## THE FIRST CLINICAL SKILLS SHORT COURSE FOR FAMILY PHYSICIANS IN MYANMAR

BY DR CHARLOTTE YUNG

The first clinical skills short course for family physicians was jointly organised by Myanmar Medical Association and the Singapore Medical Association in Yangon from Sunday 16th January to Tuesday 18th January 2000. The aims of the course are to expose family physicians to the spectrum of clinical illnesses, to hone their clinical diagnostic skills as well as to strengthen the warm friendship between the doctors of Myanmar and Singapore.

The 18 participants of the course comprised both Myanmar and Singapore doctors. The 11 doctors from Myanmar have just passed their examination for the Diploma in Family Medicine after a one-year full time study. The Singapore attendees are first and second year MMed (Family Medicine) trainees. Six are from the Private Practitioner scheme and one is a MOH trainee.

### An intensive programme

The three-day programme comprised two mornings of clinical work in Medicine and Paediatrics at the Yangon General Hospital from 8 am to 1 pm and three afternoons from 2 pm to 5 pm for General Surgery at the same hospital, orthopaedics at the Yangon Orthopaedic Hospital and O & G at the Yangon Women's Hospital.

Cases worked out by the various departments were presented for discussion. The attendees were then taken through short cases by the joint faculty of Myanmar and Singapore teachers. In addition, for Medicine and Paediatrics, Myanmar and Singapore participants were grouped together to clerk 6 different long cases, some of which were selected for presentation to the whole group.
There was also a clinical attachment to GP clinics in the evening for the Singapore doctors.

### A rich trove of clinical materials

We were presented with a rich trove of clinical materials as the faculty from Myanmar took pains to select a very good mix of cases for this course. Diseases that are very common in Myanmar like TB, Rheumatic heart disease, malaria and malnutrition were shown. We saw cases of PTB, disseminated TB in a child and Pott's disease of the spine in both an old man and a young healthy looking lady. There were 2 babies that had severe protein and vitamin malnutrition and presented with rickets and bilateral kerato-malacia. We were also shown rare cases, like a 28-year-old lady with a fungating growth in her cervix that turned out to be TB.

Some cases had atypical presentation. There was the man who suddenly became restless and irrational. Clinically, he had low grade fever, a tinge of jaundice and some resistance to head flexion. A diagnosis of cerebral malaria was made based on the history of travel to a known malarious area and treatment with I/V quinine was instituted immediately. Blood film later confirmed the presence of falciparum malaria. We learnt that malaria does not always present with fever and chills and hence the importance of taking a good history of travel. This is relevant to us in Singapore in view of the large population of foreigners and Singaporeans who travel.

We had the opportunity to elicit many classical text-book signs in the short span of two and a half days viz. MR, MS, TR and pansystolic murmurs, tracheal shift, bronchial breath sounds, pleural effusions and thickening, enlarged livers, neck lumps, poly-hydramnios, ovarian cyst, various skin rashes including Henoch Schonlein purpura to mention a few. We would have to spend weeks if not months in the wards in Singapore to see the constellation of these signs. We also saw a patient with cardiac beri-beri presenting with acute pulmonary odema.

### Lessons learnt

These were lively sessions led by the faculty from both countries. Besides discussing differential diagnoses and proper examination technique, disease patterns in both countries were compared.

We saw first hand the ravaging effects of poverty on health and disease sequelae, for example, children with closed fractures developing osteomyelitis and septic arthritis because of delayed treatment and haematogenous spread of bacteria from their skin infections.

Medical facilities are also stretched in this vast country and patients have to travel 2 to 3 days for specialist care in Yangon. As a result, they present in ways different from those seen at home.

### A GP in Yangon

This being training for family physicians, the course would not have been complete without our GP attachment. The Singapore doctors, both trainees and faculty, were divided into two groups and sent to observe various GP clinics. To me, this was the greatest eye opener.

The GP I was attached to was Dr Myint Oo. He runs his clinic in a suburb of Yangon, with his charming wife as the dispenser. His clinic is housed in a wooden building. His in-laws live behind and his sister's dental surgery is next door. His waiting room is small with chairs spilling out onto the pavement. The consultation room is also very tiny, with just enough room for an examination couch, a writing desk and some shelves. It was quite a squeeze when Drs Henry Yeo, Pat Lee, Kala and myself went inside to observe his practice.

We were there for his evening clinic and he had a steady stream of patients coming in. Unlike GP practice in Singapore, there was not one single case of URTI and patients were more sick and presented with more challenging medical problems.

He saw patients with fever that he diagnosed as malaria or typhoid. There were many hypertensive and diabetic patients with complications. One diabetic patients was a traditional Indian medicine practitioner who refused to have his gangrenous toe amputated. He was valiantly treating it with

traditional medicine as well as insulin. It apparently was healing. The doctor pointed out the scars on the body of a patient who had smallpox as a young man. It was the first time we had seen this.

