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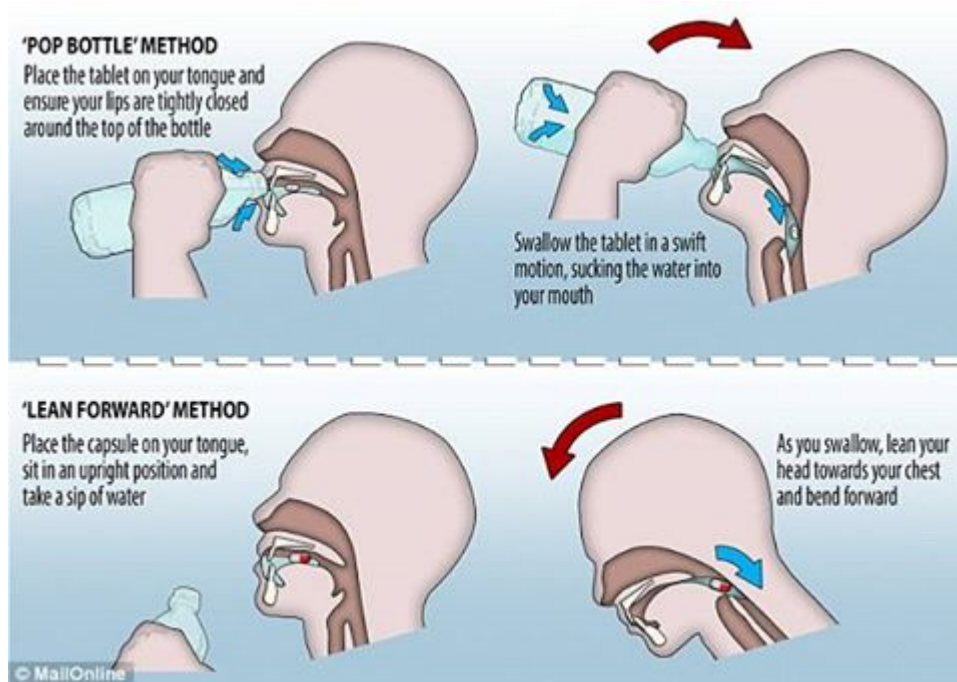
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How to swallow tablets and capsules!!!

Both tablets and capsules (also called pills) are oral solid dosage forms. There are many ways people swallow pills. Some take a mouthful of water first and throw the tablets/capsules in the mouth and swallow. Some throw the pills in the mouth first, then sip some water and swallow.

Research says that one in three persons had the difficulty of swallowing tablets with water or other drinks. I also have seen many people struggle to swallow a tablet or capsule with water. Some researchers of Heidelberg University of Germany have discovered the best way to to swallow tablets and capsules. According to the results of their study involving 151 adult volunteers, they have found that “Pill bottle” method is the best way to swallow a tablet. In this method the tablet should be placed on the tongue and a sip of water (around 20 ml/ 4 tea spoons) should be sucked from a bottle and swallow it quickly.

On the other hand, for capsules the “Lean Forward” was found to be the best. In this method, the capsule should be placed on the tongue first, then take a sip of water (around 20 ml/ 4 tea spoons) from a bottle or glass and then bent your head forward and swallow it. As the capsules have the tendency to float on water, many people cannot swallow them properly and sometimes it may got stuck on the throat.



