LOGBOOK

RAWALPINDI MEDICAL UNIVERSITY

UNIVERSITY RESIDENCY PROGRAM- 2019

ROTATIONS MD GASTROENTEROLOGY

ROTATION

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 Gastroenterology.

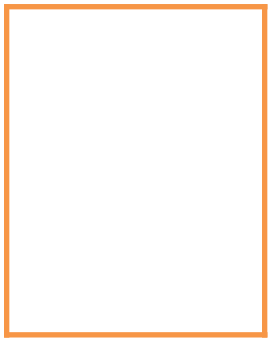
We are seeing a rise in the uptake of places on postgraduate courses in medical education, more frequent issues of medical education journals and the further development of e-journals and other new online resources. There is therefore a need to provide active support in *Post Graduate Medical Education* 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 Gastroenterology 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

SR.NO	NAME & DESIGNATION				
1.		**Prof. Mohammad Umar, *S.I,* MBBS, MCPS, FCPS (PAK), FACG (USA), FRCP (L), FRCP (G), ASGE-M(USA), AGAF (USA)** **Vice Chancellor & CEO** **Rawalpindi Medical University & Allied Hospitals** Rawalpindi Guidance regarding technical matters of Log Book of MD Gastroenterology & also Log Book for MD Gastroenterology rotations	4		**Dr. AQSA NASEER, MBBS,FCPS, E**SGE **SR Gastroenterology** **Holy Family Hospital,RWP** Over all synthesis, structuring & over all write up of Curriculum of MD Gastroenterology, Log Book of MD Gastroenterology and also Log Book for MD Gastroenterology rotations under guidance of
2.		**Dr. Bushra Kharr, MBBS.FCPS** **Ex-Professor of Medicine** **Head Department of Gastroenterology** **Holy Family Hospital Rawalpindi** Guidance regarding technical matters of Log Book of MD Gastroenterology & also Log Book for MD Gastroenterology rotations. Provision of required number of clinical procedures and educational activities for each year separately and rotation of log books of MD gastroenterology and log book MD gastroenterology rotations.	5.		**Dr. Javeria Khan, MBBS,FCPS** **Gastroenterologist** **Holy family Hospital,RWP** Proof reading, organizing and re assembling of MD gastroenterology Log book and Rotation log book
3.		**Dr. Tanveer Hussain, MBBS, FCPS(MED), FCPS(Gastroenterology)** **Assistant Professor of Gastroenterology** **Holy Family Hospital Rawalpindi** Guidance regarding technical matters of Log Book of MD Gastroenterology & also Log Book for MD Gastroenterology rotations.	6		**MR. JAHANZEB KHAN** **Computer Operator** **Holy Family Hospital,RWP** Proof reading & synthesis of final print version of Log Books of MD Gastroenterology and Rotation Log Book.

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 _____

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

BraunsKS,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	Directly observed procedures	6-10 per month
09	CPC	02 per month

MISSION STATEMENT

The mission of Gastroenterology 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 centre of liver diseases, 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 Gastroenterology Residency Program for the remainder of our professional lives.

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

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 are 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

COMPETENCIES	1 MONTH	2 MONTHS	3 MONTHS	TOTAL	TEACHING METHOD	ASSESSMENT METHODS
	LEVEL					
Endotracheal intubation	5	5	5	50	Mannequin / Hands on	DOPS
Central line placement	1,2,3	4,5	5	30	Mannequin / Hands on	DOPS
Abdominal drain placement	1,2	3,4	4,5	20	Mannequin / Hands on	DOPS
Arterial blood gas analysis	5	5	5	30	Hands on	OSPE
Plamapheresis	1,2	1,2,3	3,4	5	Live Demonstration / Video	
MARS	1,2	1,2,3	2,3,4	2	Live Demonstration / Video	

COMPETENCIES	1 MONTH	2 MONTHS	TOTAL	TEACHING METHOD	ASSESSMENT METHOD
	LEVEL				
Plain abdominal films	1,2,3	4,5	40	X-Ray films / Pictures	OSPE
Barium studies(Swallow,meal,small bowel follow through, enema)	1,2,3	4,5	35	X-Ray films / Pictures	OSPE
Ultrasound abdomen	1,2,3	4,5	80	Live Demonstration	OSPE
CT scan abdomen, pelvis and chest	1,2	3,4,5	40	CT films / CDs / Pictures	OSPE
MRI abdomen and chest	1,2	3,4	30	MRI films / CDs / Pictures	OSPE
MRCP	1,2	3,4	35	MRI films / CDs / Pictures	OSPE
Ultrasound guided liver biopsy, abscess, ascites drainage	1,2,3	3,4,5	20	Live Demonstration / Hands on	OSPE, DOPS
Mesenteric Angiography	1,2	2,3	5	Live Demonstration / Hands on	OSPE
TACE	1,2	2	20	Live Demonstration / Hands on	OSPE
PTBD	1,2	2	15	Live Demonstration / Hands on	OSPE
TIPSS	1,2	2	5	Live Demonstration / Hands on	OSPE
HVPG measurement	1,2	2	5	Live Demonstration / Hands on	OSPE

COMPETENCIES		1MONTH	2MONTHS	TOTAL no. (slides/pictures)
		LEVEL		
Esophagus	**Esophageal ADC, Esophageal SCC Barrett's metaplasia, EOE**	1,2,3	4,5	45
Stomach	**Gastritis especially H-Pylori associated gastritis, gastric ulcers, signet ring cell carcinoma Adenocarcinoma. GIST**	1,2,3	4,5	60
Small intestine	**Celiac sprue (identify villous abnormality/atrophy) giardiasis, tumours. Whipple Disease Eosinophilic Disease**	1,2,3	4,5	45
Pancreatobiliary	**Autoimmune pancreatitis Pancreatic cancer Cholangiocarcinoma IgG – Cholangiopathy**	1,2,3	4,5	20
Large Intestine	**IBD, Adenomatous polyps, Dysplasia, Serrated Polyposis, SRUS, Colorectal ADC, PJS. Microscopic colitis**	1,2,3	4,5	38
Liver	**liver fibrosis and cirrhosis. Chronic viral Hepatitis, Alcoholic, Steatohepatitis Hepatitis, Autoimmune Hepatitis, PBC, PSC, Liver storage Disease, Hepatocellular Carcinoma. Post liver transplant rejection and disease recurrence Granulomatosis diseases**	1,2,3	4,5	70

INTRODUCTION

The Curriculum of each Rotation of MD Gastroenterology at Rawalpindi Medical University is mentioned separately in the start of section of each rotation. The Core competencies and Milestones of the Curriculum are provided here to have clear concepts about the competencies and to provide knowledge 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 **Details of The Six Core Competencies of Curriculum of MD Gastroenterology**

