LOG

RAWALPINDI MEDICAL UNIVERSITY

UNIVERSITY RESIDENCY PROGRAM- 2020 OF DERMATOLOGY

BOOK

RAWALPINDI MEDICAL UNIVERSITY

UNIVERSITY RESIDENCY PROGRAM -2019 LOG BOOK FOR DERMATOLOGY

"Wherever the art of Medicine is loved, there is also a love of Humanity." — Hippocrates

PREFACE

The horizons of *Medical Education* are widening & there has been a steady rise of global interest in *Post Graduate Medical Education*, an increased awareness of the necessity for experience in education skills for all healthcare professionals and the need for some formal recognition of postgraduate training in Internal Medicine.

We are seeing a rise in the uptake of places on postgraduate courses in medical education, more frequent issues of medical education journals and the further development of e-journals and other new online resources. There is therefore a need to provide active support in *Post Graduate Medical Education* for a larger, national group of colleagues in all specialties and at all stages of their personal professional development. If we were to formulate a statement of intent to explain the purpose of this log book, we might simply say that our aim is to help clinical colleagues to teach and to help students to learn in a better and advanced way. This book is a state of the art log book with representation of all activities of the MD Internal Medicine program at RMU.A summary of the curriculum is incorporated in the logbook for convenience of supervisors and residents. MD curriculum is based on six Core Competencies of ACGME ***(Accreditation Council for Graduate Medical Education)*** including ***Patient Care, Medical Knowledge, System Based Practice, Practice Based Learning, Professionalism, Interpersonal and Communication Skills***. A perfect monitoring system of a training program including monitoring of teaching and learning strategies, assessment and Research Activities cannot be denied so we at RMU have incorporated evaluation by ***Quality Assurance Cell*** and its comments in the logbook in addition to evaluation by ***University Training Monitoring Cell (URTMC)***. Reflection of the supervisor in each and every section of the logbook has been made sure to ensure transparency in the training program. The mission of Rawalpindi Medical University is to improve the health of the communities and we serve through education, biomedical research and health care. As an integral part of this mission, importance of research culture and establishment of a comprehensive research structure and research curriculum for the residents has been formulated and a separate journal for research publications of residents is available.

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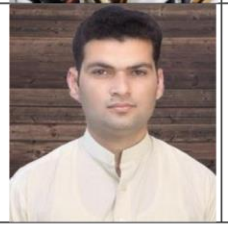
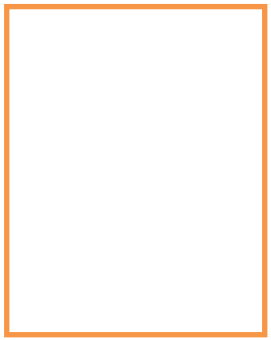
Vice Chancellor
Rawalpindi Medical University
& Allied Hospitals

CONTRIBUTIONS

SR.NO	NAME & DESIGNATION		CONTRIBUTIONS IN FORMULATION OF LOG BOOK OF MEDICINE & ALLIED
1.		**DR SAMIA SARWAR, MBBS. FCPS** Head & Professor of Department of Physiology, Rawalpindi Medical University, Old Campus	Over all synthesis, structuring & over all write up of MD Internal Medicine Curriculum, Log Book of MD Internal Medicine & Allied and also Log Book for MD Internal Medicine rotations under guidance of Prof. Muhammad Umar Vice Chancellor, Rawalpindi Medical University, Rawalpindi. Also Proof reading & synthesis of final print version of Log Books of MD Medicine & Allied and Rotations Log Book.
2.		**DR BUSHA KHAR, MBBS.FCPS** Ex-Professor of Medicine Head Department of Gastroenterology Holy Family Hospital Rawalpindi	Guidance regarding technical matters of Log Book of MD Medicine & Allied & Log Book for MD Internal Medicine Rotations.
3.		**DR MUHAMMAD KHURRAM, MBBS.FCPS** Professor of Medicine Dean of Medicine RMU	Provision of required number of clinical procedures & educational activities for each year separately and rotation of Log Books of MD Medicine & Allied & Log Book for MD Internal Medicine rotation.
4.		**DR FARZANA FATIMA, MBBS** Demonstrator / WMO Medical Education Department Rawalpindi Medical University, Old Campus	Assistance of Professor Dr. Samia Sarwar in formulating the log books & computer work under her direct guidance & supervision.
5.		**MR. MUHAMMAD IKRAM** Computer Operator Physiology Department Rawalpindi Medical University, Old Campus	Assistance of Professor Dr. Samia Sarwar in computer work under her direct guidance & supervision.

ENROLMENT DETAILS



Program of Admission _____

Session _____

Registration / Training Number _____

Name of Candidate _____

Father's Name _____

Date of Birth _____ / _____ / _____

CNIC No. _____

Present Address _____

_____

Permanent Address _____

_____

E-mail Address _____

Cell Phone _____

Date of Start of Training _____

Date of Completion of Training _____

Name of Supervisor _____

Designation of Supervisor _____

Qualification of Supervisor _____

Title of department / Unit _____

Name of Training Institute / Hospital _____

Sr. No	Discipline
1.	*Critical Care Unit (intensive care unit –ICU) & emergency Medicine*
2.	*Coronary Care Unit*
3.	*Ambulatory Medicine*
4.	*Cardiology*
5.	*Dermatology*
6.	*Endocrinology*
7.	*Gastroenterology*
8.	*General Medical Consult Service*
9.	*Neurology*
10.	*Psychiatry*
11.	*Radiology*
12.	*Haem-oncology*
13.	*Infectious diseases*
14.	*Nephrology*
15.	*Pulmonary and Critical Care Medicine*
16.	*Rheumatology*
17.	*Emergency Medicine*
18.	*Geriatrics*
Please write your discipline on the line below: **_____**	

INTRODUCTION

It is a structured book in which certain types of educational activities and patient related information is recorded, usually by hand. Logbooks are used all over the world from undergraduate to postgraduate training, in human, veterinary and dental medicine, nursing schools and pharmacy, either in paper or electronic format .

Logbooks provide a clear setting of learning objectives and give trainees and clinical teachers a quick overview of the requirements of training and an idea of the learning progress. Logbooks are especially useful if different sites are involved in the training to set a (minimum) standard of training. Logbooks assist supervisors and trainees to see at one glance which learning objectives have not yet been accomplished and to set a learning plan. The analysis of logbooks can reveal weak points of training and can evaluate whether trainees have fulfilled the minimum requirements of training.

Logbooks facilitate communication between the trainee and clinical teacher. Logbooks help to structure and standardize learning in clinical settings. In contrast to portfolios, which focus on students' documentation and self-reflection of their learning activities, logbooks set clear learning objectives and help to structure the learning process in clinical settings and to ease communication between trainee and clinical teacher. To implement logbooks in clinical training successfully, logbooks have to be an integrated part of the curriculum and the daily routine on the ward. Continuous measures of quality management are necessary.

Reference

Brauns KS,Narciss E, Schneyinck C, Böhme K, Brüstle P, Holzmann UM, etal. Twelve tips for successfully implementing logbooks in clinical training. Med Teach. 2016 Jun 2; 38(6): 564–569.

INDEX OF LOG:

1. ***MORNING REPORT PRESENTATION/CASE PRESENTATION***
2. ***TOPIC PRESENTATION/SEMINAR***
3. ***DIDACTIC LECTURES/INTERACTIVE LECTURES***
4. ***JOURNAL CLUB***
5. ***PROBLEM CASE DISCUSSION***
6. ***EMERGENCY CASES***
7. ***INDOOR PATIENTS***
8. ***OPD AND CLINICS***
9. ***PROCEDURES (OBSERVED, ASSISTED,PERFORMED UNDER SUPERVISION & PERFORMED INDEPENDENTLY)***
10. ***MULTIDISCIPLINARY MEETINGS***
11. ***CLINICOPATHOLOGICAL CONFERENCE***
12. ***MORBIDITY/MORTALITY MEETINGS***
13. ***HANDS ON TRAINING/WORKSHOPS***
14. ***PUBLICATIONS***
15. ***MAJOR RESEARCH PROJECT DURING MD TRAINING/ANY OTHER MAJOR RESEARCH PROJECT***
16. ***WRITTEN ASSESMENT RECORD***
17. ***CLINICAL ASSESMENT RECORD***
18. ***EVALUATION RECORD***
19. ***LEAVE RECORD***
20. ***RECORD SHEET OF ATTENDANCE/COUNCELLING SESSION/DOCUMENTATION QUALITY***

21.

ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS

MINIMUM LOG BOOK ENTERIES PER MONTH IN GENERAL

(This minimum number is being provided for uniformity of the training and convenience for monitoring of the resident's performance by Quality Assurance Cell & University Research Training & Monitoring Cell of RMU but resident is encouraged to show performance above this minimum required number)

SR.NO	ENTRY	Minimum cases /Time duration
01	Case presentation	01 per month
02	Topic presentation	01 per month
03	Journal club	01 per month
04	Bed side teaching	2 per month
05	Large group teaching	06 per month
06	Emergency cases	1 per month
07	OPD	500 per month
08	Indoor (patients allotted)	1 per month plus participation in daily Morning & Evening rounds
09	Directly observed procedures	6-10 per month
10	CPC	02 per month
11	Mortality & Morbidity meetings	02 per month

MISSION STATEMENT

The mission of Internal Medicine Residency Program of Rawalpindi Medical University is:

1. To provide exemplary medical care, treating all patients who come before us with uncompromising dedication and skill.
2. To set and pursue the highest goals for ourselves as we learn the science, craft, and art of Medicine.
3. To passionately teach our junior colleagues and students as we have been taught by those who preceded us.
4. To treat our colleagues and hospital staff with kindness, respect, generosity of spirit, and patience.
5. To foster the excellence and well-being of our residency program by generously offering our time, talent, and energy on its behalf.
6. To support and contribute to the research mission of our medical center, nation, and the world by pursuing new knowledge, whether at the bench or bedside.
7. To promote the translation of the latest scientific knowledge to the bedside to improve our understanding of disease pathogenesis and ensure that all patients receive the most scientifically appropriate and up to date care.
8. To promote responsible stewardship of medical resources by wisely selecting diagnostic tests and treatments, recognizing that our individual decisions impact not just our own patients, but patients everywhere.
9. To promote social justice by advocating for equitable health care, without regard to race, gender, sexual orientation, social status, or ability to pay.
10. To extend our talents outside the walls of our hospitals and clinics, to promote the health and well-being of communities, locally, nationally, and internationally.
11. To serve as proud ambassadors for the mission of the Rawalpindi Medical University MD internal Medicine Residency Program for the remainder of our professional lives.

CLINICAL COMPETENCIES FOR 1ST, 2ND, 3RD,4TH AND 5TH YEAR MD TRAINEES MEDICINE

CLINICAL COMPETENCIES\SKILL\PROCEDURE

The clinical competencies, a specialist must have, are varied and complex. A complete list of the skills necessary for trainees and trainers is given below. The level of competence to be achieved each year is specified according to the key, as follows:

1. Observer status
2. Assistant status
3. Performed under supervision
4. Performed under indirect supervision
5. Performed independently

Note: Levels 4 and 5 for practical purposes are almost synonymous

PROCEDURES	First Year (after spending 6 months dermatology)								
	6 Months		12 Months		15 Months		18 Months		Total Cases 1st Year
	Level	Cases	Level	Cases	Level	Cases	Level	Cases	
Rotations to be incorporated as and when available with the consent of respected supervisor									
Pleural Aspiration	1,2	6	3	6	4	6	4	7	25
Peritoneal Aspiration	1,2	6	3	6	4	6	4	7	25
Lumbar puncture	1	4	2	4	3	4	4	3	15
Nasogastric Intubation	1,2	12	3	12	4	12	4	14	50
Uretheral catheterization	1,2	12	3	12	4	12	4	14	50
Recording and reporting ECG	1	25	2	25	3	25	4	25	100
Proctoscopy	-	-	1	1	1	1	1	1	3
Endotracheal Intubation	1	6	2	6	3	6	3	7	25
Cardio-Pulmonary Resuscitation (CPR)	1,2	4	3	4	3	4	3	3	15
Insertion of CVP lines	1	4	2	4	3	4	3	3	15
Arterial puncture	-	8	-	8	-	8	1	6	30
Urine Examination	3	1	3	1	3	1	3	1	4

