more serious, developing into full-blown hostility or anger.

This can often be caused through lack of control or lack of fulfillment at work. Apathy and boredom are “flat” feelings, often associated with low stimulus. They can be just as stressful as more obviously stressed emotions. Most serious are the “down” emotions, such as guilt, shame, and the sense of helplessness or hopelessness, as well as depression and fatigue, which are often linked. If long lasting and severe, a downward, negative mood slide indicates more serious underlying psychological problems.

Behavioral Signals

Any behavior which indicates that you are not acting your usual self may be a sign of adverse reaction to stress. Stressed behavior can impair our ability to communicate well.

Talking too fast, too loud, or too aggressively, swearing, interrupting others or talking over them, not listening to what people have to say, and arguing for the sake of it, are typical ways in which stress alters our way of relating to other people.

Nodding off during meetings or social gatherings, trying to do without sleep, losing your senses of humor, moving in a tense jerky way, and reacting nervously or irritably to everyday sounds are other signs.

Outbursts and overreactions can occur when we lose our perceptions on problems that we would normally face with equanimity. We lose our ability to discriminate and judge even every day situations or events accurately,

to control our reactions, and to cope calmly. The occasional outbursts, whether of anger or of tears, may be a valid, healthy way to release pent-up tension. But if repeated over a long period of time, over reactive behavior may indicate serious problems.

Consistently acting and feeling out-of-character is a serious warning that we are losing our ability to cope with tension. Inability to feel or express any emotions or a sense of being on “automatic pilot” acting more like a robot than a human being, indicates loss of contact with our surroundings and ourselves. Common symptoms include: memory blocks, the inability to make decisions, mind changes, loss of short-term memory, being lost for words, and lapses of concentration. Inhibitions and anxiety when we are faced with everyday challenges are further symptoms.

STRESS SIGNALS

Nervous reflexes - biting nails, clenching fists, clenching jaws, drumming fingers, grinding teeth, hunching shoulders, picking at facial skin, picking at around fingernails, tapping feet, touching hair.

Stress-related illnesses - Asthma, back-pain, digestive disorders, headaches, migraines, muscular aches and pains, sexual disorders, skin disorders.

Mood changes - anxiety, depression, frustration, habitual anger or hostility, helplessness, hopelessness, impatience, irritability, restlessness.

Behaviour - Aggression, disturbed sleep patterns, doing several things at once, emotional outbursts, leaving jobs undone, overreactions, talking too fast or too loud.

3.5 REVIEW ARTICLE

SPECIFIC APPLICATIONS OF COUNSELLING SKILLS BY HOSPITAL STAFF IN ANY HEALTH-CARE SETTINGS.

*Sunila Karan,
Counsellor-psychologist, Nadi*

Although attitudes have improved, staff, carers, and helpers within healthcare settings may still have to counteract the medical tradition of people as patients, with all the negative overtones that the term entails. Some specific issues arise with work in health-care;

Health, illness, diagnosis and treatment are not just physical and physiological processes; feelings are also involved and can often be crucial to a positive outcome.

Ill health cannot just be seen as a person passively reacting to a condition. His or her outlook and confidence and the extent of support all have an influence on the progress and outcome. Anxiety and lack of information can worsen an individual's outlook. The disease is medically treatable, the illness is not.

Frequently, the illness of one person has an impact on others, especially in the immediate family. Continued chronic illness of an adult or a child affects all the workings of family life.

In any health-care setting you need to allow for the often strong emotional content of information about diagnosis and possible treatment.

1. Bereavement & Loss

Many societies have lost many of the supportive rituals surrounding death, with the consequence that many people are uncertain how to behave towards friends or acquaintances that have experienced a loss.

The 'medicalisation' of death has meant that today many people die in hospitals rather than at home. Bereaved relatives sometimes have to deal with brusque reactions from health care staff which worsen their own distress. Use of counseling with bereaved family members follows a similar pattern to working with any client, and can be done by hospital staff but some issues are special to this situation:

- When individuals have lost someone very close, they often go through a phase of feeling numb, of shock at what have happened and even a sense of disbelief. It can help to alert family members that such feelings are not unusual. However, family members should never be given the impression that there are fixed stages in bereavement, nor should their individuality be undermined by comments like; "Everyone goes through this."
- Family members may experience a mixed range of emotions. People may feel distressed along with feelings of guilt

about what was done or not done, anger with other family members or the medical profession who should have done more, and even anger at the person who died and left them.