The article was published in last year in the Annals of Family Medicine. Here is the link for your further reading : <http://annfammed.org/content/12/6/550.full>

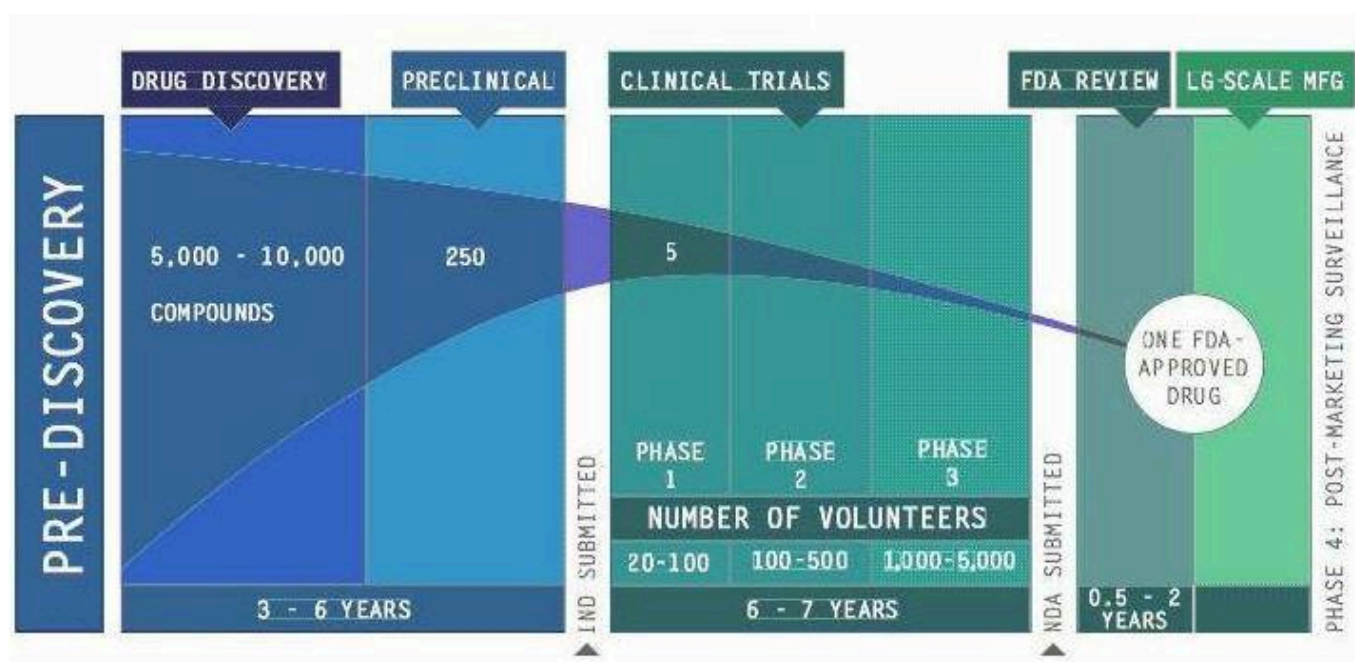
Learn to make life easy!!

Stages of New drug development

Development of a new prescription drug by an innovator company is a matter of huge investment. Currently it costs about 2.6 billion USD which is equivalent to more than 200 billion Bangladeshi Taka (1/15th of total budget of Bangladesh). Not only this huge money which is invested, it takes about 10-15 years to come to the market from its initial stage of development.

After a new potential compound is discovered or synthesized, it goes through pre-clinical investigations in test animals

such as mice, rabbits, dogs etc. After confirming its safety in animals, it enters into clinical trial stages which occurs in four phases: Phase -1, 2, 3 which involves human volunteers and phase 4 in which drugs are monitored in the market after large production. The total process of a new drug development is a combined effort of drug discovery scientists, doctors, pharmacists, nurses, technicians, social workers and most importantly the human volunteers to receives the novel drugs inspite of potential risks.



The top pharmaceutical companies which invest in new drug development (also called innovators) include Pfizer (USA), Novartis (Switzerland), Sanofi (France), Roche Holding (Switzerland), Merck and Co. (USA), GlaxoSmithKline (UK), AstraZeneca (UK), Eli Lilly & Co. (USA), Abbott Laboratories (USA) etc. (named according to their net market capitalisation, assets, sales and profit).