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 behavioural knowledge required to provide care for common GI conditions and basic preventive care.
  - Possesses the scientific, socioeconomic and behavioural knowledge required to provide care for complex medical conditions and comprehensive preventive care
  - Possesses the scientific, socioeconomic and behavioural 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 interprofessional 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 analyse own clinical performance data
- Participates in a quality improvement projects
- Familiar with the principles, techniques or importance of quality improvement
- Analyses 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 Analyses 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 inter professional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel). (PROF1)
- Consistently respectful in interactions with patients, caregivers and members of the inter professional team, even in challenging situations
- Is available and responsive to needs and concerns of patients, caregivers and members of the inter professional 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 inter professional 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 inter professional team

- **Teaches others regarding maintaining patient privacy and respecting patient autonomy Accepts 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 behaviour 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 behaviours including integrity, honesty, and professional responsibility
  - Role models integrity, honesty, accountability and professional conduct in all aspects of professional life
  - Regularly reflects on personal professional conduct

- **Professionalism (PROF1, PROF2, PROF3 AND PROF4)**
- **How To Teach**
  1. Should be taught during ward rounds.
  2. By supervisor
  3. Through workshop

- **How To Assess**
  1. Punctuality
  2. Behaviour
  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 interprofessional 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. Counselling sessions
11. OSPE
12. VIVA

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

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, radiology, histopathology, liver transplant and Hepatobiliary etc. The required knowledge and skills pertaining to the ambulatory based training in following areas shall be demonstrated;

- Critical care & Emergency Medicine
- Ambulatory Medicine
- Gastroenterology &Hepatology
- Liver transplant and Hepatobiliary
- Inpatient Oncology 81 Palliative Care Services
- 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 Geriatrics Gastroenterology, pediatric gastroenterology, 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, Occupational Medicine, Physical Medicine and Rehabilitation, Radiology, Histopathology etc

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:** Residents 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. 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 gastroenterology.

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-cantered 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.**
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 clinico pathological 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, behavioural 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 counselling 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 s***elf-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.

ROTATION CURRICULUM OF MD GASTROENTEROLOGY FOR INTENSIVE CARE UNIT – ICU & EMERGENCY MEDICINE

- On this 3 month rotation, the resident shall develop competence in the differential diagnosis and management of the critically ill, and learn to integrate these clinical skills with the biomedical instrumentation of bedside hemodynamic measurements, and computation of gas exchange variables, determination, and all aspects of mechanical ventilation and airway care.
- These principles, and those governing fluid therapy, nutritional support, and antimicrobial therapy in severely ill patients, shall be reviewed extensively.
- Gastroenterology residents will specifically learn management of diseases of gastroenterology that are managed in ICU e.g Acute liver failure, acute on chronic liver failure, acute pancreatitis, caustic injuries and post- liver transplant care and complications. Acute Abdomen/Drug Overdose/GI Bleed/PSE
- They should be able to perform basic procedures independently such as abdominal drain placement, Central line placement, and endotracheal intubation.
- Residents should also get familiar with other procedures like MARS, Plamapheresis etc during their rotation in ICU.

Educational Purpose:

- The goal of the Critical Care faculty is to train the GI internist to evaluate and treat critically ill patients, use consultants and paramedical personnel effectively, and stress sensitive, compassionate management of patients and their families.
- Training in emergency medicine and critical care is crucial for the GI internist.
- Recognition/prioritization medical emergencies is the basic knowledge that should be acquired by the internist
- Important aspects of this training include: identifying patients who are candidates for intensive care, the bedside approach to the critically-ill patient, knowledge of algorithms for diagnosis and management of common problems in the ICU, death and resuscitation issues, interaction with families

Content of required knowledge:

1. Understand blood gas results and respond appropriately.
2. Understand cardiovascular hemodynamics in a wide range of disease states.
3. Management of congestive heart failure and cardiogenic shock.
4. Basics of conventional mechanical ventilation.
5. Nutritional support of the critically ill.
6. Management of acute myocardial ischemia/Recognition of Cardiac emergencies _____.
7. Acute renal failure - diagnosis and treatment.
8. Acute endocrinologic emergencies.
9. Acute lung injury.
10. Acute Abdomen
11. Sepsis and the sepsis syndrome.
12. Acute treatment of cardiac arrhythmias.
13. Management of acute gastrointestinal bleeding.
14. Management of common neurologic emergencies.
15. Management of common toxicological emergencies

Skills and Procedures:

- Asthma management
- Evaluation of chest pain
- Evaluation of shortness of breath
- Airway management/tracheostomy Barotrauma
- Mechanical ventilation: indications, initial set-up, trouble shooting, weaning
- Critical care nutrition: indications, disease-specific nutrition, writing TPN orders
- Management of Ob/Gynae emergencies
- Oxygen transport: physiology, alterations in the critically-ill
- Arterial blood gases: approach to analysis, common alterations
- Hemodynamics: physiology, PA catheter, hemodynamic waveforms, trouble-shooting
- Critical care pharmacology: pressers / inotropes, antibiotic dosing, drug dosing in ARF
- Shock: pathophysiology, approach to resuscitation
- Fluid and electrolyte disturbances: sodium, potassium, magnesium, calcium
- Acute renal failure: approach differential diagnosis, management

Coma: pathophysiology, neurological exam, differential diagnosis
- Wound care
- Splinting techniques
- Ophthalmologic emergency management
- Multiple organ dysfunction syndrome
- Acute CHF
- Ethical issues in the ICU
- Management of environmental emergencies

Evaluation/Feedback

- Basic toxicology principles
- Sepsis prevention in the ICU
- Arterial line insertion
- Central venous catheterization
- Pulmonary artery catheterization
- Assistance in endotracheal intubation
- Cardiopulmonary resuscitation
- Ordering and rapid interpretation of laboratory tests

- At the midway point of the rotation, residents are given feedback (informally) on their performance to date. Areas and methods of improvement are suggested. A formal evaluation and verbal discussion with the resident is to be done at the end of the rotation.
- 360 degree evaluation to judge the professionalism, ethics
- A formal evaluation and verbal discussion with the PGT is to be done at the end of the rotation / PGTs are encouraged to discuss with the supervisor, co- supervisor and program director/Dean their learning experiences, difficulties or conflicts.
- Evaluation of training program by trainees pertinent to effectiveness and efficiency of program to equip trainees with necessary skills

Suggested Readings:

- Paul L. Marino, The ICU Book, 3rd edition.
- Marin H. Kollef, the Washington Manual of Critical Care.
- ATS website http://www.thoracic.org/education/career-development/residents/ats-reading-list/

Antonelli M *et.al*. "Year in review in Intensive Care Medicine 2009: 1. Pneumonia and infections, sepsis, outcome, acute renal failure and acid base, nutrition, and glycaemic control" Intensive Care Medicine 2010; 36:196-209 (available through UNM HSC library e-journal

ROTATION CURRICULUM OF MD GASTROENTEROLOGY FOR *RADIOLOGY*

Educational Purpose:

To give residents formal, informal instruction and clinical experience in the evaluation and clinical correlation of the results of various imaging techniques utilized in a modern radiology department regarding gastroenterology and hepatology diseases.