Liver biopsy	1	1	2	1	2	1	2	1	4
Pleural biopsy	-	-	1	1	2	1	2	1	3
Joint aspiration	-	-	-	-	1	1	1	-	1
Bone marrow aspiration	-	-	1	1	1	1	1	1	3
Renal biopsy	-	-	-	-	1	1	1	1	2
Haemodialysis	-	-	1	1	1	1	2	1	3
Upper G.I. Endoscopy	-	-	-	-	1	1	1	1	2
Lower G.I. Endoscopy	-	-	-	-	-	-	1	1	1
Bronchoscopy	-	-	-	-	1	1	1	1	2
Abdominal Ultrasound	-	-	-	-	1	1	1	1	2
Exercise Tolerence Test	-	-	-	-	-	-	-	-	-
Echocardiography	-	-	-	-	1	1	1	1	2
CT Scan Head	-	-	1	1	1	1	1	1	3
EEG	-	-	-	-	-	-	-	-	-
EMG/NCS	-	-	-	-	-	-	-	-	-
Chest Intubation	-	-	-	-	-	-	-	-	-
Pericardiocentesis	-	-	-	-	-	-	-	-	-

PROCEDURES	Second Year (second half)				
	21 Months	24 Months			Total Cases
	Level	Cases	Level	Cases	6 Months
Rotations to be incorporated as and when available with the consent of respected supervisor					
Pleural Aspiration	4	12	4	13	25
Peritoneal Aspiration	4	1	4	1	25
Lumbar puncture	4	1	4	1	15
Nasogastric Intubation	4	1	4	1	50
Uretheral catheterization	4	1	4	1	50
Recording and reporting ECG	4	1	4	1	100
Proctoscopy	1	1	1	1	3
Endotracheal Intubation	3	1	3	1	25
Cardio-Pulmonary Resuscitation (CPR)	3	1	3	1	15
Insertion of CVP lines	3	1	3	1	15
Arterial puncture	2	1	2	1	30
Urine Examination	4	1	4	1	2
Liver biopsy	2	1	2	1	2
Pleural biopsy	2	1	2	1	2
Joint aspiration	1	-	1	1	1
Bone marrow aspiration	1	1	1	1	2
Renal biopsy	1	-	1	1	1
Haemodialysis	2	1	2	1	2
Upper G.I. Endoscopy	1	1	1	-	1
Lower G.I. Endoscopy	1	1	1	1	2
Bronchoscopy	1	1	1	-	1
Abdominal Ultrasound	1	1	1	1	2
Exercise Tolerence Test	1	1	1	1	2
Echocardiography	1	1	1	1	2

CT Scan Head	1	1	1	1	2
EEG	1	1	1	1	2
EMG/NCS	1	1	1	1	2
Chest Intubation	1	1	1	1	2
Pericardiocentesis	1	1	1	1	2

LOG BOOK ENTERIES REQUIREMENT FOR 3RD, 4TH AND 5TH YEAR
MD DERMATOLOGY TRAINEES

PROCEDURES	THIRD YEAR								
	Level	Cases	Level	Cases	Level	Cases	Level	Cases	Total Cases in Year
Rotations to be incorporated as and when available with the consent of respected supervisor									
Skin biopsy (incisional)	4	2	4	2	4	2	4	2	12
TCA application	4	2	4	2	4	2	4	2	8
Smear for LD bodies	4	1	4	1	4	1	4	1	4
Cryotherapy	4	2	4	2	`	1	4	1	6
Cryosurgery	4	2	4	2	4	1	4	1	6
Phototherapy	4	3	4	3	4	3	4	3	8
Skin scrapings for fungal hyphae	3	1	3	1	-	-	-	-	2
Scabies mite extraction	4	1	4	1	4	1	4	1	4
Tzanck smear	4	2	4	2	4	2	4	2	8
electrocautery	3	1	3	1	-	-	-	-	2
Chemical peels	3	1	3	1	-	-	-	-	2
Hair microscopy	2	1	2	1	-	-	-	-	2
curettage	3	1	-	-	-	-	-	-	1
Carbon dioxide laser wart removal	2	1	-	-	-	-	-	-	1
Carbon dioxide resurfacing	-	-	-	-	2	2	-	-	2

PROCEDURES	THIRD YEAR								
	Level	Cases	Level	Cases	Level	Cases	Level	Cases	Total Cases in Year
Rotations to be incorporated as and when available with the consent of respected supervisor									
Excision of sebaceous cyst	2	1	2	1	-	-	-	-	2
Excision of pyogenic granuloma	4	2	4	2	4	2	4	2	8
Chemical cautery	3	1	3	1	-	-	-	-	2
Excision of NMSC	3	1	3	1	-	-	-	-	2
Histological processing of a slide	2	1	2	1	-	-	-	-	2
Smear for leprosy	3	1	-	-	-	-	-	-	1
mesotherapy	2	1	-	-	-	-	-	-	1
Excision biopsy	-	-	-	-	2	2	-	-	2
Punch biopsy	2	2	-	-	2	2	-	-	4
Laser hair reduction	2	2	-	-	2	2	-	-	4
PRP	2	1	2	1	2	1	2	1	4

PROCEDURES	FOURTH YEAR				
	15 Months		18 Months		Total Cases in Year
	Level	**Cases**	**Level**	**Cases**	
Rotations to be incorporated as and when available with the consent of respected supervisor					
Skin biopsy (incisional)	4	2	4	2	4
TCA application	4	2	4	2	4
Smear for LD bodies	4	1	4	1	2
Cryotherapy	4	10	4	10	20
Cryosurgery	4	10	4	1	2
Phototherapy	4	10	4	2	4
Skin scrapings for fungal hyphae	4	1	4	1	2
Scabies mite extraction	4	1	4	1	2
Tzanck smear	4	4	4	4	8
electrocautery	4	1	4	1	2
Chemical peels	4	1	4	1	2
Hair microscopy	3	1	3	1	2
curettage	4	2	4	2	4
Carbon dioxide laser wart removal	3	2	3	2	4
Carbon dioxide resurfacing	-	-	-	-	-
Laser hair reduction	3	1	3	1	2
PRP	3	2	3	2	4

PROCEDURES	FOURTH YEAR				
	15 Months		18 Months		Total Cases in Year
	Level	**Case**	**level**	**Case**	
Rotations to be incorporated as and when available with the consent of respected supervisor					
Excision of sebaceous cyst	2	1	2	1	2
Excision of pyogenic granuloma	2	1	-	-	1
Chemical cautery	2	2	2	2	4
Excision of NMSC	2	2	3	2	4
Histological processing of a slide	2	2	2	2	4
Smear for leprosy	2	2	2	2	4
mesotherapy	1	1	-	-	1
Excision biopsy	1	1	-	-	1
Punch biopsy	2	1	-	-	1
Microneedling	1	1	1	1	2
Laser hair reduction	1	1	1	1	2

PROCEDURES	Fifth YEAR				
	15 Months		18 Months		Total Cases in Year
	Level	**Cases**	**Level**	**Cases**	
Rotations to be incorporated as and when available with the consent of respected supervisor					
Skin biopsy (incisional)	4	2	4	2	4
TCA application	4	2	4	2	4
Smear for LD bodies	4	1	4	1	2
Cryotherapy	4	10	4	10	20
Cryosurgery	4	10	4	1	2
Phototherapy	4	10	4	2	4
Skin scrapings for fungal hyphae	4	1	4	1	2
Scabies mite extraction	4	1	4	1	2
Tzanck smear	4	4	4	4	8
electrocautery	4	1	4	1	2
Chemical peels	4	1	4	1	2
Hair microscopy	3	1	3	1	2
curettage	4	2	4	2	4
Carbon dioxide laser wart removal	3	2	3	2	4
Carbon dioxide resurfacing	-	-	-	-	-
Laser hair reduction	3	1	3	1	2
PRP	3	2	3	2	4

PROCEDURES	fifth YEAR				
	15 Months		18 Months		Total Cases in Year
	Level	**Case**	**level**	**Case**	
Rotations to be incorporated as and when available with the consent of respected supervisor					
Excision of sebaceous cyst	2	1	2	1	2
Excision of pyogenic granuloma	2	1	-	-	1
Chemical cautery	2	2	2	2	4
Excision of NMSC	2	2	3	2	4
Histological processing of a slide	2	2	2	2	4
Smear for leprosy	2	2	2	2	4
mesotherapy	1	1	-	-	1
Excision biopsy	1	1	-	-	1
Punch biopsy	2	1	-	-	1
Microneedling	1	1	1	1	2
Nail biopsy	1	1	1	1	2

INTRODUCTION

Curriculum of MD Dermatology at Rawalpindi Medical University is an important document that defines the educational goals of Residency Training Program and is intended to clarify the learning objectives for all inpatient and outpatient rotations. Program requirements are based on the ACGME (Accreditation Council for Graduate Medical Education) standards for categorical training in dermatology. Curriculum is based on 6 core competencies. Detail of these competencies is as follows

CORE COMPETENCIES

Details of The Six Core Competencies of Curriculum of MD Dermatology

COMPETENCY NO. 1 PATIENT CARE (PC)

 Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s). (PC1) ○ Collects accurate historical data ○ Uses physical exam to confirm history

- ○ Does not relies exclusively on documentation of others to generate own database or differential diagnosis ○ Consistently acquires accurate and relevant histories from patients ○ Seeks and obtains data from secondary sources when needed ○ Consistently performs accurate and appropriately thorough physical exams ○ Uses collected data to define a patient's central clinical problem(s)
- ○ Acquires accurate histories from patients in an efficient, prioritized, and hypothesis- driven fashion ○ Performs accurate physical exams that are targeted to the patient's complaints ○ Synthesizes data to generate a prioritized differential diagnosis and problem list ○ Effectively uses history and physical examination skills to minimize the need for further diagnostic testing ○ Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis ○ Identifies subtle or unusual physical exam findings
- ○ Efficiently utilizes all sources of secondary data to inform differential diagnosis
- ○ Role models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing

- **Develops and achieves comprehensive management plan for each patient. (PC2)** ○ Care plans are consistently inappropriate or inaccurate ○ Does not react to situations that require urgent or emergent care
  - ○ Does not seek additional guidance when needed Inconsistently develops an appropriate care plan ○ Inconsistently seeks additional guidance when needed ○ Consistently develops appropriate care plan ○ Recognizes situations requiring urgent or emergent care ○ Seeks additional guidance and/or consultation as appropriate ○ Appropriately modifies care plans based on patient's clinical course, additional data, and patient preferences ○ Recognizes disease presentations that deviate from common patterns and require complex decision- making ○ Manages complex acute and chronic diseases
  - ○ Role models and teaches complex and patient-centered care
  - ○ Develops customized, prioritized care plans for the most complex patients, incorporating diagnostic uncertainty and cost effectiveness principles

- **Manages patients with progressive responsibility and independence. (PC3)** ○ Assume responsibility for patient management decisions ○ Consistently manages simple ambulatory complaints or common chronic diseases ○ Consistently manages patients with straightforward diagnoses in the inpatient setting ○ Unable to manage complex inpatients or patients requiring intensive care ○ Requires indirect supervision to ensure patient safety and quality care
  - Provides appropriate preventive care and chronic disease management in the ambulatory setting ○ Provides comprehensive care for single or multiple diagnoses in the inpatient setting
  - Under supervision, provides appropriate care in the intensive care unit Initiates management plan for urgent or emergent care ○ Independently supervise care provided by junior members of the physician-led team
  - Independently manages patients across inpatient and ambulatory clinical settings who have a broad spectrum of clinical disorders including undifferentiated syndromes
  - Seeks additional guidance and/or consultation as appropriate ○ Appropriately manages situations requiring urgent or emergent care ○ Effectively supervises the management decisions of the team ○ Manages unusual, rare, or complex disorders
- **Skill in performing procedures. (PC4)** ○ Does not attempts to perform procedures without sufficient technical skill or supervision ○ Willing to perform procedures when qualified and necessary for patient care ○ Possesses basic technical skill for the completion of some common procedures
  - Possesses technical skill and has successfully performed all procedures required for certification
  - Maximizes patient comfort and safety when performing procedures
  - Seeks to independently perform additional procedures (beyond those required for certification) that are anticipated for future practice
  - Teaches and supervises the performance of procedures by junior members of the team
- **Requests and provides consultative care. (PC5)** ○ Is responsive to questions or concerns of others when acting as a consultant or utilizing consultant services ○ Willing to utilize consultant services when appropriate for patient care ○ Consistently manages patients as a consultant to other physicians/health care teams ○ Consistently applies risk assessment principles to patients while acting as a consultant ○ Consistently formulates a clinical question for a consultant to address
  - Provides consultation services for patients with clinical problems requiring basic risk assessment ○ Asks meaningful clinical questions that guide the input of consultants
  - Provides consultation services for patients with basic and complex clinical problems requiring detailed risk assessment ○ Appropriately weighs recommendations from consultants in order to effectively manage patient care
    Switches between the role of consultant and primary physician with ease
    Provides consultation services for patients with very complex clinical problems requiring extensive risk assessment Manages discordant recommendations from multiple consultants

Patient Care PC-1

- **How To Teach**
  - Discussions in ward rounds to teach history taking.
  - Discussions in ward rounds to teach physical examination. ○ Demonstration in ward rounds to teach history taking. ○ Demonstration in ward rounds to teach physical examination. ○ Discussions in wards of short cases ○ Discussions in wards of long cases ○ Simulated patient (in order to simulate a set of symptoms or problems.) ○ Should write a summary (synthesize a differential diagnosis).
- **How To Assess**
  - Discussions in ward rounds to assess history taking
  - Discussions in ward rounds to assess physical examination
  - Short cases assessment through long cases Confirmation of physical findings by supervisor Confirmation of history by supervisor.
- **OSPE Patient Care PC-2**
- **How To Teach**
  - Resident should write management plan on history sheet and supervisor should discuss management plan.
  - Resident should write investigational plans, should be able to interpret with help ○ of supervisor ○ Should be taught prioritization of care plans in complex patient by discussion.
- **How To Assess**
  - ○ Long cases and short cases to assess the clear concepts of management by the trainee.
- **Patient Care PC-3**
- **How To Teach**
  - ○ Discuss thoroughly the management side effects /interactions/dosage/therapeutic procedures and intervention
- **How To Assess** ○ Long case
  - ○ Short case OSPE Simulated patient Stimulated chart recall
  - ○ Log book ○ Portfolio
  - ○ Internal assessment record
- **Patient Care PC-4**
- **How To Teach**
  - Supervisor should ensure that the resident has complete knowledge about the procedures.
  - Trainee should observe procedures ○ Should perform procedures under supervision ○ Should be able to perform procedures independently

- Videos regarding different procedures.