Due to the huge investments needed the large local pharmaceutical companies in our country such as Square, Beximco, Incepta etc. are not currently investing any money in drug development process. They only develops formulation, manufacture and sell pharmaceutical dosage forms. However, we hope in future they will also be able to invest in research

and drug development.

Are the cough medicines waste of money?

Getting coughs and colds during winter is very common in adults and children during the winter. If you get colds with cough, you may want to go to doctor or pharmacy to get some antibiotics and cough suppressant that contains dextromethorphan. Antibiotics are useless in treating coughs as it is mainly caused by virus which the antibiotics cannot kill. So what about popular cough medicines such as dextromethorphan containing syrups?

Last year, the NHS of the UK declared that cough medicines are waste of money as the medical evidence behind them is very "weak". Now, they recommend honey to treat coughs both in children and adults. Their recommendation is based on a clinical trial done in the USA in treating nocturnal coughs in children. They found that honey is much better than dextromethorphan!!!

So, what should we prefer in Bangladesh- honey or cough medicines?

Honey is very cheap here in the UK. A 500 ml jar of pure honey will cost you 2 pounds only (240 Tk; 50 Tk/100ml) whereas a 100 mL dextromethorphan syrup costs more than 4.5 pound (500 Tk approx.). This is just the opposite in Bangladesh. You will get a 100 ml dextromethorphan syrup with only 20-35 Tk, however, a 500 ml honey (purity cannot be assured) will cost you at least 300 Tk (approx 60Tk/100 ml). So, in terms of

price, honey is costlier than cough syrup in our country. It's really surprising!!

Now, what will you use to treat cough? I think still honey is preferable due to its safety.

Dextromethorphan is not recommended in children under 12 years of old in the UK as the pediatric dose for this drug has not been established properly. It may cause sever side effects in young adults that may lead to death. So, for children honey is the best and safest option. According to NHS, a mix of lemon and honey in hot water is the best to treat cough using home remedies.

But remember that don't give honey to children less that one year old as there is a risk of botulism!!

Source:

<http://www.nhs.uk/news/2007/December/Pages/Honeysoothescoughs.aspx>



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A medical revolution

Bangladesh, a country of 161 million people, only has 0.4 physicians for every 1000 people. By contrast, in India, this figure is 0.7 for every 1,000, and in the UK, 2.8, France 3.4, and Italy 4.1. The initial picture tells us that we need to double the number of doctors available in the country if we wish to have a ratio close to India and 10 times the figure to match the developed world.

The number of doctors available in the country is concerning, but the issue of paramount importance is our pathway to producing good specialist doctors who would be instrumental in delivering the health care needed in Bangladesh, especially now, after successfully meeting the Millennium Development Goals.

I, myself, am a Colorectal Surgeon at Bart's and the Royal London Hospital with specialisation in managing colorectal cancer.

Almost 90% of my clinical work is related to colorectal cancer management. Working for the Royal College of Surgeons of England and Bart's and The Royal London Hospital, England. I also head RAHETID – a pioneering Regional Partner Institute and Hospital of RCS England in Bangladesh for the Region of South-East Asia.

As the head of the institute, my role is to ensure high

standards of medical education with support, assistance – both academic and technical – and anything else from the Royal College of Surgeons of England and NHS Institutions like the Bart's and The Royal London.

Under my leadership, the institute would offer a structured training program of the Intercollegiate Surgical Curriculum Program of the UK Royal College of Surgeons, with the opportunity of two years of salaried sub-specialty training in the UK.

This would facilitate a professional qualification to practice as a senior surgeon by Non-European Union Medical Graduates in their home country such as Bangladesh.

The UN's General Assembly, in September 2015, adopted 17 Sustainable Development Goals (SDGs) to be achieved by the year 2030. In its 17 declared SDGs, after "No Poverty" and "Zero Hunger," the UN puts "Good Health and Well-being" as the third most important goal.