Hospital staff will come across people who are terminally ill. The terminally ill should always have the choice whether to talk with someone or not; it should never be forced on them. Counseling skills in this situation can include

- Help patients talk about their situation with someone who does not resort to false hopes or cliché's.
- Listen to the person's feelings preferences and choices. Perhaps help them to action some choices.
- Support the person in coming to terms with the limited time and to consider any actions they wish to take: to complete tasks; say goodbyes or make arrangements. People may appreciate a sense of closure and appropriate support for those they leave behind.
- Support older and young people, who may be fully aware that they will not recover and value the respect of talking with someone just as much as a dying adult.

2. Accident and Trauma

Traumatic events destabilize people for weeks, months or even years. Personal feelings of control, the ability to protect yourself and others, are undermined by accidents, assaults, physical /sexual abuse, rape, and even news about a health crisis. Even minor events can cause anxieties where there had been confidence, and raised mixed feelings about what has happened and whether the situation could have been avoided.

Anyone who has experienced a potentially traumatic event should be given a choice about whether to talk with someone and when. Counseling can offer an opportunity to talk through feelings and the impact of the event. Some issues that arise include:

- People who have not been physically hurt can still be unnerved by what has happened and realize that their anxiety or fear is affecting their behavior. They want help to recognize what is happening and how best to cope.
- People need support when they have disturbing experiences such as flashbacks, intrusive thoughts about a traumatic

event or recurrent dreams. Reassurance that this is normal can be appropriate, since victims may feel that they are losing their mind.

- Children who have minor injuries from an accident can still feel great emotional distress and do not necessarily tell their parents or carers. The extent of upset becomes more obvious through their general behavior and play. Child witnesses to accidents are sometimes just as distressed as their injured sibling or friend.
- People frequently express mixed feelings, not all of which are logical. They may still need to talk through whether they could have avoided what happened. Individuals often need to locate responsibility with the criminal who attacked them or the driver who caused the road accident, rather than revisiting their own actions as if they are to blame.

3. Post-traumatic stress disorder

PTSD is defined as a specific collection of symptoms that have persisted for more than a month after a traumatic event. Similar symptoms that last less than a month are known as acute stress disorder. Some of the symptoms of traumatic-related stress are:

- Persistent recollection of the event, through intrusive thoughts or distressing dreams.
- Reliving the event through vivid flashbacks.
- Intense psychological or physiological distress reactions to experiences that are linked to the event.
- Persistent avoidance of memories and

blockage of feelings.

- Children can experience similar symptoms, although they may relive a traumatic event through repetitive play, re-enacting parts of the experience and apparently unrelated disturbed behavior triggered by an inability to talk about or deal with the distressing feelings.

Dealing with PTSD is a specialized area of offering help, unless you have received appropriate training, you should look towards referral of the patient.

4. Support for children and young people

If you work within health care, you need to take account of the age and understanding of young clients and remain sensitive to individual reactions. Normally confident adults are not at their best when worried or confused and in unfamiliar surroundings. Adults may

hide the depth of their feelings or find strategies to cope. In contrast, children will often express their distress, panic or pain without any reservations. Children experience embarrassment and loss of dignity in a similar way to adults or teenagers and dismissive or rude treatment can greatly complicate any health procedure. The feelings are the same, but what children do about them is often different from adult reactions.

Children and young people may appreciate and need the company of a familiar adult, but you should not talk only to the adult as if the child is not there. Parents will be in a better position to help and support their children if they are given information about a service or a condition. It is less effective to depend only on talking; advice is probably best given in written form as well as spoken.

Cut here



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4. ORIGINAL ARTICLE - AUDIT

AN AUDIT ON PAIN MANAGEMENT

*Dr Shanita Sen,
General Practitioner, Nasinu*

INTRODUCTION

This Audit was done as part of my assessment towards my Diploma in Family Medicine from the Monash University while doing a module on Pain Management. This is a post audit and a similar preaudit has been done. It tries to find out the understanding the patients have about their pain problem and the treatment being prescribed. The doctor at the same time is able to assess the confidence he/she has in treating the various pain syndromes.

The Practice where the audit was done is a Solo Practice in a suburban setting in the Fiji Islands in the private sector.

It would be good to introduce the Medical setup in the Fiji Islands since it has an impact on continued patient care. There are two parallel systems for outpatient care in the country. There is a Government system and a Private sector. The Government has its own Health Centers around the country in rural, urban and suburban areas. These are mainly outpatients. The patients here are seen free of charge and the clinics are always overloaded. The Private sector has General Practitioners mostly Solo Practices and not funded or subsidized by the Government. The patient pays for the services provided in the private sector. There is hardly any good communication between the two sectors. Patients are at free will to switch between the cares provided. There is no form of computerized link between the two sectors.