He also had “exotic” cases: 2 young men had multiple sinuses and abscesses of their foreskins of their penis because of repeated self-injections with some sclerosing agent from Thailand. He also showed us patients with glass beads called “goli” implanted in their prepuce. These men or their partners, tire of their “goli”, would go to Dr Myint for removal. He has a whole collection of them in a tin. We were each given one “goli” as a souvenir.

**A Karen housecall**

The highlight of our evening was when we accompanied Dr Myint on a housecall. He was asked by his former teacher, a spritely 73-year-old Karen lady to see her 75-year-old sister at home because of body ache. These two single ladies live together in a tiny wooden house in the “Karen Compound” which reminded me of a kampong. Both sisters spoke beautiful English and Drs Pat Lee and Kala who had taken their Diploma in Geriatrics last year had no problem performing a mental assessment in English. We agreed the patient had Alzheimer’s disease. We could not offer any dramatic treatment but I think our visit cheered them both. They thanked us by singing graceful Myanmese songs to melodious tunes from an ancient piano.

**Why Myanmar?**

People have asked me why I needed to travel so far for a clinical course. Some are also taken aback that we had to go to a developing country to learn medicine.

My answer is simple. We are family physicians going back to the basics and upgrade our clinical skills. Further, attendance at a clinical course is a prerequisite for the private practitioner stream for the MMed examination. There are rich clinical materials in Yangon and we have more opportunities to examine patients. The patients are very patient and obliging. Mothers did not object to groups of doctors examining their crying babies and pregnant ladies did not mind being examined by doctors.

Although we may not see the same type of cases in Singapore, the techniques of history taking and examination are the same. As trainees who may not have the opportunities of seeing many patients with abnormal clinical signs in our daily practice, but yet have to be adept at eliciting such signs in our coming exam, this course is a boon. In fact, the main grouse we had was that it was too short.

The Myanmar faculty were excellent teachers and took the trouble to select good cases for us. We did not have to pay for the course as all the teachers, both from Myanmar and Singapore gave of their time and energies gratis. We must also acknowledge our gracious hosts from the Myanmar Medical Association who took such good care of us.

A final word on the Myanmar doctors’ dedication to upgrading themselves. Private practitioners in Singapore who feel virtuous in doing the 2-year part-time Family Medicine MMed course are put to shame by our Myanmar counterparts who had to take a whole year off from their practice to obtain their Diploma in General Practice. The fact that all of us trainees want to return yet again to Myanmar if another course is organised is proof that this course is a resounding success.

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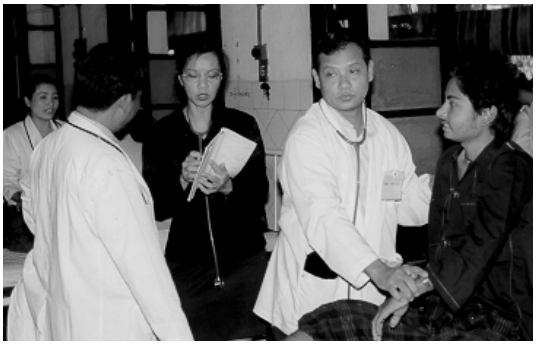
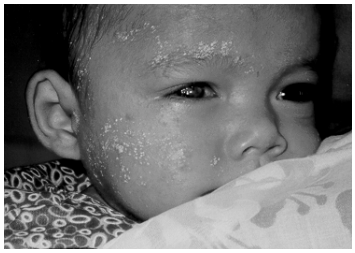
The 7 FM trainees from Singapore are Drs Adrian Tan Kok Heng, Alan Chin Yew Liang, Michael Wong Tack Keong, Kwong Kum Hoong, Patricia Lee Sueh Ying, Kalaimamani d/o Kanagasabai and Charlotte Yung. The Singapore teaching faculty and SMA official delegation comprises A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean, Drs Henry Yeo, Yue Wai Mun and Wong Chiang Yin.

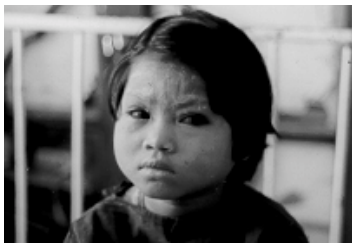


Clerking cases in the wards with fellow family medicine doctors from Myanmar.

Group photo at the Orthopaedic Hospital.



Vitamin A Deficiency - Kerato-malacia, hyperkeratosis and xerosis of skin.



Whooping Cough - paroxysmal stage with bulging blood-shot eyes, venous distension and congestion of head and neck.

Learning from a patient the art of preparing face cosmetic from tanaka roots. From left: Drs Charlotte Yung, Patricia Lee and Kalaimamani.

The Karen sisters and Dr Myint Oo singing a Myanmese song.

The 'tau-huay' from a Yangon Chinatown street vendor tastes as good as that back home.