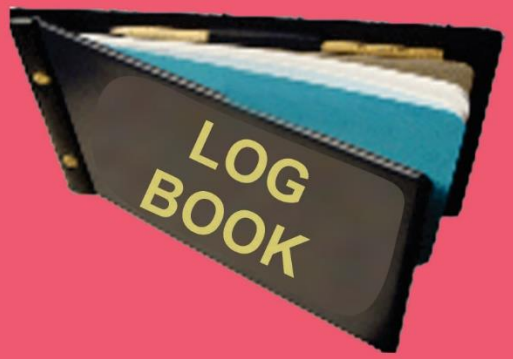
LOG

RAWALPINDI MEDICAL UNIVERSITY

# UNIVERSITY RESIDENCY PROGRAM- 2020 OF EMERGENCY MEDICINE

BOOK



# RAWALPINDI MEDICAL UNIVERSITY RAWALPINDI

# UNIVERSITY RESIDENCY PROGRAM -2019LOG BOOK FOR EMERGENCY MEDICINE

*"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.

***Prof. Muhammad Umar***
***(Sitara-e-Imtiaz)***
*(MBBS, MCPS, FCPS, FACG,*
*FRCP (Lon), FRCP (Glasg), AGAF)*
***Vice Chancellor***
***Rawalpindi Medical University***
***& Allied Hospitals***

# CONTRIBUTIONS

| | NAME & DESIGNATION | | CONTRIBUTIONS IN FORMULATION OF LOG BOOK OF MEDICINE & ALLIED |
|---|---|---|---|
| 1. |  | **DR SAMIA SARWAR, MBBS. FCPS**<br>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.<br>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**<br>Ex-Professor of Medicine<br>Head Department of Gastroenterology<br>Holy Family Hospital<br>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**<br>Professor of Medicine<br>Dean of Medicine RMU | Provision of required number of clinical procedures & educational activities for<br>each year separately and rotation of Log Books of MD Medicine & Allied & Log Book for MD Internal Medicine rotation. |
| 4. |  | **DR FARZANA FATIMA, MBBS**<br>Demonstrator / WMO<br>Medical Education Department<br>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**<br>Computer Operator<br>Physiology Department<br>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.*

***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 | 10 per month |
| 05 | Large group teaching | 06 per month |
| 06 | Emergency cases | 10 per month |
| 07 | OPD | 50 per month |
| 08 | Indoor (patients allotted) | 8 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 AND 4TH 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 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 3 Months | | 6 Months | | 9 Months | | 12 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 | | | | |
|---|---|---|---|---|---|
| | 15 Months | | 18 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 AND 4TH YEAR MD MEDICINE 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** | | | | | | | | | |
| Pleural aspiration | 4 | 2 | 4 | 2 | 4 | 2 | 4 | 2 | 8 |
| Peritoneal aspiration | 4 | 2 | 4 | 2 | 4 | 2 | 4 | 2 | 8 |
| Lumbar puncture | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 |
| Nasogastric intubation | 4 | 2 | 4 | 2 | ` | 1 | 4 | 1 | 6 |
| Uretheral catheterization | 4 | 2 | 4 | 2 | 4 | 1 | 4 | 1 | 6 |
| Recording and reporting ECG | 4 | 3 | 4 | 3 | 4 | 3 | 4 | 3 | 12 |
| Proctoscopy | 3 | 1 | 3 | 1 | - | - | - | - | 2 |
| Endotracheal intubation | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 |
| Insertion of CVP lines | 4 | 2 | 4 | 2 | 4 | 2 | 4 | 2 | 8 |
| Arterial puncture | 3 | 1 | 3 | 1 | - | - | - | - | 2 |
| Liver biopsy | 3 | 1 | 3 | 1 | - | - | - | - | 2 |
| Pleural biopsy | 2 | 1 | 2 | 1 | - | - | - | - | 2 |
| Joint aspiration | 3 | 1 | - | - | - | - | - | - | 1 |
| Bone marrow aspiration | 2 | 1 | - | - | - | - | - | - | 1 |
| Renal biopsy | - | - | - | - | 2 | 2 | - | - | 2 |
| Haemodialysis | 2 | 2 | - | - | 2 | 2 | - | - | 4 |
| Upper G.I. endoscopy | 2 | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 4 |

| 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** | | | | | | | | | |
| Colonoscopy | 2 | 1 | 2 | 1 | - | - | - | - | 2 |
| Bronchoscopy | 2 | 1 | - | - | - | - | - | - | 1 |
| Abdominal ultrasound | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 4 |
| Exercise tolerance test | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 4 |
| Echocardiography | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 4 |
| CAT scan Head,Thorax and Abdomen | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 4 |
| Electroencephalography (EEG) | 1 | 1 | - | - | - | - | - | - | 1 |
| Electromyography/Nerve conduction studies (EMG/NCS) | 1 | 1 | - | - | - | - | - | - | 1 |
| Chest intubation | 2 | 1 | - | - | - | - | - | - | 1 |