METHOD

The requirement was to assess 30 patients presenting in the clinic for various pain problems.

The Practice Nurse randomly selected three patients per day in ten random days.

The Practice Nurse obtained consent from the patients selected to be part of the audit and explained the reason why the audit was being carried out and that their treatment will not be affected in any way if they decide not to participate. It was also explained that the Doctor will not be informed which patients has refused to be in the Audit.

The Doctor was informed by the Practice nurse the patients that are included in the audit and the doctor filled in the form for the doctor provided by the Monash University after each consultation.

After the consultation the patients went to the Nurse to answer two questions on the form provided by Monash University as part of the Audit. There was a scale on which the participant had to circle a number between 1-5 as the response. (Please see in results section the two Questions asked) The nurse explained that the names are not recorded and the patients are free to fill in the forms and their treatment will not be affected in any way.

The data was collected over three weeks. It would have been possible in a week but due to heavy patient load both of the doctor and the Nurse it took longer than expected.

See graphs next page

DISCUSSION

There is almost equal distribution of gender in this audit, 57% female and 43% male. The age range of the participants was between 20 and 69.

It is noted that out of the 30 responses about 73% of the patients understood the Doctors explanation about their pain and about 83% understood the treatment plan being prescribed. If we look closely at the last scale of 5 (that is fully understands) then the percentage drops further to about 43% and 50% respectively. Comparing this to pre audit about 53% of patients seemed to understand the doctor's explanation. Therefore now there is an increase of 25%.

This means that there are about 27% patients that do not understand the explanation about their pain and 17% do not understand treatment being prescribed. When comparing this to the preaudit then there is a decrease. It is noted that there has been an improvement in the understanding of various pain problems that the patients presented with. This course has increased the knowledge of the doctor which is clearly demonstrated by the percentage of increased satisfaction of the patients. Nevertheless it is also noted that there is still patients who do not fully understand their pain problems. Some reasons for this could be the Doctor is not explaining in terms that could be understood (medical jargons and language barrier) or is not confident in what she is treating or is not spending enough time with the patients.

When I look at the confidence rating I gave myself was 80% for those with which I was confident in dealing with their problem and for 20% not confident. This is almost equal to what came out in the survey as well. There were cases Classified in the Psychiatry category that I was not confident about due to the complexity of few cases. One was a new case for the clinic and as I spend more time with this client in next visits I am confident I will be able to understand the client and vice-versa. I noted that more of the clients in the musculoskeletal category were able to understand their treatment plan. I have also noted that since my knowledge has increased about mechanical back aches and the inflammatory causes my treatment plans are also directed to the underlying pathology and thus more satisfied patients. I have noted that when I explain to the patients in a confident manner the nature of pain and the treatment plan they look satisfied already.

About 20% of all cases were headache. There were cases of migraine and tension headaches. I dealt with these same cases that I was seeing before in a much more confident way. I did more changes in the treatment plan for these cases. I explained what the changes were to the patients and the reason for the changes. I specifically told that I have just done a course on pain management and these changes are due to what I have learnt. The clients were happy that I am changing

the treatment plans because I have updated my knowledge.

The Doctor has improved on the skills and knowledge and therefore it is evident in this post audit.

The doctor used scales in review cases to determine the pain intensities etc and that has helped in better understanding of pain in patients.

There are some clients that that are still not

sure of their pain problems and treatments. As the doctor practices more of what has been learnt from the course on Pain Management the percentage of satisfied patients will increase. At the time of the Audit the clinic was very busy due to influenza and acute gastroenteritis breakout. The doctor may not have spent much time with some of the clients.

This Audit has highlighted the need for better understanding of pain in patients. After completing the Pain Management module I have gained better knowledge of patient management and the understanding of various pain problems. I have also noted the use of scales and questionnaires gives the Doctor very good and at most times reliable information about pain.

Results

1. Gender distribution of participants in Audit

Male	Female
13	17

2. Responses to question One.

"I understand Doctors explanation of why I am in pain"

Scale	Not at all (1)	Slightly (2)	Somewhat(3)	Quite a bit (4)	Fully (5)
Number of response	1	3	4	9	13

3. Response to Question two.

"I understand doctor's treatment plan to deal with my pain problem"

Scale	Not at all (1)	Slightly (2)	Somewhat(3)	Quite a bit (4)	Fully (5)
Number of response	Nil	2	3	10	15

4. Frequency of various pain syndromes.

Pain	Infection	Musculoskeletal	Gynae	Psychiatry/Psychogenic	Headache	Orthopedics
Number of response	3	8	4	5	6	2

Results from Pre audit used in discussion for comparisons.