While an integrated, well functioning, and prepared primary health care system will no doubt play a vital role in the achievement of SDGs, it is important to understand that the global health focus in recent years, on individual diseases and delivery of health care only through this system, may have underestimated the value of the development of co-ordinated surgical services.

Especially when there has been marked demographic transitions, shifting the major causes of death and disability.

Bangladesh has demonstrated significant success in terms of primary health care, sometimes referred to as the "Bangladesh miracle" – strong health gains with relatively few funds.

The joint donor funded Health, Population, and Nutrition Sector Development Program led by the government of Bangladesh has contributed to significant improvement in a number of very

important health indicators. The country has improved in women's education, economic conditions, and life expectancy.

Bangladesh has duly been applauded and accredited by the international community for its progress in the Human Development Index, associated with more robust gains than some of its neighbours with higher per capita income, like Pakistan or India. Bangladesh's improvement in health through the Millennium Development Goals, is no doubt very impressive.

However, the 20th century revolution in health, and the consequent demographic transition that the world has witnessed, has resulted in a major shift in causes of death and disability from infectious diseases to non-communicable diseases such as cancer, injury due to road traffic accidents, pregnancy-related complications requiring surgical intervention, heart disease, and so on.

Sadly, a number of factors not unique to Bangladesh are causing serious stagnation and, in fact, is preventing us from reaping the benefits of health care achievements made in the 20th century.

The major causes of death changed globally to new epidemics of non-communicable disease and injuries with the average age of death rising steadily, challenging the finances and capacities of health systems. We in Bangladesh now need significant numbers of properly trained specialists who would be able to deliver cancer care, manage injury and rehabilitate victims of injury, obstetrics and gynaecological surgery, major cardiac and diabetic medical and surgical care, together with anaesthetic care support.

Investment in the development of infrastructure and structured curriculum-based training of specialist doctors can no longer be delayed and definitely cannot be ignored.

Without urgent and accelerated investment in surgical scale-up, low and middle-income countries will continue to have

losses in economic productivity, with an estimated cumulative loss of \$12.3 trillion (economic loss in productivity due to cancer and injury is estimated at \$11.5tn) between 2015-2030. This loss, is in contrast, double the World Bank's estimated amount of \$5tn to \$7tn required for achieving all 17 SDGs.

At present, according to the Board of Investment, citizens of Bangladesh spend \$2.5bn dollars (or Tk19,698 crore) in other neighbouring countries every year for health care – almost equal to the estimated cost of the Padma bridge in 2011! If we fail to address the issue with utmost urgency it is again estimated that we will lose 2% of our GDP growth by the year 2030. Is it not time that we wake up to the reality and plan to invest in the proper development of our much-needed health care?

Fit to be a doctor(If we wish to have better doctors, some changes need to be made in how we train them)

Only recently, our honourable Health Minister Mohammad Nasim declared a radical change in the system of training doctors in Bangladesh. Instead of one year, doctors after MBBS, will have to go through two years of internship training program.

This decision must be applauded, and credit should go both to the prime minister, who dreams of an exemplary health care for her population, and the health minister himself who executes the plans to carry out that dream.

Some have raised concern, my belief is, due to the gap in communication in understanding the enormous benefits imparted by changing to two years of internship on the quality of doctors, provided that the further comprehensive way to train doctors in the developed world is followed now without further delay.

Getting a medical degree (MBBS) in the developed economies is just the beginning of medical education. Training continues, taking at least five years to become a general practitioner and 8-10 years to become a hospital consultant.

Bangladesh's health care sector has arrived at a crossroads. The phenomenal success in primary health care, the "Bangladesh Miracle," has resulted in the demographic transition that requires our doctors to be trained in the way of the developed countries' training methods.

There is no scope of the argument that Bangladesh is still a developing country and therefore needs short-cuts in producing doctors. Because our success in reducing infant mortality, combating communicable diseases (such as polio, diphtheria, diarrhoeal diseases), and the astonishingly successful improvement in other health indicators, mean we are now threatened by the same diseases like those in the West: Cancer, injury, complications of pregnancy, heart disease, diabetes, and so on.