| 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** | | | | | |
| Pleural aspiration | 4 | 2 | 4 | 2 | 4 |
| Peritoneal aspiration | 4 | 2 | 4 | 2 | 4 |
| Lumbar puncture | 4 | 1 | 4 | 1 | 2 |
| Nasogastric intubation | 4 | 10 | 4 | 10 | 20 |
| Urethral catheterization | 4 | 10 | 4 | 1 | 2 |
| Recording and reporting ECG | 4 | 10 | 4 | 2 | 4 |
| Proctoscopy | 4 | 1 | 4 | 1 | 2 |
| Endotracheal intubation | 4 | 1 | 4 | 1 | 2 |
| Insertion of CVP lines | 4 | 4 | 4 | 4 | 8 |
| Arterial puncture | 4 | 1 | 4 | 1 | 2 |
| Liver biopsy | 4 | 1 | 4 | 1 | 2 |
| Pleural biopsy | 3 | 1 | 3 | 1 | 2 |
| Joint aspiration | 4 | 2 | 4 | 2 | 4 |
| Bone marrow aspiration | 3 | 2 | 3 | 2 | 4 |
| Renal biopsy | - | - | - | - | - |
| Haemodialysis | 3 | 1 | 3 | 1 | 2 |
| Upper G.I. endoscopy | 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** | | | | | |
| Colonoscopy | 2 | 1 | 2 | 1 | 2 |
| Bronchoscopy | 2 | 1 | - | - | 1 |
| Abdominal ultrasound | 2 | 2 | 2 | 2 | 4 |
| Exercise tolerence test | 2 | 2 | 3 | 2 | 4 |
| Echocardiography | 2 | 2 | 2 | 2 | 4 |
| CAT scan head | 2 | 2 | 2 | 2 | 4 |
| Electroencephalography (EEG ) | 1 | 1 | - | - | 1 |
| Electromyography/Nerve conduction studies (EMG/NCS) | 1 | 1 | - | - | 1 |
| Chest intubation | 2 | 1 | - | - | 1 |
| MRI Brain and Spine | 1 | 1 | 1 | 1 | 2 |
| Doppler ultrasound of limbs and neck | 1 | 1 | 1 | 1 | 2 |

| PROCEDURES | Level | Cases |
|---|---|---|
| **ENDOCRINOLOGY** | | |
| Interpretation of thyroid function tests/ thyroid isotope scan / thyroid ultrasound /thyroid FNA-C | 1,2,3 | 5+5+5 |
| Interpretation of pituitary function tests /stimulation/suppression testing of pituitary | 1,2,3 | 1+1+1 |
| Interpretation of adrenal function tests /stimulation/suppression testing of adrenals | 1,2,3 | 1+1+1 |
| Evaluation of disorders of Gonadal dysfunction | 1,2,3 | 1+1+1 |
| Disorders of growth and sexual differentiation/development | 1 | 1 |
| (Interpretation of calcium metabolism (calcium and phosphorus lab tests | 1,2,3 | 1+1+1 |
| Interpretation of DEXA scan/MRI pituitary / MRI or CT Adrenals | 1 | 1 |
| Interpretation of glucose lab tests/HbA1c/OGTT for diagnosis of diabetes and its complications | 1,2,3 | 10+10+10 |
| Clinical and laboratory evaluation of patients with diabetes to evaluate glycemic, lipemic, hypertension and obesity control and its complications | 1,2,3 | 10+10+10 |
| Formulate a comprehensive management plan for patients with diabetes | 1,2,3 | 10+10+10 |
| Clinical and laboratory evaluation and management of patients with gestational diabetes | 1,2,3 | 2+2+2 |
| Prescribing and adjusting insulin for management with diabetes | 1,2,3 | 2+2+2 |

| PROCEDURES | | |
|---|---|---|
| | Level | Cases |
| **INTENSIVE CARE** | | |
| Endotracheal Intubation | 4 | 6 |
| Insertion of CVP line | 4 | 6 |
| Arterial puncture | 3,4 | 4 |
| Mechanical ventilation | 3,4 | 4 |
| Cardio Pulmonary Resuscitation (CPR) | 3,4 | 4 |
| Blood gases interpretation | 4 | 4 |
| **CARDIOLOGY** | | |
| Thrombolysis in acute MI | 4 | 6 |
| Management of arrhythmias - Drug / Defibrillation | 4 | 4 |
| ECG recordings & reporting | 4 | 6 |
| Exercise tolerance test (ETT) | 2,3 | 2 |
| Echocardiography | 1,2 | 4 |
| Cardio Pulmonary | 4 | 2 |
| Resuscitation (CPR) | | |
| **PULMONOLOGY** | | |
| Pleural Aspiration | 4 | 3 |
| Pleural Biopsy | 1 | 1 |
| Chest Intubation | 2 | 2 |
| Bronchoscopy | 2 | 2 |
| Lung function test | 2 | 2 |

| PROCEDURES | | |
|---|---|---|
| | Level | Cases |
| **NEPHROLOGY** | | |
| Hemodialysis | 2,3 | 6 |
| Renal Biopsy | 1 | 2 |
| Insertion of double lumen catheter | 3,4 | 4 |
| Peritoneal Dialysis | 2 | 2 |
| **PSYCHIATRY** | | |
| Psychotherapy Sessions | 1 | 2 |

## INTRODUCTION

Curriculum of MD Internal Medicine 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 Internal Medicine. 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 Internal Medicine

### 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**

- OSPE
- 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)**

**How to Teach**

- Books etc
- Articles
- CPC(Clinic Pathological Conference)
- Lecture
- Videos
- SDL(Self Directed Learning)
- PBL(Problem Based Learning)
- Teaching experience with medical student
- Read procedural knowledge.

**How To Assess**

- MCQs
- SEQs
- Viva
- Videos
- Internal assessment

**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
- Teaches patients and healthcare team members to recognize and address common barriers to cost- effective care and appropriate utilization of resources

- Actively participates in initiatives and care delivery models designed to overcome or mitigate barriers to cost-effective high quality care

**Transitions patients effectively within and across health delivery systems. (SBP4)**

- Regards need for communication at time of transition
- Responds to requests of caregivers in other delivery systems
- Inconsistently utilizes available resources to coordinate and ensure safe and effective patient care within and across delivery systems
- Written and verbal care plans during times of transition are complete
- Efficient transitions of care lead to only necessary expense or less risk to a patient (e.g. avoids duplication of tests readmission)
- Recognizes the importance of communication during times of transition
- Communication with future caregivers is present but with lapses in pertinent or timely information
- Appropriately utilizes available resources to coordinate care and ensures safe and effective patient care within and across delivery systems
- Proactively communicates with past and future care givers to ensure continuity of care
- Coordinates care within and across health delivery systems to optimize patient safety, increase efficiency and ensure high quality patient outcomes
- Anticipates needs of patient, caregivers and future care providers and takes appropriate steps to address those needs
- Role models and teaches effective transitions of care