1. Gender distribution of participants in Audit

Male	Female
18	22

2. Responses to question One.

"I understand Doctors explanation of why I am in pain"

Scale	Not at all (1)	Slightly (2)	Somewhat(3)	Quite a bit (4)	Fully (5)
Number of response	1	7	7	6	10

3. Response to Question two.

"I understand doctor's treatment plan to deal with my pain problem"

Scale	Not at all (1)	Slightly (2)	Somewhat(3)	Quite a bit (4)	Fully (5)
Number of response	Nil	7	6	8	8

4. Frequency of various pain syndromes.

Pain	Infection	Musculoskeletal	Gynae	Psychogenic/Psychiatry	Neurological	Cardiac
Number presented	6	6	3	12	1	1

5.1 SPECIAL REPORT

IN SEARCH OF THE ELUSIVE "EXTRA" GP DOLLAR.

*Dr Abdul Wahid Khan,
Suva.*

I have had the pleasure (and displeasure also) of visiting several general practices over January 2008 in our exercise of "re-introducing" the College to all and sundry. The exercise involves providing an Introductory Package consisting of the College Constitution, GP Journal, GP Newsletter, Introducing the College, Information on the Monash-FCGP certificate course and an introduction to the "standards process" that the College has undertaken.

A similar exercise was undertaken by Dr. Shyamendra Sharma for the Western Faculty with the help of the College Vice-President.

We have compared notes and the predominant emotion is that there are many practices which do not stand up to the Health and Safety standards we all are legally expected to adhere to. To say that these practices are "shoddy" is doing injustice to the word. Patient comforts are largely ignored and the 2 small rooms make my mind boggle as to the quality of care provided. The Privacy of Patients is a term which these practitioners know nothing about. The unfortunate part is that these practices continue to charge gargantuan fees, not at all commensurate with what I charge in my somewhat better appointed premises.

It is the dictate of our current legislation that all medical officers registered under Part 2 of the Medical and Dental Practitioners Act are eligible to go into General Practice - which is very rapidly developing into a fertile ground for any medical practitioner disgruntled with their state employers. This basic qualification allows any such practitioner to open shop in and under any circumstances they wish to. There are no regulatory authorities to check on that which is happening.

If my laments appear as the cry of a disgruntled older GP who sees competition from the newer GPs, then let it be laid to rest for once and all. I stand for HONEST practice where service to the patient in comfortable surroundings is paramount. I stand for HONEST consultation fees. I stand to HONESTLY represent the needs of the patients. To fail to do so will belittle me in my own eyes.

That brings me to another issue which the College has drawn to the attention of the Fiji Medical Council - the issue of Private Pathology services. There are 4 of these currently in Fiji.

The irony of the situation is that these entities are not governable by any single legislation of the nation - and there goes our desire to maintain standards. With no regulatory

body to oversee their operations, who will assure us that our patients are being given a fair deal for their money?

We need a Regulatory body which will be required to be reported to on a quarterly basis on a recognized accreditation process. This information, then, should be filtered to the GPs who can then make their own decisions on where to take their business. We still look towards the Fiji Medical Council to, at least, initiate the development of the necessary legislation/regulations on these entities.

Private Pathology/Imaging Services run by the GP is also another enigma to me. We are General Practitioners and not pathologists. There is a fine line between being a general practitioner and being an entrepreneur and where and when that fine line is crossed is of great concern to me.

Let's face it; establishment of a Pathology/Imaging service requires substantial investment. It then makes economic sense that to sustain such operations there has to be a commensurate level of income. What then stops the owner-operators from over servicing in the NEED to get that extra dollar? What stops them to order an MBA instead of a targeted search for pathology? What stops them to order an abdominal ultrasound for every case of abdominal pain?

So, the search for that elusive dollar by the GP continues. Run an IV Fluid line for a patient with vomiting or the patient who had a dizzy spell, and collect the extra dollars. Honestly, in my practice, the only instance I have had of putting up an IV fluid line was when stabilizing a patient prior to transferring the patient for secondary care.

The General Practitioner has to come out of moral bankruptcy and practice with an Honest Social sense. We are managers of our client's assets (translated into money!) and we need to see that we do not impose unnecessary expenses on them.

There is a real need to change the culture of our consultations to a more patient oriented one. Every patient should be given all the alternatives of management available to him/her. Oftentimes, the patient needs to be directed towards a decision, but the final decision as to how and where to spend their money are the patients.

The future lies in establishing standards for our practices and the onus is on individual practitioners to grasp this as a paramount process for 2008. Let us re-orientate ourselves towards Social Medicine.