General objectives for Radiology course:

1. The ability to understand the principles of radiological studies
2. Utilization of imaging techniques in the acutely injured or ill patient
3. Effective evaluation of acute chest and abdominal conditions
4. Therapeutic and diagnostic interventions with imaged guided procedures
5. Basics aspects of medical radiation exposure and protection
6. Physiologic principles of nuclear medicine and functional MRI
7. Newer neuroimaging techniques for cerebral diseases and conditions
8. Awareness and use of the data base that exists in radiology

1. Fundamentals of chest roentgenology
2. Plain film of the abdomen
3. CT scan of abdomen/pelvis/chest
4. MRI abdomen
5. MRCP
6. Barium studies(Esophagus, Stomach ,S1 and LI)

7. Ultrasound basic knowledge and skill (Hepatobiliary & pancreatic ,Spleen and Portal System)

Approach to Small Bowel Disease

8. Differential Diagnoses in GI Disease
9. Radiological findings of Liver diseases
10. Radiological findings of Pancreas diseases / Biliary Diseases

Assessment:

- OSCE
- MCQs
- SEQs
- Long case
- Short case

Evaluation/Feedback

1. 360 degree evaluation to judge the professionalism and ethics
2. Attendance at the required morning X-ray film review
3. Assigned case presentations and conference presentations will be evaluated
4. Ability to interpret results of commonly used imaging studies
5. Mid-rotation evaluation session between the resident and the consult service attending for that month
6. Residents will receive feedback with respect to achieving the desired level of proficiency.
7. Ways in which they can enhance their performance will be discussed when the desired level of proficiency has not been achieved.
8. Evaluation and feedback will occur during the rotation.
9. A formal evaluation and verbal discussion with the resident is to be done at the end of the rotation.

- Should be able to interpret CT and MRI scans for common diseases / MRCP

Suggested readings:

1. The Emergency Patient. Charles S. Langston, Lucy Frank Squire. Saunders, 1975
2. Emergency Radiology. T. Keats. Mosby, 1988 2nd Edition
3. Radiology of the Emergency Patient: An Atlas Approach. Edited by Edward I. Greenbaum. New York: Wiley, c1982.
4. Videodisc:, GI, GU Ultrasound files
5. Learning Radiology.com

CHARTING THE ROAD TO COMPETENCE: DEVELOPMENTAL MILESTONES FOR MD GASTROENTEROLOGY 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, Inter personal 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 Gastroenterology Training—Patient Care**		
Competency	**Developmental Milestones Informing Competencies**	**Approximate Time Frame Trainee Should Achieve Stage (months)**	**General Evaluation Strategies** **Assessment Methods/ Tools**
A. Clinical skills and reasoning • Manage patients using clinical skills of interviewing and physical examination • Demonstrate competence in the performance of procedures • Appropriately use laboratory and imaging techniques	***Historical data gathering***		
	1.Acquire accurate and relevant his Tory from the patient in an efficiently customized prioritize ,and hypothesis driven fashion	8	• Standardized patient • Direct observation
	2. Seek and obtain appropriate, verified, and prioritized data from secondary sources (eg, family, records, pharmacy)	12	
	3. Obtain relevant historical	24	

	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		
	4.Role model gathering subtle and reliable information from the patient for junior members of the healthcare team	40	
	Performing a physical examination		
	1. Perform an accurate physical examination that is appropriately targeted to the patient's complaints and medical conditions. Identify pertinent abnormalities using common manoeuvres	8	• Standardized patient Direct observation • Simulation
	2.Accurately track important changes in the physical examination overtime in the outpatient and inpatient settings	12	
	3. Demonstrate and teach how to elicit important physical findings for junior members of the healthcare team	24	
	4.Routinely identify subtle or usual physical findings that may influence clinical decision making, using advanced manoeuvres where applicable	40	

	Clinical reasoning		
	1. Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient's central clinical problem	16	• Chart-stimulated recall • Direct observation • Clinical vignettes
	2. Develop prioritized differential diagnoses, evidence- based diagnostic and therapeutic plan for common inpatient and ambulatory conditions	32	
	3.Modify differential diagnosis And care plan based on clinical course and data as appropriate	32	
	4.Recognize disease present Actions that deviate from common- patterns and that require Complex decision making	48	
	Invasive procedures		
	1. Appropriately perform invasive procedures and provide post-procedure management for common procedures	24	• Simulation • Direct observation
B. Delivery of patient-centered clinical care • Manage patients with progressive responsibility • Manage patients across the spectrum of clinical diseases seen in the practice of general internal medicine • Manage patients in a variety of health care	***Diagnostic tests***		
	1.Make appropriate decision 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 function tests, urinalysis, ascitic fluid analysis	16	• Chart-stimulated recall • Standardized tests • Clinical vignettes
	2.Make appropriate decision	24	

settings to include the inpatient ward, critical care units, the ambulatory setting ,and the emergency setting • Manage undifferentiated acutely and severely ill patients • Manage patients in the prevention, counseling, detection, diagnosis, and treatment of gender-specific diseases • Manage patients as a consultant to other physicians	Based on the results of more advanced diagnostic tests		
	Patient management		
	1.Recognizesituationswithaneedforurgentor emergent medical care, including life-threatening conditions	8	• Simulation • Chart-stimulated recall • Multisource feedback • Direct observation • Chart audit
	2. Recognize when to seek additional guidance	8	
	3.Provideappropriatepreventivecareandteachpatient 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.Managepatientswithconditionsthatrequireintensive care	48	
	8.Independentlymanagepatientswithabroadspectrum of clinical disorders seen in the practice of general internal medicine	48	
	9. Manage complex or rare medical conditions	48	
	10.Customizecareinthecontextofthepatient's preferences and overall health	48	
	Consultative care		

	1. Provide specific, responsive consultation to other services	32	• Simulation • Chart-stimulated recall • Multisource feedback • Direct observation • Chart audit
	2.Provideinternalmedicinecon sultationforpatientswith more complex clinical problems requiring detailed risk assessment	48	