 How To Assess SPE

Logbook/ portfolio Direct observation

Patient Care PC-5

How to Teach

- All consultations by the trainees should be discussed by the supervisor.

How to Assess

- Consultation record of the log book
- Feedback by other department regarding consultation

COMPETENCY NO. 2 MEDICAL KNOWLEDGE (MK)

- **Clinical knowledge (MK1)** ○ Possesses sufficient scientific, socioeconomic and behavioral knowledge required to provide care for common medical conditions and basic preventive care. ○ Possesses the scientific, socioeconomic and behavioral knowledge required to provide care for complex medical conditions and comprehensive preventive care
  - Possesses the scientific, socioeconomic and behavioral knowledge required to successfully diagnose and treat medically uncommon, ambiguous and complex conditions.

    Knowledge of diagnostic testing and procedures. (MK2)

    Consistently interprets basic diagnostic tests accurately

    Does not need assistance to understand the concepts of pre-test probability and test performance Characteristics ○ Fully understands the rationale and risks associated with common procedures ○ Interprets complex diagnostic tests accurately ○ Understands the concepts of pre-test probability and test performance characteristics ○ Teaches the rationale and risks associated with common procedures and anticipates potential complications when performing procedures
  - Anticipates and accounts for pitfalls and biases when interpreting diagnostic tests and procedures ○ Pursues knowledge of new and emerging diagnostic tests and procedures

- **Medical Knowledge (MK-1, MK-2)** ○ Teaching experience with medical student
- **How to Teach** ○ Read procedural knowledge.

  ○ Books etc **How To Assess**

  - Articles ○ MCQs
  - CPC(Clinic Pathological Conference) ○ SEQs
  - Lecture ○ Viva ○ Videos ○ Videos

- SDL(Self Directed Learning) ○ Internal assessment
- PBL(Problem Based Learning)

COMPETENCY NO. 3 SYSTEM BASED PRACTICE (SBP)

Works effectively within an inter professional team (e.g. peers, consultants, nursing, Ancillary professionals and other support personnel). (SBP1).

- Recognizes the contributions of other inter professional team members ○ Does not frustrates team members with inefficiency and errors ○ Identifies roles of other team members and recognize how/when to utilize them as resources.
- Does not requires frequent reminders from team to complete physician responsibilities (e.g. talk to family, enter orders) ○ Understands the roles and responsibilities of all team members and uses them effectively ○ Participates in team discussions when required and actively seek input from other team members
- Understands the roles and responsibilities of and effectively partners with, all members of the team ○ Actively engages in team meetings and collaborative decision-making ○ Integrates all members of the team into the care of patients, such that each is able to maximize their skills in the care of the patient
- Efficiently coordinates activities of other team members to optimize care ○ Viewed by other team members as a leader in the delivery of high quality care

Recognizes system error and advocates for system improvement. (SBP2)

- Does not ignore a risk for error within the system that may impact the care of a patient. ○ Does not make decisions that could lead to error which are otherwise corrected by the system or supervision. ○ Does not resistant to feedback about decisions that may lead to error or otherwise cause harm. ○ Recognizes the potential for error within the system. ○ Identifies obvious or critical causes of error and notifies supervisor accordingly. ○ Recognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that risk. ○ Willing to receive feedback about decisions that may lead to error or otherwise cause harm. ○ Identifies systemic causes of medical error and navigates them to provide safe patient care.
- Advocates for safe patient care and optimal patient care systems ○ Activates formal system resources to investigate and mitigate real or potential medical error. ○ Reflects upon and learns from own critical incidents that may lead to medical error.
- Advocates for system leadership to formally engage in quality assurance and quality improvement activities. ○ Viewed as a leader in identifying and advocating for the prevention of medical error. ○ Teaches others regarding the importance of recognizing and mitigating system error.

Identifies forces that impact the cost of health care, and advocates for, and practices cost-effective care. (SBP3).

- Does not ignores cost issues in the provision of care ○ Demonstrates effort to overcome barriers to cost- effective care ○ Has full awareness of external factors (e.g. socio- economic, cultural, literacy, insurance status) that impact the cost of health care and the role that external stakeholders (e.g. providers, suppliers, financers, purchasers) have on the cost of care
- Consider limited health care resources when ordering diagnostic or therapeutic interventions ○ Recognizes that external factors influence a patient's utilization of health care and Does not act as barriers to cost- effective care ○ Minimizes unnecessary diagnostic and therapeutic

tests ○ Possesses an incomplete understanding of cost- awareness principles for a population of patients (e.g. screening tests) ○ Consistently works to address patient specific barriers to cost-effective care ○ Advocates for cost-conscious utilization of resources (i.e. emergency department visits, hospital readmissions)

○ Incorporates cost-awareness principles into standard clinical judgments and decision-making, including screening tests

COMPETENCY NO. 4 PRACTICE BASED LEARNING (PBL)

- **Monitors practice with a goal for improvement. (PBLI1)** ○ Willing to self-reflect upon one's practice or performance ○ Concerned with opportunities for learning and self-improvement ○ Unable to self-reflect upon one's practice or performance ○ Avails opportunities for learning and self-improvement ○ Consistently acts upon opportunities for learning and self-improvement ○ Regularly self-reflects upon one's practice or performance and consistently acts upon those reflections to improve practice ○ Recognizes sub-optimal practice or performance as an opportunity for learning and self-improvement ○ Regularly self-reflects and seeks external validation regarding this reflection to maximize practice improvement ○ Actively engages in self- improvement efforts and reflects upon the experience
- **Learns and improves via performance audit. (PBLI2)** ○ Regards own clinical performance data ○ Demonstrates inclination to participate in or even consider the results of quality improvement efforts ○ Adequate awareness of or desire to analyze own clinical performance data ○ Participates in a quality improvement projects ○ Familiar with the principles, techniques or importance of quality improvement ○ Analyzes own clinical performance data and identifies opportunities for improvement ○ Effectively participates in a quality improvement project ○ Understands common principles and techniques of quality improvement and appreciates the responsibility to assess and improve care for a panel of patients Analyzes own clinical performance data and actively works to improve performance
    - Actively engages in quality improvement initiatives ○ Demonstrates the ability to apply common principles and techniques of quality improvement to improve care for a panel of patients
    - Actively monitors clinical performance through various data sources ○ Is able to lead a quality improvement project
    - Utilizes common principles and techniques of quality improvement to continuously improve care for a panel of patients
- **Learns and improves via feedback. (PBLI3)** ○ Does not resists feedback from others ○ Often seeks feedback ○ Never responds to unsolicited feedback in a defensive fashion ○ Temporarily or superficially adjusts performance based on feedback
    - Does not solicits feedback only from supervisors ○ Is open to unsolicited feedback ○ Solicits feedback from all members of the inter professional team and patients ○ Consistently incorporates feedback ○ Performance continuously reflects incorporation of solicited and unsolicited feedback ○ Able to reconcile disparate or conflicting feedback

Learns and improves at the point of care. (PBLI4)

○ Acknowledges uncertainly and does not revert to reflexive patterned response when inaccurate ○ Seeks or applies evidence when necessary ○ Familiar with strengths and weaknesses of the medical literature ○ Has adequate awareness of or ability to use information technology

○ Does not accepts the findings of clinical research studies without critical appraisal Can translate medical information needs into well- formed clinical questions independently

- Aware of the strengths and weaknesses of medical information resources and utilizes information technology with sophistication
- Appraises clinical research reports, based on accepted criteria
- Does not "slows down" to reconsider an approach to a problem, ask for help, or seek new information ○ Routinely translates new medical information needs into well-formed clinical questions ○ Utilizes information technology with sophistication
- Independently appraises clinical research reports based on accepted criteria
- Searches medical information resources efficiently, guided by the characteristics of clinical questions ○ Role models how to appraise clinical research reports based on accepted criteria ○ Has a systematic approach to track and pursue emerging clinical question

Practice Based Learning (PBL1, PBL2, PBL3, PBL4)

- **How to Teach**
- Discussions about problem cases ○ Should discuss errors and omissions
- **How to Assess**
- Feed back ○ 360 evaluation ○ Research article presentation ○ Journal club presentation ○ CPC presentation ○ Ward presentation
- Quality improvement of projects
-

COMPETENCY NO. 5 PROFESSIONALISM(PROF)

- Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel). (PROF1)
- Consistently respectful in interactions with patients, caregivers and members of the interprofessional team, even in challenging situations
- Is available and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to ensure safe and effective care Emphasizes patient privacy and autonomy in all interactions
- Demonstrates empathy, compassion and respect to patients and caregivers in all situations ○ Anticipates, advocates for, and proactively works to meet the needs of patients and caregivers ○ Demonstrates a responsiveness to patient needs that supersedes self-interest
- Positively acknowledges input of members of the interprofessional team and incorporates that input into plan of care as appropriate
- Role models compassion, empathy and respect for patients and caregivers ○ Role models appropriate anticipation and advocacy for patient and caregiver needs ○ Fosters collegiality that promotes a high-functioning interprofessional team

- **Teaches others regarding maintaining patient privacy and respecting patient autonomyAccepts responsibility and follows through on tasks. (PROF2)** ○ Demonstrates responsibilities expected of a physician professional ○ Accepts professional responsibility even when not assigned or not mandatory
    - Completes administrative and patient care tasks in a timely manner in accordance with local practice and/or policy ○ Completes assigned professional responsibilities without questioning or the need for reminders
    - Prioritizes multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner ○ Willingness to assume professional responsibility regardless of the situation
    - Role models prioritizing multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner
    - Assists others to improve their ability to prioritize multiple, competing tasks

Responds to each patient's unique characteristics and needs. (PROF3) ○ Willing to modify care plan to account for a patient's unique characteristics and needs

- Is sensitive to and has basic awareness of differences related to culture, ethnicity, gender, race, age and religion in the patient/caregiver encounter
- Seeks to fully understand each patient's unique characteristics and needs based upon culture, ethnicity, gender, religion, and personal preference
- Modifies care plan to account for a patient's unique characteristics and needs with complete success ○ Recognizes and accounts for the unique characteristics and needs of the patient/ caregiver ○ Appropriately modifies care plan to account for a patient's unique characteristics and needs
- Role models professional interactions to negotiate differences related to a patient's unique characteristics or needs ○ Role models consistent respect for patient's unique characteristics and needs

Exhibits integrity and ethical behavior in professional conduct. (PROF4) ○ Has a basic understanding of ethical principles, formal policies and procedures, and does not intentionally disregard them ○ Honest and forthright in clinical interactions, documentation, research, and scholarly activity ○ Demonstrates accountability for the care of patients