5.2 THE CHILDREN'S HEART FOUNDATION.

The Children's Heart Foundation is an outreach program of the Fiji College of General Practitioners funded by the Vodafone Foundation (UK).

The Fiji College of General Practitioners was founded 15 years ago to provide the Private sector medical practitioners a means to improve professionalism and raise the ethical standards of health delivery in Fiji. Apart from providing Continuing Medical Education (CME) to the 100 odd private sector primary health care providers on a voluntary basis, the college embarked on an ambitious outreach program to support the underprivileged in society some two years ago.

The College embarked on the mission to consider providing logistical/Financial support to children with congenital and acquired heart diseases. Thence the Children's Heart Foundation was set in motion. The various logistical needs were assessed and the College executive decided that developing alternative sources to undertake heart surgery was urgently needed outside of our traditional developed neighboring countries as the expenses required to send our children was prohibitive financially and many children did not survive the time span till funds were collected for the high technologically advanced surgery.

India has developed an outstanding record in Medical Tourism in that many foreign patients travel to various Specialty centers for high tech procedures at a fraction of the cost in our traditional neighbors'. Chennai in south India was sourced and assessed as a choice centre for our linkage. A fact finding team was sent in November 2005 and all related matters on screening of patients, transfers, travel, accommodation, operations, outcomes and costs were discussed with the teams in Chennai and later at New Delhi hospitals.

Dr Shanti, a resident pediatric cardiac surgeon from Chennai, was sent to Fiji to evaluate and prioritize the children who require surgery. She has ranked the first 20 of the 30 needing surgery. She will return in six

months to re-look at the balance who need assistance.

At a third of the cost to what would have been paid out to our developed neighbors', the first batch of six children return after successful heart surgery in Chennai this week. A further five will be leaving our shores for surgery in early September this year. A backlog of thirty children will benefit from this project, which will in the Colleges hope become an annual undertaking.

The College of General Practitioners was successful in initiating this project with the financial support and endorsement of the Vodafone Foundation (UK) through its Fiji operation. Vodafone Foundation (UK) endorsed to provide \$ F334, 000 towards this project. Rightly stated at the cheque handover function the Interim Minister of Health was that "Health was not the States concern only but also of professional organizations like the Fiji College of General Practitioners and that of Corporate organizations like Vodafone". Additionally the community must their hand up and be counted in providing our progeny a decent quantity of life. In many cases Children with heart disease, may in fact have their life terminated prematurely if we as a nation do not collective work together.

The first seventeen children have been treated successful with the financial support of Vodafone Foundation(UK).The College of General Practitioners will shortly need the endorsement of other organizations and the general public to carry the burden a little into the future. The Fiji College of General Practitioners continues to work closely with the Sydney Adventist Cardiac team and the newly established Cardiac team from New Zealand who visit Fiji periodically. The College is hopeful that it may input into these services by providing logistical support. Additionally the College supports the development of the Cardiac Catheter Laboratory at the CWM Hospital in the not too distant future.

*Dr Abdul Wahid Khan,
Suva.*

5.3 CODE OF ETHICS

The existence of a code is the one standard by which all professionals are judged. It provides guidance to practitioners as well as users and sets out expectations of professional practice and the manner in which services should be conducted.

* Ethics-a system of determining whether an action is right or wrong, moral or amoral.

* Morality refers to a particular situation or event that requires a decision regarding its rightfulness.

* Ethical principles are guidelines that we can apply to a situation to decide whether it is moral or amoral e.g. the difference between killing and letting die i.e. euthanasia or withholding treatment.

* An ethical dilemma is a situation where we have to place one ethical principle above the others and to do this we use values.

* Values are an estimate of worth. We de-

termine one principle to be worth more than the others in the situation we are judging eg in relation to termination of pregnancy we have to determine the life of the mother in relation to the right of life of the child.

* Values are developed over many years through a series of activities such as formal teaching, life experience, religious upbringing, cultural influences and the legal environment of a particular country.

* Since values differ according to the above influences the ethical principles used to resolve ethical dilemmas will differ.

* The challenge in Fiji will be to formulate a Code of Ethics, which embraces all the above definitions and also complements the Code of Ethics of similar professional bodies to which we are affiliated.

Dr Rosemary Mitchell.

Chairperson, Standards Committee

5.4 THE PROCESS OF SELF AUDIT.

Dr Rosemary Mitchell, Suva

ESTABLISHING STANDARDS

This manual has been designed to give general practitioners an overview of the reasoning behind the setting up of a standards committee by the College of General Practitioners. We have based our recommendations on standards set by Australia and New Zealand with some input from the standards of other countries and the personal views of individuals and organizations consulted from time to time by committee members.

