

**FIJI GENERAL PRACTITIONER**

# GP

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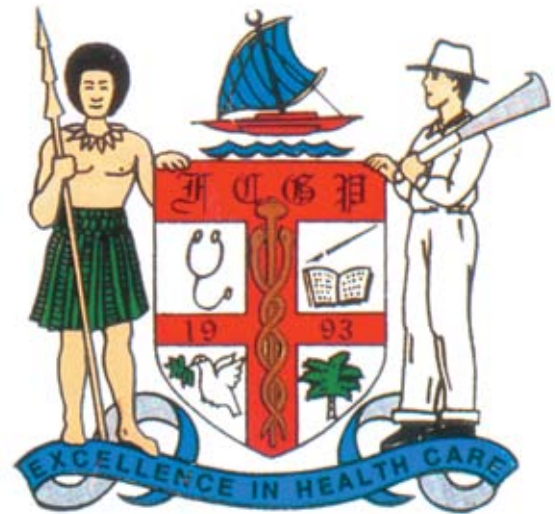
Journal of The Fiji College of General Practitioners

**THE FUTURE OF PRIMARY CARE**

**MEMORIES OF A FIJIAN GENERAL PRACTITIONER**

**A THEORETICAL APPROACH TO PAIN**

**COUNSELING DRUG ADDICTS**



Theme: A Portpourri in GP

Geno



# GP

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## Guest editorial

# WHAT CAN ONLY A GP TEACH?

**Associated with this type of clinical reasoning is the ability to examine and diagnose quickly.**

Dr. Sanjiva Wijesinha

In this 21<sup>st</sup> century, when medical schools all over the world are changing from traditional time honoured curricula to more modern student-centred teaching methods, it is timely to consider the role that general practitioners can play in teaching the doctors of the future.

All of us are, after all, “Only GPs”. What is it that medical students can learn Only from GPs? What is it that we GPs can teach better than our specialist colleagues?

One of the most important skills that we can impart to students is the type of clinical reasoning that all of us regularly utilise in general practice†—the art of Pattern Recognition. In our day to day work when we see patients we are constantly drawing on memories of patients with similar conditions, which enables us to pick up critical clues and so diagnose from apparently minimal information.

Associated with this type of clinical reasoning is the ability to examine and diagnose quickly. Unlike our specialist colleagues in hospital, we GP’s lack the luxury of junior staff and laboratory facilities and so have to learn the technique of prioritising a patient’s problems – examining in a time and cost-effective manner – and then making a quick clinical diagnosis.

Another important aspect of teaching in general practice is helping students to recognise our limitations as doctors†—to be aware of What we can treat, Whom we should treat, When we should refer and Which conditions should be left alone. I recall a saying attributed to the famous British surgeon John Hunter: “The mere feasibility of an operation should not be an indication for its performance”. This wise observation is so easy to forget in the technologically advanced and seemingly omnipotent environment of modern hospitals.

Perhaps the biggest contribution we GPs can make to the training of tomorrow’s doctors is by teaching Communication Skills. Many a time I have been consulted by one of my patients with the request “I have been to see the specialist, doctor – but he hardly spent any time with me. Can you explain about this operation he wants me to have?”

The fact remains that 50% of our medical students will end up as general practitioners. Both they, and their colleagues who go into other fields of medicine, will benefit from learning not only our General Practice arts of

clinical reasoning and our holistic attitudes but also our arts of communication. In contrast to dealing with a Cancer attached to a patient, these students need to learn how to deal with a human being suffering from malignant disease. In dealing with an old man who has had a fall, they will realise that manipulating and plastering his Colles’ fracture is just a minor aspect of treatment. They should also become aware of what arrangements have to be made for the continuing care of such a patient during his long period of incapacity.

As GP’s we are best placed of all medical practitioners to teach students the art of Rational Prescribing – to constantly be cognisant when writing scripts of what one of my colleagues used to call The Three C’s – **Cost, Compliance and Contra-indications.**

As medical students many years ago, all our clinical teaching was in the hands of hospital specialists. We learned surgery from the surgeons, medicine from the physicians, some women’s health from the obstetricians and (if we were lucky) a bit of psychiatry from the psychiatrists. After graduating, we were left to synthesise all this into an appropriate pattern for general practice.

These days, with a shortage of specialists in this country, with less and less patients ending up in hospitals and the majority of patients being seen and treated in the community, the preparation of medical students for a life time of medical practice has undergone change. The future will require the doctors of the 21<sup>st</sup> century to be confident and comfortable with looking after patients outside hospitals. They will have to manage patients with disease rather than treat diseases affecting patients†—and know that, when there is nothing more to be done for the disease, there is still much to be done for the patient.

Can I be bold enough to say that this is the sort of education which Only a GP can provide?

**Dr. Sanjiva Wijesinha is senior lecturer in the department of general practice at Monash University in Melbourne**

## **THE FUTURE OF PRIMARY CARE**

### **A helping profession that is not meeting the deepest human needs of its constituency is in trouble.**

Primary care leaders and practitioners are concerned about the future of their specialty. In this issue of *Annals*, they explain their concerns and offer suggestions based on discussions at a conference on the Future of Primary Care held in October 2001. In this editorial, I underscore some of the reasons for concern, point out key elements of the mission of primary care, and identify points of leverage for renewal of the field.

What is primary care? In 1978, the Institute of medicine offered a memorable description: primary care is first contact, comprehensive, and continuing (1). A subsequent Institute of Medicine description focused on integration, access and sustained partnerships with patients (2). Patients like this type of care and wish they got more of it. Surveys over the past 20 years consistently show that most adult Americans rely on general internists, family physicians, and general practitioners as their usual source of care (3). Surveys summarized by Safran in this issue (3) document the public's perception about primary care. Unfortunately, the picture that emerges is unflattering. The American people want a regular physician who knows their medical history and knows them as a person, but they don't think that their physicians are fulfilling this role. A helping profession that is not meeting the deepest human needs of its constituency is in trouble.

Workforce trends also paint a gloomy picture for primary care. Fewer young physicians are choosing residency training that leads to careers in primary care (4). Anecdotes about primary care physicians leaving practice are plentiful, although we lack documentation that the rate of exodus is increasing. A field is in trouble when the number of practitioners is getting smaller while the demand for services remains strong.

Moore and Showstack's article in this issue (4) documents reasons for the declining attractiveness of careers in primary care. One is money. Primary care physicians make less money than specialists, even though they work longer hours than physicians in some better-paid specialties. Increased workload is another. Primary care physicians say that they are working harder to meet their payroll and still maintain their income despite lower rates of payment. As compared with physicians in the past, many young physicians want more time with family and seek a relatively circumscribed professional life. Many physician groups have reorganized practice to respond to these needs, but it is hard to erase the image of primary physician who is always on call. Satisfaction with practice is falling as the complexity of the primary care physician's work day increases. Although the length of the primary care office

encounter has actually increased slightly between 1989 and 1998 (5), physicians report that increasing administrative requirements and the needs of sicker patients leave less time for talking with patients about their lives.