- Adheres to ethical principles for documentation, follows formal policies and procedures, acknowledges and limits conflict of interest, and upholds ethical expectations of research and scholarly activity
- Demonstrates integrity, honesty, and accountability to patients, society and the profession ○ Actively manages challenging ethical dilemmas and conflicts of interest
- Identifies and responds appropriately to lapses of professional conduct among peer group
- Assists others in adhering to ethical principles and behaviors including integrity, honesty, and professional responsibility ○ Role models integrity, honesty, accountability and professional conduct in all aspects of professional life ○ Regularly reflects on personal professional conduct

Professionalism (PROF1, PROF2, PROF3 AND PROF4)

How To Teach

1. Should be taught during ward rounds.
2. By supervisor
3. Through workshop

How To Assess

1. Punctuality
2. Behavior
3. Direct observation during ward rounds
4. Feed back
5. 360 degree evaluation

Competency No. 6 INTERPERSONAL AND COMMUNICATION SKILL (ICS)

- Communicates effectively with patients and caregivers. (ICS1) ○ Does not ignores patient preferences for plan of care ○ Makes attempt to engage patient in shared decision-making
- Does not engages in antagonistic or counter-therapeutic relationships with patients and caregivers
- Engages patients in discussions of care plans and respects patient preferences when offered by the patient, and also actively solicit preferences.
- Attempts to develop therapeutic relationships with patients and caregivers which is often successful ○ Defers difficult or ambiguous conversations to others ○ Engages patients in shared decision making in uncomplicated conversations ○ Requires assistance facilitating discussions in difficult or ambiguous conversations ○ Requires guidance or assistance to engage in communication with persons of different socioeconomic and cultural backgrounds ○ Identifies and incorporates patient preference in shared decision making across a wide variety of patient care conversations ○ Quickly establishes a therapeutic relationship with patients and caregivers, including persons of different socioeconomic and cultural backgrounds
- Incorporates patient-specific preferences into plan of care
- Role models effective communication and development of therapeutic relationships in both routine and challenging situations ○ Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic backgrounds

Communicates effectively in inter professional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel). (ICS2) ○ Does not uses unidirectional communication that fails to utilize the wisdom of the team ○ Does not resists offers of collaborative input

- Consistently and actively engages in collaborative communication with all members of the team

- Verbal, non-verbal and written communication consistently acts to facilitate collaboration with the team to enhance patient care ○ Role models and teaches collaborative communication with the team to enhance patient care, even in challenging settings and with conflicting team member opinions

 Appropriate utilization and completion of health records. (ICS3) ○ Health records are organized and accurate and are not superficial and does not miss key data or fails to communicate clinical reasoning

- Health records are organized, accurate, comprehensive, and effectively communicate clinical reasoning ○ Health records are succinct, relevant, and patient specific
- Role models and teaches importance of organized, accurate and comprehensive health records that are succinct and patient specific

Interpersonal and Communication Skill (ISC1, ICS2 AND ICS3) How to Teach

○ Teaching through communication skills by supervisor ○ Through workshop **How to Assess**

1. Direct observation 7. Article presentation
2. Feed back 8. Consultation
3. 360 degree evaluation 9. OPD working
4. History taking 10. Counseling sessions
5. CPC presentation 11. OSPE
6. Journal club presentation 12. VIVA

***FOR EXAMPLE*: In cardiology the competencies other than Medical knowledge should be monitored/supervised /evaluated as follows**

	Practice and Procedural Skills	Attitudes, Values and Habits	Professionalism	Interpersonal and Communication Skills	Practice Based Learning Improvement	Evaluation of Medical Knowledge

• Development of proficiency in examination of the cardiovascular system, in general and cardiac auscultation, in particular • Preoperative evaluation of cardiac risk in-patients undergoing non-cardiac surgery • Preoperative evaluation of cardiac risk in-patients undergoing non-cardiac surgery • The appropriate way to answer cardiac consultations • The appropriate follow-up, including use of substantive progress notes, of patients who have been seen in consultation. • Out-patient cardiac care. • Differential diagnosis of chest pain *	• Keeping the patient and family informed on the clinical status of the patient, results of tests, etc. • Frequent, direct communication with the physician who requested the consultation. • Review of previous medical records and extraction of information relevant to the patient's cardiovascular status. Other sources of information may be used, when pertinent • Understanding that patients have the right to either accepts or decline recommendations made by the physician • Education of the patient ***applied for other domains of & allied.***	• The PGT should continue to develop his/her ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty. • The PGT must be willing to acknowledge errors and determine how to avoid future similar mistakes. • The PGT must be responsible and reliable at all times. • The PGT must always consider the needs of patients, families, colleagues, and support staff. • The PGT must maintain a professional	• The PGT should learn when to call a subspecialist for evaluation and management of a patient with a cardiovascular disease. • The PGT should be able to clearly present the consultation cases to the staff in an organized and thorough manner • The PGT must be able to establish a rapport with the patients and listens to the patient's complaints to promote the patient's welfare. • The PGT should provide effective education and counseling for patients. • The PGT must write organized and legible notes • The PGT must communicate any	• The PGT should use feedback and self-evaluation in order to improve performance • The PGT should read the required material and articles provided to enhance learning • The PGT should use the medical literature search tools in the library to find appropriate articles related to interesting cases. ***Internal Medicine for details.***	• The PGT's ability to answer directed questions and to participate in the didactic sessions. • The PGT's presentation of assigned short topics. These will be examined for their completeness, accuracy, organization, and the PGTs' understanding of the topic. • The PGT's ability to apply the information learned in the didactic sessions to the patient care setting. • The PGT's interest level in learning.

appearance at all times	patient problems to the staff in a timely fashion	

se see curriculum

METHODS OF TEACHING & LEARNING DURING COURSE CONDUCTION

1. *Inpatient Services:* All residents will have rotations in intensive care, coronary care, emergency medicine, general medical wards, general medicine, ambulatory experiences etc. The required knowledge and skills pertaining to the ambulatory based training in following areas shall be demonstrated;

- General Internal Medicine Nephrology
- Critical care & Emergency Medicine Hematological Disorders
- Coronary care unit Psychiatry
- Ambulatory Medicine Inpatient Oncology 81 Palliative Care Services
- General Medical consultation service Neurology
- Cardiology Dermatology
- Pulmonary Medicine Geriatric Medicine
- Endocrinology Infectious Diseases
- Rheumatology Radiology
- Gastroenterology & Hepatology

2. ***Outpatient Experiences:*** Residents should demonstrate expertise in diagnosis and management of patients in acute care clinics and longitudinal clinic and gain experience in Dermatology, Geriatrics, Clinical immunology and allergy, Endocrinology, Gastroenterology, Hematology-Oncology, Neurology, Nephrology, Pulmonology, Rheumatology etc.
3. ***Emergency services:*** Our residents take an early and active role in patient care and obtain decision-making roles quickly. Within the Emergency Department, residents direct the initial stabilization of all critical patients, manage airway interventions, and oversee all critical care.
4. ***Electives/ Specialty Rotations:*** In addition, the resident will elect rotations in a variety of electives including nutrition, nuclear medicine or any of the medicine subspecialty consultative services or clinics. They may choose electives from each medicine subspecialty and from offerings of other departments. Residents may also select electives at other institutions if the parent department does not offer the experiences they want.

5. ***Interdisciplinary Medicine*** Adolescent Medicine, Dermatology, Emergency Medicine, General Surgery, Gynecology, Neurology, Occupational Medicine, Ophthalmology, Orthopedics and Sports Medicine, Otolaryngology, Physical Medicine and Rehabilitation, Urology.
6. ***Community Practice:*** Residents experience the practice of medicine in a non-academic, non-teaching hospital setting. The rotation may be used to try out a practice that the resident later joins, to learn the needs of referring physicians or to decide on a future career path.
7. ***Mandatory Workshops:*** *R*esidents achieve hands on training while participating in mandatory workshops of Research Methodology, Advanced Life Support, Communication Skills, Computer & Internet and Clinical Audit. Specific objectives are given in detail in the relevant section of Mandatory Workshops.
8. ***Core Faculty Lectures (CFL):*** The core faculty lecture's focus on monthly themes of the various specialty medicine topics for eleven months of the year, i.e., Cardiology, Gastroenterology, Hematology, etc. Lectures are still an efficient way of delivering information. Good lectures can introduce new material or synthesize concepts students have through text-, web-, or field-based activities. *Buzz groups* can be incorporated into the lectures in order to promote more active learning.
9. ***Introductory Lecture Series (ILS):*** Various introductory topics are presented by subspecialty and general medicine faculty to introduce interns to basic and essential topics in internal medicine.
10. ***Long and short case presentations:*** Giving an oral presentation on ward rounds is an important skill for medical student to learn. It is medical reporting which is terse and rapidly moving. After collecting the data, you must then be able both to document it in a written format and transmit it clearly to other health care providers. In order to do this successfully, you need to understand the patient's medical illnesses, the psychosocial contributions to their History of Presenting Illness and their physical diagnosis findings. You then need to compress them into a concise, organized recitation of the most essential facts. The listener needs to be given all of the relevant information without the extraneous details and should be able to construct his/her own differential diagnosis as the story unfolds. Consider yourself an advocate who is attempting to persuade an informed, interested judge the merits of your argument, without distorting any of the facts. An oral case presentation is NOT a simple recitation of your write-up. It is a concise, edited presentation of the most essential information. Basic structure for oral case presentations includes Identifying information/chief complaint (ID/CC) , History of present illness (HPI) including relevant ROS

(Review of systems) questions only ,Other active medical problems , Medications/allergies/substance use (note: e. The complete ROS should not be presented in oral presentations , Brief social history (current situation and major issues only) . Physical examination (pertinent findings only) , One line summary & Assessment and plan

11. ***Seminar Presentation:*** Seminar is held in a noon conference format. Upper level residents present an in-depth review of a medical topic as well as their own research. Residents are formally critiqued by both the associate program director and their resident colleagues.
12. ***Journal Club Meeting (JC):***A resident will be assigned to present, in depth, a research article or topic of his/her choice of actual or potential broad interest and/or application. Two hours per month should be allocated to discussion of any current articles or topics introduced by any participant. Faculty or outside researchers will be invited to present outlines or results of current research activities. The article should be critically evaluated and its applicable results should be highlighted, which can be incorporated in clinical practice. Record of all such articles should be maintained in the relevant department
13. ***Small Group Discussions/ Problem based learning/ Case based learning:*** Traditionally small groups consist of 8-12 participants. Small groups can take on a variety of different tasks, including problem solving, role play, discussion, brainstorming, debate, workshops and presentations. Generally students prefer small group learning to other instructional methods. From the study of a problem students develop principles and rules and generalize their applicability to a variety of situations PBL is said to develop problem solving skills and an integrated body of knowledge. It is a student-centered approach to learning, in which students determine what and how they learn. Case studies help learners identify problems and solutions, compare options and decide how to handle a real situation.
14. ***Discussion/Debate:*** There are several types of discussion tasks which would be used as learning method for residents including: *guided discussion*, in which the facilitator poses a discussion question to the group and learners offer responses or questions to each other's contributions as a means of broadening the discussion's scope; *inquiry-based discussion*, in which learners are guided through a series of questions to discover some relationship or principle; *exploratory discussion*, in which learners examine their personal opinions, suppositions or assumptions and then visualize alternatives to these assumptions; and *debate* in which students argue opposing sides of a controversial topic. With thoughtful and well-designed discussion tasks, learners can practice critical inquiry and reflection, developing their individual thinking, considering alternatives and negotiating meaning with other discussants to arrive at a shared understanding of the issues at hand.
15. ***Case Conference (CC):*** These sessions are held three days each week; the focus of the discussion is selected by the presenting resident. For example, some cases may be presented to discuss a differential diagnosis, while others are presented to discuss specific management issues.
16. ***Noon Conference (NC):*** The noon conferences focus on monthly themes of the various specialty medicine topics for eleven months of the year, i.e., Cardiology, Gastroenterology, Hematology, etc.