**How To Teach**

- Lecture/ orientation session
- Various system/policies should be identified and discussed with the residents.
- Examples:
- Zakaat
- Admission procedure
- Bait-ul-Mall
- Discharge procedure
- Consultation procedure
- Shifting of patients according to SOPS
- Preferably a manual should be designed regarding various systems existing in the
- Hospital for the resident.
- Cost effectiveness/availability of medicine
- Avoidance of unnecessary tests because of limited health resources.
- Direct observation by the supervisor during ward rounds
- Feed back
- Assessment during case discussion

## 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

**How To Assess**

1. Punctuality

**Professionalism (PROF1, PROF2, PROF3 AND PROF4)**

**How To Teach**

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

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
2. Feed back
3. 360 degree evaluation
4. History taking
5. CPC presentation
6. Journal club presentation
7. Article presentation
8. Consultation
9. OPD working
10. Counseling sessions
11. OSPE
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<br>Preoperative evaluation of cardiac risk in-patients undergoing non-cardiac surgery<br>Preoperative evaluation of cardiac risk in-patients undergoing non-cardiac surgery<br>The appropriate way to answer cardiac consultations<br>The appropriate follow-up, including use of substantive progress notes, of patients who have been seen in consultation.<br>Out-patient cardiac care.<br>Differential diagnosis of chest pain | Keeping the patient and family informed on the clinical status of the patient, results of tests, etc.<br>Frequent, direct communication with the physician who requested the consultation.<br>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<br>Understanding that patients have the right to either accepts or decline recommendations made by the physician<br>Education of the patient | The PGT should continue to develop his/her ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.<br>The PGT must be willing to acknowledge errors and determine how to avoid future similar mistakes.<br>The PGT must be responsible and reliable at all times.<br>The PGT must always consider the needs of patients, families, colleagues, and support staff.<br>The PGT must maintain a professional appearance at all | The PGT should learn when to call a subspecialist for evaluation and management of a patient with a cardiovascular disease.<br>The PGT should be able to clearly present the consultation cases to the staff in an organized and thorough manner<br>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.<br>The PGT should provide effective education and counseling for patients.<br>The PGT must write organized and legible notes<br>The PGT must communicate any | The PGT should use feedback and self-evaluation in order to improve performance<br>The PGT should read the required material and articles provided to enhance learning<br>The PGT should use the medical literature search tools in the library to find appropriate articles related to interesting cases. | The PGT's ability to answer directed questions and to participate in the didactic sessions.<br>The PGT's presentation of assigned short topics. These will be examined for their completeness, accuracy, organization, and the PGTs' understanding of the topic.<br>The PGT's ability to apply the information learned in the didactic sessions to the patient care setting.<br>The PGT's interest level in learning. |

***Similar competencies should be applied for other domains of medicine & allied. Please see curriculum of MD Internal Medicine for details.***

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

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 follow- up 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 INTERNAL MEDICINE 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

**Core conferences include the following: Introductory conce**

1. Hyper/hypokalemia
2. Hypoxemia
3. Evaluation of anemia
4. Metabolic acidosis
5. Respiratory acidosis and alkalosis
6. Hyponatremia
7. Azotemia
8. Dosing of aminoglycosides
9. Dietary requirements and prescriptions
10. Intravenous fluid therapy
11. Approach to the patient with:
12. Fever
13. Shortness of breath
14. Hypertension
15. GI Bleeding
16. Altered mental status
17. Pneumonia
18. Shock
19. Abdominal pain
20. AIDS

21. Seizures
22. Oncologic emergencies
23. Arrhythmias
24. Asthma
25. Hemostatic disorders
26. Chest pain
27. Respirator management
28. Psychiatric emergencies
29. Use of microbiological stains
30. Interpretation of chest x-rays

**Cardiology**

1. EKG interpretation
2. Congestive heart failure
3. Angina
4. Acute myocardial infarction
5. Hypertrophic cardiomyopathy
6. Pericardial effusion
7. Endocarditis
8. Syncope
9. Valvular heart disease

**Infectious Diseases**

1. Bacterial endocarditis
2. AIDS
3. Sepsis
4. Infectious diarrhea
5. Sexually transmitted diseases Meningitis
6. Dermatologic manifestations of infectious diseases
7. Use of antibiotics

**Endocrinology**

1. Insulin dependent diabetes mellitus
2. Non-Insulin dependent diabetes mellitus
3. Thyroid disease
4. Adrenal function and dysfunction
5. Disorders of the hypothalamus and pituitary
6. Female gonadal disorders
7. Male gonadal disorders
8. Calcium metabolism Lipid disorders

**Pulmonary Disease**

1. Pulmonary function testing
2. Sleep related respiratory diseases
3. Asthma
4. Chronic obstructive pulmonary disease
5. Respiratory failure
6. Pneumonia Tuberculosis
7. Interstitial lung disease
8. Pulmonary embolism and venous thrombosis
9. Lung cancer
10. Pulmonary disease in immunocompromised patients
11. Pleural diseases

**Gastroenterology**

1. Upper gastrointestinal tract bleeding
2. Lower gastrointestinal tract bleeding
3. Diarrhea
4. Inflammatory bowel diseases
5. Cancer of the digestive organs
6. Acute and chronic pancreatitis
7. Acute hepatitis
8. Chronic hepatitis and cirrhosis
9. Treatment of chronic liver disease