A comprehensive, structured training process must be in place to ensure that sufficient number of doctors are available in Bangladesh, who are capable of combating these new health threats for our survival.

The system of training doctors in Bangladesh is mainly an individual effort of the doctor – ambiguous, erratic, baffling, vague, and most importantly unstructured, lacking in direction and vision. This is the reality, despite the determination and efforts of the government for the last few

years, to provide the best health care to its population for the 21st century.

Any doctor wishing to practice as an independent practitioner in Bangladesh, be it as a general practitioner in the villages or as a specialist in major hospitals in rural and urban settings, without exception will have to undertake further training.

Today, I shall try to throw some light on the training system of doctors in the UK to either become general practitioners in the community, that falls under primary health care or to be specialists in hospital practice under secondary and tertiary health care systems.

First, let's see what the doctors' regulatory body in the UK requires as pre-requisite for the doctors to possess, before they are allowed to take care of their patient independently and without direct senior professional supervision:

The General Medical Council of Great Britain comprehensively defines a doctor as someone who makes the care of her/his patients the first priority.

Someone who is competent, armed with the required knowledge, skills, and attributes, capable to establish and maintain good relationships with patients and colleagues, honest and trustworthy, and acts with integrity and within the law.

A good doctor must be competent in all aspects of his/her work, including management, research, and teaching – taking every step to monitor and improve the quality of work in order to provide a good standard of practice and care, adequately assessing the patient's conditions, taking account of his/her history (including the symptoms and psychological, spiritual, social, and cultural factors).

Their views and values must have the consent or other valid authority to perform, when necessary, examination of the

patient, investigations, or treatment that serves the patient's best interest.

In providing clinical care, a good doctor must prescribe drugs or treatment only when he/she has adequate knowledge of the patient's health and is satisfied that the drugs or treatment serve the patient's needs based on the best available evidence.

After MBBS, each doctor has to complete a two year generic Foundation Training Program that forms the bridge between medical school and specialist/general practice training – similar in principle what Mr Nasim is proposing regarding the internship program years. The F1 and F2 provide trainees with opportunity to gain experience in a variety of specialties and health care settings.

What the honourable health minister does not propose, but is essential that he does, is the subsequent training program for doctors in Bangladesh to prepare them for the responsibility of providing appropriate care for the deadly diseases of today.

After successful completion of the Foundation Training Program, doctors are awarded the Foundation Achievement of Competence Document (FACD). They are then able to go on to training in a chosen specialty, or general practice (GP) training.

Training program differ in length and structure according to specialty: General practice lasts three years and other specialties can last five to eight years.

Length of training can also depend on the rate of achievement of competencies.

In order to enter into specialist training in Medicine (ST3 level) a doctor passes the MRCP Examination and to enter into specialist training in Surgery (ST3 level) a doctor passes the

MRCS Examination. MRCS/MRCP are essential post-graduate qualifications required before entering the UK specialist training program.

MRCS and MRCP both are examinations – a doctor in the UK will have to pass before entering Specialist Training Program in surgery (MRCS) or in medicine (MRCP). Then doctors in both medicine and surgery are assessed by Annual Review of Competence Progression (ARCP).

When the Joint Royal Colleges of Physicians Training Board (JRCPTB) in case of medicine and the Joint Committee on Surgical Training (JCST) is satisfied that a doctor has achieved sufficient competencies in medicine/surgery to practice as an independent consultant that may take six additional years of training (ST3 to ST8), after MRCS/MRCP examination and entering the Specialist Training Program by competition, the JCST/JRCPTB recommends for award of CCT (Certificate for Completion of Training) to the General Medical Council.

The CCT confirms that a doctor has completed an approved training program in the UK and is eligible for entry into the Specialist Register of the GMC and it is a legal requirement that a doctor practicing as a substantive or honorary consultant in NHS UK holds specialist registration.