Table-2	**Developmental Milestones for Gastroenterology Training—Medical Knowledge**		
Competency	**Developmental Milestones Informing Competencies**	**Approximate Time Frame Trainee Should Achieve Stage (months)**	**General Evaluation Strategies** **Assessment Methods/ Tools**
A. Core knowledge of general internal medicine and its subspecialties • Demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist • Demonstrate sufficient knowledge to treat medical conditions commonly managed by internists, provide basic preventive care, and recognize and provide initial management of emergency	***Knowledge of core content***		
	1. Understand the relevant pathophysiology and basic science for common medical conditions	8	• Direct observation • Chart audit • Chart-stimulated recall • Standardized tests
	2.Demonstratesufficientknowledgetodiagnoseand treat common conditions that require hospitalization	16	
	3. Demonstrate sufficient knowledge to evaluate common ambulatory conditions	24	
	4.Demonstratesufficientknowledgetodiagnoseand treat undifferentiated and emergent conditions	24	
	5. Demonstrate sufficient knowledge to provide preventive care	24	
	6.Demonstratesufficientknowledgetoidentifyandtreat medical conditions that require intensive care	32	
	7. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions	48	
	8.Understandtherelevantpathophysiologyandbasic science for uncommon or complex medical conditions	48	
	9. Demonstrate sufficient knowledge of socio behavioral sciences including but not limited to health care economics, medical ethics, and medical	48	

medical problems	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.Understandindicationsforandbasicinterpretationof common diagnostic testing ,including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs ,pulmonary function tests ,urinalysis, and other body fluids	16	• Chart-stimulated recall • Standardized tests • Clinical vignettes
	2.Understandindicationsforandhasbasicskillsin interpreting more advanced diagnostic tests	24	
	3.Understandpriorprobabilityandtestperformance characteristics	24	

Table-3 Developmental Milestones for Gastroenterology 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.Appreciatetheresponsibilitytoassessand improve care collectively for a panel of patients	16	• Several elements of quality improvement project • Standardized tests
	2.Performorreviewauditofapanelofpatients 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.Identifyareasinresident'sownpracticeand	48	

	local system that can be changed to improve effect to the processes and outcomes of care		
	5.Engageinaqualityimprovementintervention	48	
B. Learning and improvement via answering clinical questions from patient scenarios • Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; • Use information technology to optimize learning	***Ask answerable questions for emerging information needs***		
	1.Identifylearningneeds(clinical questions)as they emerge inpatient care activities	16	• Evidence-based medicine evaluation instruments • EBM mini-CEX • Chart-stimulated recall
	2. Classify and precisely articulate clinical questions	32	
	3.Developasystemtotrack,pursue,andreflect on clinical questions	32	
	Acquires the best evidence		
	1. Access medical information resources to answer clinical questions and support decision making	16	• Evidence-based medicine evaluation instruments • EBM mini-CEX • Chart-stimulated recall
	2. Effectively and efficiently search NLM database for original clinical research articles	16	
	3. Effectively and efficiently search evidence- based summary medical information resources	32	
	4.Appraisethequalityofmedicalinformation resources and select among them based on the characteristics of the clinical question	48	
	Appraises the evidence for validity and usefulness		
	1.Withassistance,appraisestudydesign, conduct, and statistical analysis in clinical research papers	16	• Evidence-based medicine evaluation instruments • EBM mini-CEX • Chart-stimulated recall
	2. With assistance, appraise clinical guidelines	32	
	3. Independently appraise study design, conduct, and statistical analysis in clinical research papers	48	
	4. Independently, appraise clinical guideline recommendations for bias and cost-benefit considerations	48	
	Applies the evidence to decision-making for individual patients		

	1.Determineifclinicalevidencecanbe generalized to an individual patient	16	• Evidence-based medicine evaluation instruments • EBM mini-CEX • Chart-stimulated recall
	2.Customize clinical evidence for an individual patient	32	
	3.Communicaterisksandbenefitsof 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 • Identify strengths, deficiencies, and limits in one's knowledge and expertise • Set learning and improvement goals • Identify and perform appropriate learning activities • Incorporate formative evaluation feedback into daily practice • Participate in the education of patients, families, students, residents, and other health professionals	***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 • Self-evaluation forms with action plans
	2.Activelyseekfeedbackfromallmembersof the health care team	24	
	3. Calibrate self-assessment with feedback and other external data	32	
	4.Reflectonfeedbackindevelopingplansfor improvement	32	
	Improves via self-assessment		
	1. Maintain awareness of the situation in the moment ,and respond to meet situational needs	32	• Multisource feedback • Reflective practice surveys
	2.Reflect(inaction)when surprised, applies new insights to future clinical scenarios ,and reflects(on action)back on the process	48	
	Participates in the education of all members of the health care team		
	1. Actively participate in teaching conferences	16	• OSCE with standardized learners Direct observation • Peer evaluations
	2. Integrate teaching, feedback, and evaluation with supervision of interns' and students' patient care	32	
	4. Take a leadership role in the education of all members of the health care team.	48	

Table-4 Developmental Milestones for gastrpenterology 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.Providetimelyandcomprehensiveverbaland written communication to patients/advocates	16	• Multisource feedback • Patient surveys • Direct observation • Mentored self-reflection
	2.Effectivelyuseverbalandnonverbalskillstocreate rapport with patients/families	16	
	3.Usecommunicationskillstobuildatherapeutic 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.Appropriatelycounselpatientsabouttherisksand benefits of tests and procedures, highlighting cost awareness and resource allocation	48	
	8.Rolemodeleffectivecommunicationskillsin challenging situations	48	
	Intercultural sensitivity		
	1.Effectivelyuseaninterpretertoengagepatientsin the clinical setting, including patient education	8	• Multisource feedback • Direct observation • Mentored self-reflection
	2.Demonstratesensitivitytodifferencesinpatients including but not limited to race, culture, gender, sexual orientation, socioeconomic status ,literacy, and religious beliefs	16	
	3.Activelyseektounderstandpatientdifferencesand views and reflects this in respectful communication and shared decision-making with the patient and the health care team	40	
B. Physicians and other health care	***Transitions of care***		

professionals • Communicate effectively with physicians, other health professionals, and health-related agencies • Work effectively as a member or leader of a health care team or other professional group • Act in a consultative role to other physicians and health professionals	1.Effectivelycommunicatewithothercaregiversin order to maintain appropriate continuity during transitions of care	16	• Multisource feedback • Direct observation • Sign-out form ratings • Patient surveys
	2.Rolemodelandteacheffectivecommunication with next care givers during transitions of care	32	
	Inter professional team		
	1. Deliver appropriate, succinct, hypothesis-driven oral presentations	8	• Multisource feedback
	2.Effectivelycommunicateplanofcaretoall members of the health care team	16	
	3.Engageincollaborativecommunicationwithall members of the health care team	40	
	Consultation		
	1. Request consultative services in an effective manner	8	• Multisource feedback • Chart audit
	2.Clearlycommunicatetheroleofconsultanttothe patient ,in support of the primary care relationship	16	
	3. Communicate consultative recommendations to the referring team in an effective manner	48	
C. Medical records • Maintain comprehensive, timely, and legible medical records	***Health records***		
	1. Provide legible, accurate, complete, and timely written communication that is congruent with medical standards	8	• Chart audit
	2. Ensure succinct, relevant, and patient-specific written communication	32	