17. ***Grand Rounds (GR):*** The Department of Medicine hosts Grand Rounds on weekly basis. Speakers from local, regional and national medicine training programs are invited to present topics from the broad spectrum of internal medicine. All residents on inpatient floor teams, as well as those on ambulatory block rotations and electives are expected to attend.
18. ***Professionalism Curriculum (PC)*****:** This is an organized series of recurring large and small group discussions focusing upon current issues and dilemmas in medical professionalism and ethics presented primarily by an associate program director. Lectures are usually presented in a noon conference format.
19. ***Evening Teaching Rounds:*** During these sign-out rounds, the inpatient Chief Resident makes a brief educational presentation on a topic related to a patient currently on service, often related to the discussion from morning report. Serious cases are mainly focused during evening rounds.
20. ***Clinico-pathological Conferences:*** The clinicopathological conference, popularly known as CPC primarily relies on case method of teaching medicine. It is a teaching tool that illustrates the logical, measured consideration of a differential diagnosis used to evaluate patients. The process involves case presentation, diagnostic data, discussion of differential diagnosis, logically narrowing the list to few selected probable diagnoses and eventually reaching a final diagnosis and its brief discussion. The idea was first practiced in Boston, back in 1900 by a Harvard internist, Dr. Richard C. Cabot who practiced this as an informal discussion session in his private office. Dr. Cabot incepted this from a resident, who in turn had received the idea from a roommate, primarily a law student.
21. ***Evidence Based Medicine (EBM)*****:** Residents are presented a series of noon monthly lectures presented to allow residents to learn how to critically appraise journal articles, stay current on statistics, etc. The lectures are presented by the program director.
22. ***Clinical Audit based learning:*** "Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria…Where indicated, changes are implemented…and further monitoring is used to confirm improvement in healthcare delivery." *Principles for Best Practice in Clinical Audit (2002, NICE/CHI)*
23. ***Peer Assisted Learning:*** Any situation where people learn from, or with, others of a similar level of training, background or other shared characteristic. Provides opportunities to reinforce and revise their learning. Encourages responsibility and increased self-confidence. Develops teaching and verbalization skills. Enhances communication skills, and empathy. Develops appraisal skills (of self and others) including the ability to give and receive appropriate feedback. Enhance organizational and team-working skills.
24. ***Morbidity and Mortality Conference (MM):*** The M&M Conference is held occasionally at noon throughout the year. A case, with an adverse outcome, though not necessarily resulting in death, is discussed and thoroughly reviewed. Faculty members from various

disciplines are invited to attend, especially if they were involved in the care of the patient. The discussion focuses on how care could have been improved.

25. ***Clinical Case Conference:*** Each resident, except when on vacation, will be responsible for at least one clinical case conference each month. The cases discussed may be those seen on either the consultation or clinic service or during rotations in specialty areas. The resident, with the advice of the Attending Physician on the Consultation Service, will prepare and present the case(s) and review the relevant literature
26. ***SEQ as assignments on the content areas:*** SEQs assignments are given to the residents on regular basis to enhance their performance during written examinations.
27. ***Skill teaching in ICU, emergency, ward settings& skill laboratory:*** Two hours twice a month should be assigned for learning and practicing clinical skills. List of skills to be learnt during these sessions is as follows:

- Residents must develop a comprehensive understanding of the indications, contraindications, limitations, complications, techniques, and interpretation of results of those technical procedures integral to the discipline (mentioned in the Course outlines)
- Residents must acquire knowledge of and skill in educating patients about the technique, rationale and ramifications of procedures and in obtaining procedure-specific informed consent. Faculty supervision of residents in their performance is required, and each resident's experience in such procedures must be documented by the program director
- Residents must have instruction in the evaluation of medical literature, clinical epidemiology, clinical study design, relative and absolute risks of disease, medical statistics and medical decision-making
- Training must include cultural, social, family, behavioral and economic issues, such as confidentiality of information, indications for life support systems, and allocation of limited resources
- Residents must be taught the social and economic impact of their decisions on patients, the primary care physician and society. This can be achieved by attending the bioethics lectures and becoming familiar with Project Professionalism Manual such as that of the American Board of Internal Medicine
- Residents should have instruction and experience with patient counseling skills and community education
- This training should emphasize effective communication techniques for diverse populations, as well as organizational resources useful for patient and community education
- Residents may attend the series of lectures on Nuclear Medicine procedures (radionuclide scanning and localization tests and therapy) presented to the Radiology residents

- Residents should have experience in the performance of clinical laboratory and radionuclide studies and basic laboratory techniques including quality control, quality assurance and proficiency standards.

28. ***Bedside teaching rounds in ward:*** ***"To study the phenomenon of disease without a book is to sail an uncharted sea whilst to study books without patients is not to go to sea at all" Sir William Osler 1849-1919***.Bedside teaching is regularly included in the ward rounds. Learning activities include the physical exam, a discussion of particular medical diseases, psychosocial and ethical themes, and management issues
29. ***Directly Supervised Procedures - (DSP)*****:** Residents learn procedures under the direct supervision of an attending or fellow during some rotations. For example, in the Medical Intensive Care Unit the Pulmonary /Critical Care attending or fellow, or the MICU attending, observe the placement of central venous and arterial lines. Specific procedures used in patient care vary by rotation.
30. ***Self-directed learning:*** self-directed learning residents have primary responsibility for planning, implementing, and evaluating their effort. It is an adult learning technique that assumes that the learner knows best what their educational needs are. The facilitator's role in self-directed learning is to support learners in identifying their needs and goals for the program, to contribute to clarifying the learners' directions and objectives and to provide timely feedback. Self-directed learning can be highly motivating, especially if the learner is focusing on problems of the immediate present, a potential positive outcome is anticipated and obtained and they are not threatened by taking responsibility for their own learning.
31. ***Follow up clinics:*** The main aims of our clinic for patients and relatives include (a) Explanation of patient's stay in ICU or Ward settings: Many patients do not remember their ICU stay, and this lack of recall can lead to misconceptions, frustration and having unrealistic expectations of themselves during their recovery. It is therefore preferable for patients to be aware of how ill they have been and then they can understand why it is taking some time to recover.(b)Rehabilitation information and support: We discuss with patients and relatives their individualized recovery from critical illness. This includes expectations, realistic goals, change in family dynamics and coming to terms with life style changes.(c)**Identifying physical, psychological or social problems**
    Some of our patients have problems either as a result of their critical illness or because of other underlying conditions. The followup team will refer patients to various specialties, if appropriate. (d)**Promoting a quality service**: By highlighting areas which require change in nursing and medical practice, we can improve the quality of patient and relatives care. Feedback from patients and relatives about their ICU & ward experience is invaluable. It has initiated various audits and changes in clinical practice, for the benefit of patients and relatives in the future.

32. ***Core curriculum meeting:*** All the core topics of Medicine should be thoroughly discussed during these sessions. The duration of each session should be at least two hours once a month. It should be chaired by the chief resident (elected by the residents of the relevant discipline). Each resident should be given an opportunity to brainstorm all topics included in the course and to generate new ideas regarding the improvement of the course structure
33. ***Annual Grand Meeting*** Once a year all residents enrolled for MD Internal Medicine should be invited to the annual meeting at RMU. One full day will be allocated to this event. All the chief residents from affiliated institutes will present their annual reports. Issues and concerns related to their relevant courses will be discussed. Feedback should be collected and suggestions should be sought in order to involve residents in decision making. The research work done by residents and their literary work may be displayed. In the evening an informal gathering and dinner can be arranged. This will help in creating a sense of belonging and ownership among students and the faculty.
34. ***Learning through maintaining log book:*** *it is* used to list the core clinical problems to be seen during the attachment and to document the student activity and learning achieved with each patient contact.
35. ***Learning through maintaining portfolio:*** Personal Reflection is one of the most important adult educational tools available. Many theorists have argued that without reflection, knowledge translation and thus genuine "deep" learning cannot occur. One of the Individual reflection tools maintaining portfolios, Personal Reflection allows students to take inventory of their current knowledge skills and attitudes, to integrate concepts from various experiences, to transform current ideas and experiences into new knowledge and actions and to complete the experiential learning cycle.
36. ***Task-based-learning:*** A list of tasks is given to the students: participate in consultation with the attending staff, interview and examine patients, review a number of new radiographs with the radiologist.
37. ***Teaching in the ambulatory care setting:*** A wide range of clinical conditions may be seen. There are large numbers of new and return patients. Students have the opportunity to experience a multi-professional approach to patient care. Unlike ward teaching, increased numbers of students can be accommodated without exhausting the limited No. of suitable patients.
38. ***Community Based Medical Education:*** CBME refers to medical education that is based outside a tertiary or large secondary level hospital. Learning in the fields of epidemiology, preventive health, public health principles, community development, and the social impact of illness and understanding how patients interact with the health care system. Also used for learning basic clinical skills, especially communication skills.

39. ***Audio visual laboratory:*** audio visual material for teaching skills to the residents is used specifically in teaching gastroenterology procedure details.
40. ***E-learning/web-based medical education/computer-assisted instruction:*** Computer technologies, including the Internet, can support a wide range of learning activities from dissemination of lectures and materials, access to live or recorded presentations, real-time discussions, self-instruction modules and virtual patient simulations. distance-independence, flexible scheduling, the creation of reusable learning materials that are easily shared and updated, the ability to individualize instruction through adaptive instruction technologies and automated record keeping for assessment purposes.
41. ***Research based learning:*** All residents in the categorical program are required to complete an academic outcomes-based research project during their training. This project can consist of original bench top laboratory research, clinical research or a combination of both. The research work shall be compiled in the form of a thesis which is to be submitted for evaluation by each resident before end of the training. The designated Faculty will organize and mentor the residents through the process, as well as journal clubs to teach critical appraisal of the literature.
42. ***Other teaching strategies specific for different specialties as mentioned in the relevant parts of the curriculum***

    Some of the other teaching strategies which are specific for certain domains of internal medicine are given along with relevant modules.

CURRICULUM FOR DERMATOLOGY

Goals and Objectives

The curriculum outlined here is intended to ensure that you have a clear understanding of the overall learning goals of an Internal Medicine residency. Medical care of adults occurs across a continuum from preventive care of healthy adults to care for the dying. The core competencies that internists must develop during training are outlined below:

Patient Care: Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, and treatment of disease.

Medical Knowledge: Residents are expected to demonstrate knowledge of biomedical, clinical and social sciences and to be able to apply their knowledge to patient care and the education of others.

Practice-Based Performance Improvement: Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

Interpersonal and Communication Skills: Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

Professionalism: Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

Systems-Based Practice: Residents are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

The curriculum describes both required and elective rotations - the educational goals and objectives of the rotation or activity as well as the teaching formats and suggested educational content. The topics listed under "educational content" are generally disease entities that we think you should read about during your rotation in that particular site, regardless of whether you have a patient with that problem or not. We have developed this curriculum to provide some guidelines for your studying as well as to make clear the specific goals and objectives of each rotation. You should be aware of the learning objectives in each rotation and attempt to reach them.

In addition to these rotation-specific expectations, there are general requirements in each year related to milestones in each of the core competencies

Goals and Objectives:

Patient care

- Demonstrate the ability to perform a comprehensive history and physical as well as the ability to focus and adjust the history and physical based on each patient's severity of illness, level of comfort, and ability to communicate
- Know the approach to commonly observed in-patient problems, e.g. pain, acute shortness of breath, fever, palpitations, chest pain, hypotension, falls, acute changes in mental status
- Demonstrate proficiency in use and interpretation of standard laboratory tests and x-rays
- Implement the management of common diseases seen in in-patients
- Perform common invasive procedures skillfully and safely

Medical knowledge

- Know the differential diagnosis and treatment of commonly encountered disease entities in medicine
- Know the indications, contraindications, risks, benefits, and alternatives to commonly performed invasive procedures

PBPI/SBP

- Know how to use information technology to supplement your medical knowledge
- Understand the departmental and institutional performance improvement projects and patient safety goals
- Consistently utilize infection control strategies, e.g. hand hygiene, and safe use of needles and other sharps
- Understand the role of each member of the patient care team
- Demonstrate ability to obtain needed services for patients and to implement appropriate discharge plans

Interpersonal and communication skills

- Write notes that accurately and completely reflect the patient's condition
- Effectively communicate patient information to colleagues, consultants, and other members of the health care team
- Establish rapport with patients of different cultural backgrounds
- Educate patients and families appropriately about medical conditions, diagnostic and therapeutic plans, and discharge plans
- Obtain informed consent for invasive procedures with full discussion of risks, benefits, and alternatives to the procedure Learn the steps involved in delivering bad news to patients

Professionalism

- Consistently demonstrate respect for patients and staff members
- Consistently put the patients' interests ahead of any other considerations
- Understand the ethical principles involved in obtaining advance directives and informed consent
- Maintain the confidentiality of personally identifiable patient information

CHARTING THE ROAD TO COMPETENCE: DEVELOPMENTAL MILESTONES FOR MD DERMATOLOGY PROGRAM AT RAWALPINDI MEDICAL UNIVERSITY

Remember to celebrate for the milestones as you prepare for the road ahead----Nelson Mandela.