Revamping reimbursement for primary care services might solve many of the problems of primary care, but the realities of U.S. health care expenditures suggest that change is unlikely. U.S. expenditures on health care are unprecedented in world history, in large part because a prosperous public wants all the benefits of medical science when they are unwell. The twin engines of capitalism and science ensure that we will always have a steady stream of medical advances. As long as the country tries to keep a lid on expenditures for health care, physicians will compete with health technology for limited dollars. In an accompanying editorial, Ginsburg (6) discusses the recent history of payment for primary care services and its future prospects. Perhaps primary care physicians will experience small financial gains if payment policy starts to support innovations in providing medical care. However, solutions to the problems of primary care are more likely to be found by re-examining how the profession relates to the public (7).

How can primary care restructure itself to be more responsive to patients and more attractive to in-training physicians? While the basic mission of providing accessible first contact, comprehensive, and continuing care remains the bedrock of primary care, the profession must respond to societal changes.

One critical societal change is the emergence of a public that is increasingly well informed about its choices. This trend has its counterpart in health care, as many patients want to play a more active role in defining their care needs. Showstack and colleagues (8) discuss one of the most exciting concepts articulated during the primary care conference: active patient-physician relationships in which the patient often takes the initiative or engages in shared responsibility for decisions that the physician alone once made. Primary care physicians must sit at the table with patients and start to define strategies that respond to the need for consumer participation and choice in health care.

Another societal change is the emergence of an older population that carries an increasing burden of chronic disease. This burden will increase as medical technology makes it possible to survive acute exacerbations of chronic diseases. The article by Anderson Rothman and Wagner (9) describes a strategy for chronic disease management. Subspecialists and primary care physicians have complementary roles to play in this vision of chronic disease management. A recent

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article provides evidence to support this view: The outcome of postmyocardial infarction care was better for patients for whom both primary physicians and subspecialists provided care than for patients seen by specialists alone or primary physicians alone (10). The reform of primary care must include a more systematic approach to coordinating chronic disease care.

Primary care needs help if it is to re-form itself. I identify four principal points of leverage that primary care leaders must engage: health care system executives, medical school deans, legislators, and the public. Professional organizations can promote professionalism (7) and sustain excellence through continuing medical education, but durable change will require action by local leaders.

Health care executives are important because local circumstances shape the culture of medical care. The large organizations that employ an ever-increasing proportion of the physician workforce will shape the mission of its primary physicians. Executive leaders can promote the mission of primary care, or they can tolerate primary care as necessary but a threat to profitability. I hope that these leaders will take a page from the playbook of successful patient care

organizations. We asked the CEOs of Kaiser Foundation Health Plan, Group Health Cooperative, and Denver Health to tell us about the mission of primary care in their organizations. Everyone should read these brief statements. They show that primary care is an integral part of the corporate strategy of three highly successful patient care organizations.

Medical school deans are also key players in the reformation of primary care. Inui and others feel that the leaders of medical education must become advocates for primary care (11). Someone will have to talk with the deans because it appears that many of them have forgotten primary care. Deans bear responsibility when primary care faculty have heavy teaching assignments but no salary support for teaching, when promotion criteria don't reward teaching and clinical excellence, and when practice group directors marginalize a sector of the faculty because their practices require subsidy. If the deans don't act decisively, the faculty will impart the message of the "hidden curriculum" of medical school: "primary care no, subspecialties yes". Deans have a remarkable opportunity for leadership if they recognize their key role in shaping our nation's medical care workforce to avoid a shortage of primary care physicians.

State legislators can influence deans by their role in shaping the state's share of medical centre budgets, and they can create incentives that would improve primary care. Who will galvanize legislators into action? The public. According to surveys, the public wants primary care (2). However, the public probably does not know that primary care physicians will be in short supply because of an expanding population in need, declining student interest in primary care, and migration of primary care physicians to other careers. Patients must realize that their access to primary care is in danger, and they must act to

protect their interests.

Yet, patients are unlikely to rally for primary care unless primary care physicians rally for them. Primary physicians and their colleagues must take the first step. They must somehow find the time to know their patients better as people, respond to patients who want to be active participants in their own care, and improve chronic disease care. Some practices are building a system of primary care so good that patients really notice the difference. Some of their satisfied patients may speak their mind about primary care. Some health care executives, deans and legislators may listen. This story has a promising beginning, but I don't know how it will end.

You finish the story.

Harold C. Sox, MD  
Editor

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We asked the CEOs of three large, mission-driven health care systems to describe the role of primary care health professionals in their organizations. Their responses affirm the central role of primary care. They also provide clues to these organizations' vision of the primary care of the future and what they are doing to prepare.

—The Editors

#### DENVER HEALTH

Denver Health is a large integrated public safety net system. An integral component of this system are the 10 family health centers and 13 school-based clinics located throughout Denver's underserved neighbourhoods. The mission of primary care health professionals in this system is to provide high-quality care for acute and chronic illness as well as preventive health care. They also assess which patients will

benefit from additional care from specialists and coordinate that care. We staff these clinics almost exclusively with internists, pediatricians, family physicians, nurse practitioners, physicians assistants, child health associates, and housestaff. In addition to playing a critical role in creating a healthy community, our primary care providers enable Denver Health to have a successful Medicaid managed care product, teach the next generation of health care providers, and engage in meaningful health services research. The vital roles played by primary care providers will continue into the foreseeable future.

Patricia Gabow, MD

CEO and Medical Director, Denver Health, Denver, CO 80204

#### **GROUP HEALTH COOPERATIVE**

Group Health Cooperative is a non profit health care system that coordinates care and coverage. It includes hospitals and medical centers, an associated 1050-physician group practice, choices of different health plans, a research centre and a charitable foundation.

Primary care physicians have long played a central and integrative role at Group Health Cooperative. They are "there" for their patients through a whole host of life and medical experiences, from birth to death. Most individuals want and benefit from the continuity of having a personal physician who knows them and their health history. Primary care physicians are broadly trained to provide care as well as to help their patients navigate through increasingly complex medical options, subspecialty care, and the growing sea of health information. Rapidly developing new technologies at Group Health provide exciting new ways to enhance the partnership between personal physicians and their patients. These advances include secure electronic messaging between physician and patients and the development of on-line guidelines, protocols, and other clinical resources. The primary care physician plays a pivotal role in achieving Group Health's purpose of transforming health care: partnering with our members to ensure that their care experience responds to their needs.