Table-5 Developmental Milestones for gastrpenterology Training— Professionalism			
Competency	**Developmental Milestones Informing Competencies**	**Approximate Time Frame Trainee Should Achieve Stage (months)**	**General Evaluation Strategies** **Assessment Methods/ Tools**
A. Physician ship • Demonstrate compassion, integrity, and respect for others • Responsiveness to patient needs that supersedes self-interest • Account- ability to patients ,society, and the profession	***Adhere to basic ethical principles***		
	1. Document and report clinical information truthfully	1.5	• Multisource feedback
	2. Follow formal policies	1.5	
	3. Accept personal errors and honestly acknowledge them	8	
	4. Uphold ethical expectations of research and scholarly activity	4 8	
	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	3 2	
	4. Provide leadership for a team that respects patient dignity and autonomy	3 2	
	Provide timely, constructive feedback to colleagues		
	1.Communicateconstructivefeedbacktoothermembersofthehealthcaretea m	16	• Multisource feedback • Mentored self-reflection • Direct observation
	2.Recognize,respondto,andreportimpairmentincolleaguesorsubstandard care via peer review process	24	
	Maintain accessibility		
	1. Respond promptly and appropriately to clinical responsibilities including but not limited to calls and pages	1.5	• Multisource feedback
	2.Carryouttimelyinteractionswithcolleagues,patients,andtheirdesignate d caregivers	8	

	Recognize conflicts of interest		
	1.Recognizeandmanageobviousconflictsofinterest,suchascaringforfamily members and professional associates as patients	8	• Multisource feedback • Mentored self-reflection • Clinical vignettes
	2. Maintain ethical relationships with industry	40	
	3. Recognize and manage subtler conflicts of interest	40	
	Demonstrate personal accountability		
	1. Dress and behave appropriately	1.5	• Multisource feedback • Direct observation
	2. Maintain appropriate professional relationships with patients, families, and staff	1.5	
	3. Ensure prompt completion of clinical, administrative, and curricular tasks	8	
	4. Recognize and address personal, psychological, and physical limitations that may affect professional performance	16	
	5.Recognizethescopeofhis/herabilitiesandaskforsupervisionandassistance appropriately	16	
	6.Serveasaprofessionalrolemodelformorejuniorcolleagues(eg, medical students ,interns)	40	
	7. Recognize the need to assist colleagues in the provision of duties	40	
	Practice individual patient advocacy		
	1. Recognize when it is necessary to advocate for individual patient needs	8	• Multisource feedback • Direct observation
	2. Effectively advocate for individual patient needs	40	
	Comply with public health policies		
	1. Recognize and take responsibility for situations where public health supersedes individual health (eg, reportable infectious diseases)	32	• Multisource feedback
B. Patient-centeredness • Respect for patient	***Respect the dignity, culture, beliefs, values, and opinions of the patient***		
	1.Treatpatientswithdignity,civilityandrespect,regardlessofrace,culture,gender	1.5	• Multisource

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	, ethnicity, age, or socio economic status		feedback
	2. Recognize and manage conflict when patient values differ from their own	4 0	• Direct observation
	Confidentiality		
	1. Maintain patient confidentiality	1.5	• Multisource feedback • Chart audits
	2. Educate and hold others accountable for patient confidentiality	24	
	Recognize and address disparities in health care		
	1.Recognizethatdisparitiesexistinhealthcareamongpopulationsandthat they may impact care of the patient	16	• Multisource feedback • Direct observation • Mentored self-reflection
	2.Embracephysicians'roleinassistingthepublicandpolicymakersin understanding and addressing causes of disparity in disease and suffering	4 0	
	3. Advocates for appropriate allocation of limited health care resources.	4 0	

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 • Work effectively in various health care delivery settings and systems relevant to their clinical practice	***Works effectively within multiple health delivery systems***		
	1. Understand unique roles and services provided by local health care delivery systems.	16	• Multisource feedback • Chart-stimulated recall • Direct observation
	2. Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, sub-acute, acute, rehabilitation, and skilled nursing.	32	
	3. Negotiate patient-centered care among multiple care providers.	48	

• Coordinate patient care within the health care system relevant to their clinical specialty • Work in inter professional teams to enhance patient safety and improve patient care quality • Work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients, including the transition of care between settings	***Works effectively within an inter professional team***		
	1.Appreciate roles of a variety of health care providers, including but not limited to consultants, therapists, nurses, home care workers, pharmacists, and social workers.	8	• Multisource feedback • Chart-stimulated recall • Direct observation
	2. Work effectively as a member within the inter professional 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 inter professional 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.Recognizehealthsystemforcesthatincreasetheriskfor error including barriers to optimal patient care	16	• Multisource feedback • Quality improvement project
	2.Identify,reflecton,andlearnfromcriticalincidents such as near misses and preventable medical errors	16	
	3.Dialoguewithcareteammemberstoidentifyriskfor and prevention of medical error	32	
	4.Understandmechanismsforanalysisandcorrectionof systems errors	32	
	5. Demonstrate ability to understand and engage in a system-level quality improvement intervention.	48	
	6.Partner with other healthcare 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***		
	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 healthcare.	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	

LIST OF ROTATIONS/ELECTIVES FOR UNIVERSITY RESIDENCY PROGRAM GASTROENTEROLOGY

ROTATION: 1 ***RADIOLOGY (Duration: 2 Months)***

ROTATION: 2 HISTOPATHOLOGY ***(Duration: 1 Month)***

ROTATION: 3 SURGERY / LIVER TRANSPLANT ***(Duration: 1 Month)***

ROTATION: 4 ONCOLOGY ***(Duration: 1 Month)***

ROTATION-1

RADIOLOGY

- During their rotation in radiology, residents will learn interpretation and methods of various radiological investigations, indications and contraindications. They should be able to pick gross findings on ultrasound abdomen like ascites, cirrhotic liver, mass in abdomen and biliary system.
- Trainees should learn ultrasound guided procedures such as abscess drainage, liver biopsy, drain placement etc
- They will learn X-Ray chest and abdomen, fluoroscopic images including barium swallow, barium meal, follow through and barium enema.
- They should learn procedures and reporting of different imaging modalities in gastroenterology such as CT scan, MRI, MRCP etc.
- Apart from these they will learn interpretation of fluoroscopic images of ERCP, PEI, RFA, TACE, PTBD, TIPSS, Angioplasty/Mesenteric Angiography, Angioembolization and various other procedures used in gastroenterology.