High-quality assessment of resident performance is needed to guide individual residents' development and ensure their preparedness to provide patient care. To facilitate this aim, reporting milestones are now required across all internal medicine (IM) residency programs. Milestones promote competency based training in internal medicine. Residency program directors may use them to track the progress of trainees in the 6 general competencies including ***patient care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and SystemsBased Practice.*** Mile stones inform decisions regarding promotion and readiness for independent practice. In addition, the milestones may guide curriculum development, suggest specific assessment strategies, provide benchmarks for resident self-directed assessment-seeking, assist remediation by facilitating identification of specific deficits, and provide a degree of national standardization in evaluation. Finally, by explicitly enumerating the profession's expectations for graduates, they may improve public accountability for residency training.

Table-1	**Developmental Milestones for Internal Medicine Training—Patient Care**		
Competency	**Developmental Milestones Informing Competencies**	**Approximate Time Frame Trainee Should Achieve Stage (months)**	**General Evaluation Strategies Assessment Methods/ Tools**
A. Clinical skills and reasoning • Manage patients using clinical skills of interviewing and physical examination • Demonstrate competence in the	***Historical data gathering***		
	1. Acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion	8	• Standardized patient • Direct observation
	2. Seek and obtain appropriate, verified, and prioritized data from secondary sources (eg, family, records, pharmacy)	12	

performance of procedures • Appropriately use laboratory and imaging techniques	3. Obtain relevant historical subtleties that inform and prioritize both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient	24	
	4. Role model gathering subtle and reliable information from the patient for junior members of the health care team	40	
	Performing a physical examination		
	1. Perform an accurate physical examination that is appropriately targeted to the patient's	8	☐ Standardized patient Direct observation
	complaints and medical conditions. Identify pertinent abnormalities using common maneuvers		☐ Simulation
	2. Accurately track important changes in the physical examination over time in the outpatient and inpatient settings	12	
	3. Demonstrate and teach how to elicit important physical findings for junior members of the health care team	24	
	4. Routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced maneuvers where applicable	40	
	Clinical reasoning		

	1. Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient's central clinical problem	16	▯ Chart-stimulated ▯ recall ▯ Direct observation Clinical vignettes
	2. Develop prioritized differential diagnoses, evidence- based diagnostic and therapeutic plan for common inpatient and ambulatory conditions	32	
	3. Modify differential diagnosis and care plan based on clinical course and data as appropriate	32	
	4. Recognize disease presentations that deviate from common patterns and that require complex decision making	48	
	Invasive procedures		
	1. Appropriately perform invasive procedures and provide post-procedure management for common procedures	24	▯ Simulation ▯ Direct observation
B. Delivery of patient- centered clinical care • Manage patients with progressive responsibility • Manage patients across the	***Diagnostic tests***		
	1. Make appropriate clinical decisions based on the results of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary	16	• Chart-stimulated recall • Standardized tests

spectrum of clinical diseases seen in the practice of general internal medicine • Manage patients in a variety of health care settings to include the inpatient ward, critical care units, the ambulatory setting, and the emergency setting • Manage undifferentiated acutely and severely ill patients • Manage patients in the prevention, counseling, detection, diagnosis, and treatment of genderspecific diseases • Manage patients as a consultant to other physicians	function tests, urinalysis and other body fluids		☐ Clinical vignettes
	2. Make appropriate clinical decision based on the results of more advanced diagnostic tests	24	
	Patient management		
	1. Recognize situations with a need for urgent or emergent medical care, including life-threatening conditions	8	☐ Simulation ☐ Chart-stimulated recall ☐ Multisource feedback ☐ Direct observation Chart audit
	2. Recognize when to seek additional guidance	8	
	3. Provide appropriate preventive care and teach patient regarding self-care	8	
	4. With supervision, manage patients with common clinical disorders seen in the practice of inpatient and ambulatory general internal medicine	16	
	5. With minimal supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory general internal medicine	16	
	6. Initiate management and stabilize patients with emergent medical conditions	16	
	7. Manage patients with conditions that require intensive care	48	

	8. Independently manage patients with a broad spectrum of clinical disorders seen in the practice of general internal medicine	48	
	9. Manage complex or rare medical conditions	48	
	10. Customize care in the context of the patient's preferences and overall health	48	
	Consultative care		
	1. Provide specific, responsive consultation to other services	32	☐ Simulation ☐ Chart-stimulated recall ☐ Multisource
	2. Provide internal medicine consultation for patients with more complex clinical problems	48	

	requiring detailed risk assessment		feedback Direct observation Chart audit

Table-2 Developmental Milestones for Internal Medicine Training— Medical Knowledge

Competency	Developmental Milestones Informing Competencies	Approximate Time Frame Trainee Should Achieve Stage (months)	General Evaluation Strategies Assessment Methods/ Tools
A. Core knowledge of general internal medicine and its subspecialties • Demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist • Demonstrate sufficient knowledge to treat medical conditions commonly managed by internists, provide basic preventive care, and recognize and provide initial	***Knowledge of core content***		
	1. Understand the relevant pathophysiology and basic science for common medical conditions	8	• Direct observation • Chart audit • Chart-stimulated recall • Standardized tests
	2. Demonstrate sufficient knowledge to diagnose and treat common conditions that require hospitalization	16	
	3. Demonstrate sufficient knowledge to evaluate common ambulatory conditions	24	
	4. Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions	24	
	5. Demonstrate sufficient knowledge to provide preventive care	24	

management of emergency medical problems	6. Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care	32	
	7. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions	48	
	8. Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions	48	
	9. Demonstrate sufficient knowledge of sociobehavioral	48	
	sciences including but not limited to health care economics, medical ethics, and medical education		
B. Common modalities used in the practice of internal medicine& Demonstrate sufficient knowledge to interpret basic clinical tests and images, use common pharmacotherapy, and appropriately use and perform diagnostic and therapeutic procedures.	***Diagnostic tests***		
	1. Understand indications for and basic interpretation of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis, and other body fluids	16	□ Chart-stimulated recall □ Standardized tests □ Clinical vignettes

	2. Understand indications for and has basic skills in interpreting more advanced diagnostic tests	24	
	3. Understand prior probability and test performance characteristics	24	

Table-3 Developmental Milestones for Internal Medicine Training— Practice-Based Learning and Improvement

Competency	Developmental Milestones Informing Competencies	Approximate Time Frame Trainee Should Achieve Stage (months)	General Evaluation Strategies Assessment Methods/ Tools
A. Learning and improving via audit of performance& Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement	***Improve the quality of care for a panel of patients***		
	1. Appreciate the responsibility to assess and improve care collectively for a panel of patients	16	• Several elements of quality improvement project • Standardized tests
	2. Perform or review audit of a panel of patients using standardized, diseasespecific, and evidence-based criteria	32	
	3. Reflect on audit compared with local or national benchmarks and explore possible explanations for deficiencies, including doctor- related, system-related, and patient related factors	32	

	4. Identify areas in resident's own practice and local system that can be changed to improve effect of the processes and outcomes of care	48	
	5. Engage in a quality improvement intervention	48	
B. Learning and improvement via answering clinical questions from patient scenarios • Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; • Use information technology to optimize learning	***Ask answerable questions for emerging information needs***		
	1. Identify learning needs (clinical questions) as they emerge in patient care activities	16	• Evidence-based medicine evaluation instruments • EBM mini-CEX • Chart-stimulated recall
	2. Classify and precisely articulate clinical questions	32	
	3. Develop a system to track, pursue, and reflect on clinical questions	32	
	Acquires the best evidence		
	1. Access medical information resources to answer clinical questions and support decision making	16	• Evidence-based medicine evaluation instruments • EBM mini-CEX • Chart-stimulated recall
	2. Effectively and efficiently search NLM database for original clinical research articles	16	
	3. Effectively and efficiently search evidence- based summary medical information resources	32	
	4. Appraise the quality of medical information resources and select among them based on the	48	

	characteristics of the clinical question		
	Appraises the evidence for validity and usefulness		
	1. With assistance, appraise study design, conduct, and statistical analysis in clinical research papers	16	Evidence-based medicine evaluation instruments EBM mini-CEX Chart-stimulated recall
	2. With assistance, appraise clinical guidelines	32	
	3. Independently appraise study design, conduct, and statistical analysis in clinical research papers	48	
	4. Independently, appraise clinical guideline recommendations for bias and cost-benefit considerations	48	
	Applies the evidence to decision-making for individual patients		
	1. Determine if clinical evidence can be generalized to an individual patient	16	Evidence-based medicine evaluation instruments EBM mini-CEX Chart-stimulated recall
	2. Customize clinical evidence for an individual patient	32	
	3. Communicate risks and benefits of alternatives to patients	48	
	4. Integrate clinical evidence, clinical context, and patient preferences into decision making	48	
	Improves via feedback		

C. Learning and improving via feedback and selfassessment • Identify strengths, deficiencies, and limits in one's knowledge and expertise • Set learning and improvement goals • Identify and perform appropriate learning activities • Incorporate formative evaluation	1. Respond welcomingly and productively to feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients, and their advocates	16	Multisource feedback Self-evaluation forms with action plans
	2. Actively seek feedback from all members of the health care team	24	
	3. Calibrate self-assessment with feedback and other external data	32	
	4. Reflect on feedback in developing plans for improvement	32	
	Improves via self-assessment		
	1. Maintain awareness of the situation in the moment, and respond to meet	32	Multisource feedback
feedback into daily practice Participate in the education of patients, families, students, residents, and other health professionals	situational needs		Reflective practice surveys
	2. Reflect (in action) when surprised, applies new insights to future clinical scenarios, and reflects (on action) back on the process	48	
	Participates in the education of all members of the health care team		
	1. Actively participate in teaching conferences	16	OSCE with standardized learners Direct observation Peer evaluations
	2. Integrate teaching, feedback, and evaluation with supervision of interns' and students' patient care	32	

	3. Take a leadership role in the education of all members of the health care team.	48	

Table-4 Developmental Milestones for dermatology— Interpersonal and Communication Skills

Competency	Developmental Milestones Informing Competencies	Approximate Time Frame Trainee Should Achieve Stage (months)	General Evaluation Strategies Assessment Methods/ Tools
A. Patients and family Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds	***Communicate effectively***		
	1. Provide timely and comprehensive verbal and written communication to patients/advocates	16	• Multisource feedback • Patient surveys • Direct observation • Mentored self-reflection
	2. Effectively use verbal and nonverbal skills to create rapport with patients/families	16	
	3. Use communication skills to build a therapeutic relationship		
	4. Engage patients/advocates in shared decision making for uncomplicated diagnostic and therapeutic scenarios	32	
	5. Use patient-centered education strategies	32	
	6. Engage patients/advocates in shared decision making for difficult, ambiguous, or controversial scenarios	48	

	7. Appropriately counsel patients about the risks and benefits of tests and procedures, highlighting cost awareness and resource allocation	48	
	8. Role model effective communication skills in challenging situations	48	
	Intercultural sensitivity		
	1. Effectively use an interpreter to engage patients in the clinical setting, including patient education	8	☐ Multisource feedback ☐ Direct observation ☐ Mentored self-reflection
	2. Demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs	16	
	3. Actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team	40	
B. Physicians and other health care professionals • Communicate effectively with physicians, other health	***Transitions of care***		
	1. Effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care	16	☐ Multisource feedback ☐ Direct observation ☐ Sign-out form ratings ☐ Patient surveys
	2. Role model and teach effective communication with next caregivers during transitions of care	32	

professionals, and healthrelated agencies • Work effectively as a member or leader of a health care team or other professional group • Act in a consultative role to other physicians and	***Interprofessional team***		
	1. Deliver appropriate, succinct, hypothesisdriven oral presentations	8	Multisource feedback
	2. Effectively communicate plan of care to all members of the health care team	16	
	3. Engage in collaborative communication with all members of the health care team	40	
	Consultation		
	1. Request consultative services in an effective manner	8	Multisource feedback Chart audit
	2. Clearly communicate the role of consultant to the patient, in support of the primary care relationship	16	
	3. Communicate consultative recommendations to the referring team in an effective manner	48	

health professionals			
C. Medical records • Maintain comprehensive, timely, and legible medical records	***Health records***		
	1. Provide legible, accurate, complete, and timely written communication that is congruent with medical standards	8	• Chart audit
	2. Ensure succinct, relevant, and patient-specific written communication	32	

Table-5 Developmental Milestones for Internal Medicine Training— Professionalism

Competency	Developmental Milestones Informing Competencies	Approximate Time Frame Trainee Should Achieve Stage (months)	General Evaluation Strategies Assessment Methods/ Tools
A. Physician ship	***Adhere to basic ethical principles***		
• Demonstrate compassion, integrity, and respect for others • Responsiveness to patient needs that supersedes selfinterest • Account- ability to patients, society, and the profession	1. Document and report clinical information truthfully	1.5	• Multisource feedback
	2. Follow formal policies	1.5	
	3. Accept personal errors and honestly acknowledge them	8	
	4. Uphold ethical expectations of research and scholarly activity	48	
	Demonstrate compassion and respect to patients		
	1. Demonstrate empathy and compassion to all patients	4	• Multisource feedback