Gary Feldbau, MD

Medical Director, Group Health Cooperative, President, Group Health Permanente

#### **Cheryl M. Scott, MHA**

President and CEO, Group Health Cooperative, Seattle, WA 98121

#### **KAISER PERMANENTE**

At Kaiser Permanente, our primary care providers work together with our specialists to deliver a coordinated, quality health care experience for our members. In most cases, our primary care physicians, nurses, nurse practitioners, and physician assistants are organized into formal patient-care teams, which provide the best of both worlds†—the ability to deliver best-practice medicine while building strong, consistent patient-provider relationships.

As we move forward into the new world of computer-supported care delivery, the role of primary care providers will be even more important. As the number of people with chronic conditions increases, the ability of primary care to intervene early in disease management, to promote patient self-care, and to apply the best in medical evidence will be paramount. An automated medical record that will provide optimal data to the care provider at the site and point of care will play a central role in supporting providers as they grapple with these challenges, reduce medical errors, and raise the bar on health outcomes. The ideal primary utilizer of that care-enhancing technology will be our frontline physicians and primary care staff. Kaiser Permanente is committed to fully implementing a system for all of its providers over the next few years.

Greg Halvorson

Chairman and CEO, Kaiser Foundation Health Plan, Inc., Oakland, CA 94612

## **NEXT ISSUE:**

### **Conference Proceedings**

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# MEMORIES OF A GENERAL PRACTITIONER

## Down memory-Lane

Dr Arjun Singh  
General Practitioner,  
Sigatoka

I recall at the age of 10, a moth crawled into one of my ears, fluttering and giving me discomfort, I was escorted to the old dispensary at Koromumu Hospital, Sigatoka in 1948.

The good doctor, Seruvatu Ilikimi walked down the hill from his residence to the dispensary where some 30 patients had gathered. I recall those faces gleaming to see him; an angel has descended, bringing relief and good tidings.

Fascinated I was by the long white coat with the stethoscope dangling around the neck. I pondered could I wear it one day?

### Early Days

My father came to Fiji from Hoshiarpur, Punjab India in 1906, with his uncle to farm cane land in the district of Ba where he worked for him for some two half years. He later moved to Sigatoka where in company of three other Sikhs started their own cane farming and prospered through hard work.

When he left India he had only one pound in his pocket. My mother who was born in Ba later moved to Sigatoka with his family. We were five brothers and two sisters presently I have one elder brother and younger sister, alive.

School began at the Methodist Primary School in Sigatoka. My father admitted me to the school at the age of 4, to find that his son didn't learn much. I was at Methodist till 1947 and I continued my last 4 years of primary education at St. Joan of Arch School from where I went to Natabua High School for 3 years and did my Senior Cambridge Examination.

After completing high school with a Senior Cambridge Certificate my ambition to become a doctor persisted. During my secondary school years, I wrote to many universities overseas. In 1957 I wrote to Sydney Boys High seeking entry to qualify to enter Sydney University. I did indicate to them the need for accommodation. The high school wrote back. They could not find a place at the school but sent my letter to External Affairs, which looked after Asian students under the Colombo Plan.

Within 2 months I had a school to go to, accommodation was found and a visa was issued to study in Australia. I completed my secondary school at Randwick Boys High School, Sydney from where I matriculated to study medicine at Sydney University for my M.B.B.S.

The annual fee for High School was \$12.00 (six pound), which included supply of all textbooks. Full board then cost \$8.00 per week (meals, board, laundry)

### University days

My father was in sound financial position to get me educated in Australia although it was not expensive those days, as it is today. As students we were able to work during our holidays. I was fortunate to work for 3-4 weeks at the GPO Martin Place until Christmas Eve and then Bus conduct-



ing from January till start of the University. This I did for five years of my university days.

University fees were only 300 dollars (150.00 pounds) per year and one has to pass all required subjects. Failure of any one subject meant repeating that year.

As there was only matriculation (arts/

science) for enrolling into University lots of students enrolled in the medical faculty. There were 800 medical student doing 1<sup>st</sup> year medicine with me. Only 350 passed. Failure rates were high. Those days there not many Fiji students at the "Sydney University". Those few that were there were doing Medicine or law. One was studying for pharmacy and we had one who was doing Veterinary Science under Fiji Govt Scholarship. The Ramrakhas had graduated, Dr Yusuf Hussain from Ba was doing his finals and Drs Ram Pal Singh, SB Kashyap Ali Sahu Khan, Kam Young were my seniors. The University of Technology, currently the University of New South Wales had some Fiji students enrolled in optometry, electrical trades courses, television courses and radio repairing. Most girls were doing Nursing. There were some stow aways who were married to aboriginal girls to remain in Australia. We formed the first Fijian Association of NSW. The social gathering gave us the opportunity to eat a good goat curry, which was brought from Forbes, in NSW by our student surveyors, purchased at 18 shillings. There were other students in Brisbane and Melbourne.

I did my internship at Prince Henry and Prince of Wales. After six months of surgery I wanted to become a Pediatric Surgeon and worked at the Prince of Wales pediatric section. I met Dr. Sharma (CWM) who was attached to the hospital for some three weeks, doing pediatrics.

My father died in 1966. I came to Fiji for a few months to sought out his estate. I took up the practice of Dr Keating Clay who wanted to go for a long overdue vacation to Canada. The practice blossomed and my few months turned to 36 years. I am still here.

### Practice in Fiji was challenging.

It took me several months to learn the colloquial language. Often it was frustrating to find out what they really meant. Embarrassing as the colloquial lingo had vulgar connotations too.

Mind you, English is so simple. A classic example was when women referred to vaginal itchiness as "DEHI KHAJUWAI" literally meaning itchiness of the body. There are many other bizarre names for symptoms. It was a steep learning process, which was mastered in a short time.

### 1966-1990

I started my practice late 1966 having registered myself with the Fiji medical Council. I dived straight into private practice and did not, unfortunately work in the Fijian hospital system. The consulting fees then was one dollar (ten shillings). My high school mate Raghwan Mudaliar had opened up a pharmacy in Sigatoka by then and Sigatoka now had two general practitioners and a Pharmacist.

In early seventies with the development of hotels on the coral coast, I became consultant for nearly all the hotels then, as my senior colleague Dr Cecilia Hands wanted to take things easy. I became Resident Doctor for the Fijian Hotel in 1972 where I lived for some 19 years and retired in the year 1990 to continue my practice in town.

Much later Dr. Michael Reddy who started a practice joined us but this was taken over by Dr Avinash Naidu who is still practicing in Sigatoka. Michael Reddy migrated to Tasmania. Dr. Mahend Singh next joined us for some 10 years, later migrating to Sacramento U.S.A. where he has a flourishing practice.