It is time that we wake up to the reality of the consequence of our successes in primary health care so far, and plan to invest in proper health care and human resource development – if we wish to prevent death, disability, and further economic loss.

Studying Medicine

Medicine as a career can be vastly rewarding but not without challenges and the life of a doctor can be exceptionally frustrating and at times, very distressful. Pursuing a career in medicine means not only do we have to work industriously for five to seven years in the medical college but then continue with strenuous lifestyle for years faced with yet more grinding training and exams, long hours of diligent duty in hospital wards and helping people through some of the most difficult and personal experiences of their lives.

Life as a doctor has numerous and continued challenges only matched by the positive reasons that medical students commit for choosing an uphill task in medicine. Choice in medical career may be instilled by altruism, because of academic achievement in the sciences, or because of the admiration for relatives or family friends already working in the field but most are also attracted by the potential for a steady career, a healthy income and a respected status in society. Many in the society believe that becoming a doctor is more than a career – it's a life choice and that doctors shouldn't be able to shirk the hard work while keeping the status that doctors command.

Today I shall start with my own experience and reflect on how I became a doctor. In this context I must mention my father whose journey of becoming a doctor ignited my dream of becoming a medical/surgical practitioner. My father, I believe was an exceptional person. When I was 11-years-old, I overheard a conversation between my uncle, my cousin and my father regarding what I ought to do when I grow up. My cousin being at the University of Dhaka insisted that as I am so good in maths, I should become an engineer, my uncle being a civil servant wanted me to be CSP (Civil Service of Pakistan) officer. My father didn't say what he wanted me to be but told me his story of how he was misled into not going to Kolkata

Medical School in early 1940s when he was offered a place to study medicine there. My grandfather died when my father, I think, was only two. My widowed grandmother was an extremely capable and hard working lady who successfully raised her children, making sure at the same time that her farmers who used her land property cleared their taxes in due time, not an easy task for a widowed lady in those days. Once my father was offered a chance in Kolkata to study medicine, my grandmother went to her second cousin whose son was at the time studying in Kolkata. Her cousin laughed at her explaining that living costs in Kolkata and studying medicine were so expensive that she must have been crazy to even dream of sending her son to that city. My grandmother was told that it will be very costly and was misinformed about the tuition costs for studying medicine there, which were a lot more than what it actually required. So she returned home heartbroken and told her son that he was not going to medical school. This piece of history from my father's life made me decide to become a doctor.

When I was only 13-years-old. I was riding on the front bar of a bicycle being paddled by my older cousin. We were headed to my maternal grandparents' house about seven or eight miles from the town we lived in when a bull was racing towards us from the other side of the road. By the time we noticed it, it was too late. I was left unconscious after the collision. Although my family and friends were very worried about me at the hospital, I still remember that there was a surgeon stitching my head wound and I was attempting to scream. Then I looked at him and his calm, composed and confident smile helped me calm down. But a very strange thing kept happening after that day; I kept seeing myself in the surgeon's place every time I thought about it.

People rightly become sceptical of such an exaggerated description of a revelatory moment and the ignited desire to become a doctor or a surgeon to be precise. It is surely not enough to convince ourselves that we have the motivation for

medicine by simply saying that we do.

Enhancing the understanding of the role of a doctor can be achieved through interacting with medical students and doctors, learning from someone's own or close friends' or relatives' experience of being a patient. Hands-on work experience in a caring role such as helping elderly members in the neighbourhood, volunteering in the local hospital or working with disadvantaged children in special schools being set up in recent times can be exceptionally useful in comprehending what a career in caring for people may involve. Taking part in club activities and social events, fund raising campaigns, games and sports and other community activities may contribute to develop useful qualities for achieving a successful career in medicine.