LOG OF RADIOLOGY

The rotation can be taken in a one month or a two-week block. The purpose of this rotation is for the resident to become familiar with interpretation and utilization of common radiological procedures and findings. Education goals and objectives of rotation is :

- To become familiar with the radiological tests available.
- To learn the proper utilization of imaging modalities in diagnosis and intervention particularly gastrointestinal diseases.
- To understand the indications and contraindications of radiological tests.
- To understand the utilization of appropriate radiological tests based on indication, cost effectiveness and risks vs. benefits.
- To improve accuracy of interpretation of selected radiological procedures.

The resident will acquire knowledge of:

- Radiological procedures available _____, USG, Barium Study, CT/MRI/MRCP, Indications/Contraindications/Interpretation.
- Preparation of patients for tests.
- Indications and limitations in the use of imaging equipment including CT scans, ultrasound, radio nuclear techniques and angiographies.
- Side effects and complications of invasive studies and contrast media.
- Hazards of radiation guidelines.
- Cost-effective diagnostic testing.
- Acute/GI Bleeding. radiological intervention, indications/Treatment

REFERENCE:

https://med.unr.edu/gastroenterology/residency/curriculum/radiology

Section-1

MORNING REPORT PRESENTATION/ CASE PRESENTATION SEEN IN LAST EMERGENCY OR INDOOR (2/month)

(Presentation with Radiology Consultants)

SR #	DATE	REG# OF PATIENT	BRIEF HISTORY, IMAGING, DIAGNOSIS, TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR #	DATE	REG# OF PATIENT	BRIEF HISTORY, IMAGING, DIAGNOSIS, TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

Section-2

TOPIC PRESENTATION/SEMINAR (1/MONTH)

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)

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 (1/MONTH)

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 (TWO /MONTH)

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

SECTION 5

DIDACTIC LECTURE/INTERACTIVE LECTURES ATTENDED

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

SECTION 6

OPD AND CLINICS

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

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

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

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

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

SR#	DATE	REG # OF the patient	BRIEF HISTORY, IMAGING, DIAGNOSIS, TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF the patient	BRIEF HISTORY, IMAGING, DIAGNOSIS, TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF the patient	BRIEF HISTORY, IMAGING, DIAGNOSIS, TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF the patient	BRIEF HISTORY, IMAGING, DIAGNOSIS, TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF the patient	BRIEF HISTORY, IMAGING, DIAGNOSIS, TREATMENT & OUTCOME IF ANY	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

Section-7

Procedures (Ultrasounds & Related Procedures)

(Estimated cases to be seen are 50 patients per month)

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. PATIENT	NAME OF PROCEDURE	(O)/(A)/(P	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	DATE	REG NO. PATIENT	NAME OF PROCEDURE	(O)/(A)/(P	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S

SR.#	DATE	REG NO. PATIENT	NAME OF PROCEDURE	(O)/(A)/(P	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S

SR.#	DATE	REG NO. PATIENT	NAME OF PROCEDURE	(O)/(A)/(P	DETAIL OF PROCEDURE	PLACE OF PROCEDURE	SUPERVISOR'S REMARKS	SUPERVISOR'S

Section-8

REPORTING OF X-RAYS

(Estimated cases to be seen are minimum 50 patients per month 10 cases each of Abdomen, Chest)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR.#	PATIENT ID	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SECTION 9

REPORTING OF CT SCAN

(Estimated cases to be seen are minimum 20 patients per month 5 cases each of Abdomen, pelvis

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

Section-10

REPORTING OF MRI / MRCP

(Estimated cases to be seen are minimum 15 patients per month

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

Section-11

CONSULTATIONS

SR. #	DEPARTMENT SEEKING CONSULTATION	PATIENT ID /NAME	BRIEF DESCRIPTION ABOUT PROBLEM	OPINION GIVEN AFTER DISCUSSION WITH SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION 12

MULTI DISCIPLINARY MEETINGS (MDM)

SR#	DATE	BRIEF DESCRIPTION	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION-13

CLINICOPATHOLOGICAL CONFERENCE (CPC)

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

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

HANDS ON TRAINING/WORKSHOPS

SECTION-14

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION-15

PUBLICATIONS (if any)

S. NO.	NAME OF PUBLICATION	TYPE OF PUBLICATION ORIGINAL ARTICLE/EDITORIAL/CASE REPORT ETC	NAME OF JOURNAL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION-16

WRITTEN ASSESSMENT RECORD OF THIS ROTATION

SNO	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)

CLINICAL ASSESSMENT RECORD OF THIS ROTATION

SECTION-17

SR.#	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

EVALUATION RECORDS

SUPERVISOR APPRAISAL FORM

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)Exhibits system based learning methods smartly					
c)Exhibits 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/SUPERVISOR'S REMARKS REGARDING PERFORMANCE OF THE TRAINEE

Total Score _____/155

_____ _____ _____ _____

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

SECTION 19

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

Section-20

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

Section-21

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

TO BE FILLED AT THE END OF ROTATION

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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

SECTION-22

ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS

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**			

ROTATION-2

HISTOPATHOLOGY

- During rotation in histopathology, residents will learn gross pathology of gastrointestinal and liver diseases, preparation of slides of biopsy specimen and histopathology of common diseases of liver and gastroenterology.
- See and learn the normal histological slide.
- See and learn the normal histological features of different segments of gastrointestinal tract and liver.
- During their rotation in histopathology, residents should learn use of various stains like H&E, Trichome stain, Giemsa stain and Indian ink etc
- Gastroenterology trainees should gain knowledge about different immunohistochemical stains used in various diseases.
- They should see enough number of slides/pictures of GI and liver malignancies.
- Have knowledge about liver protocol stains, H&E, trichome, iron, orcein, PASD, reticulin and appreciate their diagnostic importance.
- See archived slides of EUS FNAC detail to understand the concept of adequacy of material on slide distinguish cellular material from non cellular debris only.
- Appreciate the use of immunotisto chemistry as an adjunct to the morphological diagnosis only.
- Have an insight about the advances in histopathology, molecular pathology targeted therapy and personalized medicine.
- Residents are encouraged to seek guidance by verily under supervision large number of web images of histopathological slides to enhance their recognition of the various histopathological features of common GI and Liver diseases.
- Identity cardinal histopathological features of about following common GI and liver disorders.