Dr. Nisha Hanif and Dr Ram Raju set up practices in Sigatoka but left to go to Australia and Nadi respectively.

Dr. Arvind and Sneha Tiwari took over from Dr. M. Singh. They moved to Queensland, Australia not too long ago. Drs (Mr. and Mrs.) Gerona resigned from hospital to start up their practice in Sigatoka and are still around, since 1990. Dr. Dasi has taken over from Dr Tiwari and is the other colleague in town. Dr. Senivalati also started up a practice in Sigatoka in 1983 but rejoined the public sector, 6-8 months later. Sigatoka town has five general practitioners working now.

### Ruminations

My 35 years in Sigatoka took me to many remote areas as far as Durumoli, up valley Rd., Serua, Momi and Nabitu to do calls and at times payments included more of kind than cash. Nevertheless it was satisfying to be able to help the poor ones.

My practice grew as years went by and between Dr. C. Hands and myself, we were looking after the people of Sigatoka district, possibly a radius of forty-miles from town. I had two half days off (Wednesday and Saturday) and Dr. Hands had 1/2 days on Tuesday and Thursday in Sigatoka town.

### Frustrations in general practice.

The frustrating aspect of doing private practice was the animosity shown by hospital doctor's and nurses to patients referred for investigation or further management (although the hospitals consultants were very helpful and obliging). Patient were snarled at, and told off when some of the hospital staff found that they were being treated by general practitioners. I am happy to say that over the years this attitude has changed. The general practitioner have taken a big load of overworked hospital medical staff.

I have another disappointment when I first

started to practice in Sigatoka. Dr. S. Lomani who was then the SDMO at Koronunu Hospital allowed me to treat my patients at the Sigatoka Hospital. This arrangement suited me and took load off the SDMO. Unfortunately a colleague reported this to Dr. Gurd. Dr. Lomani was also taken to task.

### WHO Fellowship

#### China, here I come.

In 1983 I was offered a WHO fellowship to study Acupuncture at the Nanjing College of Chinese Traditional medicine, China. Though skeptical about poking needles to cure ailments, I decided that I would take the opportunity to visit China and study alternatives medicine. Acupuncture study was fascinating and puzzling. The physiology relevant to acupuncture was completely different to what was taught to us at medical school however it did make sense. Acupuncture definitely has a place in our therapeutic Armour.

In my experience (although limited) it is amenable to some 15 or so diseases, which can be cured, or symptoms can be alleviated. It gives excellent relief to people suffering from rheumatism, migraine and acute pains.

The 3 1/2 months sojourn to China was an exposure in itself. It gave me the opportunity to visit places like Nauru, Guam, Saipan, Philippines, China and Hong Kong. We also had opportunity to stay at Beijing (Peking) for 1 week and visit the Great Wall of China and many other important places. Our study took place at Nanjing (old Nanking) where we spent our 3 months to study acupuncture. The Japanese ravaged Nanjing in the 2<sup>nd</sup> World War (1942).

Few experiences in China are worth noting.

1. Witnessed craniotomy, thyroidectomy done under ACP. Anesthesia —using points on the Ears. Ear is depicted as a whole body (fetal with head presentation).
2. That patients carried their medical records with them and entries were made for Diagnosis or treatment on the booklet and returned to them (Saves Medical record).
3. That both husband and wife equally shared all the household chores. One could see men washing clothes in a tub on the footpath and tending to the baby.
4. That they ate boiled eggs which would had formed an embryo (7-10 days gestation) - No Cholesterol only protein.

Most Chinese lived in communes and shared toilet facilities. Interesting feature was a large pond where all sewerage drains into, and the pond had fish and ducks in them. The water is also used to irrigate vegetable patches. The stench was everywhere.

### Generalist in the Community

Being a local boy, I had to indulge into lot of other community activities and have been rewarded for my input. I had a very busy life as a doctor, family and man and have been involved in civic and social activities. I often reflect to say that I have spent a lot of time in committee meetings but it has been gratifying.

# Eli L centres

# Lilly spread

### The Present

I have slowed down now, almost semi retired. My children, one son is living in Sydney for the last 12 years and my daughter (M.D—Internal Medicine) is working for University of Illinois Hospital in the United States. Medical practice in a small country town with limited facilities for medical seminars' or Post Graduate teaching almost makes one feel inadequate. Reading journals helped us, as did attending Sydney University refresher courses. Now we have mini seminar journal clubs, visiting lecturers to enlighten us with new developments in medicine.

### The Future

The Private Medical Practitioners of today scattered through out various districts and suburbs are better equipped to cope up with the demands for comprehensive medical services to the community.

With few facilities and limited ongoing post-graduate education one had to rely mainly on clinical acumen for the diagnosis and treatment. The formation of the College of GP's and great emphasis on Continuing Medical Education through various seminars peer and journal clubs the medical providers of today are better positioned to look after the health of our communities.

It would be nice to get all practitioners under the banner of the college of GP and the official recognition of the college by Govt. is long over due. All medicos, private and those with the medical departments should work together to provide the best medical care for our community as all Doctors where-ever their practices might be, should have a good rapport among themselves to give the sick ones the best of treatment.

### Conclusion

Over the years I have come across many patients and made acquaintances with a lot of people in the Nadroga area. The privilege to serve them

has been an honour and medical practices in Sigatoka in the last 36 years have been gratification and very pleasant.

### Dedication

I met my wife Manorama in Sydney where she was studying towards a secretarial course at the metropolitan Business College. We got married in Sydney and our son was born there. My wife worked as a receptionist for three years when I started my practice in Sigatoka in 1966. I must say that all my involvement's in civic, educational and other social activities has been possible through my wife's support. A lot of time has been spent in committee meetings.

Thank you Manorama.

Author detail  
Dr. Arjun Singh  
G.P. Sigatoka

Dr Singh has had a long association with Sigatoka Town Council and served as mayor 87-89, 93-95.

He has been involved with the Consumer Council of Fiji, Nadroga Football Association, Sigatoka Crippled childrens Society, Cuvu College, Rotary Club of Sigatoka.

In recognition of his civil, social and community services, he has been honored with the following awards.

- i)Justice of Peace (1989)
- ii)Office of the Order of Fiji (1991)
- iii)Commissioner of Oaths (1996)

## Cialis information for Fiji

Approximately 150 million men worldwide sufferer from some form of erectile dysfunction.

- Cialis represents an effective and safe new treatment option for ED that is already addressing a current unmet need in the market place.
- Based on Cialis' 36-hour period of effectiveness, it is unique among PDE5 inhibitors. Cialis is an important step forward because, unlike the short-acting PDE5 inhibitors, it allows couples to enjoy a more normal sex life given that they can once again "choose their moments" for intimacy.

