

fibrocystic breasts can sometimes make breast cancer more difficult to detect with mammography. Therefore, ultrasound may be necessary in some cases if breast abnormality is detected in a woman with fibrocystic breasts. According to the American Cancer Society, fibrocystic breasts affect at least half of all women at some point in their lives. Fibrocystic changes are the most common cause of breast lumps in women between 30 and 50 years old. Tamoxifen therapy also reduced the risk for fibroadenoma and fibrosis compared with the placebo group, the tamoxifen group had fewer biopsies and fewer women who underwent a biopsy for fibrocystic disease, hyperplasia, and metaplasia. This resulted in a reduction in the risk of biopsy in women treated with tamoxifen. This risk reduction occurred predominantly in women younger than 50 years.⁴ While in the past 100 years has introduced a variety of terms to describe the abnormality, a consensus for treatment has developed to treat this significant health problem. Any treatment of fibrocystic breast problem is designed to: 1. alleviate breast pain, 2. reduce or remove irregularity and 3. rule out the possibility of breast cancer. Medical treatment can include: 1. Use of sex hormones (estrogens, progestins, androgens). 2. Pharmaceutical use of vitamins (A, B1, E), diuretics, and tamoxifen (an anti-estrogen). In December 11, 2001, researchers from the National Surgical Adjuvant Breast and Bowel Project (NSABP) Breast Cancer Prevention Trial reported that tamoxifen is well described for its ability to reduce the risk of developing breast cancer by 50% in high-risk patients and apparently also dramatically lowers the risk of developing benign breast cancer.⁴ In a study presented by Tan-Chiu et al⁴ at the 24th Annual Meeting of the San Antonio Breast Cancer Symposium, that treatment with tamoxifen reduces adenosis, cysts, duct ectasia, hyperplasia, metaplasia, fibrocystic disease and other benign mass formation by up to 47%. We considered that use of tamoxifen would result in a reduced incidence of benign breast disease in tamoxifen-treated women. In our study, after 2-4 months with doses of 10-20 mg, we removed irregularities and alleviated breast pain in more than 78% of patients. These findings support the therapeutic effects of tamoxifen on breast fibrocystic changes.

A low incidence of side effects has been reported with tamoxifen, resulting in the proposal to use the antiestrogen as a preventive agent for breast cancer.² Tamoxifen is an effective treatment to control moderate to severe mastalgia and had a reduced incidence of clinically detected benign breast disease.

Received 3rd October 2005. Accepted for publication in final form 4th January 2006.

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Family medicine in Turkey. Need for trainers in general practice

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Growing development of family medicine (FM) in the world revealed the necessity of teaching and learning the philosophy and paradigm of the discipline. With this concern, training the teachers of the FM has become the basic interest of the pioneers of the discipline.¹ The European Academy of Teachers (EURACT) in general practice (GP) supports various training courses.² The objective of the EURACT Teaching the Teachers (ETC) teaching methods in general practice course, which is one of the basic courses of EURACT, is to train peculiar trainers for primary care on the basis of family medicine/general practice (FM/GP) discipline. Family Medicine in Turkey is established as a specialty program in 1985 at the training hospitals of the Ministry of Health (MOH) and spread to universities in 1993.³ Despite many countries, which FM/GP raised on the hands of general practitioners as a new and progressed definition of the discipline, Turkey Specialty Program is established by the government within the preparation in accordance with European community, whereas practitioners had no knowledge on the subject of being a discipline. The word "practitioner" is used for the physicians who works in primary care, without further training after medical school either any specialty including FM/GP or retraining program. However, health reforms in Turkey is also

Table 1 - Distribution of the participants according to their qualifications and working places.

Course	No. of participants			Where they work					
	Family Medicine Specialist	Practitioner	Resident	Total	Family Medicine Department	Hospital	Primary care	Regional Office of Health Ministry	Other
Kusadasi	28	-	1	29	25	2	1	-	-
Cesme	19	15	1	35	10	5	11	5	3
Aydin	4	14	-	18	2	2	14	-	-
Izmir 1	4	16	-	20	-	-	20	-	-
Izmir 2	2	19	-	21	1	-	17	3	-
Izmir 3	-	19	-	19	-	-	16	3	-
Ankara	21	-	14	35	11	5	5	-	-
Istanbul	25	-	2	27	7	11	7	-	-
Total	103	83	18	204	56	25	91	11	3