[Professor Raqibul Mohammad Anwar is a practising colorectal surgeon at RAHETID, a global partner organisation of the Royal College of surgeons of England in Dhaka. He also works for Bart's and The Royal London Hospital in England. He is a retired colonel from the Royal Army Medical Corps of the British Army and a convener of examinations and an ambassador of the Royal College of Surgeons of England.]

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PCRC 課程內容包括：基礎醫學、臨床醫學、藥理學、病理學、微生物學、免疫學、解剖學、生理學、生物化學、分子生物學、遺傳學、發育生物學、神經科學、行為科學、環境健康、職業安全、法律醫學、醫學倫理、醫學史、醫學教育、醫學寫作、醫學英語、醫學溝通、醫學團隊合作、醫學領導力、醫學創新、醫學研究、醫學實踐、醫學服務、醫學管理、醫學政策、醫學改革、醫學未來。

MCCQ1 課程內容包括：基礎醫學、臨床醫學、藥理學、病理學、微生物學、免疫學、解剖學、生理學、生物化學、分子生物學、遺傳學、發育生物學、神經科學、行為科學、環境健康、職業安全、法律醫學、醫學倫理、醫學史、醫學教育、醫學寫作、醫學英語、醫學溝通、醫學團隊合作、醫學領導力、醫學創新、醫學研究、醫學實踐、醫學服務、醫學管理、醫學政策、醫學改革、醫學未來。

LMCC 課程內容包括：基礎醫學、臨床醫學、藥理學、病理學、微生物學、免疫學、解剖學、生理學、生物化學、分子生物學、遺傳學、發育生物學、神經科學、行為科學、環境健康、職業安全、法律醫學、醫學倫理、醫學史、醫學教育、醫學寫作、醫學英語、醫學溝通、醫學團隊合作、醫學領導力、醫學創新、醫學研究、醫學實踐、醫學服務、醫學管理、醫學政策、醫學改革、醫學未來。

Specialization) Family Practice) LMCC hospitalist

... LMCC hospitalist ...

BMDC CPSBC (College of Physician and Surgeons of BC) RCPSC (Royal College of Physician and Surgeons, Canada) BCPS The College of Family Physicians Canada.

MBBS International Medical Graduate IMG MCC IMG

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family physician 醫師 醫師 醫師 醫師
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Hospitalist 醫師 醫師 醫師 Hospitalist 醫師 醫師
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2022 年 10 月 1 日開始，所有在 2022 年 10 月 1 日或之前獲得執照的醫生，必須在 2022 年 10 月 1 日或之前，通過 USMLE 的 Step 2 考試，才能獲得執照。如果醫生在 2022 年 10 月 1 日或之前，沒有通過 Step 2 考試，則其執照將被暫停。如果醫生在 2022 年 10 月 1 日或之前，通過了 Step 2 考試，則其執照將繼續有效。如果醫生在 2022 年 10 月 1 日或之後，通過了 Step 2 考試，則其執照將被恢復。如果醫生在 2022 年 10 月 1 日或之後，沒有通過 Step 2 考試，則其執照將被暫停。如果醫生在 2022 年 10 月 1 日或之後，通過了 Step 2 考試，則其執照將繼續有效。如果醫生在 2022 年 10 月 1 日或之後，沒有通過 Step 2 考試，則其執照將被暫停。

對於在 2022 年 10 月 1 日或之前獲得執照的醫生，USMLE 將提供 MCC 執照，以確保其執照在 2022 年 10 月 1 日或之前有效。對於在 2022 年 10 月 1 日或之後獲得執照的醫生，USMLE 將提供 LMCC 執照，以確保其執照在 2022 年 10 月 1 日或之前有效。如果醫生在 2022 年 10 月 1 日或之前，通過了 Step 2 考試，則其執照將繼續有效。如果醫生在 2022 年 10 月 1 日或之後，通過了 Step 2 考試，則其執照將被恢復。如果醫生在 2022 年 10 月 1 日或之後，沒有通過 Step 2 考試，則其執照將被暫停。

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