### Cialis Efficacy and Safety

To date, regulatory authorities in the EU, New Zealand, Australia and Brazil have concluded that the benefit/risk profile of Cialis is favorable. The safety profile of Cialis has been established through clinical studies involving more than 7,800 patients.

The safety and efficacy of Cialis is well established. Integrated analysis of five randomized clinical trials; Brock GB et al Efficacy and safety of tadalafil for the

treatment of erectile dysfunction: results of integrated analyses. Journal of Urology 2002; 168: 132-1336

### Efficacy

Cialis 20mg is the recommended dose.

The efficacy results for the 20mg group were as follows.

81% of men reported significantly improved erections

75% of intercourse attempts were successful

59% of men achieved normal erectile function scores whilst taking Cialis 20mg

**"Safety results.** All doses of tadalafil were well tolerated over the dose range. The most frequently reported treatment emergent adverse events were headache and dyspepsia", "These events were mostly mild or moderate and decreased in frequency with continued treatment in most patients. The rate of discontinuation due to adverse events in the tadalafil group was 2.1% compared with 1.3% in controls".

# A THEORETICAL APPROACH TO PAIN

## We avoid touching hot objects for fear of torment from burns

Rajeshwar Sharma, Suva

### ABSTRACT

Although pain is vital for existence, it does not always correlate proportionately with pathology. In an attempt to expound the psychosomatic processes, this paper propounds that the neural impulses give rise to perpendicular electromagnetic waves that are phased and stored by glial cells. The amplified waves are retrieved in accordance to the principle of hologram and interphased to interact with Consciousness Devices to generate feelings. Accordingly four factors – reflexive baser, augmentation from memory, controlling actions and activity of Consciousness Devices – determine perception of pain. The article employs this model to elucidate several pain producing phenomena such as phantom limb, chronic, organic, and psychogenic pains.

### INTRODUCTION

Pain; the spectrum of unpleasant sensations—from trivial discomfort to intractable agony—is absolutely essential for existence because it is the cardinal alarm system of the body. Akin to fire alarms, pain alerts us of danger. Without this unpleasant sensation we would not have early warning of life threatening situations such as acute appendicitis, myocardial infarctions, ruptured ectopic pregnancies and the like. At the same time, the threat of soreness helps prevent tissue damage. We avoid touching hot objects for fear of torment from burns, for instance. Apprehensiveness of unwanted feelings also improve patients' compliance. Finally, the threat of mental anguish enables us to maintain optimal social bonding. On the whole, pain is paramount for health.

Yet pain does not always correlate proportionately with tissue damage. Research has shown that at least fifty percent of patients who present with aches do not have significant pathology (Egan 1998). Further evidence of only 40-60% success rate in chronic pain management to purely medical treatment, (Weiten 1984) supported by personal experience of blotting out a minor affliction—an injured toe, for example—to attend to an emergency, reveals that psychosomatic factors play a pivotal role in feeling soreness. Indeed, all painful disorders fall within an imagined spectrum in which at one end tissue damage produces, reflexively, proportionate distress and at the other extreme, no identifiable pathology can be pinpointed. Simply put, intricate mental processes determine the ultimate perception of pain.

This paper overviews the theoretical aspects of pain. It attempts to postulate a mechanism for conversion of neural impulses into perception of the unpleasant feelings. Various organic and non-organic pain phenomena are also explained.

The paper concludes that understanding pain processes will be beneficial in future research and clinical medicine.

Nerves and Synapses: From Nociceptors to Brain.

Our bodies are infiltrated by billions of nerves that carry external and internal environmental data from every part of the soma to the brain. Stimulation of specialized nerve endings (Nociceptors) by substances such as prostaglandins (Youngson 1992) and

over stimulation of all sensory receptors, produces pain. From the affected sites messages are transmitted to the brain via neurons. The way these specialized cells conduct impulses is well known.

Above a certain threshold, stimulation of the axon alters its membrane's permeability and allows sodium ions to move inside. The result is an increase of the outside electrical charge to +40 from -70 millivolts. (Rathus 1997).

This initiates rapid polarization along the nerve, allowing the electrical impulse to be transmitted to the end of the axon. In myelinated axons the impulse jumps from node to node with resultant increase in speed from 2 to 225 miles per hour. Although each neuron transmits electrical impulse of the same strength (All or None Law), they may fire at variable frequencies. (Rathus 1997). Thus a stronger stimulus will lead to more frequent firing. When the electrical impulse reaches the end of the axon, it stimulates release of chemical messengers or

**neurotransmitters** that determine transmission of message across the synapses to the adjacent nerve cells. There are two groups of neurotransmitters. (Hilgard et al 1975). The first group includes acetylcholine, adrenaline, noradrenaline and the like. This group excites adjacent neurons.

Dopamine, GABA, endorphins serotonin and other such neurotransmitters, on the other hand, inhibit transmission. As a consequence of these two groups, excitatory and inhibitory pathways transpose modulated information throughout the entire body.

### PAIN PROCESSES : From Nerve Impulses to Pain

An intriguing question is frequently asked by academics: How does the nerve impulse result in perception of pain? A possible mechanism is propounded by Baser-Hologram Theory of Brain Function. This theory proposes that the electrical impulse of the neuron gives rise to perpendicular electromagnetic waves (Fig.01). The propagated electromagnetic waves are taken up by the surrounding glial cells – astrocytes in particular—that amplify the waves and store them at subatomic levels in special proteinous structures.

The amplified electromagnetic waves are retrieved and projected to form holograms. These 3D projections interact with specialized corti-

cal neuro-glial complexes (collectively called Conscious Devices) to give rise to awareness of pain, emotions, thoughts, senses, sense of self and other psychological phenomena. These processes – encoding, storage and recall are, of course, part of memory.

The amplification of electromagnetic waves is not unlike Laser (Light Amplification by Stimulated Emission of Radiation, Youngson 1992). However, unlike Laser; that is limited to visible light waves, the brain waves include a very wide range of electromagnetic waves. Nevertheless, we can call brain wave production as Brain waves Amplification by Simulated Emission of Radiation or Baser.

Like Laser, the phased brain waves (Baser) have two distinct characteristics. First, they both follow a well defined pattern of projection. Thus, the stored baser are retrieved in accordance to a unique configuration called principle of Hologram. This principle is stated as;

Contact a small part, any part, even a single wave, and the entire will be retrieved instantly together with all the closely related holograms.