named as FM reforms, which is basically formed of 3 major parts; general health insurance, privatization, and contractual employment. Using the name FM for 2 new and different issues almost at the same interval caused confusion and chaos regarding what the term is representing for. Many organizations such as Turkish Medical Association and Labor Unions who were against privatization and contractual employment became opposed to FM without knowing the difference between the system and the discipline. This situation became an obstacle for the development of the FM and resulted confusion in understanding even the basic matters of FM/GP. Despite the lack of detailed and consistent policies on this subject, the number of FM specialists gradually increased and started to be recognized in health care provision. Actually, there are FM residency programs at 20 out of 45 medical schools throughout the country, and in 16 training hospitals of MOH, which are localized in 3 big cities.⁴ Although many university FM departments have outpatient clinics, the registered training program based on the training in hospital wards, neglecting the fundamental part of FM training in primary care. Realization of the primary care component of the specialty training requires the preparation of both the primary health care centers, and the teachers practicing in these centers for teaching. However, besides the medical school graduates every year, there are already approximately 35,000 practitioners working in primary care who are expected to be the future family physicians. Due to the huge number of the candidate trainees, MOH have established a short training program that is suggested by WHO.⁵ Since the short training program offered by WHO is mostly based on the teaching in primary care, it raises the need for teachers in primary care. The

changes in the medical education towards student, and community-based formation brought the need for trainers in primary care settings. Since the ETC was constructed on the philosophy and principles of FM/GP discipline, it could be an important and useful tool for removing the ignorance and misunderstandings on FM/GP matters and providing communication among different parties besides training teachers for primary care.

The courses. A total of 8 courses were given in 4 different cities between the year 2000 and 2003. The aims of the courses were to enable participants to assess their own continuing needs as teachers, and to gain the skills required to meet those needs on a continuing basis. Sore throat or hypertension was used as models for teaching, but the course did not target to have medical content. The general strategy and the method of the courses were learning by doing. Due to the different background of the participants, each course was re-formed without changing the fundamental principles, according to needs and expectations of the participants. The features of the discipline and the differences from other disciplines, the concepts such as FM, GP, and necessity for specialty training to work in primary care were the discussion subjects throughout the courses. Each subject was considered as a learning need and formed the structured discussions of follow-up meetings. The last version of the course was translation of the course, not only in the language, but also in needs and necessities of Turkish teachers.

Follow-up meetings. The follow-up meetings could not be performed regularly and systematically in other cities than Izmir due to the limited time of the trainers. We constituted 6 follow-up groups, with 10 participants in each. Four meetings with each of

the groups were conducted by 3 months intervals. At the last meetings, a semi-structured focus groups were conducted, encouraging the group members to share their feelings and thoughts regarding using their teaching skills in their practice and the teaching environment. At the end of each meeting, 2 of the trainers gathered the ideas and feelings of the participants regarding the similar issues from the collected data by thematic analysis. Although the main purpose of follow-up meetings was to share teaching experiences and learning from others, the basic subjects of FM were also discussed. With each group, we focused on 3 main subjects: the origin, philosophy and definition of FM/GP, development of FM/GP in Turkey, and in the world, the clinical method in FM/GP. The short training program was the focus of all meetings. The features of the participants are given in **Table 1**. The results of focus group studies were as follows: most of the participants stated that although they could not use their teaching skills regularly, they use communication skills in their daily lives even at home with their spouses and children. Almost all of them pointed out that there had been significant changes in communicating with their patients. They would listen more and be supportive. They stated that their relationship with subordinates changed, as well; they started to share more, and felt as a team more than they used to be. Although the participants did not have residents to train, they enjoyed using their teaching skills for undergraduate students, which they already have. The teaching environment was depressing, and the primary care setting was not relevant to training. There were too many patients, insufficient equipment, and insufficient or ineffective human force. Trainers were not named officially, and various centers without a communication and collaboration among them organized training activities. All those circumstances together were demotivating and frustrating the trainers. No incentives, no recognition, working harder than others, jealousy of the colleagues, unwillingness of the subordinates to work with them were some of the results of being a trainer in the primary care. They were feeling lonely, and losing self-confidence at their practices, outside the meeting group. They had uncertainty regarding the short training program, the future, the health policies, and regarding the discipline.

The EURACT courses initiated the discussion of where the family doctors in Turkey would place themselves as trainers. Conducting the ETC at the national level brought together various advantages. Talking in native language facilitated improving communication skills by using of metaphors, rhymes as well as voice tone, posture, and so forth. Practitioners and family physicians had a chance to understand how close they are, by sharing their experiences and expectations during the courses, and to discuss different aspects of the discipline and equalize the knowledge, develop common understanding, and generate new ideas. In developing countries, it is not possible to encounter all social, historical and economic factors that transform traditional GP to a discipline. Communicable diseases such as measles, water sanitation, and low-income ratios are still problems in such countries. However, high life expectancy rates, high level patient expectations, usage of high technology exists in the developing countries just as in the developed countries. This situation creates very specific problems for establishing and improving FM/GP in developing countries. That is why we have to use all the tools that we have gotten, by using them for purposes other than they are intended to.

Received 1st October 2005. Accepted for publication in final form 10th January 2006.

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