The documentation will form the basis of an accreditation program for general practitioners with an aim to contributing to the uplifting of professional and ethical standards of medical practice in Fiji.

DEFINITION OF GENERAL PRACTICE

General practice is part of the Fiji health care system and operates predominantly through private medical practices, which provide universal, un-referred access to whole person medical care for individuals, families and communities. General practice care means comprehensive, coordinated and continuing medical care.

A general practice must accept un-referred patients presenting to the practice and take responsibility to ensure that practice patients have access to care by an appropriately quali-

fied Medical practitioner at all times and at locations away from the practice when necessary eg emergencies, specialist referral etc.

Primary care practices that specialise in services such as gynaecology, eye surgery etc will not be recognised as a general practice unless these services are provided as part of a comprehensive range of general practice services.

A practice unit is defined as a (1) solo practice or (2) group practice if all medical practitioners working at the practice share a medical records system, an appointment system, patients and premise (3) The outpatient Medical Centre of a licensed Private Hospital will be defined as being a group practice-the general practice standards will only apply to this area of the Hospital.

The aims of accrediting general practices is as follows:

- a) To attain the highest quality of general practice in an achievable and gradual manner.
- b) To provide a publicly recognizable measure of quality in general practice.
- c) Be voluntary, but have tangible benefits.
- d) Be for a defined period eg three years.
- e) Be an educational and developmental process and not a punitive one.

f) Be in the hands of the profession.

The initial phase of the accreditation process will be to circulate a self-assessment format to individual doctors who can then assess their needs in order to fully comply with the standards.

There will then be a gradual introduction of formal accreditation once procedures are agreed upon.

The self-assessment checklist will cover the following issues

Practice set up

Practice location and building

- Should comply with local council requirements for a business licences
- Have facilities for the disabled or alternatively arrangements for consultation eg home visits
- Adequate parking
- Public transport, or facility for calling taxi available
- Ambulance access
- Clearly visible and well placed signage which includes details regarding opening and after hours arrangements

Reception

- Appointment system is flexible and able to accommodate appointments and waiting patients.
- Patients can request a preferred GP.
- Patients informed of waiting time and offered new appointment or alternative doctor if necessary.
- Adequate safeguards in reception to ensure confidentiality of information.
- Staff can observe the clinical condition of patients and know when to give preference eg asthma, chest pain etc and refer to doctor.
- Staff has adequate training and maintain a helpful, empathic attitude to patients.
- Practice does not discriminate against patients on any basis.

Waiting area

- The waiting area is of adequate size to seat waiting patients in comfort
- The area is kept clean at all times
- Patients potentially causing distress to others or in personal distress can be removed to a private area
- Waiting area can accommodate wheelchairs
- Waiting area should provide reading materials and when indicated a designated area for children.
- Practice fees
- No smoking
- Access to adequate toilet facilities

Laboratory

- Practice has facilities for laboratory

services etc or is able to refer patients appropriately for these services

- The practice safely disposes of sharps and contaminated materials

Consultation room

- Patients are informed regarding permission for a third party
- Facilities for translator when necessary
- Staff and doctors to be aware of the problems associated in consulting patients in a second language
- At least one room for each GP working in the practice at any one time
- Each room should be free from excess noise, adequate lighting, protection of privacy for undressing eg screen, clean, gown, and sheet.
- Privacy of consultation ensured
- Adequate range of educational information to complement the consultation process
- Adequate examination equipment - stethoscope, torch etc
- Facilities for hand hygiene in each room

Treatment room

- Separate provision for a treatment room is preferable, otherwise a dedicated area for storage of treatment equipment within the examination room
- The following equipment should include
 - Auroscope
 - Blood glucose monitor
 - Disposable needles and syringes
 - Equipment for resuscitation and maintaining an airway
 - Examination light
 - Gloves
 - Measuring tapes etc
 - Ophthalmoscope
 - Patella hammer
 - Oxygen
 - Peak flow meter
 - Scales
 - Spacer, inhaler for asthma
 - Specimen collection equipment
 - Sphygmomanometer
 - Stethoscopes
 - Thermometer
 - Torch
 - Tourniquet
 - Urine testing strips
 - Vaginal speculum
 - Visual acuity charts
 - X-ray screen
 - ECG
- Any other surgical or other instruments necessary for the practice to provide safe, effective treatment for any procedure offered by the practice eg minor surgery etc.