Pain, emotions, thoughts, mental images, memory and other cognitive processes are made up of amplified electromagnetic waves. Logically they all follow the principle of Hologram. For example, when we think of someone special, that person's 3D image is projected instantly. The baser that construct the beloved's hologram interact with our Consciousness Devices to make us feel wonderful. Almost simultaneously other intimately associated memories inundate us! Indeed memory recall and other psychological phenomena are based on principle of Hologram.

The second notable feature of amplified electromagnetic waves is that they have a very high concentration of energy. Laser's ease of slicing steel demonstrates the power of phased waves. The concentrated brain waves can easily explain the curiosities of intense feelings (pain and emotions), arousal, motivation and multifarious mysterious, often supernatural-like, powers such as the impetuosity of psychotics, the boundless seemingly never-ending vigour of maniacs and precipitate unpremeditated stoutness of a meddling mother who performs a miraculous feat to save her child by lifting a car single handedly. Most importantly, the brain is powered by amplified electromagnetic waves.

As mentioned above, these baser interact with our consciousness Devices to generate awareness. Within certain limits our awareness is directly proportionate to the strength of baser. We begin to feel someone's touch above a certain threshold, for example. Moreover, as the strength of stimulus increases the sensation intensifies. That is, we begin to feel irritable in response to stronger baser generation. At the same time, we feel pain, anger, fear, sadness and other negative emotions with increased strengths of phased waves. Even more intense baser results in agony. Finally, above a certain limit the over-powering baser causes the Reticular Activating System (RAS) to shut down our Consciousness Devices.

In this model pain is proportionate to the intensity of the amplified waves but not necessarily equitable with the intensity of stimulus or tissue damage. That is, pain need not have a linear correlation with tissue damage. This is because the ultimate perception of pain is dependent on four factors. These are;

#### 1. Reflex pain

At the most basic level neural activity is directly proportionate to the strength of the stimulus. A larger injury, for instance, causes much more pain than a smaller one. This reflex pain generation is naturally pre-programmed in our genes.

#### 2. Augmentation from memory

All amplified electromagnetic waves generated by the brain are stored in glial cells. They are part of memory. This means that everytime we feel pain the baser that produce pain are stored. In future they will be retrieved in accordance to the principle of Hologram.

It follows that all our past pains —felt or not felt—are potentially retrieval. That is, any reflex pain will instantly recall the stored pain. These memory pains augment the reflex baser. In other words, a very small injury or tissue damage can cause very intense distress in those people who have undergone past traumatic experiences.

#### 3. Controlled Pain

The stimulus that induces reflex generation of baser also activates several controlling mechanisms that modulate the final amplified wave generation. There are many controlling pathways throughout the Nervous System. Spinal gates (Melzack 1980), Thalamus, Reticular Activating System (RAS), Septum of the Limbic System, Regulator Pathways of Cerebrum, (Hilgard et al 1975) and Consciousness Devices are prominent examples of modulating mechanisms. They are based on inhibitory synapses.

Besides suppressing reflex impulses, these devices also modulate retrieval of intense baser from memory. Their effect, therefore, is also based on principle of Hologram. A doctor's reassuring words, for example, initiate holographic recall of the patient's courage-baser. This positive emotion helps balance distress likewise; placebos, acupuncture, massage, cold sprays and electrical stimulation of the skin all exert their effect by activating the controlling neurons.

Interaction of the three —reflex, augmentation, and controlling mechanisms—give rise to resultant baser. It is this final set of amplified electromagnetic waves that interact with consciousness devices to give rise to the perception of unpleasant sensations.

#### 4. Consciousness Devices' Activity

The final determinant of perception of pain is the activity of a group of closely integrated neuro-glial complexes located throughout the cerebral cortex but concentrated in the frontal lobe. The activity of those consciousness devices varies widely; from minimal activation in the fourth stage of sleep to maximum in hyperalert furore. Furthermore, the activity of these devices

varies from moment to moment and is principally dependent on the activity of RAS that itself relies on the intensity of the resultant baser.

As illustrated in Fig 02, we begin being aware of pain beyond a certain threshold. As the intensity of resultant baser increases we feel more pain. In other words the spectrum of unpleasant sensations — from discomfort to agony — is explained by increasing arousal of consciousness devices from escalating resultant baser.

However, beyond a particular threshold our RAS switches off consciousness (Woolridge 1968 in Hilgard et al 1975) This means that even though there are massive amounts of resultant phased waves we do not feel pain because we are either numbed or unconscious.

Severe stress, for instance, can leave us dazed, confused, and emotionally paralysed. A very strong punch also may not be felt if our RAS shuts down our consciousness devices. Nevertheless, the massive resultant baser continue to be stored in our memory. These repressed waves are retrieval in accordance to the principle of Hologram and if not adequately modulated they will influence future perception of pain.

#### **Pain Phenomena: From Organics to Psychogenic**

The ultimate perception of pain is from the resultant baser's interaction with our consciousness devices. The resultant amplified waves are determined by control of augmented reflexive impulses. This model can be used to explain a wide variety of painful conditions. Let us consider three cases that exhibit similar severity of anguish

a) AM: age 41 yrs, severe epigastric pain, endoscopic diagnosis: Large duodenal ulcer

b) BL; aged 39 yrs, severe epigastric pain endoscopic diagnosis: minimal gastric erosions

c) CK, aged 38 yrs, severe epigastric pain, extensive investigations do not reveal any pathology.

Obviously these cases, despite similarity of severity of suffering, do not have equivalent pathology. They demonstrate the variable influence of the four factors that determine the eventual perception of unpleasant sensations. Since AM has a significant lesion, we can conclude that a large portion of his pain occurs reflexively from the organic pathology. On the other hand, BL's minimal lesions do not correlate proportionately with her pain. This implies that most of her pain is from her memory. Likewise CK's pain can also be explained in terms of augmentation — in accordance to the principle of Hologram — from stored baser. Both BL and CK must have undergone past traumatic experiences and their controlling devices are no longer able to cope with the painful memory recall.

#### **Organic Pains: Acute and Chronic**

Although we attributed AM's ulcer pain predominantly to reflex generation of baser, this is strictly factual in only acute cases. On the whole, in acute cases of organic pathology the severity of distress is primarily equitable to the extent of

tissue involvement. Nevertheless, the other three factors — augmentation from memory, effect of controlling systems, and activity of consciousness devices — also play a role in all cases of pain. These four factors interact to give rise to diverse pain sensitivities not only amongst different individuals but also in the same person at different times.

In contrast to acute lesions, the contribution of pain from memory begins to take a greater role in long standing afflictions. As the impulses from an affected site get converted into amplified waves they keep getting stored in the glial cells. In other words, these baser become part of memory. In chronic cases this leads to hypertrophy of the affected neuro-glial complexes and their substructures such as mitochondria, sodium-potassium pumps, Neuro transmitter devices and so on. At the same time, the controlling mechanisms will attempt to suppress the pain. The final outcome is ultimately dependent on the ability of the controlling systems to overcome the pain producing baser that comes predominantly from memory.