	2. Demonstrate a commitment to relieve pain and suffering	4	
	3. Provide support (physical, psychological, social, and spiritual) for dying patients and their families	32	
	4. Provide leadership for a team that respects patient dignity and autonomy	32	
	Provide timely, constructive feedback to colleagues		
	1. Communicate constructive feedback to other members of the health care team	16	• Multisource feedback • Mentored self-reflection
	2. Recognize, respond to, and report impairment in colleagues or substandard care via peer review process	24	Direct observation
	Maintain accessibility		
	1. Respond promptly and appropriately to clinical responsibilities including but not limited to calls and pages	1.5	Multisource feedback
	2. Carry out timely interactions with colleagues, patients, and their designated caregivers	8	
	Recognize conflicts of interest		
	1. Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients	8	• Multisource feedback • Mentored self-reflection • Clinical vignettes
	2. Maintain ethical relationships with industry	40	

	3. Recognize and manage subtler conflicts of interest	40	
	Demonstrate personal accountability		
	1. Dress and behave appropriately	1.5	• Multisource feedback • Direct observation
	2. Maintain appropriate professional relationships with patients, families, and staff	1.5	
	3. Ensure prompt completion of clinical, administrative, and curricular tasks	8	
	4. Recognize and address personal, psychological, and physical limitations that may affect professional performance	16	
	5. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately	16	
	6. Serve as a professional role model for more junior colleagues (eg, medical students, interns)	40	
	7. Recognize the need to assist colleagues in the provision of duties	40	

	Practice individual patient advocacy		
	1. Recognize when it is necessary to advocate for individual patient needs	8	☐ Multisource feedback ☐ Direct observation
	2. Effectively advocate for individual patient needs	40	
	Comply with public health policies		
	1. Recognize and take responsibility for situations where public health supersedes individual health (eg, reportable infectious diseases)	32	☐ Multisource feedback

B. Patient-centeredness □ Respect for patient privacy and autonomy Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation	***Respect the dignity, culture, beliefs, values, and opinions of the patient***		
	1. Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age, or socioeconomic status	1.5	□ Multisource feedback □ Direct observation
	2. Recognize and manage conflict when patient values differ from their own	40	
	Confidentiality		
	1. Maintain patient confidentiality	1.5	□ Multisource feedback □ Chart audits
	2. Educate and hold others accountable for patient confidentiality	24	
	Recognize and address disparities in health care		
	1. Recognize that disparities exist in health care among populations and that they may impact care of the patient	16	□ Multisource feedback □ Direct observation □ Mentored self-reflection
	2. Embrace physicians' role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering	40	
	3. Advocates for appropriate allocation of limited health care resources.	40	

Table-6 Developmental Milestones for Internal Medicine Training— Systems-Based Practice

Competency	Developmental Milestones Informing Competencies	Approximate Time Frame Trainee Should Achieve Stage (months)	General Evaluation Strategies Assessment Methods/ Tools
A. Work effectively with other care providers and settings	***Works effectively within multiple health delivery systems***		
Work effectively in various health care delivery settings and systems relevant to their clinical practice	1. Understand unique roles and services provided by local health care delivery systems.	16	• Multisource feedback • Chart-stimulated recall • Direct observation
	2. Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, subacute, acute,	32	
Coordinate patient care within the health care system relevant to their clinical specialty Work in interprofessional teams to enhance patient safety and improve patient care quality Work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients, including the transition of care between settings	rehabilitation, and skilled nursing.		
	3. Negotiate patient-centered care among multiple care providers.	48	
	Works effectively within an interprofessional team		
	1. Appreciate roles of a variety of health care providers, including but not limited to consultants, therapists, nurses, home care workers, pharmacists, and social workers.	8	• Multisource feedback • Chart-stimulated recall • Direct observation
	2. Work effectively as a member within the interprofessional team to ensure safe patient care.	8	
	3. Consider alternative solutions provided by other teammates	16	

	4. Demonstrate how to manage the team by using the skills and coordinating the activities of interprofessional team members.	48	
B. Improving health care delivery Advocate for quality patient care and optimal patient care systems Participate in identifying system errors and implementing potential systems solutions Recognize and function effectively in high-quality care system	***Recognizes system error and advocates for system improvement***		
	1. Recognize health system forces that increase the risk for error including barriers to optimal patient care	16	• Multisource feedback • Quality improvement project
	2. Identify, reflect on, and learn from critical incidents such as near misses and preventable medical errors	16	
	3. Dialogue with care team members to identify risk for and prevention of medical error	32	
	4. Understand mechanisms for analysis and correction of systems errors	32	
	5. Demonstrate ability to understand and engage in a system-level quality improvement intervention.	48	
	6. Partner with other health care professionals to identify, propose improvement opportunities	48	

	within the system.		
C. Cost-effective care for patients and populations & Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population- based care as appropriate	***Identifies forces that impact the cost of health care and advocates for cost-effective care***		
	1. Reflect awareness of common socioeconomic barriers that impact patient care.	16	• Standardized examinations • Direct observation • Chart-stimulated recall
	2. Understand how cost-benefit analysis is applied to patient care (ie, via principles of screening tests and the development of clinical guidelines)	16	
	3. Identify the role of various health care stakeholders including providers, suppliers, financiers, purchasers, and consumers and their varied impact on the cost of and access to health care.	32	
	4. Understand coding and reimbursement principles.	32	
	Practices cost-effective care		
	1. Identify costs for common diagnostic or therapeutic tests.	8	□ Chart-stimulated recall
	2. Minimize unnecessary care including tests, procedures, therapies, and ambulatory or hospital encounters	8	

	3. Demonstrate the incorporation of costawareness principles into standard clinical judgments and decision making	24	
	4. Demonstrate the incorporation of costawareness principles into complex clinical scenarios	48	

SECTION -1	MORNING REPORT PRESENTATION/ CASE PRESENTATION SEEN IN LAST EMERGENCY OR INDOOR

	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#					

DATE

SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

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SR#	DATE	REG# OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -2	TOPIC PRESENTATION/SEMINAR

SR#		NAME OF THE TOPIC & BRIEF DETAILS OF THE ASPECTS COVERED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

DATE

SR#	DATE	NAME OF THE TOPIC & BRIEF DETAILS OF THE ASPECTS COVERED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -3

JOURNAL CLUB

SR#	DATE

TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	TITLE OF THE ARTICLE	NAME OF JOURNAL	DATE OF PUBLICATION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -4	PROBLEM CASE DISCUSSION

SR #	DATE	REG.# OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR #	DATE	REG.# OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -5	DIDACTIC LECTURES/INTERACTIVE LECTURES

SR #		TOPIC & BRIEF DESCRIPTION	NAME OF THE TEACHER	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

DATE

SR #	DATE	TOPIC & BRIEF DESCRIPTION	NAME OF THE TEACHER	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR #	DATE	TOPIC & BRIEF DESCRIPTION	NAME OF THE TEACHER	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-6

EMERGENCY CASES (Repetition of Cases Should Be Avoided)
(Estimated 50 cases to be documented/Year) (8 cases/month)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -7	**INDOOR PATIENTS (repetition of cases should be avoided)** (Estimated cases to be attended are 30 patients per year)

SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

R#	DATE	REG # OF THE PATIENT	DIAGNOSIS	MANAGEMENT	PROCEDURES PERFORMED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -8	**OPD AND CLINICS (repetition of cases should be avoided)**

(Estimated cases to be attended are 100 patients per month)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

R#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -9	**MEDICAL PROCEDURES** **OBSERVED (O)/ASSISTED (A)/ PERFORMED UNDER SUPERVISION (PUS)/PERFORMED INDEPENDENTLY (PI)**

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS)/ (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS) / (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	REG NO. OF PATIENT	NAME OF PROCEDURE	(O)/(A)/(PUS) / (PI)	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-10	MULTI DICIPLINARY MEETINGS

SR#	DATE	BRIEF DESCRIPTION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	BRIEF DESCRIPTION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -11	**CLINICOPATHOLOGICAL CONFERENCE (CPC)**

(50% attendance of CPC is mandatory for the resident every year)

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	BRIEF DESCRIPTION OF THE TOPIC/CASE DISCUSSED	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-12

MORBIDITY/MORTALITY MEETINGS

(T Morbidity/Mortality Meetings to be attended TWO Morbidity/Mortality Meetings per year)

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	REG. # OF THE PATIENT DISCUSSED	BRIEF DESCRIPTION OF THE CASE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -13 HANDS ON TRAINING/WORKSHOPS

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION - 14	PUBLICATIONS

SNO.		TYPE OF PUBLICATION ORIGINAL ARTICLE /EDITORIAL/CASE REPORT ETC	NAME OF JOURANL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

NAME OF PUBLICATION

SNO.	NAME OF PUBLICATION	TYPE OF PUBLICATION ORIGINAL ARTICLE /EDITORIAL/CASE REPORT ETC	NAME OF JOURANL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -15	MAJOR RESEARCH PROJECT DURING MD TRAINING/ANY OTHER MAJOR RESEARCH PROJECT

SNO.	TOPIC	PLACE OF RESEARCH	NAME AND DESIGNATION OF SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SNO.	RESEARCH TOPIC	PLACE OF RESEARCH	NAME AND DESIGNATION OF SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION - 16

WRITTEN ASSESSMENT RECORD

S.NO	WRITTEN MINATION	TYPE OF THE TEST MCQS OR SEQS OR BOTH	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

TOPIC OF TEST/EXA						

S.NO	TOPIC OF WRITTEN TEST/EXAMINATION	TYPE OF THE TEST MCQS OR SEQS OR BOTH	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION -17	CLINICAL ASSESSMENT RECORD

SR.#	DATE	TOPIC OF CLINICAL TEST/ EXAMINATION	TYPE OF THE TEST& VENUE (OSPE, MINICEX, CHART STIMULATED RECALL, DOPS, SIMULATED PATIENT, SKILL LAB e.t.c)	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SR.#	DATE	TOPIC OF CLINICAL TEST/ EXAMINATION	TYPE OF THE TEST& VENUE OSPE, MINICEX, CHART STIMULATED RECALL, DOPS, SIMULATED PATIENT, SKILL LAB e.t.c	TOTAL MARKS	MARKS OBTAINED	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)

SECTION-18	

Evaluation records

RAWALPINDI MEDICAL UNIVERSITY

SUPERVISOR APPRAISAL FORM

To Be Filled At the End of 1st Year of Training

Hospital Name: _____

_____ Department: _____ Unit : _____ one of the llowing ratings to describe the performance of the individual in each of the categories.