- Medicines should be stored safely and checked regularly for expiry dates and, spoilage
- Safe disposal of expired or damaged medicines
- Practice should have effective vaccine storage, adequate cold chain,
- Register of medications
- Only authorized personnel to have access
- Equipping and maintenance of doctors bag

Occupational health and safety practice

- Practice and office equipment should be appropriate for its use and regularly maintained.
- Staff should be trained in the use of equipment.
- At least one staff member in addition to the GP is present at all times when practice is open.
- Staff members welfare is supported including immunization status, medical checks, no smoking etc
- Adequate infection control is in place
- Practice demonstrates a commitment to OHS standards
- Practice has adequate fire safety procedures including fire extinguishers and alarms

Telecommunications

- Telephone system with sufficient inward and outward call capacity
- E-mail access is recommended
- Patients can obtain advice related to their medical care over the phone. However the doctor has the right to request the patient attends for consultation if appropriate.
- Processes in place for staff receiving and answering calls
- A telephone register should be kept.
- Patients are informed how to access a 24 hour medical cover
- Systems should be available for patients with hearing or seeing disability

Infection control

- When necessary use sterile equipment eg disposable needles, syringes and maintain regular checks on expiry dates.
- Each consulting room, waiting room and treatment room should have hand-washing facilities.
- Disposable towels are preferred otherwise regular changing of dirty towels.
- Toilet facilities should be clean, have a good supply of toilet tissues and able to provide privacy to the patient.
- There should be adequate facility for urine collection when required.
- The disposal of sharps and human waste

should be in line with OHS requirements.

- There should be procedures in place for managing blood products and spills.
- Routine use of cleaning, disinfecting and decontaminating clinical and non-clinical areas.
- Regular change of sheets and pillowcases.
- There should be a commitment to reporting infectious disease to Ministry of Health using the necessary forms.
- Facemasks should be available for use when appropriate.
- Staff should not be in contact with patients if they have a communicable disease eg boils, influenza.
- There should be provisions to remove obviously contagious patients from contact with other waiting patients.
- Good pest control should be a priority.

Security

There should be adequate security measures in place to comply with council regulations. Security should not compromise fire safety.

Practice Management

- All members of the practice team have been orientated and trained in procedures relevant to their position
- It is recommended that practices make use of courses offered by TPAF for training of office staff in customer service etc.
- Nurses and staff should be kept upto date on their responsibilities in regard to patient care and customer service.
- Routine practice meetings should be held as a valuable communication tool
- Staff should be given the opportunity to take time off to pursue further studies
- The practice has a system to address serious or potentially serious practice problems including patient complaints

Patient management

- Confidentiality and security of health records should be ensured
- Patients should be provided with access to their records
- Procedures in place for transfer of records to another provider
- Request by a patient for transfer should be respected
- Patient records only to be transferred with patient consent
- Patient should be informed if a third person requests information without consent -even if the third person is related.
- Patient records should be kept for at least 10 years before being disposed of.

- Procedures for back up and confidentiality in place for practices using computer records
- Patient records should record all consultations including telephone and house calls and notes made of consulting doctor
- Patient laboratory tests and specialist records should be readily accessible
- Referral letters to specialists, doctors, insurance company and others should be legible and include
 - The purpose of referral
 - Relevant history, examination and current management
 - List of allergies and medication
 - Be on appropriate stationary and copies kept for future reference
 - Each patient should have an individual health record which should include history, allergies, chronic conditions etc
- Patients should be advised of practice fees either posted in the waiting room or via a practice information sheet
- In the event further procedures are required patients should be informed of costs
- Patients are given information on health promotion and illness prevention
- Practice is encouraged to keep a reminder system for chronic care patients
- Doctors have ready access to references relevant to general practice i.e. journals, text books, internet
- Should encourage the concept of continuity of care by allowing patients to see the doctor of choice and the doctor following up with specialists after referral.
- System to follow up and recall patients with clinically significant tests and results.

The above self-assessment is the first draft of a final document which we plan to improve on and then introduce formally at the launching of a full program of practice audits.

Please walk through your practice and make notes on the above recommendations. We need your input on requirements you think need to be added or removed. Also your reasons why certain requirements may not be possible in your practice eg cost restraints.

OBITUARY

Dr. Serupepeli Lomani

It is extremely difficult to write an obituary for a colleague who was a most private person. Despite this privateness of Dr. Serupepeli Lomani, his demise has left a gaping deficit at the Suva Bayly Clinic.

If there was a "Gentleman Doctor", then it was none other than Dr. Lomani. Quietly minding his own business, speaking softly and yet being pragmatic in instances which required such actions; he left a legacy that can not be repeated.

My personal interactions with Dr. Lomani started in 1993 when he joined the esteemed group of doctors at Suva Bayly Clinic, although I had met him on several occasions prior to his enrolment in the Bayly Family.