#### **Thoughts, Feelings, and Cognition: Stress – Distress Syndrome**

Pain is constructed of intense amplified waves. These baser also give rise to strong feelings such as anger, fear, sorrow, guilt and the like. Moreover, these phased electromagnetic waves also make up thoughts. It follows that patients who are in pain also experience intensively negative feelings and have predominantly negative thoughts. If uncontrolled, they cause stress. Furthermore, if the pain is not reduced the cognitive processes compound to give rise to distress. Conversely, stress-distress syndrome worsens the perception of pain. In short, intense baser is central to pathophysiology of mental processes.

#### **Phantom Limbs: The Ghost who comes back**

The case of John's Phantom Limb can now be easily explained. During the accident the vast stimuli reflexively generated an enormous amount of baser; so intense that John's RAS had to shut off his consciousness devices. However the amplified electromagnetic waves were stored in his glial cells. The operations that followed added to the bank of intense baser. Nevertheless, as he recovered, John's controlling mechanisms began to overcome his pain and eventually he was weaned off the pain-killers. He went home from hospital without his left leg a fortnight later. Years later, John still feels pain in his Phantom Left leg. The stump has healed but the pain, which is accompanied by anxiety, is real enough.

Phantom limbs are classical validity of Baser-Hologram Theory of Brain Function; demonstrating clearly the reflex, augmentative and modulated memory processes. Recall of pain and negative emotions as well as the presence of the amputated limb show the holographic nature of memory. The ultimate fate of pain is dependent on the interaction of retrieval and control mechanisms. If for instance, John's controtendency of the traumatic event, he will eventually be able to lead a symptom-free life. On the other hand, if his modulating mechanisms do not inhibit the retrieval of baser from the accident, he will develop

psychological problems. The involved neuro-glial complexes and associated circuits will hypertrophy. As a result he will be miserable; almost always in pain; angry for little or no reason; and depending on the predominant baser, develop one of the wide range of disorders. Needless to say, the pain of Phantom Limb is a stored pain.

Indeed all past traumatic experiences have the potential to augment present time pain. The whole or part of the past event is holographically recalled and re-experienced and as expected, intensively negative feelings (pain and emotions) and thoughts accompany the abnormal recollections. In severe cases Post Traumatic Stress Disorder (PTSD) ensues (Weiten 1984).

Several traumatic events such as rape, homicide exposure, physical assault, victimization, war, fire-fighting (Rathus 1997) lead to PTSD. A similar model of unmodulated retrieval of intense baser is operational in heart-breaks, bereavement and childhood trauma caused by serious illness, severe injuries, physical and/or sexual abuse and the like. The past event may or may not be remembered but still affects present sensations. The resultant psychological disorder will depend on the most prominent recalled baser. If the principal retrieved amplified waves cause pain, the affected can experience pain without pathology or psychogenic pain.

**Psychogenic Pain: The Demons Identified**

Almost every doctor remembers a patient who had severe – usually recurrent – pain but despite extensive investigations, no pathology could be identified. This is typical of Psychogenic Pain Disorder. It's pathophysiology is very simple. The patient has a lot of stored pain-baser in his or her memory. In other words, such patients underwent severe traumatic experiences in the past. At present their controlling mechanisms are not able to modulate the retrieval of stored baser. In particular, they will experience pain when they are stressed since impact of very intense amplified electromagnetism reduces the action of the


controlling systems.

**Conclusion**

The mental processes involved in pain as well as the disparity between perception of distress and pathology can be explained by Baser-Hologram Theory of Brain Function. In this model four factors —reflex impulses, memory, inhibitory synapses and consciousness — ultimately determine the perception of pain. Unpleasant sensations result when neural impulses are converted into amplified electromagnetic waves that interact with consciousness devices to give rise to awareness. Since these waves also make up all cognitive processes, pain is closely associated with intense negative thoughts and emotions. Moreover, pain is stored in memory. Understanding these processes will help in management of pain and provide impetus for future research.

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# COUNSELING DRUG ADDICTS

**It does not, of course, mean that it is not an adult problem.**

Many psychological aspects of drug addiction represent non-adjustive behaviour that some individuals resort to. Broadly speaking, the reactions of drug addicts fall under the category of character disorders. In the last three decades, phenomenon a very serious threat to order and society's survival. Hence it demands urgent consideration. In the early decades of the twentieth century, alcoholism posed a serious social problem and usually involved adults and older persons. Now drug addiction has taken roots among adolescents and youth. It does not, of course, mean that it is not an adult problem. Those who pick up this habit choose a path to destruction.

Over the last three decades, there has been a sea change in the socio-economic conditions of the youth all over the world. They are becoming highly politicised. Owing to defective economic planning and educational policies, more and more youth are dropping out of schools and colleges and ending on streets. More youth are becoming unemployable, either because they have no proper education, or they are disillusioned because the education they have received was not designed to equip them with skills or competencies for the employment market. Naturally, there is growing frustration. Those who are in schools and Universities are losing faith in the value of the education system. They are also exposed to other tensions and stressors present in the society, owing to socio-economic and political factors. Youth are becoming alienated. They have strong feelings of 'anomie'. Some begin to experience identity crisis and further develop feelings of distress. All these factors lead to unrest, stress and even depression. This restless state of mind often makes these youth weak and vulnerable who fall into the company of 'already' drug users. In course of time, they become drug users themselves and victims of drug addiction. There is no escape for them. These drugs become a means to escape feelings of void and helplessness. Those initially attracted to the thrill of drugs soon become addicts and helplessly dependent. They develop a sense of craving heightened states of anxiety and physical suffering.

The youth is not altogether to be blamed for this state of affairs. In our rapidly growing society, no one has the time to lie down if feeling unwell. People want instant relief and therefore swallow one pill or another. Most of us find it difficult to get relief from our tensions and anxieties through self-discipline. We find it easier to swallow pills, even if they give brief or temporary relief. We are developing an increasing inability to tolerate even small amounts of physical and emotional discomfort. Modernised urbanized societies look for painless life at the cost of freedom.

In the initial stages, drugs provide the kind of experiences youth crave for. Many produce severe emotional and psychotic reactions. They make the users progressively depressed and bring about severe physiological states of drug-craving which make them want more and more. They will get drugs any possible way they can, thus leading to criminal activities. Sometimes an entire society is left to a state of delinquency. It is necessary that effective steps are

taken to prevent drug abuse and to wean the drug addicts from their use.