**Rheumatology**

1. Rheumatoid arthritis
2. Spondyloarthropathies and reactive arthritis
3. Crystal arthropathies
4. Systemic lupus erythematosus
5. Lupus nephritis
6. Myositis and polymyalgia rheumatica
7. Septic arthritis
8. Scleroderma and mixed connective tissue diseases
9. Osteoarthritis and soft tissue rheumatism
10. Vasculitis

**Nephrology**

1. Approach to differential diagnosis
2. Diabetic nephropathy
3. Systemic diseases and the kidney
4. Kidney stones
5. Renal osteodystrophy
6. Hypertension
7. Glomerular disease
8. Interstitial renal disease
9. Role of radiology and kidney biopsy
10. Disorders of sodium and potassium
11. Progression of renal disease
12. Drug effects on the kidney
13. Complications of renal failure and dialysis

**Hematology/Oncology**

1. Disorders of hemostasis
2. Physiologic adjustments to anemia
3. Hemolytic anemias
4. Hemoglobinopathies
5. Myeloproliferative disorders
6. Plasma cell dyscrasias
7. Hodgkin's and non-Hodgkin's lymphoma

## Allergy and Immunology

1. Types of immunological reactions
2. Immune response and interleukins
3. Immunodeficiency states
4. Complement in health and disease
5. Food allergy and anaphylaxis
6. Urticaria and angioedema
7. Eosinophilia Asthma
8. Rhinitis, sinusitis, and asthma
9. Drug allergy

## Pathophysiology

1. Hyponatremia
2. Edema in pulmonary disease
3. Hepatorenal syndrome
4. Lactic acidosis
5. Hyperkalemia
6. Adrenal dysfunction and AIDS Polyuria
7. Diabetic ketoacidosis
8. Metabolic alkalosis in heart failure
9. Mixed acid base disturbances
10. Bartter's syndrome
11. Hyporeninemic hypoaldosteronism
12. Metabolic acidosis due to ingestion of ethylene glycol
13. Hyperosmolar non-ketotic coma
14. Electrolyte abnormalities in alcoholics
15. Hypercalcemia in cancer

8. Carcinoma of the lung and colon
9. Carcinoma of the breast and prostate
10. Oncologic emergencies
11. Selection and interpretation of diagnostic procedures in cancer
12. Introduction to molecular genetics

**HEMATOLOGY / ONCOLOGY CURRICULUM 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 type of cancer, severity of illness, level of comfort, and ability to communicate

Know the approach to commonly observed in-patient problems of oncology patients, e.g. pain, acute shortness of breath, fever, acute changes in mental status

Demonstrate proficiency in use and interpretation of common laboratory tests and imaging studies in oncology patients

Implement the common therapeutic protocols in oncology patients

Perform common invasive procedures skillfully and safely

**Medical knowledge**

Know the treatment and prognosis of commonly encountered cancers

Know the indications, contraindications, risks, benefits, and alternatives to commonly performed invasive procedures

Know the principles of pain management with particular attention to the management of chronic pain in cancer patients

Understand the management of non-pain symptoms in end of life care

**PBPI/SBP**

Know how to use information technology to supplement your medical knowledge

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

Understand the role of hospice care – entry requirements and benefits

**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, prognosis, 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

Learn how to approach the common discussions in end of life care, i.e. advance directives, switching from aggressive to palliative or hospice care

**Professionalism**

Consistently demonstrate respect for patients and staff members

Consistently put the patients' interests ahead of any other considerations

Understand the ethical issues involved in end of life care

Maintain the confidentiality of personally identifiable patient information

**Educational content**

Colorectal cancer screening

Epidemiology, diagnosis, and management of colorectal cancer
Epidemiology, diagnosis, and management of esophageal cancer
Epidemiology, diagnosis, and management of gastric cancer
Epidemiology, diagnosis, and management of pancreatic cancer
Management of osteogenic and soft tissue sarcomas
Epidemiology, diagnosis, and management of mesothelioma
Prostate cancer screening
Epidemiology of prostate cancer
Diagnosis, workup and staging of prostate cancer
Treatment options for prostate cancer
Epidemiology, diagnosis, and management of bladder cancer
Epidemiology, diagnosis, and management of head and neck cancer
Chemoprevention in head and neck cancer
Evaluation and management of cancer of unknown primary site
Pain and palliative care issues in the cancer patient
Neutropenic fever and other infectious complications of malignancies
Diagnosis and management of small bowel obstruction
Diagnosis and management of malignant ascites
Metabolic complications in the cancer patient
Neurologic complications in the cancer patient

**AMBULATORY CARE CURRICULUM Goals and Objectives**

**Patient care**

Gain a broad range of skills required for a primary care providers.

The curriculum highlights diagnostic testing for cardiac and pulmonary diseases, mental health issues, and exposure to non- medical fields. It allows first hand participation in treatment programs including substance abuse, smoking cessation, and palliative care.

The curriculum also ensures that residents acquire competence in interpretation of gram staining of sputum and urinalysis by completing required internet tutorials and, finally, provides an opportunity to learn the technique of arthrocentesis of the knee and other joints through direct instruction with a simulator.

**Medical knowledge**

Expand knowledge of multiple aspects of primary care medicine through didactic sessions outlined below and self-study

**Communication skills**

Expand and reinforce research, writing, and public speaking skills by participating in resident - run morning seminars on topics in primary care and completing a 1-2 page writing assignment.

**Practice-based performance improvement**

Expand and reinforce research and critical thinking skills by participation in a library based computer search skills class, Journal Club, as well as a weekly Evidence Based Medicine seminar.

The curriculum is also intended to improve utilization of consultant services by affording house staff the opportunity to observe firsthand how consults are completed by receiving services.