LOG OF HISTOPATHOLOGY

The rotation can be taken in a one month or a two-week block. The purpose of this rotation is for the resident to become familiar with interpretation and utilization of common histopathological procedures and findings. Education goals and objectives of rotation is :

- To become familiar with the Histopathology tests available.
- To learn the proper utilization of stains in diagnosis.
- To understand the utilization of appropriate histopathological tests based on indication, cost effectiveness and risks vs. benefits.

The resident will acquire knowledge of:

  - Findings of different diseases in biopsies available.
  - Preparation of patients for tests.
  - Indications and limitations in the use of equipment.

- Cost-effective diagnostic testing.

REFERENCE: https://med.unr.edu/gastroenterology/residency/curriculum/Histopathology

GI Diseases- Topics

- **Infection**
  - **Giardia, MCV /HSV/ Candidiasis /Fungal/ H-Pylori, M ALT, Gastritis**
  - **CD, PAS, SIBO/Granulomatis Diseases**
  - **IBD**
    - **MC (LC, CC)**
  - **Eosinophlic Syndrome**
- **Malignancies**
  - **Esophagus**
  - **Stomach**
  - **SI, LI**
  - **GIST**

Section-1

MORNING REPORT PRESENTATION/ CASE PRESENTATION SEEN IN LAST EMERGENCY OR INDOOR (2/month)

(Presentation with Histopathology Consultants)

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

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

Section-2

TOPIC PRESENTATION/SEMINAR (1/MONTH)

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

Section-3

JOURNAL CLUB (1/MONTH)

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

PROBLEM CASE DISCUSSION (TWO /MONTH)

Section-4

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	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS,TREATMENT & OUTCOME IF ANY	SUPERVISOR'S	SUPERVISOR'S

Section-5

DIDACTIC LECTURE/INTERACTIVE LECTURES ATTENDED

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

SECTION 6

OPD AND CLINICS

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

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, HISTOPATHOLOGY REPORT, 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 AND OUTCOME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF THE PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUTCOME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

Section-7

PROCEDURES

(OBSERVED (O)/ASSISTED (A)/PERFORMED UNDER SUPERVISION (PUS)/PERFORMED INDEPENDENTLY (PI)

(Estimated cases to be seen are 50 patients per month)

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-8

REPORTING OF LAB REPORTS

(Estimated cases to be seen are minimum 50 patients per month 10 cases)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SR.#	PATIENT ID /NAME	PATIENT PROBLEM/ DISEASE	BRIEF OVERVIEW OF THE REPORT	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

Section-9

CONSULTATIONS

SR. #	DEPARTMENT SEEKING CONSULTATION	PATIENT ID /NAME	BRIEF DESCRIPTION ABOUT PROBLEM	OPINION GIVEN AFTER DISCUSSION WITH SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

MULTI DICIPLINARY MEETINGS (MDM) (1/month)

SECTION-10

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)

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

SECTION-12

HANDS ON TRAINING/WORKSHOPS

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

PUBLICATIONS (if any)

SECTION-13

S. NO.	NAME OF PUBLICATION	TYPE OF PUBLICATION ORIGINAL ARTICLE/EDITORIAL/CASE REPORT ETC	NAME OF JOURNAL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION-14

WRITTEN ASSESSMENT RECORD OF THIS ROTATION

SNO	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-15

CLINICAL ASSESSMENT RECORD OF THIS ROTATION

SR.#	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-16

EVALUATION RECORDS

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 skilfully					
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)Exhibits system based learning methods smartly					
c)Exhibits 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) Analyses 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/SUPERVISOR'S REMARKS REGARDING PERFORMANCE OF THE TRAINEE

Total Score _____/155

_____ _____ _____ _____

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

Section-17

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

Section-18

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

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

Section-19

TO BE FILLED AT THE END OF ROTATION

MONTH January	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 CASES	
	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH February	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 CASES	
	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

MONTH March	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 CASES	
	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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

SECTION-20

ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS

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			

228

ROTATION-3

SURGERY / LIVER TRANSPLANT

- This popular rotation shall provide residents with an intense introduction to the selection of transplant candidates and the management of these patients after transplantation.
- Residents shall work with a dedicated group of organ transplant physicians and learn the indications, contraindications and the relative protocols and precautions required for these transplantations.
- Trainees should be able to identify and manage post liver transplant complications, infection, surgical and drugs related.
- They should also get an overview of different surgical techniques used for liver transplant.
- They should have ample knowledge of hepato-pancreatobiliary surgeries.

LOG OF LIVER TRANSPLAN AND HEPATOBILIARY

The rotation can be taken in a one month or a two-week block. The purpose of this rotation is for the resident to become familiar with indications, contraindications, and complications of liver transplant. Education goals and objectives of rotation is :

- To become familiar with surgical options available for different Hepatobiliary diseases
- To learn the indications, contraindications and complications of liver transplant.
- To understand the indications and contraindications of surgical procedures for Hepatobiliary diseases , short terms and long terms.
- To understand the utilization of appropriate donor selection, based on indication, cost effectiveness and risks vs. benefits.

The resident will acquire knowledge of:

- Hepatobiliary surgeries available.
- Preparation of patients for liver transplant and other surgeries.
- Indications and limitations in the use of surgical options
- Side effects and complications of surgical options in post transplant (short and long terms.)
- Cost-effective of surgical options
- Post transplant care regarding Drugs, Infections and Rejection
- How to evaluate transplant complications**.**

REFERENCE:

https://med.unr.edu/gastroenterology/residency/curriculum/liver transplant and Hepatobiliary rotation.

Section-1

MORNING REPORT PRESENTATION/ CASE PRESENTATION SEEN IN LAST EMERGENCY OR INDOOR (2/month)

(Presentation with Surgeons)

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/SEMINAR (1/MONTH)

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

SECTION 3

JOURNAL CLUB (1/MONTH)

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

Section-4

SECTION 4

PROBLEM CASE DISCUSSION (TWO /MONTH)

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 LECTURE/INTERACTIVE LECTURES ATTENDED

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

SECTION 6

OPD AND CLINICS

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

Section-5

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 PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

Section-7

PROCEDURES

(OBSERVED (O)/ASSISTED (A)/PERFORMED UNDER SUPERVISION (PUS)/PERFORMED INDEPENDENTLY (PI)

(Estimated cases to be seen are 50 patients per month)

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 8

CONSULTATIONS

SR. #	DEPARTMENT SEEKING CONSULTATION	PATIENT ID /NAME	BRIEF DESCRIPTION ABOUT PROBLEM	OPINION GIVEN AFTER DISCUSSION WITH SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION 9

MULTI DICIPLINARY MEETINGS (MDM)