Modern youth live in an age of accelerated technological advancement, social upheaval, family breakdowns and religious turmoil. They are being given increased freedom and encouraged to become independent. Sometimes this freedom is not only undesirable but also dangerous. This situation arises from misconceptions regarding child-rearing methods. Much of the information is contradictory and sometimes even inimical because it is inappropriate. Confusion concerning the best type of child-rearing technique leads to feelings of uncertainty, helplessness and inadequacy. For example, we are told that to spare the rod is to spoil the child. We are also told that too much discipline kills initiative and affects the personality development. Thus the problem of balance between freedom and restriction has not been solved. Too much permissiveness is as bad as too many restrictions. The adults are unsure of themselves as to how far they must go with regard to giving freedom or restricting it. Children under such circumstances grow up with no inconsistent pattern of adult behaviour. This unconsciously encourages deviant, excitement-seeking behaviour. For various reasons, especially political, organized religion has lost ground to technology. Religion, unfortunately, is looked upon suspiciously and is charged with being retrograde and failing to keep pace with modern needs, attitudes and values. Consequently, modern men turn inwards or outward toward society, but they do not see the need to turn upwards. The loss of importance of symbols, authority and established conventions and traditions appear to have abandoned the youth to arbitrary modes of behaviour, which can be at times, inconsistent and often irrational. The young today find themselves living in a void without personal involvement and a sense of belonging. Drugs come to fill that vacuum and become a means to gain a sense of belonging and to escape from the sense of alienation. A number of young people are becoming so excited with speed that they seek drugs that provide them the 'kick' they seek. Some drugs lead to hallucinations and paranoid states. In other cases they even produce a disorientation of time and place and cause amnesia as the effect wears off.

Continued use of drugs can cause permanent brain damage and serious personality changes.

The dynamics of drug addiction are complex and not fully understood. However, a number of socio-cultural and psychological factors have been emphasised. The personality traits of addicts suggest impulsiveness, rebelliousness, dependency, etc. As a group they are characterised by low frustration tolerance, inability to endure tension and exhibiting feelings of inadequacy and self-devaluation. Many addicts are immature and dependent individuals who have unrealistic levels of aspirations and are unable to face failures. And thus they begin using drugs for their insecurities, anxieties and tensions.

Treatment on a psychological level involves personality assessment which focuses on the individual's present mental state and on personality and emotional stress in the development of the disorder. The assessment requires interviews and the use of

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psychological tests. Information regarding marital, occupational and other relevant data concerning the individual's life situations obtained from family and other sources and this is picture is used as a basis for understanding and providing appropriate treatment for the disorder. Treatment may involve medical, psychological and sociological procedures. Medical treatment involves drug therapy. Although it is effective in alleviating some neurotic and psychotic reactions, it does not, however, lead to the resolution to inner conflicts or personality change. Therefore, there is often a relapse when treatment is withdrawn. Psychological treatment fall under three categories:

1. Supportive Psychotherapy aims at helping the individual feel more adequate to face his problems confidently.

2. Behaviour Modification aims at modifying the individual's maladaptive behaviour through the substitution of better coping techniques.

3. Re-educative Psychotherapy helps gain an insight into oneself so that he/she is able to modify and/or change wrong assumptions and attitudes. It is also necessary to deal with the person's social environment. Conditions of stress in the person's life situations that interfere with his changes should also be modified. In most cases, changes in family situation help make more effective adjustment possible.

An effective programme of treatment should include medical, psychological and sociological approaches. Psychological preventive measures need attention in public education, concerning the detection and correction of pathological tendencies

at the earliest stage. Rehabilitation of drug addicts is of vital importance. Psychological and sociological measures have to play an important role in this regard.

#### SUMMARY

i) Family therapy consultation is counselling with families in small groups. The counsellor initially meets the families individually and later brings them together for family group consultations. The families are introduced to each other by the counsellor. Usually the families meet for 8 to 12 sessions and gain from discussing each other's problems and finding solutions to them.

ii) Many parents and caregivers sometimes experience some difficulties. They are often inexperienced and uninformed. Counselling with parents is an important area. Most parents fail to understand and appreciate the limitations and difficulties of their children. This leads to disappointment on their part and emotional tensions. Parents should be helped to become more sensitive to their children's problems and to gain insights into such issues so that they can better understand the problems.

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## ABSTRACT

# TOURIST HEALTH PROBLEMS SEEN IN A G.P. SETTING IN FIJI

### Introduction

As part of the Diploma in Travel Medicine Course (University Of Glasgow 2000-2001), a research project was undertaken on the topic "Tourist Health problems Seen in a G.P. setting in Fiji.

### Aims ... Objectives

- Look at incidence of major ... minor disorders among visitors to Fiji.
- Study pattern of diseases seen in the clinic during office hours compared with problems encountered during house calls, often after hours.
- Profile of tourist numbers arriving in the Country, nationality etc.

### METHODOLOGY

Study type†—Retrospective, descriptive, cross sectional study.

Two years Data analysis from 1<sup>st</sup> January 1999 – 31<sup>st</sup> December 2001. The study population/sample comprised all tourist patients presenting in the author's clinic or as house calls.

### RESULTS

In the two year period, a total of 1,605 patients were seen, either in the clinic or as house calls. House calls numbered 890 (55.45%) and those seen in the clinic were 715 (44.54%). This represents 0.84% or close to 1 patient per thousand visitors (from an estimated number of visitors during this period of study in this locality). Highest number of patients were from Australia (18.5%) closely followed by

New Zealand (18.19%). Third highest was USA with 9.3%, followed by Japan, UK and Canada.

Two hundred and thirty three cases (14.5%) of acute gastroenteritis were seen which represent the single most common condition. Gastroenteritis or Traveller's Diarrhoea was also by far the most common condition for house calls (19.3%). Otitis Externa (9.4%), Otitis Media (8.7%) and Ear Wax (7.4%) were the next most common conditions. The other significant conditions were pharyngitis (6.6%) and skin infections (6.4%).

### SUMMARY ... CONCLUSION

No vaccination is required for visitors to Fiji and Fiji is relatively free of exotic diseases that is endemic to many tropical areas.

Disorders of the Ear and Traveller's Diarrhoea was found to be the commonest causes of morbidity in this study.

This study has defined the wide range of illnesses in a diverse group of visitors to Fiji. By understanding the disease pattern of travellers, the travel health provider or Family Physician can better counsel patients and emphasis the prevention and care of diarrhoeal diseases, ear disorders etc.

Fiji is certainly not a high risk destination and most visitors to Fiji remain healthy and fit. Early and prompt treatment of ear disorders, travellers' diarrhoea and other conditions will allow the visitors to enjoy their holiday and return home safely.