**PROGRAM DESCRIPTION:**

**1. Managed-care clinic assignments:**

Each resident will be assigned to a minimum of one primary care and one specialty care clinic per week. Under designated supervision, residents will be responsible for assessing new patients assigned to the clinic.

**2. Other Clinical training assignments**

Palliative Care - on a rotating basis, interns will attend the palliative care clinic to learn about strategies for treating chronic pain, explore psychosocial issues including advance directives related to the care of the terminally ill.

Noninvasive Cardiology - on a rotating basis, interns will be exposed to echocardiography, chemical and exercise stress testing to become familiar with the appearance of the heart on echo, to learn how to interpret echo reports, and understand role of these studies in diagnosis and management of coronary disease.

PFT Lab - on a rotating basis, interns will become familiar with the PFT exam, learn how to interpret flow volume loops, spirometry and ABG's, and understand the role of this testing in treatment of obstructive and restrictive lung disease.

Smoking Cessation - on a rotating basis, interns will observe actual smoking cessation classes and learn strategies to motivate people to quit smoking as well as behavioral and pharmacological therapies available to facilitate and maintain cessation.

Diabetes Diet Class - on a rotating basis, interns will observe actual classes and learn about strategies used to motivate people to change eating habits as well as components of a successful ADA diet.

Acupuncture – on a rotating basis, residents attend acupuncture clinic. Appropriate selection of patients for a complementary approach is stressed.

Rehab - on a rotating basis, where review of the physiatric history and exam will be stressed. Attendance in OT/PT clinic and EMG clinic is also included in this component.

Mental Hygiene – on a rotating basis, residents will attend and observe recovery programs for alcoholics with emphasis on improving interviewing and assessment skills. Exposure to other substance abuse programs is also included in this component.

Podiatry Clinic – on a rotating basis, residents will attend both general podiatry, diabetic foot, and wound clinics. Working with PRIME Podiatry residents, residents review the appropriate examination of the foot, injection and wound care techniques.

Rheumatology – on a rotating basis, house officers will attend rheumatology clinic where review of joint examination, arthrocentesis and joint injection are emphasized

Pain Management – on a rotating basis, house officers will attend pain management clinic to learn more about treatment strategies for chronic (non-cancer related) pain.

**3. Didactic sessions:**

The following didactic sessions will be held during each month's rotation residents:

1. Dermatology
2. Optometry
3. Neurology
10. Impotence and Incontinence
11. Screening Guidelines
12. CHF

4. PubMed Tutorial
5. Rheumatology
6. Joint aspiration and injection
7. Substance Abuse
8. Topics in Psychology/Psychiatry (including PTSD; counseling for change)
9. Palliative Care/end-of-life-care
13. Diabetes
14. Hypertension
15. Falls in the Elderly
16. Coagulation
17. Ethics issues
18. Obesity

Each resident is required to research and lead a discussion on four topics selected from a list of core ambulatory topics. The focus of these presentations is on diagnosis and treatment of medical problems commonly seen in the outpatient setting..

**MEDICAL INTENSIVE CARE UNIT CURRICULUM Goals**

Become competent in the initial evaluation and comprehensive care of critically ill patients.

Understand indications for admission to the ICU.

Formulate and understand the differential diagnosis, diagnostic approach and treatment plan of specific conditions pertaining to critically ill patients.

Set initial ventilator settings for patients with acute respiratory failure, indications for tracheal intubation and non-invasive ventilation.

Understand and apply principles of resuscitation and stabilization of critically ill patients.

Function as a member of a multidisciplinary team caring for critically ill patients. Become an effective communicator with family members and to learn how to address end of life issues with patients and family.

**Specific Learning Objectives Patient care:**

Demonstrate competency in medical interviewing, physical diagnosis and data collection of critically ill patients.

Formulate a differential diagnosis and outline a thorough, comprehensive and organized plan.

Demonstrate organizational skills necessary for the care of critically ill patients, including prioritization of patient problems and the use of information technology.

**Medical knowledge:**

Efficiently and effectively record daily progress and events in the medical record. Know the indications for invasive and non- invasive forms of ventilation. Understand the basic principles of mechanical ventilation, modes of ventilation, ventilatory parameters; approach to reducing ventilatory support; complications of mechanical ventilation; approach to patient dysynchrony, distress or alarms; and indications for tracheostomy.

Understand the principles and methods of fluid resuscitation for various shock states, the use of crystalloids or colloids, assessing perfusion at the bedside and the endpoints of resuscitation.

Understand the approach to a patient with fever in the ICU, including diagnosis and treatment of hospital acquired infections as well as noninfectious causes of fever.

Interpret simple and mixed acid-base disorders. Understand the clinical manifestations, pathophysiology and treatment of common electrolyte disturbances.

Understand the pathophysiology and management of diabetic ketoacidosis.

Understand and address the basic nutritional requirements of critically ill patients.

Understand the diagnosis and treatment of anxiety, agitation, pain and delirium in the ICU, including the appropriate use of sedatives with paralytics and identification of drug/alcohol withdrawal syndromes.

Understand the evaluation, approach and treatment of seizures (status epilepticus), CVA, coma and the basic approach to diagnosis of brain death.

Understand the indications/contraindications for DVT and stress ulcer prophylaxis.

Understand the indications/contraindications for, risks of, and be able to perform: venipuncture, arterial puncture, arterial catheterization, central venous access, lumbar puncture & nasogastric tube placement.

Participate in family meetings and be able to discuss general condition of a patient with immediate family members.

**Communication skills**

Participate in family meetings and be able to discuss general condition of a patient with immediate family members.

Demonstrate an ability to obtain informed consent for procedures and imaging studies

Learn the process of death notification

**PBPI/SBP**

Understand and implement procedures used to promote patient safety and minimize errors

Understand and adhere to infection control practices

**Professionalism**

Consistently demonstrate respect for patients and staff and place patients' interests above all other considerations

**Daily Schedules & Rounds**

This team is responsible for the provision of care to all patients in the MICU. The day interns are responsible for the care of their assigned patients, although they, as well as senior residents, should be familiar with all of the patients in the MICU. Before morning rounds begin the day interns should have examined each of their patients, reviewed the current data (laboratory studies and cultures) & formulated an organized, systematic plan for each component of the patient's problem list. In general presentations of existing patients on rounds should consist of:

1. Overnight events.
2. Vital data – Temp max, pulse range, BP range respiratory rate, ventilator settings (if applicable), oxygen saturation and input/output (including overall fluid balance and average hourly urine output).
3. Directed physical examination that is specific to that particular patient.
4. Review of laboratory results, including cultures (these must be reviewed daily!)
5. Review of the medication list, including dosages and intervals (many of our patients have fluctuating renal and hepatic function, therefore it is of paramount importance to review this information in order to identify and prevent toxicity).
6. Assessment – this must be brief and concise.
7. Plan – this must be organized and systems oriented! For example:
    - **Respiratory** – continue or change aspects of ventilation, etc.
    - **Infectious** – what antibiotics the patient is on and what are we trying cover, culture results, etc.
    - **Cardiovascular/Hemodynamic** – vasopressors in use, therapies being employed based on invasive monitoring, etc.
    - **Hematologic** – bleeding problems, anticoagulation, etc.

- **Metabolic** - fingerstick monitoring, insulin requirements, electrolyte replacements, changes in renal function, etc.
- **Alimentary/Nutrition –** assessment of patient's nutritional status, hepatic dysfunction, type of NGT feeds, rate of infusion, TPN/PPN, etc.
- **Neurologic** – sedatives or paralytic drugs, etc.
- **DVT Prophylaxis** – pneumatic compression devices (at the bare minimum) and LMWH if there are no bleeding issues or contraindications.

- **Stress Ulcer Prophylaxis** – either an H2 blocker or a PPI. (This applies to all patients who are mechanically ventilated or NPO.) It is important to maintain a systematic approach even if there is no problem in a particular system. This ensures that all aspects of ICU care are being addressed. Afternoon rounds will begin at 5PM to provide follow-up of the days events, new admissions and plans for the on-call residents and fellow.

**Notes & Documentation**

A progress note from either an intern or resident is required for each patient, every day!

Please make sure to fill out consultation requests completely, including date and time called, reason for consultation; print and sign your name.

Whenever a patient is being transferred to the general ward or to another service a detailed summary note, including presenting complaint and hospital course is required, in addition to the daily note.

**Patients who die in the ICU require the following:**

1. **Death Note** – a note documenting that there are no signs of life on physical examination.
2. **Death Summary** – a note that details why the patient was admitted and a brief hospital course.
3. **Code Note (if applicable)** – a note documenting when a code was called, status of the patient on your arrival, ACLS protocol employed, duration of the code and outcome.
4. **Death Certificate**.

If a patient is discharged home from the ICU then a standard discharge note is required. Charts that are lacking these components are deemed incomplete and will require that the resident or intern go to Medical Records to complete deficient charts. Failure to comply with this policy will be noted by the Department of Medicine.

**Standard Precautions**

**Hand washing or use of an alcohol-based gel is mandatory before and after each patient interaction. This is the best way to reduce the spread of bacteria from patient to patient.**

Stethoscopes should be cleaned between each patient contact with an alcohol pad. Resistant bacteria require masks, gowns, and gloves for ANY contact in the room. When used, dispose in proper receptacle IN the patient's room. Do not bring flow sheets or charts into isolation rooms! Respiratory masks are required for all patients on respiratory isolation.

**Invasive Procedures**

The MICU fellow is responsible for supervising or performing all relevant invasive procedures. Appropriate informed consent must be obtained from the patient prior to the procedure. Residents must be supervised for procedures they are not certified in by either a certified fellow or attending. **Do not attempt to perform a procedure if you are not confident in your ability to do so.**

**Central venous access site preference: jugular vs. subclavian vs. femoral. Femoral access should be obtained only for emergent access, since there is a higher risk for infection and DVT.**

Sterile technique – cap, sterile gown & gloves, drapes, supervision. Please be very attentive to your field and maintenance of sterility. Remember, the technique you employ during the procedure will determine the likelihood of developing an infectious complication!

Povidone iodine solution is used for sterilization in standard way.

Antibiotic-coated central lines (blue catheters) should be changed every 10 days & arterial lines every 7 days. In addition all catheter sites should be evaluated each day for signs of infection.

Guidewire line changes for central venous lines ONLY when a new stick cannot be done or when changing a PA catheter to TLC (See Protocol) – all venous catheter tips must be cut into a sterile container and sent for semi-quantitative culture.

Procedure forms should be filled out for ALL invasive procedures done in the ICU.

Do not draw blood from central lines because it breaks sterility!

The nurses will do central line and arterial line dressings.

## Orders

### Verbal orders do not exist in the ICU!

Admission orders on order sheets, including admission, attending of record, patient's condition, daily labs, etc.

All orders must be communicated verbally to the nurse in addition to computer entry. This will ensure that all members of the team know what changes are occurring for a particular patient's care and that those changes will be implemented in a timely fashion.

Ventilator changes must be ordered in the computer and communicated directly to the respiratory therapist.

Review medication sheets daily from the nurses' medication list.

TPN & PPN order must be in by 12 noon.

### Labs

Review need for daily labs, EKG's and CXR's.

Respiratory therapists are certified to do radial ABGs only (and not other labs!)

### Clinical Protocols

Sedation is titrated to the Ramsey scale. Use midazolam infusion if first choice is anxiolysis/sedation. For anticipated short term intubations, use propofol. For agitated delirium, use haloperidol by intermittent dosing, rarely by infusion.

Neuromuscular blockade - preferred agent is cis-atracurium which is mostly metabolized in the blood and tissues, so it can be given in liver or renal failure. Dose is titrated to ventilator synchrony, and is monitored by the "train of four." A drug holiday should ideally be given once a day to permit a neurological exam, to see if the patient still needs to be paralyzed and if the level of sedation is adequate. Daily CK levels must be sent while the patient is on continuous neuromuscular blockade.

DVT prophylaxis - pneumatic compression boots, low dose warfarin .Double prophylaxis (compression boots and something else) should be given to high risk patients (sedated paralysis, hemiplegia, and femoral lines - virtually all of our patients).

GI prophylaxis - all mechanically ventilated or NPO patients must receive prophylaxis with an H2 blocker or PPI. If there is no clinical preference H2 blocker should be the default choice and whenever possible enterally.

### Nutrition

Although the clinical nutritionist often assesses each patient and recommends nutritional orders, house staff is expected to understand

and know the patient's nutritional regimen and requirements.

### Boarding

Senior members of the team usually handle boarding of patients in other ICU's. Beds cannot be "saved" for potential admissions.

## Bedside & Transport Equipment

You should be familiar with how to use the standard equipment, including bed controls, ambu-bags, IV pumps, monitoring equipment and inline suction catheters. For transporting patients, you should be familiar with the Lifepak/ambu-bag/oxygen mask and emergency medications, as well as what medications the patient are being transported with and which IV site can be used to administer medications in an emergency. **IF YOU DON'T KNOW HOW TO USE SOMETHING, SAY SO!!**

### Privacy

Privacy should be maintained while examining a patient or doing a procedure remember to pull curtains appropriately. Also don't forget that though the patients may be sedated, they may still hear you talking about them, so use judgment when talking about prognosis, etc. If you remove restraints on a patient or put the side rails down to do a procedure, **PLEASE REMEMBER TO REPLACE THE RESTRAINTS AND PUT THE RAILS BACK UP.**

***In order for the ICU experience to be valuable and rewarding it is important to spend as much time as possible at the patient's bedside in order to appreciate the clinical relevance of principles that are discussed on rounds, such as fluid resuscitation or changes in ventilator management. Also by working with other members of the team (nurses, nutritionists, pharmacists, physician assistants and respiratory therapists) you will maximize your knowledge base by understanding the different perspectives of caring for the critically ill. By making a therapeutic decision and following up on its effect you will better understand the practice of Critical Care Medicine.***

**PALLIATIVE CARE CURRICULUM:** One of our departmental performance improvement projects is to improve the teaching of palliative care. Our goals for you are straightforward.

## Goals

By the end of the year we want you to achieve the following:

- Understand how to provide optimal care for patients whose conditions cannot be cured and those at the end of life
- Demonstrate proficiency in the use of analgesics, particularly narcotic analgesics, in the setting of chronic pain
- Know how to manage the common non-pain symptoms that arise in end of life care
- Be able to communicate effectively and empathically with patients and families in delivering bad news, and in discussing prognosis of common cancers, advance directives, DNR orders, switching from aggressive care to palliative or hospice care, and other issues in end of life care
- Understand the ethical issues involved in palliative care
- Utilize all available resources, including hospice care, to provide for patients' needs and ensure a smooth transition to outpatient care

## Teaching Methods

Interns spend a month on the oncology service and are actively involved in treatment of cancer patients as well as those undergoing palliative care.

Interns make weekly teaching rounds with the physician taking care of the palliative care patients on the oncology service.

Regardless of rotation, interns participate in a day-long seminar covering all aspects of palliative care.

Lectures are given throughout the year as part of the core conference schedule

**CHARTING THE ROAD TO COMPETENCE: DEVELOPMENTAL MILESTONES FOR MD INTERNAL MEDICINE 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 Systems-Based 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*** | ***Historical data gathering*** | | |
| Manage patients using clinical skills of interviewing and physical examination<br>Demonstrate competence in the performance of procedures<br>Appropriately use laboratory and imaging techniques | 1. Acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion | 8 | Standardized patient<br>Direct observation |
| | 2. Seek and obtain appropriate, verified, and prioritized data from secondary sources (eg, family, records, pharmacy) | 12 | |
| | 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<br>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<br>Direct observation<br>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<br>Direct observation |
| | ***Diagnostic tests*** | | |

| | | | |
|---|---|---|---|
| ***B. Delivery of patient- centered clinical care***<br>Manage patients with progressive responsibility<br>Manage patients across the | 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<br>Standardize d tests |

| | | | |
|---|---|---|---|
| spectrum of clinical diseases seen in the practice of general internal medicine<br>Manage patients in a variety of health care settings to include the inpatient ward, critical care units, the ambulatory setting, and the emergency setting<br>Manage undifferentiated acutely and severely ill patients<br>Manage patients in the prevention, counseling, detection, diagnosis, and treatment of gender-specific diseases<br>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<br>Chart-stimulated recall<br>Multisource feedback<br>Direct observation<br>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<br>Chart-stimulated recall<br>Multisource |
| | 2. Provide internal medicine consultation for patients with more complex clinical problems | 48 | |
| | requiring detailed risk assessment | | feedback<br>Direct observation<br>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<br>Demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist<br>Demonstrate sufficient knowledge to treat medical conditions commonly managed by internists, provide basic preventive care, and recognize and provide initial management of emergency medical problems | ***Knowledge of core content*** | | |
| | 1. Understand the relevant pathophysiology and basic science for common medical conditions | 8 | Direct observation<br>Chart audit<br>Chart-stimulated recall<br>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 | |
| | 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<br>Standardized tests<br>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<br>Standardized tests |
| | 2. Perform or review audit of a panel of patients using standardized, disease-specific, 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**<br>Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;<br>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<br>EBM mini-CEX<br>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<br>EBM mini-CEX<br>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<br>EBM mini-CEX<br>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<br>EBM mini-CEX<br>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 | |

| | | | |
|---|---|---|---|
| **C. Learning and improving via feedback and self-assessment**<br>Identify strengths, deficiencies, and limits in one's knowledge and expertise<br>Set learning and improvement goals<br>Identify and perform appropriate learning activities | ***Improves via feedback*** | | |
| | 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<br>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 | |

| | | | |
|---|---|---|---|
| Incorporate formative evaluation | ***Improves via self-assessment*** | | |
| | 1. Maintain awareness of the situation in the moment, and respond to meet | 32 | Multisource feedback |

| | | | |
|---|---|---|---|
| feedback into daily practice | 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 | |
| Participate in the education of patients, families, students, residents, and other health professionals | ***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 Internal Medicine Training— 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<br>Direct observation<br>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**<br><br>Communicate effectively with physicians, other health professionals, and health-related agencies<br><br>Work effectively as a member or leader of a health care team or other professional group | ***Transitions of care*** | | |
| | 1. Effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care | 16 | Multisource feedback<br>Direct observation<br>Sign-out form ratings<br>Patient surveys |
| | 2. Role model and teach effective communication with next caregivers during transitions of care | 32 | |
| | ***Interprofessional team*** | | |
| | 1. Deliver appropriate, succinct, hypothesis- driven 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<br>Chart audit |

| | | | |
|---|---|---|---|
| Act in a consultative role to other physicians and | 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** | ***Health records*** | | |
| Maintain comprehensive, timely, and legible medical 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 | 1. Document and report clinical information truthfully | 1.5 | Multisource feedback |
| Responsiveness to patient needs that supersedes self-interest | 2. Follow formal policies | 1.5 | |
| Account- ability to patients, society, and the profession | 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<br>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<br>Mentored self- reflection<br>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<br>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<br>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***<br>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<br>Direct observation |
| | 2. Recognize and manage conflict when patient values differ from their own | 40 | |
| | ***Confidentiality*** | | |
| | 1. Maintain patient confidentiality | 1.5 | Multisource feedback<br>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<br>Direct observation<br>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<br>Chart-stimulated recall<br>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 | rehabilitation, and skilled nursing. | | |
| | 3. Negotiate patient-centered care among multiple care providers. | 48 | |
| Work in interprofessional teams to enhance patient safety and improve patient care quality | ***Works effectively within an interprofessional team*** | | |
| Work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients, including the transition of care between settings | 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<br>Chart-stimulated recall<br>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 within the system. | 48 | |
| ***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 cost-awareness principles into standard clinical judgments and decision making | 24 | |
| | 4. Demonstrate the incorporation of cost- awareness principles into complex clinical scenarios | 48 | |

SECTION 1

## MORNING REPORT PRESENTATION/ CASE PRESENTATION SEEN IN LAST EMERGENCY OR INDOOR

| 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) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| 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) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| 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/SEMIN

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

| 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 # | 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) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| 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 50 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**

(Total Morbidity/Mortality Meetings to be attended TWO Morbidity/Mortality Meetings per month)

| 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. | 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) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| 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. | RESEARCH 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 | 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) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| 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

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

**RAWALPINDI MEDICAL UNIVERSITY**

**SUPERVISOR APPRAISAL FORM**

**Resident's Name:** _____ **Hospital Name:** _____

**Evaluator's Name(s):** _____ **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 | | | | | |

2

| | | | | | |
|---|---|---|---|---|---|
| **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**

**Resident's Name:** _____ **Hospital Name:** _____
**Evaluator's Name(s):** _____ **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 | | | | | |
| **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 3rd Year Of Training**

**Resident's Name:** _____ **Hospital Name:** _____
**Evaluator's Name(s):** _____ **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 | | | | | |
| **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 4th Year Of Training**

**Resident's Name:** _____ **Hospital Name:** _____
**Evaluator's Name(s):** _____ **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 | | | | | |
| **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

**EVALUATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)**

**(AT THE END OF 1ST YEAR OF TRAINING)**

# SECTION-18

**EVALUATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)**

**(AT THE END OF 2ND YEAR OF TRAINING)**

SECTION-18

**EVALUATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)**

**(AT THE END OF 3RD YEAR OF TRAINING)**

# SECTION-18

**EVALUATION / REMARKS BY UNIVERSITY TRAINING MONITORING CELL (UTMC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)**

**(AT THE END OF 4th YEAR OF TRAINING)**

## SECTION=18

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

SECTION=18

**EVALUATION / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)**

**(AT THE END OF 2ND YEAR OF TRAINING)**

# SECTION-18

**EVALUATION / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME)**

**(AT THE END OF 3RD YEAR OF TRAINING)**

## SECTION-18

**EVALUATION / REMARKS BY QUALITY ENHANCEMENT CELL (QEC) WORKING UNDER DEPARTMENT OF MEDICAL EDUCATION (DME) (AT THE END OF 4th YEAR OF TRAINING)**

SECTION 19

**LEAVE RECORD**

(Signed & 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** | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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

TO BE FILLED AT THE END OF FIRST 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 - 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 | | | | | | | | | | | | |

| 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 | | | | | | | | | | | | |

| 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 | | | | | | | | | | | | |

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 | |
| 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 | | | | | | | | | | | | |

TO BE FILLED AT THE END OF THIRD 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 | | | | | | | | | | | | |

| 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 | |
| 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 | | | | | | | | | | | | |

TO BE FILLED AT THE END OF FOURTH 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 | | | | | | | | | | | | |

| 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 | | | | | | | | | | | | |

| 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 | | | | | | | | | | | | |

SECTION 21

## ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS

# SECTION 21

**ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS**



Page | 156