SR #	DATE	BRIEF DESCRIPTION	SUPERVISORS REMARKS	SUPERVISORS NAME AND STAMP

SECTION-10

CLINICOPATHOLOGICAL CONFERENCE (CPC)

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

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

MORBIDITY/MORTALITY MEETINGS (MMM) 10

SECTION-11

(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-12

HANDS ON TRAINING/WORKSHOPS

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

PUBLICATIONS (if any)

SECTION-13

S. NO.	NAME OF PUBLICATION	TYPE OF PUBLICATION ORIGINAL ARTICLE/EDITORIAL/CASE REPORT ETC	NAME OF JOURNAL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION-14

WRITTEN ASSESSMENT RECORD OF THIS ROTATION

SNO	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-15

CLINICAL ASSESSMENT RECORD OF THIS ROTATION

SR.#	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-16

EVALUATION RECORDS

EVALUATION RECORDS

SUPERVISOR APPRAISAL FORM

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
h) Clinical Knowledge is up to the mark					
i) Follows procedures and clinical methods according to SOPs					
j) Uses techniques, materials, tools & equipment skillfully					
k) Stays current with technology and job-related expertise					
l) Works efficiently in various workshops					
m) Has interest in learning new skills and procedures					
n) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1
b) Sets and adheres to protocols and improving the skills					
b)Exhibits system based learning methods smartly					
c)Exhibits practice based learning methods efficaciously					
g) Actively participates in large group interactive sessions for postgraduate trainees					
h) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
i) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
j) Uses resources sensibly and economically					
k) 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/SUPERVISOR'S REMARKS REGARDING PERFORMANCE OF THE TRAINEE

Total Score _____/155

_____ _____ _____ _____

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

Section-17

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

Section-18

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

Section-19

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

TO BE FILLED AT THE END OF ROTATION

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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

SECTION-19

ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS

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**			

ROTATION-4

ONCOLOGY

- This popular rotation shall provide residents with an intense introduction to the selection of chemotherapy and radiotherapy for cancer patients and their management.
- Residents shall work with a dedicated group of oncologist and learn the indications, contraindications and the relative protocols and precautions required for chemotherapy or radiotherapy.
- Trainees should be able to identify and manage chemotherapy related complications including infections and side effects.

LOG OF ONCOLOGY ROTATION

The rotation can be taken in a one month or a two-week block. The purpose of this rotation is for the resident to become familiar with indications, contraindications, and complications of chemotherapy and radiotherapy. Education goals and objectives of rotation is :

- To become familiar with chemotherapy and radiotherapy options available for GI and Hepatobiliary cancers.
- To learn the indications, contraindications and complications of chemotherapy and radiotherapy.
- To understand the utilization of appropriate radiotherapy and chemotherapy drug selection, based on indication, cost effectiveness and risks vs. benefits.

Section-1

MORNING REPORT PRESENTATION/ CASE PRESENTATION SEEN IN LAST EMERGENCY OR INDOOR (2/month)

(Presentation with Oncologists)

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/SEMINAR (1/MONTH)

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

SECTION 3

JOURNAL CLUB (1/MONTH)

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

~~Section-4~~
SECTION 4

PROBLEM CASE DISCUSSION (TWO /MONTH)

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 LECTURE/INTERACTIVE LECTURES ATTENDED

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

SECTION 6

OPD AND CLINICS

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

Section-5

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 PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

SR#	DATE	REG # OF PATIENT	BRIEF DESCRIPTION//HISTORY, DIAGNOSIS, TREATMENT AND OUT COME	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURES

Section-7

PROCEDURES (Chemotherapy/Radiotherapy)

(OBSERVED (O)/ASSISTED (A)/PERFORMED UNDER SUPERVISION (PUS)/PERFORMED INDEPENDENTLY (PI)

(Estimated cases to be seen are 50 patients per month)

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 8

CONSULTATIONS

SR. #	DEPARTMENT SEEKING CONSULTATION	PATIENT ID /NAME	BRIEF DESCRIPTION ABOUT PROBLEM	OPINION GIVEN AFTER DISCUSSION WITH SUPERVISOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION 9

MULTI DICIPLINARY MEETINGS (MDM)

SR #	DATE	BRIEF DESCRIPTION	SUPERVISORS REMARKS	SUPERVISORS NAME AND STAMP

SECTION-10

CLINICOPATHOLOGICAL CONFERENCE (CPC)

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

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

MORBIDITY/MORTALITY MEETINGS (MMM) 10

SECTION-11

(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-12

HANDS ON TRAINING/WORKSHOPS

SR#	DATE	TITLE	VENUE	FACILITATOR	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

PUBLICATIONS (if any)

SECTION-13

S. NO.	NAME OF PUBLICATION	TYPE OF PUBLICATION ORIGINAL ARTICLE/EDITORIAL/CASE REPORT ETC	NAME OF JOURNAL	DATE OF PUBLICATION	PAGE NO.	SUPERVISOR'S REMARKS	SUPERVISOR'S SIGNATURE (NAME/STAMP)

SECTION-14

WRITTEN ASSESSMENT RECORD OF THIS ROTATION

SNO	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-15

CLINICAL ASSESSMENT RECORD OF THIS ROTATION

SR.#	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-16

EVALUATION RECORDS

EVALUATION RECORDS

SUPERVISOR APPRAISAL FORM

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
o) Clinical Knowledge is up to the mark					
p) Follows procedures and clinical methods according to SOPs					
q) Uses techniques, materials, tools & equipment skillfully					
r) Stays current with technology and job-related expertise					
s) Works efficiently in various workshops					
t) Has interest in learning new skills and procedures					
u) Understands & performs assigned duties and job requirements					
II. QUALITY / QUANTITY OF WORK	5	4	3	2	1
c) Sets and adheres to protocols and improving the skills					
b)Exhibits system based learning methods smartly					
c)Exhibits practice based learning methods efficaciously					
j) Actively participates in large group interactive sessions for postgraduate trainees					
k) Actively takes part in morning& evening teaching and learning sessions & noon conferences					
l) Actively takes part in Multidisciplinary Clinic O Pathological Conferences (CPC)					
g)Actively participates in Journal clubs					
l) Uses resources sensibly and economically					
m) 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/SUPERVISOR'S REMARKS REGARDING PERFORMANCE OF THE TRAINEE

Total Score _____/155

_____ _____ _____ _____

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

Section-17

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

Section-18

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

Section-19

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

TO BE FILLED AT THE END OF ROTATION

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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
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 CASES	
December	WARD												
	CPC												
	LECTURE												
	WORKSHOP												

SECTION-19

ANY OTHER IMPORTANT AND RELEVANT INFORMATION/DETAILS

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**			