Graduating in 1945 from the then Central Medical School in Suva, Dr. Lomani's illustrious medical career spanned some 63 years and which was based on the old adage - "never give up". Up to his last day, he continued providing his valuable service for the needy.

His illustrious career saw him, besides

serving the Fijian Ministry Of Health, spend a stint in the Solomon Islands, gaining a Masters in Public Health from the University of Hawaii and then a Diploma in Dermatology from Edinburgh, England. He was one of the very first locally qualified skin specialists in Fiji.

Dr. Lomani also was a lecturer at the Fiji School of Medicine prior to joining General Practice in 1993.

At the Bayly Clinic Dr. Lomani served as the Medical Superintendent in two instances. He was especially interested in the Public Health issues and started a taped program for patients to listen to whilst waiting for consultations. Although this has been discontinued, due to technical production programs, it was a very popular program at the time.

The Suva Bayly Clinic sorely misses this kind doctor and shares the grief of this loss with his spouse and only daughter.

Dr. A W Khan
Medical Superintendent
Suva Bayly Clinic



MED-WATCH

* A recent excursion to Nadi proved fruitful when some aviation professionals got around to discussing their favourite General Practitioner's attributes. Laughingly, we were told of a certain doctor who requested all his male patients to strip into a gown even when the site of injury/pain was very peripheral. Maybe the holistic approach to examination was being utilized? The term "voyeurism" was floated that evening. We backed off doing a house visit when we noted the exuberant home with entertainment bure, spa pools and beautifully manicured gardens.

* Selective fee structures for locals, local-urbanites, local and international travellers/air crew was also on the menu at the Nadi meet. One prominent practitioner had a rolling rate of \$18, \$25, \$40, \$60-80 for the mentioned groups for basic consultation. A drip (one Litre of normal saline) recently cost a budget airline crew member \$460. No wonder the poor lass ended up pole dancing at a reputed bar in Martintar, Nadi, in a state of depression.

* Urgent CAT scans are in the news once again. Practitioners ordering such investigations must not forget that an urgent procedure is to be considered in life threatening situations and not because it is "after hours." Someone will fork out the cost even if it is the health insurance scheme. Allegiance to institutions must be weighed against its relevance to patients' needs holistically. A non urgent CAT scan costs 1/3 of its after hour brethren. Where does the 2/3 get siphoned off?

ACUTE CRISIS EFFECTS - Sunila Karan

The amount and type of stress we can cope with before damaging our health varies for everyone but we all have a crisis point, beyond which we can become seriously ill. A build up of long term pressures can lead to the relentless, accumulated strain that result in this crisis.

Acute crisis effects take on very definite characteristics - they are not always obvious to the sufferer and the difficulty lies in being able to notice them and accept them as deviations from the norm.

Breakdown

Under healthy pressure, arousal leads to an automatic increase in performance, followed by a healthy fatigue which we remove by resting. In the case of repeated, unrelenting pressures, arousal persists but our performance falls short of the intended mark. As we push ourselves even harder to attain our goal, we are caught in a self-defeating struggle to close the gap between what we are capable of achieving and what we think we should achieve. Greater arousal depletes our resources to the point where any further demand may lead to a breakdown.

Among the many symptoms of arousal and unhealthy fatigue the most common are: disturbed sleep patterns, chronic tiredness, loss of energy and judgment, overdependence of alcohol and drugs, eating disorders, including anorexia and bulimia, hyperventilation, and panic attacks. People suffering from a breakdown may also display neurotic, manic, or depressive

behavior, and we will probably deny that their performance is impaired by the breakdown.

* The symptoms of breakdown

The cause of physical breakdown can range from heart attack, angina, and stroke, to kidney disease, viral infection, stomach and respiratory disorders. The "nervous breakdown" is something of a misnomer: our nervous cannot literally break down. Any behavior which is uncharacteristic, uncontrollable, and irrational, although perceived as quite normal by the person displaying it, usually indicates a severe psychological disorder. Severe mental strain can for example cause prolonged bouts of sobbing, screaming, shouting, physical violence, self-mutilation, or even attempted suicide. Hyperventilation can become extreme, triggering acute and crippling panic attacks that mimic the symptoms that may indicate this type of breakdown. Suddenly resigning from one's job or ending a close relationship; running away from home; abandoning one's children; shoplifting; becoming completely dependent on hard drugs or alcohol; and developing a "split" personality are among the most serious. Such symptoms are likely to require instant medical treatment. Removal of the source of stress, enforced rest and sleep, short-term drug therapy, and psychotherapy usually cause the symptoms of breakdown to improve, encouraging renewed well being on both physical and mental levels.



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