Unsatisfactory	Performance does not meet expectations for the job
Needs Improvement	Performance sometimes meets expectations for the job
Good	Performance often exceeds expectations for the job
Merit	Performance consistently meets expectations for the job
Special Merit	Performance consistently exceeds expectations for the job

Resident's Name:
Evaluator's Name(s):

1. Use

	I. CLINICAL KNOWLEDGE / TECHNICAL SKILLS	5	4	3	2	1
1	Clinical Knowledge is up to the mark					
2	Follows procedures and clinical methods according to SOPs					
3	Uses techniques, materials, tools & equipment skillfully					
4	Stays current with technology and job-related expertise					
5	Works efficiently in various workshops					
	Has interest in learning new skills and procedures					

a)	Understands & performs assigned duties and job requirements					
b)						
c)	**II. QUALITY / QUANTITY OF WORK**	5	4	3	2	1
d)	Sets and adheres to protocols and improving the skills					
e)	Exihibts system based learning methods smartly					
f)	Exihibts practice based learning methods efficaciously					
g)	Actively participates in large group interactive sessions for postgraduate trainees					
a)	Actively takes part in morning& evening teaching and learning sessions & noon conferences					
b)	Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
c)	Actively participates in Journal clubs					
d)	Uses resources sensibly and economically					
e)						
f)						
g)						
h)						

i) Accomplishes accurate management of different medical cases with minimal assistance or supervision					
j) Provides best possible patient care					
III. INITIATIVE / JUDGMENT	5	4	3	2	1
a) Takes effective action without being told					
b) Analyzes different emergency cases and suggests effective solutions					
c) Develops realistic plans to accomplish assignments					
IV. DEPENDABILITY / SELF-MANAGEMENT	5	4	3	2	1
a) Demonstrates punctuality and regularly begins work as scheduled					
b) Contacts supervisor concerning absences on a timely basis					
c) Contacts supervisor without any delay regarding any difficulty in managing any patient					
d) Can be depended upon to be available for work independently					
e) Manages own time effectively					
f) Manages Outdoor Patient Department (OPD) efficiently					
g) Accepts responsibility for own actions and ensuing results					
h) Demonstrates commitment to service					
i) Shows Professionalism in handling patients					
j) Offers assistance, is courteous and works well with colleagues					
k) Is respectful with the seniors					
OVERALL RATINGS/SUGGESTIONS/REMARKS REGARDING PERFORMANCE OF THE TRAINEE					

Total Score _____/155

_____	_____	_____	_____
Date	Resident's Name &Signatures	Date	Evaluator's Signature &Stamp

RAWALPINDI MEDICAL UNIVERSITY
SUPERVISOR APPRAISAL FORM

To Be Filled At The End Of 2nd Year Of Training

Hospital Name: _____

Department :_____ Unit : _____

1. Use one of the following ratings to describe the performance of the individual in each of the categories.

1	**Unsatisfactory**	Performance does not meet expectations for the job
2	**Needs Improvement**	Performance sometimes meets expectations for the job
3	**Good**	Performance often exceeds expectations for the job
4	**Merit**	Performance consistently meets expectations for the job
5	**Special Merit**	Performance consistently exceeds expectations for the job

I. CLINICAL KNOWLEDGE / TECHNICAL SKILLS	5	4	3	2	1
a) Clinical Knowledge is up to the mark					
b) Follows procedures and clinical methods according to SOPs					
c) Uses techniques, materials, tools & equipment skillfully					
d) Stays current with technology and job-related expertise					
e) Works efficiently in various workshops					
f) Has interest in learning new skills and procedures					
g) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1

Resident's Name: _____

Evaluator's Name(s): _____

a) Sets and adheres to protocols and improving the skills					
b) Exihibts system based learning methods smartly					
c) Exihibts practice based learning methods efficaciously					
d) Actively participates in large group interactive sessions for postgraduate trainees					
e) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
f) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
h) Uses resources sensibly and economically					
i) Accomplishes accurate management of different medical cases with minimal assistance or					
supervision					
j) Provides best possible patient care					
III. INITIATIVE / JUDGMENT	5	4	3	2	1
a) Takes effective action without being told					
b) Analyzes different emergency cases and suggests effective solutions					
c) Develops realistic plans to accomplish assignments					
IV. DEPENDABILITY / SELF-MANAGEMENT	5	4	3	2	1
a) Demonstrates punctuality and regularly begins work as scheduled					
b) Contacts supervisor concerning absences on a timely basis					
c) Contacts supervisor without any delay regarding any difficulty in managing any patient					
d) Can be depended upon to be available for work independently					

e) Manages own time effectively					
f) Manages Outdoor Patient Department (OPD) efficiently					
g) Accepts responsibility for own actions and ensuing results					
h) Demonstrates commitment to service					
i) Shows Professionalism in handling patients					
j) Offers assistance, is courteous and works well with colleagues					
k) Is respectful with the seniors					
OVERALL RATINGS/SUGGESTIONS/REMARKS REGARDING PERFORMANCE OF THE TRAINEE					

Total Score _____/155

_____ _____ _____ _____

Date Resident's Name &Signatures Date Evaluator's Signature &Stamp

To Be Filled At the End Of 3rd Year Of Training

Resident's Name: _____

Evaluator's Name(s): _____

RAWALPINDI MEDICAL UNIVERSITY

SUPERVISOR APPRAISAL FORM

Hospital Name: _____

Department :_____ **Unit :** _____

1. Use one of the following ratings to describe the performance of the individual in each of the categories.

1	**Unsatisfactory**	Performance does not meet expectations for the job
2	**Needs Improvement**	Performance sometimes meets expectations for the job
3	**Good**	Performance often exceeds expectations for the job
4	**Merit**	Performance consistently meets expectations for the job
5	**Special Merit**	Performance consistently exceeds expectations for the job

I. CLINICAL KNOWLEDGE / TECHNICAL SKILLS	5	4	3	2	1
a) Clinical Knowledge is up to the mark					
b) Follows procedures and clinical methods according to SOPs					
c) Uses techniques, materials, tools & equipment skillfully					
d) Stays current with technology and job-related expertise					
e) Works efficiently in various workshops					
f) Has interest in learning new skills and procedures					
g) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1

a) Sets and adheres to protocols and improving the skills					
b) Exihibts system based learning methods smartly					
c) Exihibts practice based learning methods efficaciously					
d) Actively participates in large group interactive sessions for postgraduate trainees					
e) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
f) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
h) Uses resources sensibly and economically					
i) Accomplishes accurate management of different medical cases with minimal assistance or supervision					
j) Provides best possible patient care					
III. INITIATIVE / JUDGMENT	5	4	3	2	1
a) Takes effective action without being told					
b) Analyzes different emergency cases and suggests effective solutions					
c) Develops realistic plans to accomplish assignments					
IV. DEPENDABILITY / SELF-MANAGEMENT	5	4	3	2	1
a) Demonstrates punctuality and regularly begins work as scheduled					
b) Contacts supervisor concerning absences on a timely basis					
c) Contacts supervisor without any delay regarding any difficulty in managing any patient					
d) Can be depended upon to be available for work independently					

Resident's Name: _____

Evaluator's Name(s): _____

e) Manages own time effectively					
f) Manages Outdoor Patient Department (OPD) efficiently					
g) Accepts responsibility for own actions and ensuing results					
h) Demonstrates commitment to service					
i) Shows Professionalism in handling patients					
j) Offers assistance, is courteous and works well with colleagues					
k) Is respectful with the seniors					
OVERALL RATINGS/SUGGESTIONS/REMARKS REGARDING PERFORMANCE OF THE TRAINEE					

Total Score _____/155

_____ _____ _____ _____

Date Resident's Name &Signatures Date Evaluator's Signature &Stamp

To Be Filled At The End Of 4th Year Of Training

RAWALPINDI MEDICAL UNIVERSITY
SUPERVISOR APPRAISAL FORM

Hospital Name: _____

Department: _____ Unit : _____

1. Use one of the following ratings to describe the performance of the individual in each of the categories.

1	**Unsatisfactory**	Performance does not meet expectations for the job
2	**Needs Improvement**	Performance sometimes meets expectations for the job
3	**Good**	Performance often exceeds expectations for the job
4	**Merit**	Performance consistently meets expectations for the job
5	**Special Merit**	Performance consistently exceeds expectations for the job

I. CLINICAL KNOWLEDGE / TECHNICAL SKILLS	5	4	3	2	1
a) Clinical Knowledge is up to the mark					
b) Follows procedures and clinical methods according to SOPs					
c) Uses techniques, materials, tools & equipment skillfully					
d) Stays current with technology and job-related expertise					
e) Works efficiently in various workshops					
f) Has interest in learning new skills and procedures					
g) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1

Resident's Name: _____

Evaluator's Name(s): _____

a) Sets and adheres to protocols and improving the skills					
b) Exihibts system based learning methods smartly					
c) Exihibts practice based learning methods efficaciously					
d) Actively participates in large group interactive sessions for postgraduate trainees					
e) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
f) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
h) Uses resources sensibly and economically					
i) Accomplishes accurate management of different medical cases with minimal assistance or					
supervision					
j) Provides best possible patient care					
III. INITIATIVE / JUDGMENT	5	4	3	2	1
a) Takes effective action without being told					
b) Analyzes different emergency cases and suggests effective solutions					
c) Develops realistic plans to accomplish assignments					
IV. DEPENDABILITY / SELF-MANAGEMENT	5	4	3	2	1
a) Demonstrates punctuality and regularly begins work as scheduled					
b) Contacts supervisor concerning absences on a timely basis					
c) Contacts supervisor without any delay regarding any difficulty in managing any patient					
d) Can be depended upon to be available for work independently					

e) Manages own time effectively					
f) Manages Outdoor Patient Department (OPD) efficiently					
g) Accepts responsibility for own actions and ensuing results					
h) Demonstrates commitment to service					
i) Shows Professionalism in handling patients					
j) Offers assistance, is courteous and works well with colleagues					
k) Is respectful with the seniors					
OVERALL RATINGS/SUGGESTIONS/REMARKS REGARDING PERFORMANCE OF THE TRAINEE					

Total Score _____/155

_____	_____	_____	_____
Date	Resident's Name &Signatures	Date	Evaluator's Signature &Stamp

SECTION-18	UATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL

SECTION-18	ATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL

EDUCATION (DME) (AT THE END OF 2ND YEAR OF TRAINING)

SECTION-18	ON / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL

EDUCATION (DME) (AT THE END OF 3RD YEAR OF TRAINING)

SECTION-18	ATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL

EDUCATION (DME) (AT THE END OF 4th YEAR OF TRAINING)

SECTION=18

/ REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME) 1ST YEAR OF TRAINING)

(AT THE END OF

SECTION=18	/ REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME) 2ND YEAR OF TRAINING)

(AT THE END OF

SECTION -18

N / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME) 3RD YEAR OF TRAINING)

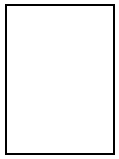
(AT THE END OF

SECTION -18 / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME) 4th YEAR OF TRAINING)

(AT THE END OF

SECTION - 19	**LEAVE RECORD** ned & Approved Leave Application/Certificate to Be Kept In Record and To Be Brought In Meetings with URTMC & QEC)

SR.#	TYPE OF LEAVE(Casual Leave, Sick Leave, Ex –Pak Leave, Maternity Leave, Any Other Kind Of Leave)	YEAR	DATE		REASON	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (Name/Stamp)
			FROM	TO			



SECTION -20

Year - I

TO BE FILLED AT THE END OF FIRST YEAR OF TRAINING

RECORD SHEET OF ATTENDANCE/COUNCELLING SESSION/DOCUMENTATION QUALITY PER YEAR

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
January	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
February	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	

March	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - I

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
April	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
May	WARD												
	CPC												

	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
June	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - I

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	

July	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
August	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
September	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - I

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
October	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
November	WARD												
	CPC												
	LECTURE												

	WORKSHOP												

MONTH	**ATTENDANCE RECORD**				**DOCUMENTATION QUALITY**					**COUNCELLING SESSION**			**SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)**
		TOTAL	**ATTENDED**	**%**	**Poor**	**Average**	**Good**	**V. Good**	**Excellent**	**YES**	**NO**	**IF YES THEN NUMBER OF SESSIONS**	
December	**WARD**												
	CPC												
	LECTURE												
	WORKSHOP												

Year - II

TO BE FILLED AT THE END OF SECOND YEAR OF TRAINING

MONTH	**ATTENDANCE RECORD**				**DOCUMENTATION QUALITY**					**COUNCELLING SESSION**			**SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)**
		TOTAL	**ATTENDED**	**%**	**Poor**	**Average**	**Good**	**V. Good**	**Excellent**	**YES**	**NO**	**IF YES THEN NUMBER OF SESSIONS**	

January	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
February	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
March	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - II

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
April	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
May	WARD												
	CPC												
	LECTURE												

	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
June	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - II

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
July	WARD												
	CPC												

	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
August	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
September	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - II

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
October	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
	WARD												
	CPC												

November	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - III

TO BE FILLED AT THE END OF THIRD YEAR OF TRAINING

		ATTENDANCE RECORD	DOCUMENTATION QUALITY	COUNCELLING SESSION	SUPERVISOR'S REMARKS

MONTH		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	SIGNATURE (Name/Stamp)
January	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
February	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
March	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - III

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
April	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
May	WARD												
	CPC												

	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
June	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - III

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	

July	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
August	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
September	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - III

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
October	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
	WARD												
	CPC												

November	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - IV

TO BE FILLED AT THE END OF FOURTH YEAR OF TRAINING

		ATTENDANCE RECORD	DOCUMENTATION QUALITY	COUNCELLING SESSION	SUPERVISOR'S REMARKS

MONTH		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	SIGNATURE (Name/Stamp)
January	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
February	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
March	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - IV

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
April	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
May	WARD												
	CPC												

	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
June	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - IV

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	

July	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
August	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
September	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

Year - IV

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
October	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH	ATTENDANCE RECORD				DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
	WARD												
	CPC												

November	LECTURE												
	WORKSHOP												

MONTH		ATTENDANCE RECORD			DOCUMENTATION QUALITY					COUNCELLING SESSION			SUPERVISOR'S REMARKS SIGNATURE (Name/Stamp)
		TOTAL	ATTENDED	%	Poor	Average	Good	V. Good	Excellent	YES	NO	IF YES THEN NUMBER OF SESSIONS	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

SECTION-21

ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS

SECTION -21	ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS