DUBAI RESIDENCY TRAINING PROGRAMME

SPECIALIST TRAINING PROGRAMME IN FAMILY MEDICINE (2007-8)

Four Year Residency Training Programme

Primary Health Care
Professional Development Office
Dubai Department of Health and Medical Services

Programme Administration

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POSTGRADUATE TRAINING PROGRAM OF FAMILY MEDICINE

Introduction:

A family physician is concerned with the total health care of the individual and the family, is trained to diagnose and treat a wide variety of ailments in patients of all ages. Special emphasis is placed on prevention of disease and the primary health care (PHC) of entire families, utilizing consultations and community resources.

More patient visits are made to family physicians than to any other type of doctors. According to the American Academy of Family Physicians, the demand for family physicians far surpasses the demand for all other specialties.

Health care systems are particularly reliant on family physicians because of their ability to practice with the greatest cost efficiency.

Rationale:

Family physicians play a major role in integrating and coordinating care provided to patients and their families. They are responsible for the implementation of the concept of PHC through their work in general practice. Therefore, a well designed and effective training program in family medicine should be an essential component of our medical services.

I. Mission Statement:

The mission of the programme of the postgraduate studies in family medicine (PPGSFM) is to provide the community of Dubai and the United Arab Emirates (UAE) with highly qualified family physicians. This will be achieved through continuous planning and quality monitoring of all aspects of the training program.

II. Vision Statement:

The (PPGFM) will rise to international prominence as leader in postgraduate training in family medicine and will become an international model for innovative teaching and learning.

III. Core Values:

We are trainee-centered.
We value quality training.
We are responsive to change.
We embrace diversity.
We believe in empowering trainee.
We are committed to accessibility.
We are committed to satisfaction of community, trainee and the training staff.

VI. Goals and Objectives

Upon completion of training, a resident in Family Medicine (General Practice) is expected to be a competent specialist in Family Medicine (General Practice), capable of independent practice in the specialty.

The goals and objectives may be summarized as follows. The resident must:

• acquire a working knowledge of the theoretical basis of the specialty, including its foundations in the basic medical sciences and research.
• acquire the knowledge, attitudes, and skills common to Family Medicine (General Practice).
• demonstrate knowledge of the pathophysiology, presentation of historical and clinical features, and appropriate investigation and medical management of acute and chronic disease processes.
• be able to identify, diagnose and treat single system or multi-system disease with appropriate prioritization of patient' problems.
• demonstrate the knowledge, skills and attitudes relating to gender, culture and ethnicity pertinent to Family Medicine (General Practice).
• demonstrate an ability to incorporate gender, cultural and ethnic perspectives in research methodology, data presentation and analysis.
• contribute to research
• have self-evaluation and learning skills in the areas of problem-solving, evidence based medicine, and critical appraisal at a level to ensure that they remain effective clinicians, teachers and investigators throughout their careers

V. Educational Objectives:

At the completion of training, the resident will have acquired the following competencies and will function effectively as a:

1. Medical Expert/Clinical Decision-Maker
Family Physicians (General Practitioners) possess a defined body of knowledge and procedural skills, which are used to collect and interpret data, make appropriate clinical decisions, and carry out diagnostic and therapeutic procedures within the boundaries of their discipline and expertise. Their care is characterized by up-to-date, ethical, and cost-effective clinical practice and effective communication in partnership with patients, other health care providers, and the community. The role of medical expert/clinical decision-maker is central to the function of Family Physician (General Practitioner), and draws on the competencies included in the roles of scholar, communicator, health advocate, manager, collaborator, and professional.
General Requirements
• Demonstrate diagnostic and therapeutic skills for ethical and effective patient care using the best available medical practices.
• Access and apply relevant information to clinical practice.
• Demonstrate effective consultation services with respect to patient care and education.
• Demonstrate an understanding of medico-legal issues as they apply to Family Medicine (General Practice).

Specific Requirements
- • Elicit, present, and document a history that is relevant, concise, accurate and appropriate to the patient's problem(s).
- • Perform, interpret the findings of, present and document a physical examination that is relevant and appropriate.
- • Select medically appropriate investigative tools, interpret the results of common diagnostic tests and demonstrate an understanding of their cost effectiveness, limitations

and complications.
• Formulate a comprehensive patient problem list, synthesize an effective diagnostic and therapeutic plan and establish appropriate follow up.
• Demonstrate effective consultation skills in presenting well-documented assessments and recommendations in written and/or verbal form.
• Be able to assess, diagnose, and manage patients with common diseases in the appropriate setting (emergency and ambulatory). Also, to demonstrate an understanding of the epidemiology of such conditions.
• Demonstrate expertise in the management of:
multi-system and/or undifferentiated disease;
medical complications of pregnancy;
preoperative care; and
issues related to health maintenance and disease prevention.
• Apply knowledge and technical expertise in performing the common general practice procedures, interpreting the results and demonstrating an understanding of their limitations and complications:
• Retrieve, critically appraise and apply relevant information to clinical practice.
• Demonstrate an understanding of basic pharmacology and its application to clinical practice.

2. Communicator

To provide humane, high-quality care, specialists establish effective relationships with patients, other physicians, and other health professionals. Communication skills are essential for the functioning of Family Physician (General Practitioner), and are necessary for obtaining information from, and conveying information to patients and their families. Furthermore, these abilities are critical in eliciting patients' beliefs, concerns, and expectations about their illnesses, and for assessing key factors impacting on patients' health.

General Requirements
• Establish therapeutic relationships with patients/families.
• Obtain and synthesize relevant history from patients/families/communities.
• Listen effectively.
• Discuss appropriate information with patients/families and the health care team.

Specific Requirements
• Recognize that being a good communicator is an essential function of a Family physician (general Practitioner), and understand that effective doctor-patient communication can foster patient satisfaction and compliance as well as influence the manifestations and outcome of a patient's illness.
• Establish relationships with the patient characterized by understanding, trust, respect, empathy and confidentiality.
• Demonstrate the ability to communicate professionally and compassionately, while considering the influence of factors such as the patient's age, gender, sexuality, and ethnic cultural and socio-economic background.
• Demonstrate skills in:
providing clear, concise and timely verbal and written communication as applied to consultation notes, sign over of patient care and management plans; communication with patients and families regarding informed consent, the medical condition, plan of treatment, prognosis, primary and secondary prevention, adverse events, medical uncertainty, &

medical errors; and communication with other health care professionals regarding all aspects of patient care.

3. Collaborator

Family Physicians (General Practitioners) work in partnership with others who are appropriately involved in the care of individuals or specific groups of patients. It is therefore essential for Family Physician (General Practitioner) to be able to collaborate effectively with patients and a multidisciplinary team of expert health professionals for provision of optimal patient care, education, and research.

General Requirements

• Consult effectively with other physicians and health care professionals.
• Contribute effectively to other interdisciplinary team activities.

Specific Requirements

• Identify and describe the role, expertise and limitations of all members of an interdisciplinary team required to optimally achieve a goal related to patient care, a research problem, an educational task, or an administrative responsibility.
• Develop a care plan for a patient they have assessed, including investigation, treatment and continuity of care, in collaboration with members of the interdisciplinary team, the patient and the family.
• Participate in an inter-physician or an interdisciplinary team meeting, demonstrating the ability to accept, consider and respect the opinions of other team members, while contributing specialty-specific expertise.

4. Manager

Family Physicians (General Practitioners) function as managers when they make everyday practice decisions involving resources, co-workers, tasks, policies, and their personal lives. They do this in the settings of individual patient care, practice organizations, and in the broader context of the health care system. Thus, Family Physicians (General Practitioners) require the abilities to prioritize and effectively execute tasks through teamwork with colleagues, and make systematic decisions when allocating finite health care resources. As managers, Family Physicians (General Practitioners) take on positions of leadership within the context of professional organizations and the health care system.

General Requirements

• Utilize resources effectively to balance patient care, learning needs, and outside activities.
• Allocate finite health care resources wisely.
• Work effectively and efficiently in a health care organization.
•Utilize information technology to optimize patient care, life-long learning and other activities.

Specific Requirements

• Utilize appropriate time management for effective patient care, administrative duties and scholarly activities.
• Recognize the business and financial skills needed for a successful medical practice and/or academic career.
• Implement patient care practices considering available health care resources.
• Have an understanding of population-based approaches to health care services and recognize their implication for medical practice.

• Demonstrate conflict resolution skills.

5. Health Advocate

Family Physicians (General Practitioners) recognize the importance of advocacy activities in responding to the challenges represented by those social, environmental, and biological factors that determine the health of patients and society. They recognize advocacy as an essential and fundamental component of health promotion that occurs at the level of the individual patient, the practice population, and the broader community. Health advocacy is appropriately expressed both by the individual and collective responses of Family Physicians (General Practitioners) in influencing public health and policy.

General Requirements

• Identify the important determinants of health affecting patients.
• Contribute effectively to improved health of patients and communities.
• Recognize and respond to those issues where advocacy is appropriate.

Specific Requirements

• Educate patients and families about and promote the importance of long-term healthy behaviors and preventive health care (e.g. smoking cessation, screening tests, vaccinations, exercise, and nutrition).
• Respect and empower patient autonomy.
• Promote equitable health care.
• Apply the principles of quality improvement and quality assurance.
• Appreciate the existence of global health advocacy and initiatives for elimination of poverty and disease, (e.g. tuberculosis, malaria, Acquired Immune Deficiency Syndrome).

6. Scholar

Family Physicians (General Practitioners) engage in a lifelong pursuit of mastery of their domain of professional expertise. They recognize the need to be continually learning and model this for others. Through their scholarly activities, they contribute to the appraisal, collection, and understanding of health care knowledge, and facilitate the education of their students, patients, and others.

General Requirements

• Develop, implement and monitor a personal continuing education strategy.
• Critically appraise sources of medical information.
• Facilitate learning of patients, house staff/students and other health professionals.
• Contribute to development of new knowledge.

Specific Requirements

• Understand the principles of scientific research and how these principles apply to the development and implementation of a research proposal.
• Understand how to search and critically appraise the medical literature.
• Demonstrate the ability to teach medical students, residents, patients, colleagues and other health care professionals.
• Develop lifelong learning skills.

7. Professional

Family Physicians (General Practitioners), as professionals, have a unique societal role with a distinct body of knowledge, skills, and attitudes dedicated to improving the health and well

being of others. Family Physicians (General Practitioners) are committed to the highest standards of excellence in clinical care and ethical conduct, and to continually perfecting mastery of their discipline.

General Requirements
• Deliver highest quality care with integrity, honesty and compassion.
• Exhibit appropriate personal and interpersonal professional behaviors.
• Practice medicine ethically consistent with obligations of a Family Physicians (General Practitioners).

Specific Requirements
- Discipline-based objectives:
- Display attitudes commonly accepted as essential to professionalism.
- Evaluate one's abilities, knowledge and skills, recognize one's limitations and use appropriate strategies to maintain and advance professional competence.
- • Personal/Professional Boundary Objectives:
- Strive to heighten personal and professional awareness and explore and resolve interpersonal difficulties in professional relationships.
- Strive to balance personal and professional roles and responsibilities.
- Demonstrate ways of attempting to resolve conflict and role strain.
- • Objectives related to Ethics and Professional Bodies:
- Know and understand the professional, legal and ethical codes to which Family Physicians (General Practitioners), are bound.
- Recognize, analyze and attempt to resolve in clinical practice ethical issues such as truth telling, consent, advanced directives, confidentiality, end-of-life care, conflict of interest, resource allocation, research ethics, interactions with the pharmaceutical industry.
- Understand and apply relevant legislation that relates to the health care system in order to guide one's clinical practice.
- Recognize and know how to deal with unprofessional behaviors in medical practice, taking into account local and provincial regulations.

VI. Administrative Structure

1. Programme Director
The program director is senior physician responsible for the overall conduct of the Residency Program. The Residency Program Director is responsible to to the Postgraduate Dean and is a member of the Postgraduate Education Sub-Committee.

2. Responsibilities of the Programme Director The responsibilities of the Program Director, assisted by the Residency Program Committee include:
- Development and operation of the Program such that it meets the standards of accreditation for a specialty program in Family Medicine.
- Selection of candidates for admission to the program
- Evaluation and promotion of residents in the program in accordance with policies approved by the Postgraduate Medical Education Sub-Committee.
- Establishment of mechanisms to provide career planning and counseling for residents and to deal with problems such as those related to stress in collaboration with the Residents Affairs

- An ongoing review of the Program to assess the quality of the educational experience and to review the resources available in order to ensure that maximal benefit is being derived from the integration of the components of the program. This review must include:
- An assessment of each component of the Program to ensure that the educational objectives are being met
- An assessment of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness
- An assessment of the teachers in the program

Further to those responsibilities listed above, the Program Director must function as a resident advocate and aid in the organization of other educational opportunities. The Program Director is responsible for assigning residents their rotation and service schedules. The Program Director is responsible to the residents to train them well in a humane atmosphere.

The Program Director reports to the Postgraduate Dean.

3. Program Site Co-director

The Program site Co-Director is responsible for the day- to -day functioning of the residency program in the field. The Program site Co-Director is responsible to Program Director. There must be active liaison between the Program Director and Program Co-Director.
The Program Site Co-directors are responsible for:

- Preparation of the scientific modules in cooperation with the teaching staff.
- The day-to-day functioning of the Residency Program.
- Regular tutorials and supervision to the trainee
- Supervision of the rotation program phase and the evaluation of the final report of each candidate at the end of each rotation.
- Annual evaluation of trainee for board of training and examination

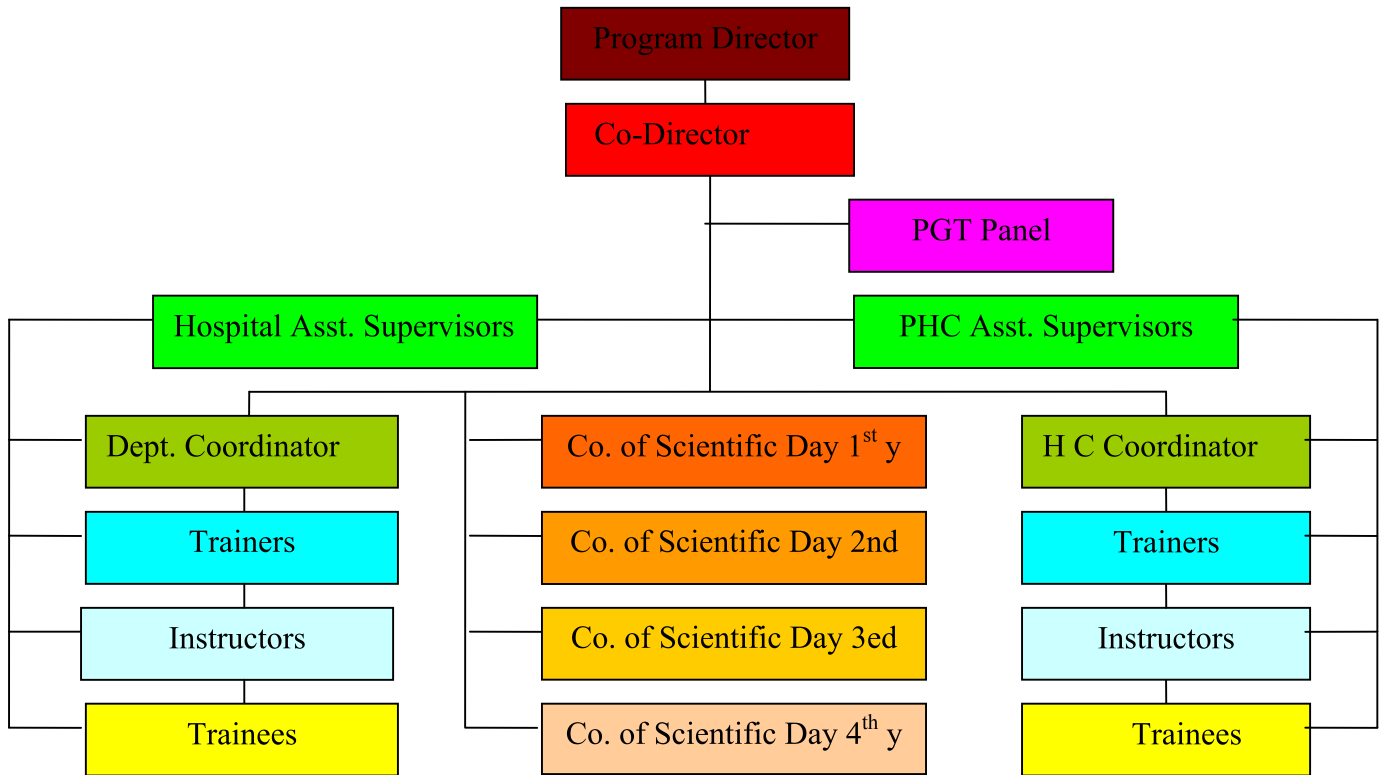
4. Residency Program Committee

The Residency Program Committee assists the Program Director in the planning, organization, and supervision of the Program. The Residency Program Committee should meet regularly, at least quarterly, and maintain the minutes of the meetings. The Program Director who is its executive officer chairs it.

This committee includes

- The Program Site Co-Director
- A representative of each major component of the program
- Representative from co-coordinators of the hospitals
- Representative from coordinator of each Scientific day
- Representative of Residents.

DEPARTMENT OF HEALTH AND MEDICAL SERVICES
PRIMARY HEALTH CARE
PROFISSIONAL DEVELOPMENT OFFICE
POSTGRADUATE TRAINING PROGRAM OF FAMILY MEDICINE



TRAINING PROGRAM ORGANIZATION STRUCTURE

5. Program Sites
The Residency Program in Family Medicine (General Practice) will utilize the following sites:
- Dubai Hospital, Dubai
- Rashid Hospital, Dubai
- Al Wasl Hospital, Dubai
- Primary Health Centers and institutions recognized for training by the Accreditation Committee of the Postgraduate Medical Education Committee

VII. The Training Program:

The Postgraduate Training in Family Medicine is a four-years training program in which resident receives broad range of training in all major medical subspecialties. The first two and half years are predominantly based in the hospital. During the other one and half years, there is a much greater component of ambulatory family medicine. The course begins with a one-month Introduction to Family Medicine. Residents have received block rotations in Paediatrics, Internal Medicine, Accident and Emergency Medicine, Surgery, Obstetrics & Gynecology, Psychiatry, Geriatrics, Ophthalmology, ENT, Dermatology, Community medicine and Public Health.
There are specific sessions on the following generic topics: teaching areas include, physician/patient communications, consulting skills, problem-solving, medical ethics, community screening, disease prevention, evidence based medicine, quality and medical audits, planning and health management
In the last year of the residency, residents are attached to one of the teaching primary health care centers in Dubai.

1. Teaching Staff:
More than 25 family physician and senior PHC doctors, qualified in postgraduate training, are involved at all levels in the training program. They contribute to planning, development, evaluation of the program, training processes and evaluation of residents.

2. Family Medicine Scientific days and Teaching Methods:
Through out the four years of residency, trainees are released from the hospitals and health centers for one day per week to attend an organized scientific day program at the teaching primary health care center. The program includes small group work, and case studies and critical appraisal presentations by the residents. Residents then provide care in a Primary Health Care Centre for the balance of the working day.
Active methods of teaching and learning are used, like problem-solving, case studies, group discussions, random case analysis, direct clinical training in health centers, tutorials with applications in a community context and patient-centered care.
Daily discussions with trainers and instructors will help identify learning needs, plan self-learning activities and encourage self-directed and life-long learning.

3. Assessment of residents:
Hospital departments do evaluation for residents at completion of every rotation to ensure residents have acquired the relevant clinical competencies.
Performance assessment is carried out by the supervisors, mentors and trainers for all residents on completion of rotation and modules. Evaluation is done for residents using for their logbook and on their performance on scientific day program. Periodic formal assessments are held during the course of the program including the American Board written examination papers and clinical examinations.

Formative Assessment
End of Rotation Examination : At the end of each rotation the resident will set for end of rotation examination, this will form part of their formative assessment.
Summative Assessment
Block Examinations: On successfully completing the training requirements for each phase the resident will sit an examination consisting of a written paper, an OSCE examination, and oral examination. The results of these examinations will be used to determine the resident's readiness to progress to proceed to the next block or to sit The Board Examinations. Other components used in this assessment will be the assessments in the various rotations, the logbook, mentors reports and satisfactory attendance and participation in all aspects of the training program.
Failure to Pass a Block
Failure to pass either component of the assessment (examination or trainer evaluation) will result in required re-examination in six months following a remedial clinical experience. Failure of two consecutive assessments will result in review by the training board and possible dismissal from the program. If a resident is not able to attend the examination due to medical leave or other valid reason, he/she will need to take the examination on other available opportunity, as he/she cannot progress to the next block until he/she pass the examination. Other non-accredited clinical experiences may be arranged but will not count toward completion of the residency.

4. Time Table
The annual schedule for each resident will be decided in consultation between the program supervisor and the resident

5. Mentors
Each resident will have a trainer family physician who will act as his or her mentor. The residents are expected to meet with their mentor on a regular basis, the minimum being once in every 10 -week. This time can be used to deal with any problems they may be experiencing in the program and to discuss their learning progress.

6. Senior Residents Small Group Learning Experience
Senior residents will have a tutorial session on weekly basis. This small group learning experience will focus on more advanced family medicine topics utilizing a variety of formats.

7. Research Project
Senior residents are asked to do a research project to gain practical experience in research area. The project will be due before the end of the training period, and will be graded fail, pass or honors.

8. Resident Evaluation of the Program
Residents will be asked to evaluate each rotation and to evaluate each of the Scientific day sessions. In this way residents can contribute to the improvement of the program.

9. Successful completion of the program will require:
- Satisfactory completion of all required and elective rotations.
- Satisfactory participation in all elements of the formative assessment including seminar case presentations, journal article review and the Family Practice in-training examination.
- Attendance at and satisfactory participation in residency Scientific day.
- Satisfactory completion of the Community Medicine rotation,

- A pass grade or better in the Project.
- A pass-grade or better in each summative examination.
- Satisfactory assessment of a resident's clinical performance by hospital, family medicine and PHC trainers for each component of the clinical program

10. Certification:

At the end of the program the residents are eligible to sit the Arab Board of Family Medicine examination and MRCGP (Int).

This specialty-training program for family medicine is a collaborative program involving the Department of Health and Medical Services, and The Arab Board for Medical Specialization in Family Medicine

The Training Program had been recognized by the Arab Board for medical specialization in Family Medicine. On successful completion of the four-year program, residents will receive the 'Report of Satisfactory Completion of Training. They will then be recommended as eligible to sit the Arab Board examination in Family Medicine.

The training process also enables residents to sit the MRCGP INT. after completion of the third year of training

VIII. Entry Requirements

Prospective candidates:

• Should have successfully completed basic medical training leading to MBBS, MD, or MB Ch from a recognized institution.

• Must have completed a one year internship program

• Must be fully registered by the competent Authority, to practice Medicine in the United Arab Emirates.

• Must be successful at an Evaluation Examination which may include an oral and/or written examination and oral interview. The Office of Postgraduate Education in collaboration with the Admission Committee will supervise the Evaluation. Applications will be submitted on line in response to advertisement.

IX. Number of Posts and Duration of Program.

The number of posts in the Family Medicine Residency Program is **10**. This number reflects the available resources at the program sites.

X. Program Structure

Residents will enter the program having received a broad foundation in several aspects of general medicine and surgery during their internship year. Fundamental to the program is a graded increase in responsibility for the resident as they proceed through the training. This level of responsibility will be dependent on their ability, experience and level of training. Appropriate levels of supervision for the trainee will be maintained throughout the program to maximize educational opportunities as well as to optimize patient care and satisfaction.

DEPARTMENT OF HEALTH AND MEDICAL SERVICES PRIMARY HEALTH CARE PROFESSIONAL DEVELOPMENT OFFICE POSTGRADUATE TRAINING PROGRAM OF FAMILY MEDICINE		
RESIDENCY PROGRAMME IN FAMILY MEDICINE		
YEAR	NAME OF THE COURSE	DURATION WEEKS
1ST YEAR		
	INTRODUCTION TO "FM"	4
	COMMUNITY MEDICINE (1)	4
	FM (1) (IN PHC CENTRE)	10
	INTERNAL MEDICINE	24
	DIAGNOSTIC IMAGING & LABORATORY MEDICINE	6
	ANNUAL LEAVE	4
		52
2ND YEAR	COMMUNITY MEDICINE (II)	4
	FM (II) (IN PHC CENTRE)	12
	PAEDIATRICS	16
	OBS/GYN	12
	ENT	4
	ANNUAL LEAVE	4
		52
3RD YEAR	FM (III) (IN PHC CENTRE)	12
	SURGERY & ORTHOPEDICS	12
	PSYCHIATRY	8
	DERMATOLOGY	4
	OPHTHALMOLOGY	4
	ACCIDENT & EMERGENCY	8
	ANNUAL LEAVE	4
		52
4TH YEAR	FM (IV) (IN PHC CENTRE)	40
	ELECTIVE	8
	ANNUAL LEAVE	4
		52
	TOTAL	208

a). Elective:

The resident will be given the opportunity for additional experience in an area of interest that

may be outside of the prescribed selective experiences. This 8 week elective period will be in an area to be chosen by the resident in consultation with the Program Supervisor.

b). Scientific Day:
One day per week will be designated as protected academic time. This period will be utilized to bring all residents in the program together in order to undertake lectures, workshops and other learning experiences that are best delivered in this format. These sessions are meant to compliment and augment learning that is taking place in the clinical setting.

c). Annual Leave:
Each year will include four weeks of annual leave with the approval of the Program Supervisor and the supervisor of the affected rotation. An effort will be made to avoid significantly impacting the educational experience on any single rotation that might occur should a prolonged leave take place within a single rotation.

d). Absences from training
Residents are statutorily entitled to short breaks as per government announcements. In addition they are entitled to absence for special leave, compassionate leave, sick leave and maternity leave. The totality of leave for these purposes should not exceed ten weeks during the four years of training. If this period is exceeded, additional training will be required and the date of Certification will be postponed.

XI. Evaluation of Resident Performance

a). Format
The ultimate responsibility for compiling the Final In-Training Evaluation of the resident lies with the Program Director. During each rotation of the program the resident will be supervised and evaluated by the rotation supervisor directly or by the members of the rotations teaching faculty as co-coordinated by the rotation supervisor. Evaluations will reflect the goals and objectives for the rotation as set out in this document. At the beginning of each rotation the goals and objectives for the rotation will be reviewed by the rotation supervisor with the resident and these will be reviewed periodically during the rotation to ensure that progress is being made towards their attainment.

Evaluation will be ongoing throughout the rotation and be composed of several components and will include a formal written exam, oral exam as well as by direct observation of resident performance in clinical situations. This evaluation will be at the end of each rotation.

Clinical and operative skills will be assessed by direct observation by the rotation's teaching staff. Communication skills will be assessed by direct observation of resident interaction with patients and families as well as by examining written communications to patients and colleagues. Resident's interpersonal skills will be assessed by observing collaborations with all members of the patient care team and their wise use of consultations with other specialties, subspecialties and non-medical disciplines. Teaching skills will be assessed by written student evaluation and by direct observation of the resident in seminars, lectures and case presentations. Attitudes will be assessed by observation and by using feedback from peers, supervisors, allied health personnel, and patients and their families.

b). Feedback:
Honest and constructive feedback will be provided to the resident in a timely fashion. Formal

feedback sessions will take place at the midpoint of each rotation and at the end of the rotation following the evaluation process. Examples of formats for the end of rotation In-Training Evaluation Form are in the appendix. There should also be regular feedback to residents on an informal basis. To facilitate this and to provide the rotation supervisor with further information to complete the end rotation In-Training Evaluation Form a day to day evaluation tool will be used. A log will be maintained by the resident and signed by the senior clinician involved with the particular case. The Program Supervisor will inspect this periodically by the rotation supervisor and discussion around it will occur to ensure progress in the area of patient management. Examples of a log page may be found in the appendix.

c). Standards

The residents and the Program Supervisor are ultimately responsible for the candidates' successful progress through and completion of the Program. The Program Supervisor will review each rotation evaluation and any concerns will be reviewed with the resident. As well, rotation supervisors and site co-coordinators will be encouraged to make any concerns about the resident known at the earliest opportunity in order that any deficiencies may be addressed in a timely and effective manner. A clear plan for addressing any deficiencies will be developed by the involved parties.

If two consecutive evaluation reports are either "Borderline" or "Poor", or the resident is absent from the Program for two months in any one year, the resident will be invited for counseling by the Program Supervisor and the resident's progress reviewed. Such a resident is allowed to continue with the Program at the discretion of the Postgraduate Dean and based on the recommendation of the Program Supervisor and the Training Panel. It is expected that inputs from the trainers and tutors involved rotation and supervisors will weigh heavily in these considerations.

Any period of absence in excess of two months will result in the addition of a make-up period. The duration, timing and composition of this period will be at the discretion of Program Supervisor after consultation with the Training Panel and the involved resident.

Should a resident be dissatisfied with their assessment at any point in the program they are encouraged to review the issues with the involved rotation supervisor or the Program Director. If satisfactory resolution cannot be obtained the resident has the right to lodge a formal complaint with the Program Supervisor, Training Panel, or the Postgraduate Dean. The complaint will then undergo the process as outlined in the guidelines for appeal.
Before the end of Year 4, a resident must have successfully completed all components of the Arab Board and British Royal College of General Practitioners Examinations.

XII. Evaluation of the Program

a). Residency Program Committee

The Training Panel under the leadership of the Program Supervisor will be responsible for the ongoing evaluation of the program. This will include an assessment of the strengths and weaknesses of the program and recommendation of improvements. As well, all residency training sites, including elective experiences will be assessed and evaluated. Formal evaluation of all of the teaching staff affiliated with the program. Discussion regarding the program will occur at all residency program committee meetings and a formal evaluation of the program accompanied by a report should occur on a yearly basis.

b). Internal Review
The internal review is intended as a mechanism to assist the sponsor in maintaining the quality of Residency Program and providing the Program Administrators with information about the strengths and weaknesses of the Program, so that necessary corrective measures may be taken.

The Postgraduate Dean should initiate the internal review and the team should include: a Program Supervisor from another Program, a staff member from another discipline who is experienced in postgraduate medical education, and a resident from another discipline. The review team should have available all documentation regarding the Program. A series of interviews should take place with the Program Supervisor, teaching staff, members of the resident group, and with the Residency Program Committee.
Visits to individual sites should occur when indicated. The internal review team should review all residency education sites and elective experiences. There should be a careful assessment of the quality of the program and the degree to which it fulfills its Goals and Objectives.

The written report of the internal review should include the strengths and weaknesses of the Program and specific recommendations for continued development and improvements. This report should be submitted to the Postgraduate Dean, and made available to the Chair of the department, the Program Supervisor, and members of the Training Panel
Internal Review should take place every two years

c). External Review
The Program should undergo an external review every 5 to 6 years. The process of the external review is similar to that of the internal review with the exception of the make up of the review committee. The external review is initiated by the Postgraduate Dean and the team should include: a representative of an accrediting body in Family Medicine, a Program Supervisor from another Family Medicine Program accredited by the aforementioned body, a faculty member from another discipline who is experienced in postgraduate medical education, and a resident from an accredited external program.
The external review committee would generate a report that should include the strengths and weaknesses of the program and specific recommendations for continued development and improvements. This report should be submitted to the Postgraduate Dean and made available to the Chair of the Department, the Program Supervisor, and members of the Residency Program Committee.

XIII. The Certificate:
On satisfactory completion of the entire program of Family Medicine training, the Program Supervisor will notify the Postgraduate Dean and a certificate of completion of training will be issued. The authorized signatories on the certificate will be the Program Supervisor, Director General/Assistant Director General (MA) and Postgraduate Dean

APPENDIX 1
CORE CURRICULUM

Definition of Family Practice:

Family practice is the medical specialty, which provides continuing and comprehensive health care for the individual and the family. It is the specialty in breadth, which integrates the biological, clinical, and behavioral sciences. The scope of family practice encompasses all ages, sexes, each organ system and every disease entity. AAFP (2003)

Quality Healthcare in Family Practice:

Quality healthcare in family practice is the achievement of optimal physical and mental health through accessible, cost-effective care that is based on best evidence, responsive to the needs and preferences of patients and populations, and respectful of patients' families, personal values, and beliefs. AAFP (2000)

Scope, Philosophical Statement:

Family practice is the continuing and current expression of the historical medical practitioner. The first physicians were generalists. For thousands of years, these generalists provided all of the medical care available. They diagnosed and treated illnesses, performed surgery, and delivered babies. As medical knowledge expanded and technology advanced, many physicians chose to limit their practices to specific, defined areas of medicine. With World War II, the age of specialization began to flourish. In the two decades following the war, the number of specialists and sub-specialists increased at a phenomenal rate, while the number of general practitioners declined dramatically. The public became increasingly vocal about the fragmentation of their care and the shortage of personal physicians who could provide initial, continuing and comprehensive care. Thus began the reorientation of medicine back to personal, primary care. The concept of the generalist was reborn with the establishment of family practice as a specialty.

In summary, the family physician of today is rooted in the historical generalist tradition. The specialty is three dimensional, combining knowledge and skill with a unique process. The patient-physician relationship in the context of the family is central to this process and distinguishes family practice from other specialties. Knowledge and skills vary among family physicians according to their patients' needs and the ability to incorporate new information into their practices. Above all, the scope of family practice is dynamic, expanding, and evolutionary. AAFP (1992) (1998)

The following four principles will be used as a guide during this training

1- The family physician is a skilled clinician.

Family physicians demonstrate competence in the patient-centered clinical method; they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in-patients and their families.

Family physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Family physicians have an expert knowledge of the wide range of common problems of

patients in the community, and of less common, but life threatening and treatable emergencies involving patients of all age groups. Their approach to health care is based on the best scientific evidence available.

2-Family medicine is a community-based discipline.
Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.
Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life threatening), and complex bio-psychosocial problems. Finally, the family physician may provide palliative care to people with terminal diseases.
The family physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

3-The family physician is a resource to a defined practice population.
The family physician views his or her practice as a "population at risk", and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients' health.
Family physicians have effective strategies for self-directed, lifelong learning.
Family physicians have the responsibility to advocate public policy that promotes their patients' health.
Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources.
They consider the needs of both the individual and the community.

4-The patient-physician relationship is central to the role of the family physician.
Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients' response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.
Family physicians respect the privacy of the person. The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients' well being, whether or not patients are able to follow through on their commitments.
Family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.
Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient. CFPC 1996 2000

APPENDIX 2
Outline of Scientific days curriculums

First year scientific day curriculum outline

1. Being a General Practitioner
2. Consultation skills in General Practice
3. Cardiovascular problems
4. Men's health
5. Healthy People: promoting health and preventing disease
6. Digestive problems
7. Metabolic Problems
8. Respiratory problems
9. Ethics and Values Based Medicine
10. Evidence-based Practice
11. Research and Academic Activity

Second year scientific day curriculum outline

1. Management in Primary Care
2. Genetics in Primary Care
3. Care of Acutely Ill People
4. Care of Children and Young People
5. Women's health
6. Sexual Health

Third year scientific day curriculum outline

1. Promoting equality and valuing diversity
2. Care of People with Cancer & Palliative Care
3. Care of people with Learning Disabilities
4. Care of Older Adults
5. Rheumatology and conditions of the musculoskeletal system
6. (Including trauma)
7. Teaching, Mentoring and Clinical Supervision

Fourth year scientific day curriculum outline

1. Drug and Alcohol problems
2. ENT and facial problems
3. Eye problems
4. Care of People with Mental Health Problems
5. Neurological problems
6. Skin problems

APPENDIX 3
The syllabus

This syllabus has two main aims:
The first is to set out, for the benefit of candidates, a description of the breadth and depth of the knowledge and attributes expected of them. The syllabus thus provides a template onto which a training program of family medicine can be constructed.
The second aim is to provide a frame of reference for trainers as they set schedules and undertake development of training.
While this syllabus is comprehensive as the, it should not be taken as an exhaustive or exclusive list of the topics which may covered in training. The absence of any relevant topic from the syllabus should not be taken as a guarantee that it will not be included in the Examination.
This syllabus will inevitably tend to become out of date as the content and context of general practice evolve. Moreover, the syllabus will reflect continuing developments in the curriculum of vocational training and in assessment methodology and policy. therefore we intend to update it on a regular, probably annual, basis. Candidates should ensure that they refer to the version current at the time of application.
A number of important themes, e.g. doctor-patient communication or evidence-based practice inevitably cross the arbitrary boundaries of categorization used in this document. A certain amount of apparent duplication of items in different sections is therefore unavoidable; we hope readers will be tolerant of this and will take it as indicating the importance attached to the recurring theme.
However, an exact one-to-one mapping of sections from these antecedents onto the syllabus has not been rigidly attempted. For the purpose of guiding candidates' training, it was found necessary to expand some areas very considerably (notably clinical knowledge and skills), and to highlight others (e.g. 'generalist skills', 'risk management', 'population, preventive and societal issues' and 'research & evaluation methods') in order to afford them their necessary prominence within this syllabus.
While the syllabus in the context of primary care, it also reflects the broader principles set out in The European Definition of General Practice / Family Medicine, published by WONCA Europe in 2002. In particular, this document lists in a context-independent form eleven central characteristics which define the discipline of primary care, and clusters them into six core competencies as follows:

(1) Primary care management
- a) managing primary contact with patients
- b) coordinating care with other professionals

(2) Person-centered care
- c) adopting a person-centered approach
- d) developing the consultation and the doctor/patient relationship
- e) providing Continuity of care

(3) Specific problem-solving skills
- f) using knowledge of the community prevalence of illness
- g) managing undifferentiated or serious conditions appropriately

(4) Comprehensive approach
- h) managing acute and chronic problems simultaneously
- i) applying health promotion and disease prevention strategies

(5) Community orientation
- j) reconciling the needs of individuals and communities

(6) Holistic modeling

k) using bio-psycho-social, cultural and existential dimensions

This syllabus aims produce competence in the following areas:
(1) Good medical practice and care
(2) Generalist skills
(3) The doctor-patient relationship, communication and consulting skills
(4) Professional, ethical and legal obligations
(5) Population, preventive and societal issues
(6) Information management and technology
(7) Risk management
(8) Monitoring of quality of performance, audit and clinical governance
(9) Continuing Professional Development, learning and teaching
(10) Working with colleagues
(11) Organizational, administrative and regulatory framework
(12) Practice management

In the following sections of the syllabus, each of these areas is further described and, where appropriate, subdivided into its component attributes.

1 Good medical practice and care
1.1 Being able to recognize and manage medical conditions in the following broad categories:
- Common
- Preventable
- Treatable
- Potentially catastrophic, i.e. life-threatening or disabling
- Uncommon but serious
- Atypical or non-diagnosable
- Untreatable
- (See Appendix 1)

1.2 Elucidating and evaluating a patient's condition, based on information gathering (history and symptoms) and, when necessary, clinical examination (interpreting signs) and appropriate procedural skills and/or special tests
(See Appendix 2)
1.3 Knowing, evaluating, and being guided by, the appropriate evidence base
(See Appendix 3)
1.4 Demonstrating the ability to make competent clinical decisions (diagnosis) and selection of appropriate investigation and/or treatment and knowing when no investigation or treatment is indicated
1.5 Employing sound skill-based clinical judgment to assess the seriousness of an illness in order to prioritize care
1.6 Respecting the autonomy of patients as partners in medical decision-making
1.7 Recognizing and working within the limits of one's professional competence, showing a willingness to consult with colleagues, and where appropriate delegating or referring care to those who are recognized as competent
1.8 Performing consistently well and with a commitment to improving one's competence
1.9 Practicing ethically, honestly and with integrity, so that patients can safely entrust their lives and well-being to the doctor
1.10 Accepting the responsibility of being available and accessible to patients

1.11 Having a knowledge of, and assisting patients to access, additional sources of information e.g. alternative and complementary health care, local and national support groups, voluntary and self-help organizations

2 Generalist skills

N.B. While many of the following attributes are required of specialists as well as generalists, in general practice they assume sufficient prominence to merit stating in their own right. The ability to integrate the various skills is more important than the possession of any individual one.

- 2.1 Treating the patient as a unique person
- 2.2 Being an advocate for the individual patient
- 2.3 Providing longitudinal or continuous care
- 2.4 Simultaneously managing both acute and ongoing problems
- 2.5 Integrating information on physical, psychological, social and cultural factors which impact on patients
- 2.6 Demonstrating an appropriately focused assessment of a patients' condition based on the history, clinical signs and examination
- 2.7 Demonstrating the appropriate use of equipment routinely used in general practice and a familiarity with the breadth of tests offered in secondary care
- 2.8 Emphasizing where appropriate the self-limiting or relatively benign natural history of a problem and the importance of patients developing personal coping strategies
- 2.9 Managing uncertainty, unpredictability and paradox by displaying an ability to evaluate undifferentiated and complex problems
- 2.10 Managing conflict, e.g. those which may arise when making decisions about the use of resources, when the needs or expectations of the individual patient and the needs of a population of patients cannot both be fully met
- 2.11 Demonstrating awareness of individual and family psycho-dynamics and their interaction with health and illness
- 2.12 Balancing conflicting interests when having a dual responsibility, and an obligation to patients
- 2.13 Showing a flexibility of approach according to the different needs of a wide variety of patients irrespective of their age, gender, cultural, religious or ethnic background, sexual orientation or any other special needs
- 2.14 Practicing medicine which is wherever possible evidence based, with individuals and populations
- 2.15 Balancing clinical judgment against evidence-based practice as determined by individual patient needs
- 2.16 Coordinating and integrating care by flexibly adopting the various roles (clinician, family physician etc) of a GP in the course of ordinary practice
- 2.17 Recognizing the GP's frontline role, both by facilitating patients' access to specialized care and by protecting them from unnecessary interventions
- 2.18 Managing time and workload effectively, and setting realistic goals
- 2.19 Maintaining comprehensive written and computerized records
- 2.20 Being able to recognize and meet the doctor's needs as a person including self and family care ('(See Appendix 1) housekeeping')
- 2.21 Recognizing and working within the limits of one's professional competence
- 2.22 Being able to work effectively in a team, either as a member or leader, accepting the principles of collective responsibility, and to consult colleagues when appropriate

3 The doctor-patient relationship, communication and consulting skills

3.1 Respecting patients as competent and equal partners with different areas of expertise
3.2 Sharing decision-making with patients, enabling them to make informed choices
3.3 Respecting patients' perception of the experience of their illness (health beliefs); their social circumstances, habits, behavior, attitude to risk, values and preferences
3.4 Understanding the role of patients' ideas, values, concerns and expectations in their understanding of their problems
3.5 Incorporating patients' expectations, preferences and choices in formulating an appropriate management plan
3.6 Showing an interest in patients, being attentive to their problems, treating them politely, considerately, and demonstrating active listening skills
3.7 Demonstrating communication and consultation skills and showing familiarity with well-recognized consultation techniques
3.8 Establishing effective rapport with the patient
3.9 Responding to patients' verbal and non-verbal cues to any underlying concerns
3.10 Being able to detect, elicit and respond to patients' emotional issues
3.11 Being able to deal with patients' difficult emotions, e.g. denial, anger, fear
3.12 Making links between emotional and physical symptoms, or between physical, psychological and social issues
3.13 Communicating and articulating with patients effectively, clearly, fluently and framing content at an appropriate level, wherever the consultation takes place, including by telephone or in writing
3.14 Involving patients' significant others such as their next of kin or carer, when appropriate, in a consultation
3.15 Sensitively minimizing any potentially embarrassing physical or psychological exposure by respecting patients' dignity, privacy and modesty
3.16 Explaining to the patient the purpose and nature of an examination and offering a chaperone when appropriate
3.17 Where appropriate, facilitating changes in patients' behavior
3.18 Having an understanding of family or group dynamics sufficient to allow effective intervention in patients' family contexts
3.19 Demonstrating an awareness of the doctor as a therapeutic agent, the impact of transference and counter-transference, the danger of dependency, and displaying an insight into the psychological processes affecting the patient, the doctor and the relationship between them
3.20 Understanding the factors, such as longer consultations, which are associated with a range of better patient outcomes

4̃ Professional, ethical and legal obligations

4.1 Demonstrating appropriate professional values and attitudes, including caritas; trustworthiness; accountability; respect for the dignity, privacy and rights of patients; concern for their relatives; and providing equity of care
4.2 Adhering to contemporary ethical principles
4.3 Observing and keeping up to date with the laws and statutory codes affecting medical practice.
4.4 Respecting the principle of confidentiality; and, if breaching it without the patient's consent, being prepared to justify the decision
4.5 Demonstrating a commitment to maintaining professional integrity, standards and responsibility

4.6 Ensuring that whenever possible the patient has understood what treatment or investigation is proposed and what may result, and has given informed consent before it is carried out

4.7 Applying guidelines for the treatment of patients under 16 years of age with or without the consent of those with parental responsibility

4.8 Demonstrating an awareness of issues relating to clinical responsibility, e.g. with regard to drug treatment or patients attending complementary practitioners

4.9 Acknowledging the 'good Samaritan' principle, i.e. offering to anyone at risk treatment that could reasonably be expected

4.10 Making appropriate use of available sources of advice on legal and ethical issues at individual, professional, local and national levels

4.11 Following guidance on doctors' obligation to protect patients from a colleague's poor performance, health or conduct

4.12 Respecting a patient's right to a second opinion

4.13 Adopting safe practice and methods in the working environment relating to biological, chemical, physical or psychological hazards, which conform to health and safety legislation

5 Population, preventive and societal issues

5.1 Demonstrating an awareness of the doctor's role in society as an advocate of good health

5.2 Understanding the concept of public interest

5.3 Displaying an ability to make decisions or interventions in the interests of a community or population of patients

5.4 Understanding current ideas concerning the relative rights and responsibilities of Government, the medical profession and the public

5.5 Understanding the concepts of health and normality, the characteristics of healthy people, the qualitative measurement of health, and models of health and disease

5.6 Knowing the conditions which constitute the main reasons for patients consulting in primary care, namely respiratory, eye, ear, nose and throat, musculo-skeletal, psycho-social, dermatology, cardio-vascular and gastro-intestinal problems

5.7 Demonstrating an understanding of demographic and epidemiological issues and the health needs of special groups, and the way in which these factors modify people's use of the health care services

5.8 Recognizing the impact of adverse environmental factors on health, including poverty, unemployment, poor housing, malnutrition, occupational hazards and pollution

5.9 Possessing a working knowledge of population-based preventive strategies including immunization, health screening and population screening.

5.10 Understanding the acceptable criteria for screening for disease, and applying the concepts of primary, secondary and tertiary prevention

5.11 Having a working knowledge of screening and recall systems

5.12 Recognizing and using opportunities for individual disease prevention and promoting the positive aspects of a healthy lifestyle

6 Information management and technology

6.1 Keeping clear, accurate, legible and contemporaneous patient records, which report the relevant clinical findings, the decisions made, the information given to patients (including by telephone), details of any drugs or other treatment prescribed (including repeat prescriptions), and advice about follow-up arrangements
6.2 Employing written communication skills to make referrals, write reports and issue certification
6.3 Ensuring that colleagues are well informed when sharing the care of patients especially to ensure adequate follow-up
6.4 Providing all relevant information about a patient's history and current condition when referring a patient to a colleague
6.5 Ensuring that patients are informed about the information shared within teams and between those providing their care
6.6 Assisting patients who choose to exercise their right to review their clinical records
6.7 Having knowledge of, and the means to access, printed and electronic sources of medical data, information and advice
6.8 Applying population-based screening and recall systems
6.9 Making informed choices about the relative roles of paper-held and electronic data in practice
6.10 Making full and appropriate use of available information technology to facilitate clinical practice, audit, chronic disease surveillance
6.11 Using, where appropriate, computer links with outside agencies e.g. hospitals, Health Sections and medical departments / Authorities and Primary Care regions
6.12 Maintaining an awareness of advances in health informatics, telemetric medicine and computing technology, and their application in improving the delivery of health care

7 Risk management

7.1 Practicing in such a way as to minimize the risk to patients of harm or error
7.2 Fully informing patients about their diagnosis, treatment and prognosis
7.3 Explaining why a treatment is being prescribed, or a management plan proposed, and the anticipated benefits and potential side effects
7.4 Discussing the advantages and disadvantages of alternative courses of action
7.5 Effectively communicating risk by exchanging information, preferences, beliefs and opinions with patients about those risks
7.6 Providing clear explanations of the nature of clinical evidence and its interpretation
7.7 Ensuring appropriate follow up arrangements and 'safety-netting'
7.8 Improving patient safety by critical event reporting, clinical audit, analysis of patients' complaints or information provided by colleagues
7.9 Responding to criticisms or complaints promptly and constructively, and demonstrating an ability to learn from them
7.10 Being aware of the obligations for notifying outside agencies, for example, regarding safety of medicines and devices to the concerned authority, and notifiable diseases

8 Monitoring of quality of performance, audit & clinical governance

8.1 Demonstrating a commitment to professional audit and peer review\

8.2 Using feedback and comments from patients to identify their needs and wishes and using them to bring about improvements in service

8.3 Participating in, and responding constructively to, appraisals and assessments of professional competence.

8.4 Demonstrating commitment to the principles of clinical governance, which is 'designed to enshrine high standards of practice, quality assurance and service improvement'

8.5 Using information technology where appropriate as a tool for audit and quality control

8.6 Understanding and applying the principles and terms used in inferential statistics and evidence-based medicine
(See Appendix 3)

8.7 Applying critical appraisal skills, statistical interpretation and the audit cycle to evaluate and improve care
(See Appendix 3)

8.8 Demonstrating an awareness of local and national systems for monitoring standards of care

9 Continuing Professional Development (CPD), learning, teaching and training

9.1 Demonstrating a commitment to lifelong learner-centered higher professional education (HPE) and CPD through, for example, personal learning and development plans

9.2 Demonstrating a commitment to keeping up to date with evolving knowledge, news and thinking

9.3 Fostering skills of self-awareness and self-appraisal necessary to identify one's own strengths, weaknesses and learning needs

9.4 Participating willingly and with candour in regular mentoring or appraisal

9.5 Offering non-judgmental feedback and advice to colleagues as part of their professional development

9.6 Using self-assessment and formal appraisal as a prelude to acquiring explicit competencies and skills

9.7 Possessing the skills and commitment to formulate practice development programs

9.8 Undertaking teaching in its widest sense, including the education of patients, doctors in training and colleagues

9.9 Ensuring that patients have genuine choice over whether or not to participate in the education of students or doctors in training, and that their care is not thereby jeopardized

9.10 Understanding the interdependence of clinical practice, organization, information management, research, education and professional development

10 Working with colleagues

10.1 Treating colleagues fairly, and not discriminating against them on grounds of gender, race, disability, beliefs or lifestyle

10.2 Ensuring that patients are not encouraged to doubt any colleague's knowledge or skills by making unnecessary or unsustainable comments about them

10.3 Recognizing and respecting the roles of other members of the extended primary care team and colleagues in the secondary, social and voluntary sectors and working with them to deliver a high quality of care

10.4 Demonstrating an awareness of the contribution of complementary practitioners and the nature of therapies that patients may use or request

10.5 Demonstrating a commitment to team collaboration and working in a multi-professional environment

10.6 Having an understanding of team dynamics, leadership and where individual responsibility lies for clinical and managerial issues

10.7 Developing strategies for communicating effectively internally within the primary health care team and externally with other organizations

10.8 Demonstrating a commitment to staff development, education, appraisal and training including the ability to conduct needs assessments

10.9 Possessing an awareness of potential employer/employee issues

10.10 Working with colleagues in Primary Care Organizations, for example, to develop guidelines and protocols

10.11 Having a knowledge of the role of ancillary sources of primary health care, e.g. social workers.

10.12 Cooperating with any formal enquiry into the treatment of a patient, not withholding any relevant information, and assisting the coroner or procurator fiscal if an inquest or inquiry is held into a patient's death

11 Organizational, administrative and regulatory framework

11.1 Understanding the duties and responsibilities of being a doctor working with the DOHMS

11.2 Understanding the importance for both doctors and patients of ensuring adequate insurance or professional indemnity cover

11.3 Understanding the regulatory and contractual frameworks under which doctors practise DOHMS

11.4 Understanding and applying the main areas of legislation covering human rights, equal opportunities, data protection, access to medical reports, consumer protection, health and safety, abortion, births, deaths, controlled drugs, driving motor vehicles

11.5 Demonstrating an awareness of standards and guidelines for health care and performance review, including those defined and promulgated by DOHMS

11.6 Possessing an awareness of workload issues relating to general and personal medical services including activities such as clinics, telephone consultations, home visiting, teaching, outside commitments and, including data on consultation and referral rates

11.7 Knowing the range of career opportunities available to general practitioners, including research, education and assessment

12 Practice management

12.1 Demonstrating planning skills (strategic and operational) at level of health center and higher

12.2 Understanding characteristics of leadership and management in general practice at deferent levels

12.3 Understanding the business and managerial aspects of practice, such as sources of income and expenditure, use of premises, marketing, and the interpretation of accounts

12.4 Demonstrating truthfulness and honesty when completing certificates and other documents

12.5 Ensuring that any research undertaken in practice is done to the highest standards, as approved by a research ethical committee, so that the care and safety of patients is paramount.

12.6 Providing accurate, objective, honest and unbiased comments in references and including relevant important information, which might have a bearing on a colleague's competence, performance, reliability or conduct

APPENDICES

Appendix 1 ̃ Medical knowledge

Within the general context of primary care, the following areas should be considered for each problem or disease

- The natural history of the untreated condition including whether acute or chronic
- An accurate idea of the prevalence and incidence across the ages and any changes over time
- Typical and atypical presentations
- Risk factors
- Diagnostic features
- Recognition of 'alarm' or 'red flag' features
- Treatment including initial, emergency and continuing care
- Prognosis

The problems and diseases listed below are tabulated in groups of conditions seen in general practice.

Seriously ill patients

- Cardiovascular problems including cardiac arrest, acute coronary syndrome, acute myocardial infarct, acute left ventricular failure, dissecting aneurysms, severe hypertension and life-threatening arrhythmias
- Respiratory problems including acute severe asthma, pulmonary embolus, pneumothorax, pneumonia, epiglottitis, bronchiolitis and respiratory failure
- Central nervous system problems including cerebrovascular problems such as strokes, seizures including febrile convulsions, infections such as meningitis or encephalitis, and signs of other significant intracranial pathology such as tumors
- Gastrointestinal problems including gastroenteritis especially in childhood, hemorrhages, acute abdominal pain and liver failure
- Infectious diseases not covered elsewhere e.g. malaria
- Shocked patients including septicemia, carcinogenic and anaphylactic shock, and hemorrhage
- Unconscious patients including those with diabetic problems such as hypoglycemia, hyperglycemic ketoacidosis and hyperosmolar non-ketotic coma
- Psychiatric problems including acute psychoses, acute organic reactions, the suicidal patient, psychological crises
- Urological problems including torsion of the testis, priapism, paraphimosis, gross haematuria, ureteric colic and acute retention of urine
- Women's problems including severe vaginal bleeding and/or pelvic pain e.g. ectopic pregnancy and emergencies associated with pregnancy e.g. placental abruption or eclampsia
- Sudden unexpected death including sudden infant death syndrome, confirmation of death, dealing with relatives, certification

Complex and undifferentiated conditions

including symptoms and ill-defined conditions for which no diagnosis classifiable elsewhere is recorded.

- 'Tiredness all the time' / malaise / fatigue / weakness / lassitude
- 'Funny turns' / dizziness / giddiness / faints / blackouts / ataxia /'gone off legs'
- Anorexia and/or weight loss

Weight gain and/or obesity and conditions, which may be associated with obesity
'Swelling': localized, mass, lump including single lymph nodes
Non-specific rashes
Fever, including pyrexia of unknown origin and 'burning up'
Allergic problems
Pallor including patients who may be anemic for any cause
Confusion, memory loss, poor concentration and forgetfulness
Frequency of micturition, including metabolic causes

Trauma/Injuries/Toxic effects.
Abuse: sexual adult, child; non-accidental child, elder
Wounds (including surgical) and lacerations: management and principles of care
Fractures, sprains, strains and other significant soft-tissue trauma: recognition and principles of management
Head injuries including minor, with or without loss of consciousness, concussion and more serious cranial or intracranial injuries
Internal injuries of the chest, abdomen or pelvis: recognition and principles of management
Poisoning including by drugs (prescribed, over the counter or non-medicinal), foods, and other chemicals whether deliberately or unintentionally and including adverse effects of prescribed drugs
Postoperative complications including those related to the procedure, infections and other systems for example, respiratory or circulatory
Miscellaneous including epistaxis, foreign bodies, burns

Respiratory tract diseases
Sore throats and colds, upper respiratory tract infections including nasopharyngitis, pharyngitis, tonsillitis, peri-tonsillar abscess, epiglottitis, laryngitis and tracheitis
Shortness of breath including lower respiratory tract infections, e.g. bronchiolitis, bronchitis and pneumonia (of any cause), bronchiectasis, emphysema, pneumothorax and pulmonary embolus
Wheezing including asthma, chronic obstructive pulmonary disease
Cough including haemoptysis
Stridor
Hoarseness, change in character of voice

Ear, nose and throat problems
Nasal problems including catarrh, hay fever, 'rhinitis', polyps, epistaxis
Otalgia including otitis externa and media
Mouth problems including pain such as ulceration, infections such as gingivitis, malignancies, disorders of the salivary glands, and medical problems associated with the dentition
Sinus problems
Hearing problems including deafness, tinnitus and associated speech or language disorders

Eye problems
Red eye including conjunctivitis of various causes, iritis, episcleritis, corneal or dendritic ulcers
Loss of vision including visual impairment such as cataracts and retinal problems

such as detachment, vascular lesions, atrophy or tumors
Eye pain such as glaucoma or retrobulbar neuritis
Eyelid problems such as blepharitis, ectropion and disorders of tears

Dermatological problems

Pruritus either generalized or localized
Rashes including dermatoses, eczema, acne and those associated with internal disease
Skin tumors including benign lesions such as naevi and various moles and malignant lesions such as malignant melanoma, squamous cell carcinoma, basal cell carcinoma
Nail and/or hair disorders including alopecia

Gastrointestinal problems

Abdominal masses including ascites, intra-abdominal masses or enlarged organs and localized swellings for example, hernias
Abdominal pain
Change in bowel habit
Constipation
Diarrhoea including infective, malabsorption, inflammatory bowel disease
Gastrointestinal hemorrhage
'Indigestion'/ 'heartburn'/dyspepsia including esophageal reflux and peptic ulcer disease
Rectal problems including bleeding, pain and masses
Nausea and/or vomiting and/or diarrhea
Jaundice including hepato-biliary conditions such as infection, malignancy, gall bladder disease and hemolysis for any cause

Musculo-skeletal problems

Back pain including mechanical, disc lesions or tumors
Neck pain including cervical spondylosis, torticollis and 'whiplash' injuries
Joint pain, swelling or stiffness including individual joints such as hip, knee or shoulder or generalized
Soft tissue problems including pain in a limb, connective tissue disorders such as polymyalgia rheumatica
Rheumatic problems including osteoarthrosis, systemic conditions such as rheumatoid arthritis and osteoporosis
Sports medicine

Neurological problems

Headaches including tension, vascular such as migraine and raised intracranial pressure
Vertigo including vertebro-basilar, labyrinthine or cerebellar problems
Seizures
Strokes and transient ischaemic attacks
Speech disorders
Degenerative disorders including multiple sclerosis, Parkinson's disease, motor neurone disease and encephalopathies
Sensory and/or motor disturbances including neuropathies and neuralgias such as face pain

Cardiovascular problems

Risk factors for coronary heart disease and other thromboembolic diseases such as lipid disorders
Chest pain including ischaemic heart disease and pericarditis
Cardiac failure including left ventricular dysfunction
Hypertension
Palpitations including conduction defects such as atrial fibrillation
Murmurs including congenital heart disease and acquired valvular problems
Circulation disorders including arterial problems such as peripheral vascular disease and aneurysms and venous problems such as thromboembolism

Psychiatric disorders

Communication problems including autistic spectrum disorder
Behavior problems such as attention deficit hyperactivity disorder, encopresis, school problems
Problems of particular life stages e.g. childhood, adolescence, old age
Family, social and cultural context of psychiatric illness
Depression, including features of a major illness such as biological symptoms, assessment of suicidal risk, detection of masked depression
Major mental illness including psychotic disorders such as schizophrenia
Somatization disorder
Personality disorder
Anxiety including generalized anxiety disorder, situational anxiety and adjustment reactions
Substance misuse including alcohol
Sleep disorders
Dementias
Learning difficulties and mental disability).
Co-morbidity: the association of psychiatric disorders with other medical conditions

Children's problems

Prenatal diagnosis
Neonatal problems including jaundice and feeding problems
Delayed development including knowledge of normal developmental milestones
Failure to thrive
Childhood infections including exanthemata
Common diseases of childhood
Coping with childhood physical or learning disability
Child health surveillance and immunization
Non-accidental injury

Urogenital problems

Urinary tract infections
Haematuria
Loin pain
Dysuria
Vaginal discharge
Incontinence

Sexual health

Issues of sexual identity and sexual orientation

Contraception male and female
Infertility, primary or secondary
Assisted conception
Sexually transmitted diseases including safe sex and contact tracing.
Sexual problems including loss of libido, anorgasmia and impotence.

Men's health

Testicular problems including pain e.g. orchitis and swelling e.g. tumors.
Urinary problems including benign prostatic hypertrophy or malignancy

Women's health

Breast problems including pain or lumps; malignancy
Pregnancy including pre-conceptual and normal antenatal care, antenatal problems such as bleeding or hyperemesis; postnatal problems
Abnormal vaginal bleeding including intermenstrual bleeding, post-coital or post-menopausal
Hormonal problems including the menopause and premenstrual syndrome
Menstrual problems including pain such as endometriosis or bleeding such as menorrhagia
Pelvic mass including cysts, fibroids and malignancy
Pelvic pain including pelvic inflammatory disease
Urinary problems including stress and/or urge incontinence
Vaginal discharge and/or pruritus including infections such as bacterial vaginosis, atrophic changes and malignancy

Miscellaneous problems

Bleeding and bruising problems and other hematological disorders
Endocrine disorders
Genetic disorders
Lymphatic disorders including functional asplenia
Occupational medicine
Preventive medicine including screening, opportunistic health promotion especially with regard to smoking, immunization, harm minimization and promotion of a healthy lifestyle
Travel medicine including preventive aspects and treatment of infections contracted abroad.

Serious communicable diseases

Particularly, but not limited to, infections such as Human Immunodeficiency Virus (HIV), tuberculosis and hepatitis B and C
Means and control of transmission, awareness of diagnosis, investigation, management, consent for testing, issues of confidentiality and the implications to the patient of a positive result
Role of Public Health Services

Pharmaco-therapeutics

Application of the concept of rational prescribing, especially with regard to patient safety
Awareness of drug contraindications, adverse effects, iatrogenic disorders and potential interactions

Awareness of the factors affecting dose, drug requirements, compliance and monitoring
Evaluating independent evidence regarding the appropriateness of treatment

Appendix 2̃ PRACTICAL SKILLS

The ability to perform general clinical examination of organ systems, including digital rectal and vaginal examinations

Proficient use of the following:

- Auriscope.
- Ophthalmoscope
- Sphygmomanometer
- Stethoscope
- Fetal stethoscope and/or 'Sonic aid'
- Patella hammer
- Thermometer
- Tuning fork.
- Visual acuity and color tests
- Proctoscope
- Vaginal speculum

Proficiency in the following:

- Cardio-pulmonary resuscitation including use of a defibrillator
- Controlling a hemorrhage
- Venepuncture
- Giving intravenous, intramuscular, subcutaneous or intradermal injections including via a syringe driver
- Performing and interpreting an electrocardiogram
- Performing basic respiratory function tests
- Administering oxygen safely
- Use of a nebuliser
- Near patient testing e.g. urinalysis
- Removal of ear wax
- Passing a urinary catheter
- Performing a cervical smear
- Collecting other relevant samples including endocervical or per-nasal swabs
- Suturing a wound
- Minor surgical procedures e.g. cryotherapy, joint injection and aspiration, and surgical excisions as appropriate for approved practitioners, and including referral of relevant samples for histology

Appendix 3̃ RESEARCH & EVALUATION METHODS

(The knowledge and skills required for evidence-based practice)
Understanding and application of the following:

- Concepts used in evidence-based medicine including: specificity, sensitivity, absolute risk (AR), absolute risk increase (ARI), absolute risk reduction (ARR), hazard ratio (HR), negative predictive value, number needed to harm (NNH), number needed to treat (NNT), odds, odds ratio (OR), positive predictive value (PPV), relative risk (RR), relative risk increase (RRI), relative risk reduction (RRR)
- Basic statistical concepts, including the representativeness of the sample, inclusion and exclusion criteria, bias, prevalence, confidence intervals, probability and correlation coefficients to enable interpretation of results from common statistical tests used for parametric data (e.g. t-tests, analysis of variance, multiple regression) and non-parametric data (e.g. chi squared, Mann-Whitney U)
- Most appropriate research design to examine the hypothesis proposed in prospective and retrospective studies; the limitations and strengths of research methodologies, including case-control, cohort, pilot studies, questionnaire design, quantitative and qualitative studies; use of techniques such as interviews, focus groups, transcripts of narrative material; randomized controlled trials
- Methodology of systematic reviews and meta-analysis, including the potential sources of bias and error in the interpretation of overviews
- Issues relating to research results and conclusions including reliability, validity, generalizability and evaluation of the appropriateness of the study design
- Systematic appraisal of research papers and an ability concisely to summarize the results
- Extent to which results or conclusions of research may be applied in the clinical context, taking into account contemporary views and practice. (RCGP UK 2005)

Specific objectives for the 1st residency year:

At the end of the first residency year, the resident should learn and be able to demonstrate:

1. Proficiency in the following interviewing and communication (consultation) skills:

a. How to be efficient, concise and gentle in the care of his/her patients and their families.
b. The ability to establish good rapport with the patients and their families, and be able to handle the psychological impact of the problem on both.
c. Use of hypothetico deductive method in his or her diagnostic process.
d. Establishing the diagnoses which takes into account the physical, psychological and social components of the problem.
e. Expression of warmth by:
-
Voice
- Contact
- Encouragement
- Body position
- Repetition of key phrases
- Listening and patience
f. Expression of respect by:
- Assurance of confidentiality
- Non judgemental approach
- Appropriate use of facts and open ended questions
- Concern for patient's feelings of comfort
g. Expression of empathy and understanding by:
- Providing an appropriate support and praise
- Exploration of psycho-social symptoms
- Avoidance of careless comments
- Demonstrating self confidence
h. Performance of an appropriate and relevant physical examination taking into an account patient's comfort and agreement.
i. The termination of the consultation should consist of:
- Clear instructions regarding treatment plan and follow upvisits.
- Recheck of patient's understanding and acceptance of diagnosis and treatment plan.
- Openness to questions for any item that may arise.
- When appropriate, making a contract with the patient regarding treatment plan and general health care.

2. He or she will demonstrate presence of the followings in patients medical record:

a. Documentation of patient's basic data, listing patients past medical problems and long term medications.
b. Proper use of SOAP system.
c. Documenting and updating "Active medical problem list".
d. Use of personal stamp and signature.
e. Designing Family Genogram when appropriate.

3. He or she will be able to diagnose, investigate and treat patients presenting with the following problems encountered in family practice clinics:

a. Adults presenting with the following problems:
Cold and Cough 2. Sputum and Hemoptysis
Difficulty in breathing and wheezing
Chest pain
High blood pressure
Palpitations
Heart burn and epigastric pain
Nausea and vomiting
Diarrhoea and Constipation
Jaundice
Proteinuria
Dysuria
Frequency and or urgency
Back pain

Headache
Polydipsia, polyurea and Diabetes
Anemia
Fever
Eye discharge
Red eye
Periodic health screening

b. Women presenting with the following problems:
Dysmenorrhea
Vaginal discharge
Abnormal vaginal bleeding
Dyspareunia
Amenorrhoea

b. Children and adolescents presenting with the followings:
Neonatal jaundice
Abdominal mass
Poor appetite
Pallor and Anemia
Abdominal pain
Vomiting
Loose motion
Constipation
Common skin infections and impetigo
Pediculosis
Hematuria
Fever
Cough and wheezing
Urinary tract infection
Failure to thrive
Earache
Dyspnea
Heart murmur
Febrile convulsions
Exanthematous rashes
Obesity
Sore throat
Polyurea and polydipsia
Lower extremity pain
Limbing
Acne
Enuresis
Short stature
Meningitis
Tuberculosis
Cyanosis
Parasitic infestation
Infantile colic

4. Proficiency in mastering the skills for the following clinical and surgical procedures:

<u>a. Clinical procedures:</u>
1. I.V. line insertion
2. Performing and interpreting E.C.G.
3. Local anesthesia infiltration
4. P.R. examination and proctoscopy
5. Vaginal examination and pap smear
6. K.O.H. and wet mount preparation
7. Testing visual acuity, color vision and visualfields

<u>b. Minor surgical procedures:</u>
Suturing of simple wounds
Incision and drainage of abscesses
Management of simple burns.

Proper and professional ATTITUDE to all the medical, social and psychological problems presented to him. This includes:

a. Assessing patient's perception of the problem and responding to his needs.
b. Exploring behavioral and ecological aspect of the problem and its impact on the family.
c. Determining how and why the condition has occurred.
d. Explaining the nature of the problem to the patient as a routine practice and to the other family members when it is indicated.

e. Keeping the family members informed of patient's health status during an emergency.
f. Involving the patient and his family in managing clinical and chronic problems.
g. Stressing the behavioral and life style modifications for the preventable conditions.
h. Recognizing family anxiety and making every effort to alleviate their suffering.
i. Providing personal, comprehensive, and continuous care to the patients and their families.
6. The ability to properly select and design a protocol for the community research project.

Specific objectives for the 2nd residency year:

In addition to the specific objectives for the first residency year, the second year residents should learn and demonstrate:

1. That they will be able to diagnose, investigate and treat patients presenting with the following problems encountered in family practice clinics:

a. Adults presenting with the following problems:

1. Dizziness and Vertigo
2. Heart murmur
3. Irregular rhythm
4. Abdominal distention
5. Renal and ureteric colic
6. Neck pain
7. Knee pain
8. Shoulder pain
9. Hip pain
10. Foot pain
11. Mono and polyarthritis
12. Urethral discharge
13. Thyroid disease
14. Postural hypotension
15. Lymph node enlargement
16. Cardiac neurosis
17. Tuberculosis
18. Irritable bowel syndrome
19. Osteoarthritis
20. Leukemias and Lymphomas
21. Epistaxis
22. Hair fall
23. Nail problems
24. Corn, callosity, and warts
25. Discharging ear
26. Nasal discharge
27. Facial pain
28. Hallitosis
29. Painful eye
30. Eye injury
31. Sudden visual loss
32. Bells palsy

b. Women presenting with the following problems:

33. Contraception
34. Incontinence
35. Ante natal care
36. Post natal care
37. Prescribing in pregnancy
38. Maternal nutrition

c. Children and adolescents presenting with the followings:

39. Headache
40. Epilepsy
41. Proteinuria
42. Child screening
43. Growth and development
44. Childhood nutrition
45. Undescended testicle
46. In-toing and out-toing
47. Bowleg
48. Sexual precocity
49. Behavioral problems in adolescent
50. Anal pain and fissures
51. Rectal bleeding
52. Scoliosis

2. Proficiency in mastering the SKILLS for the following clinical and surgical procedures:

1. Electrocautery
2. Ear syringing
3. Ear wick insertion
4. C.P.R. and endotracheal intubation
5. Corneal foreign body removal with cotton swab
6. Fluroscien corneal stain
7. Gram stain technique

3. The ability to design a protocol for the community research project, collect relevant data and analyze the final results.

Specific objectives for the 3rd residency year:

In addition to the specific objectives for the first and second residency years, the third year residents should learn and demonstrate:

1. That they will be able to diagnose, investigate and treat patients presenting to them with the following problems:

a. Adults presenting with the following clinical problems:

1. Syncope
2. Leg edema
3. Dysphagia
4. Hematamesis
5. Malena
6. Scrotal pain, swelling, and mass
7. Urinary retention
8. Tremors
9. Dementia
10. Coma
11. Parises and paralysis
12. Hirsutism
13. Narcotic prescription
14. Leukopenia
15. Esinophilia
16. Weakness and fatigue
18. Weight loss
19. Post M.I. follow-up
20. Inflammatory bowel disease
21. Osteoporosis
22. Smoking problems
23. Arthritis and other joint problems
24. Sickle cell disease and other heamoglobinopathies
25. Foreign body in the ear or nose
26. Antibiotics, use and abuse
27. Hearing problems
28. Hoarseness
29. Nasal block and allergy
30. Neck swelling
31. Poor vision
32. Blurring of vision
33. Counselling
34. Depression and anxiety
35. Grief reaction
36. Bereavement
37. Sleep disorders
38. AIDS and related immune deficiency disorders
39. Tingling and numbness
40. Alcohol and drug addiction
41. Psychosomatic disorders
42. Malingering
43. Health risk screening

b. Women presenting with the following problems:

44. Unwanted pregnancy
45. Breast problem
46. Infertility
47. Menopausal problems
48. Vaginal discharge

c. Children and adolescents presenting with the followings:

49. Micro and macrocephaly
50. Enlarged lymph nodes
51. Encopresis
52. Speech and learning disorder.

2. The ability to evaluate, diagnose and initiate primary treatment to the patients with the following life threatening and emergency conditions, before referring them to the Accident and Emergency department:

1. Acute myocardial infarction
2. Pulmonary edema
3. Acute respiratory failure
4. Hypertensive crisis
5. G.I. bleeding
6. Shock (hypovolemic, septic)
7. Anaphylaxis and severe drug eruption
8. Status asthmaticus
9. Status epilepticus
10. Acute renal failure
11. Diabetic ketoacidosis
12. Hypoglycemic coma
13. Comatose patient.

3. The ability to perform the following life threatening and surgical skills:

1. Excision of the skin and the subcutaneous lesions

e.g. Sebaceous cyst, lipoma, skin tag
2. I.U.C.D. insertion
3. Cardioversion
4. Tracheostomy
5. Chest tube placement
6. Primary management of fractures
7. Excision of in-growing toe nail.

4. Awareness of the counselling techniques, preventive care and health promotion. This will include the followings:

1. Counselling for the loss of autonomy, self image and employment.
2. Pre marital and marital counselling.
3. Nutritional counselling.
4. Screening principles.
5. Life style modifications and stress management techniques.
6. Reduction of risk factors.
7. Exercise and fitness.

5. The ability to conduct health education sessions pertinent to the community needs, to the school children and in the social clubs.

6. Competency in designing the protocol for the community research project, collecting relevant data, analyzing the results and properly writing the research paper.

HOSPITAL TRAINING OBJECTIVE GUIDELINES

DEPARTMENT OF ACCIDENT & EMERGENCY:

GENERAL OBJECTIVES:
Duration: The residents will spend two months in this department during their 3rd residency year.
General learning guidelines: At the end of the Accident &Emergency rotation the resident should demonstrate:

1. Proficiency in diagnosing and managing the following life threatening conditions:
- Acute M.I.
- Left ventricular failure
- Arrythmias
- Acute bronchial asthma
- Status asthmaticus
- Hypoglycemia
- Diabetic Ketoacidosis
- Epilepsy
- Unconscious patient
- Sickling crisis

2. Competency in managing the following surgical problems:
- Severely injured patient
- Head injury
- Fractures
- Acute abdomen
- Appendicitis
- Perforated D.U.
- Peritonitis
- Cholecystitis
- pancreatitis
- Exacerbation of D.U.
- Renal colics
- Croup
- S.C. crisis
- Intestinal obstruction
- Pelvic inflammation
- Tendon, nerve and muscle cuts
- 2nd and 3rd degree burns

3. Ability to diagnose and manage the following pediatric problems presenting to A & E department.
- Febrile convulsions
- Acute respiratory distress
- Dehydration

4. The skills in performing the following procedures:
- I.V. canulation, and blood collection
- Suturing of uncomplicated skin cuts
- Stitch removal
- P.O.P. application and managing its complications
- X-ray reading and their interpretation
- Drainage of abscesses
- Catheterization

DEPARTMENT OF MEDICINE

GENERAL TRAINING OBJECTIVES

Duration: The residents will spend six months in various sections of the medical department.

General objectives: At the end of the rotation, the residents should be able to demonstrate:

1. Competency to diagnose, investigate and treat the following presenting problems:

a) Related to cardiology
- Chest pain
- Syncope
- Palpitation
- Leg edema
- Dyspnea

b) Related to respiratory system
- Dyspnea
- Wheezing
- Cough
- Haemoptysis

c) Related to gastroenterology
- Dyspepsia
- Dysphagia
- Abdominal pain
- Haematemesis
- Malena
- Nausea & vomiting
- Diarrhoea
- Constipation
- Abdominal distension
- Jaundice

d) Related to nephrology
- Dysuria
- Frequency
- Haematuria
- Proteinuria
- Oliguria
- Anuria

e) Related to neurology
- Headache
- Pain and numbness
- Pareisis & Paralysis
- Seizures
- Tremors
- Memory disorders
- Coma
- Dizziness

f) Related to endocrinology
- Thyroid swelling
- Hirsutism
- Polyuria/Polydypsia
- Hypoglycaemia

g) Related to haematology
- Pallor
- Plethora
- Lymphadenopathy

h) Related to rheumatology
- Neck pain
- Back pain
- Monoarticular pains
- Polyarticular pains

i) Related to Non-differentiated systems
- Weakness
- Fatigue
- Weight loss
- Prolonged fever.

2. Fundamental knowledge of the following chronic conditions:

a) Related to cardiology
- Congenital heart disease
- Ischaemic heart disease
- Conductive disorders & arrythmias
- Valvular heart diseases
- Hypertension
- Heart failure
- Thrombo embolic disorders
- Carditis
- Cardiomyopathy
- Rheumatic fever

b) Related to respiratory system:
- COPD
- Asthma
- Tuberculosis
- Pneumonias
- Lung cancer
- Pulmonary embolism
- Bronchiectasis

c) Related to gastroenterology
- Acid peptic disease
- Inflammatory bowel disease
- Irritable bowel syndrome
- Diverticulosis
- Malabsorption
- Hepato biliary diseases
- Pancreatitis

d) Related to nephrology

- Pyelonephritis
- Glomerulonephritis
- Nephrotic syndrome
- Uraemia
- Renal failure

e) Related to neurology
- Cerebro vascular accidents & T.I.A.
- Seizure disorders
- Neuropathies
- C.N.S. infections (meningitis, encephalitis, Neurosyphilis)
- Dementia
- Space Occupying lesions
- Parkinsonism

f) Related to endocrinology
- Thyroid disorders
- Diabetes Mellitus
- Cushing syndrome
- Addisons disease
- Hyperlipidemia
- Hyperprolactinaemia
- Acromegaly

g) Related to haematology
- Anemias
- Polycythaemia
- Luekaemias
- Haemoglobinopathies

h) Related to rheumatology
- Osteo arthritis
- Rheumatoid arthritis
- Connective tissue disorders
- Gouty arthritis
- Ankylosing spondylitis

3. Competency in recognizing and performing primary management for the following life threatening and emergency conditions:
- Acute myocardial infarction
- Pulmonary edema
- Acute respiratory failure
- Malignant hypertension
- Gastro intestinal haemorrhage
- Shock
- Anaphylaxis
- Status asthmaticus
- Status Epilepticus
- Acute renal failure
- Diabetic ketoacidosis
- Comatose patient

4. Competency in performing the following clinical skills:

a) Procedures used in medical practice
- E.C.G. tracing & interpretation
- Lumbar puncture
- Arterial puncture
- Peritoneal tap
- Bone marrow aspiration & biopsy
- P.P.D testing & interpretation
- Joint aspiration
- Pulmonary function testing
- Renal dialysis
- CPR with cardioversion & intubation

b) Interpretation of laboratory results
- Interpret commonly used laboratory tests
- interpret specialized laboratory tests such as ABG's, TFT, Pituitary, adrenocortical and sex hormones

c) Interpretation of:
- Chest x-rays (Pnemonias, Cardiomegrly)
- Abdominal x-rays
- X-rays of the bones and the joints

DEPARTMENT OF PEDIATRICS

GENERAL TRAINING OBJECTIVES

Duration: The residents will spend four months in various sections of the pediatric department.

General objectives: By the end of the pediatric rotation, the residents should be able to:

1. Establish rapport with the patients and their families, and obtain a comprehensive history.
2. Perform a complete physical examination.
3. Put a problem list, differential diagnosis and plan of management, taking into consideration the available resources.
4. Asses growth and development, use growth charts, and detect the deviant cases.
5. Interpret common laboratory results, and read simple x-rays (i.e. chest, fractures, abdomen).
6. Gain pharmacological knowledge of common medications used including antibiotics, decongestants, antihistamines, diuretics, antiasthmatics, chronotropics and inotropics.
7. Know how to provide care to the new borns and the infants, and be able to advise the parents about it.
8. Demonstrate proficiency in scheduling vaccinations and know their contraindications.
9. Diagnose common community illnesses and manage them properly.
10. Recognize cases that need referral to the hospital or to the specialist.

Generally the primary care physicians should be able to provide preventive as well as curative medical care to infants, children and adolescents.

Specific learning objectives:

a) Pediatric emergencies:

1. The residents should recognize the following life threatening conditions and be able to stabilize the patient before transferring to the hospital.

- Epiglottitis
- Chocking
- Anaphylaxis
- Septic shock
- Hypovolemic shock
- Status asthmaticus
- Seizure disorders
- CCF, and cyanotic heart diseases
- Poisoning and drug overdose

2. The resident should be competent in cardiorespiratory resuscitation and should participate in active resusciation at least once if possible.

b) Pediatric procedures:

The residents are expected to perform the following basic procedures by the end of their rotation:

- Withdrawing blood
- Starting I.V line
- Lumbar puncture
- Bladder tap
- Resuscitation of the newborn and older children

c) Care of the newborn babies:

1. The family physician residents are expected to be knowledgable and skillful in performing the followings:

- Resuscitation of newborn babies
- Giving apgar score

- Doing routine newborn examination and detect any abnormalities
- Managing neonatal jaundice
- Managing infant of diabetic mother

2. The residents should have some knowledge about:

- BPD
- Prematurity
- Birth asphyxia
- Respiratory distress syndrome
- Neonatal and intrauterine infections

d) Genetics and Congenital anomalies:

The family physician residents should gain adequate knowledge related to the following areas:

- Mode of inheritence of genetic disorders
- Consanguinity and its impact on health
- Prenatal diagnosis
- Genetic counselling

e) Pediatric Nutrition:

The family physician residents should acquire basic knowledge about the followings:

- Breast feeding and its advantages
- Modified cow's milk formula, its advantages and disadvantages
- Recommended children's daily requirements for proteins,carbohydrates, fat, vitamins and minerals.
- Weaning food and time of its use.
- Protein energy malnutrition, causes, manifestation and management
- Iron deficiency anemia, diagnosis, and management

f) Behavioral Pediatrics:

The residents are required to detect the following abnormal behaviors and refer the child to the hospital:

- Learning disorder
- Mental retardation
- Enuresis
- Language problems
- Hyperactivity

g) Systemic infections:

The residents should be able to recognize and manage the following common pediatric problems:

- Upper respiratory infections including tonsillitis, otitis media,pharyngitis
- Pneumonias and tuberculosis
- Gastroenteritis and dehydration
- Simple urinary tract infection
- Viral infections like measles, rubella, mumps, and chicken pox.

h) Cardiovascular System:

The residents should be able to recognize the following clinical conditions and transfer them to the hospital for further work up:

- Organic murmurs (congenital and rheumatic).
- Hypertension
- Arrythmias
- Congestive heart failure

i) Gastrointestinal System:

The residents should have adequate knowledge and ability to diagnose and manage the

following conditions:
- Mild to moderate gastroenteritis
- Simple cases of nutritional anemias
- Acute and chronic constipation
- Intestinal infestations
They should be able to recognize the following conditions and refer them for further work-up and management:
- Chronic diarrhoea and malnutrition
- Failure to thrive
- Chronic malabsorption
- Liver disease

j) Central nervous system:

The family physician residents should acquire basic knowledge about:
- Differential diagnosis of headache in children
- Diagnosing and managing simple febrile convulsions
- Diagnosing non febrile seizures
- Symptoms and signs of raised intracranial pressure - Cerebral palsy and its complications

k) Hematological system:

The family physician residents should acquire basic knowledge pertinent to the following conditions:
- Diagnosis, and management of iron deficiency anemia
- Diagnosis, and management of sickle cell disease, and other hemoglobenopathies
- Diagnosis of G6PD deficiency, and hemolytic crises
- Signs and symptoms of leukemias and other bleeding disorders

l) Endocrinal conditions:

The residents should acquire basic knowledge to recognize thefollowings:
- Symptoms and signs of diabetes mellitus and diabetic ketoacidosis
- Presentation of hypothyroidism, and hyperthyrodism

m) Skin disorders:

The residents should be able to diagnose and treat the following common skin conditions:
- Diaper rash
- Impitigo
- Eczema
- Scabies

n) Musculoskeletal system:

The residents should be able to recognize signs, symptoms and differential diagnosis of the followings:
- Septic arthritis and/or osteomyelitis
- Rheumatic arthritis
- Rheumatoid arthritis
- Arthralgia

DEPARTMENT OF RADIOLOGY

GENERAL TRAINING OBJECTIVES

Duration: The residents will spend two weeks in various sections of radiology.
General objectives: At the end of the radiology rotation the residents should demonstrate:
1. Awareness of the various radiological facilities and procedures available in the Ministry of Health
2. Proficiency in interpreting the following plain x-rays commonly used in Primary Care setting.
a. Chest X-rays:
- Normal findings of chest x-rays
- Abnormalities of thoracic cage
- Disorders of the pleura e.g. pneumothorax, effusion and adhesions.
- Disorders of the diaphragm
- Mediastinal lesions
- Hilar enlargement
- Cardiac abnormalities
- Parenchymal lesions
- Pulmonary nodules or masses
- Pulmonary cavitary or destructive lesions
- Lesions secondary to changes in air content e.g. Atelectasis & Emphysema.

b. Bones and joints:
- Common fractures & dislocations
- Fracture healing complications
- Joint abnormalities e.g. Narrowing, Erosions and soft tissue swelling
- Alteration in bone density
- Solitary and multiple bone lesions
- Osteomyelitis
- Abnormalities of the spine - e.g. scoliosis, arthritic changes, vertebral & disc. lesions.

c. Abdomen/urinary tract & pelvis
- Abdominal calcifications
- Disorders of intestinal gas pattern
- Abnormalities of the kidneys e.g. size, position and contour
- Presence of urinary calculi

3. Ability to recognize the indications, limitations and common abnormalities of the following special studies:
a. Upper gastroentestinal barium studies:
- Esophageal abnormalities e.g. strictures, filling defects, dilatations and hiatus hernia
- Abnormalities of the stomach and duodenum e.g. ulcers and gastric out let obstructions
- Abnormalities of the small intestine: e.g. dilatations, mucosal abnormality, narrowing and ulcerations.

b. Barium enema (conventional and double contrast)
- Narrowings (stricture, neoplasm & ulceration)
- Dilatation (Obstruction, Ileus & volvolus)
- Filling defects

c. Intravenous pyelography (I.V.P)
- Kidneys (size, shape, dimensions and masses)
- Collecting system (caliceal dilatations)
- Pelvis and ureters (dilatations and displacement)
- Urinary bladder

d. Intravenous and oral cholecystography
e. Myelography
f. Arteriography
g. Computed tomography
h. Ultrasound (abdomen, pelvis & thyroid)
4. Ability to explain to the patients the investigational process, and the preparation needed for it.
5. Awareness of the side effects and cost effectiveness of various radiological procedures.

DEPARTMENT OF PATHOLOGY

GENERAL TRAINING OBJECTIVES

Duration: The resident will spend two week rotation in various sections of S.M.C. Laboratory.

General objectives: At the end of the pathology (laboratory) rotation the residents should demonstrate:

1. Awareness of the various laboratory facilities available at S.M.C, Public health and Primary care centers.
2. Proficiency to instruct the patients for various common laboratory tests.
3. Fundamental knowledge of precautions needed for various common laboratory tests
4. Rationality for requesting common laboratory studies.
5. Ability to interpret common laboratory tests efficiently in correlation to the available clinical data.
6. Awareness of the cost effectiveness of various common laboratory tests.
7. Knowledge of drug interference in Laboratory tests and the caution to be exercised in the interpretation of such situations.

DEPARTMENT OF DERMATOLOGY

GENERAL TRAINING OBJECTIVES

Duration: The resident will spend 1 month in this department

General training objectives: At the end of the dermatology rotation the residents should be able to demonstrate:

1. Fundamental Knowledge in the following areas:

a) The function and the structure of the skin.
b) Common bacterial skin problems.
- Impetigo - Erysipeles
- Folliculitis - Cellulitis
- Erythrasama

c) Common viral skin disorders.
- Herpes simplex - Herpes Zoster
- Herpangina - Molluscum contagiosma
- Skin & genital warts - Lymphgranuloma Venereum
- Hand foot and mouth disease.

d) Common fungal diseases.
- Tinea capitis - Tinea pedis
- Tinea corporis - Tinea unguium
- Tinea cruris - Tinea versicolor
- Candidiasis

e) Common parasitic Infections.
- Scabies - Pediculosis

f) Common scaling disorders.
- Psoriasis - Seborrheic Dermatitis
- Pityriasis Rosea - Lichn planus

g) Common blistering disorders.
- Pemphigus - Dermatitis Herpetiformis
- Epidermolysis Bullosa

h) Eczematous disorders of the skin.
- Atopic Dermatitis - Neurodermatitis
- Stasis Dermatitis - Contact Dermatitis

i) Skin lesions in sexually transmitted diseases.
- Gonorrhea - Chancroid
- Syphilis - Granuloma Inguinale

j) Commonly used Dermatological drugs.
- Antihistamines - Shampoos
- Tars - Sunscreens
- Topical antibiotics
- Topical and systemic steroids
- Topical and systemic anti-fungal drugs

k) Pigmentation Disorders.
- Vitiligo - Melasma

l) Tumors of the skin and Blood Vessels
- Benign tumors
- Malignant tumors
  e.g. Basal & Squamous cell carcinoma
  Malignant Melanoma
  Leukoplakia

m) Hair problems.
- Alopecia - Hirsutism

n) Cutaneous manifestation of internal disease.
- D.M. - Erythema nodosum
- purpura - Rheumatoid nodules
- Nutritional deficiency

o) Miscellaneous skin conditions: e.g.
- Pruritus - Hyperkeratosis
- Skin corns - Intertrigo

2. Proficiency in taking dermatological history, performing appropriate physical examination and initiating therapy for the common skin disorders seen at primary care level.

3. Proper use of the following diagnostic and therapeutic dermatological techniques.
- Thermal cautery - Cryotherapy
- KOH preparation - Skin biopsy
- Use of Wood's light - Excision of small tumor
- Intralesional injection - Culture of infected material
- Use of topical cream, ointment and solutions

4. The skills in identifying the dermatologic problems that needs urgent referral.

5. Proficiency in managing the patient presenting with the following clinical problems:
- Pruritus - Poor skin hygiene
- Skin rash - Acne and acneform eruption
- Hair fall - Nail problems
- Corns and callosities

DEPARTMENT OF OB/GYN

GENERAL TRAINING OBJECTIVES

Duration: The resident will spend three months in various sections of obstetrics and gynecology department.

General Guidelines: The family physicians are expected to provide preventive, and curative primary health care to all the women during and after their reproductive age, and even to the children who presents with gynecological problems.

Training objectives:

1. By the end of residents training, they will be able to perform the following clinical procedures:

a.
Gynecological skills:
- Technique of vaginal examination
- Cervical smear and screening for Ca. Cervix
- Post natal check-up
- IUCD insertion
- Family planning counselling
- Breast examination
- Menopause counselling

b. Obstetrical skills:
- Routine ante-natal examination with special attention to the 1st ante-natal visit
- Normal deliveries
- Perineal repair
- High risk pregnancy
- High risk deliveries
- High risk postnatal care

2. The family physician resident will be able to recognize, investigate and manage the following Gynecological conditions:

- Abortion
- Ectopic pregnancy
- Pelvic inflammatory diseases
- Vaginal discharge
- Sexually transmitted diseases
- Amenorrhea
- Abnormal uterine bleeding
- Oral contraceptives
- Other methods of contraception

3. The residents will have sufficient knowledge to diagnose, investigate and manage the following obstetrical cases:
- Pregnancy complicated with medical disorders such as Hypertension, Diabetes, Heart Diseases, Kidney problems, Epilepsy & other chronic medical disorders.
- Multiple gestation
- Premature rupture of the membrane and premature labour
- Patients with bad obstetric history
- Intra uterine growth retardation
- Intra uterine death

4. The residents will gain enough knowledge and clinical skills for the following conditions:
- Pre-operative Care
- Post-operative Care
- Trophoplastic disease and its follow-up
- Malignancies of the genital tract

DEPARTMENT OF SURGERY

GENERAL TRAINING OBJECTIVES
Duration: The residents will spend three months in various sections of surgery.
General objectives: At the end of Surgery rotation the residents should be able to:
1. Demonstrate basic knowledge related to:
a. Implementation of sterile techniques
b. Wound healing and care
c. Application of local and regional anesthesia
2. Perform the following office surgical procedures:
a. Suturing of simple wounds: Head, face, fingers.
b. Excision of skin and subcutaenous lesions: Sebaceous, dermoid cysts or lipomas.
c. Incision and drainage of abscesses
d. Removal of ingrowing toe nails
e. Circumcision
f. Care of burns
g. Casting and splint use
h. Management of uncomplicated fractures and complications.
3. Manage, stabilize, transport and perform life saving procedures in the following conditions:
a. Penetrating trauma to the neck, thorax or abdomen.
b. Blunt trauma to chest or abdomen
c. Blunt trauma to head
d. Multiple fractures
e. Pneumothorax and hemothorax
f. Fractures of the spine
4. Diagnose and refer the following acute surgical conditions:
a. Acute abdomen
- Perforating peptic ulcer
- Appendicitis
- Cholecystitis
- Volvolus
b. Intractable haemorrhage
c. Acute arterial occlusion
d. Torsion of the testes
e. Incarcerated hernia
5. Diagnose and manage the following conditions that may need surgery:
a. Breast lump
b. Thyroid nodule
c. Benign prostatic hypertrophy
d. Hydrocele or varicocele
e. Undescended testicle
6. Learn and perform preoperative preparation and postoperative patients care.

DEPARTMENT OF OTOLARYNGIOLOGY

GENERAL TRAINING OBJECTIVES
Duration: The resident will spend 1 month in this department.
General learning guidelines: By the end of the rotation, the family physician resident will be able to:

I. PERTINENT TO OTOLOGY FIELD:

1. Understand the basic parts of the anatomy and physiology of the ear.
2. Take good history, perform relevant physical examination, and assess the hearing.
3. Understand how to diagnose and treat all types of acute otitis media, non supurative otitis media and chronic otitis media.
4. Demonstrate proper approach to the patient with vertigo, dizziness and tinnitus. He/she will know how and when to initiate management, perform basic investigations and refer to E.N.T clinic.
5. Recognize all types of audiological and vestibular tests, and their clinical significance.
6. Recognize speech disorders in children and it's relation to diminished hearing in childhood. He/she will know how to approach a deaf-mute child and when to refer him.
7. Demonstrate how to perform minor procedures like ear syringing, wick insertion and foreign body removal.

II. PERTINENT TO NOSE AND THROAT FIELDS:

1. Understand the basic anatomy and physiology of the nose and throat with it's relation to the clinical practice.
2. Learn how to do full examination of the nose and throat, including the use of the head mirror. He/she will perform indirect laryngoscopy to assist the larynx.
3. Diagnose and initiate management for acute sinusitis, chronic sinusitis, allergic and vaso-motor rhinitis.
4. Understand how to diagnose, manage, and approach the patient with bleeding nose.
5. Diagnose and manage the patient with blocked nose. He/she will recognize when to refer such cases to the specialist
6. Learn how to approach and manage a patient presenting with dysphagia.
7. Manage patients with throat infections and know when to refer these patients for surgery.
8. Understand the causes of dysphonia, diagnose and initiate the management before referring the patients to the E.N.T department.
9. Understand the causes of stridor in children and in adults. He/she will provide the emergency management and will refer the patient when needed.
10. Know the causes of lumps in the neck and salivary glands swellings, how to diagnose, investigate and when to refer these cases.
11. Demonstrate the ability to interpret plain x-rays of the neck, nasal sinuses, sialograms and barium swallow.
12. Learn how to perform minor procedures like removal of the foreign body from the nose, removal of fish bone from the throat, nasal cautery and nasal packing for epistaxis.

DEPARTMENT OF OPHTHALMOLOGY

GENERAL TRAINING OBJECTIVES

Duration: The resident will spend 1 month in Ophthalmology.

General objectives: At the end of the ophthalmology rotation the resident should be able to demonstrate:

1. Competency to examine, investigate and treat the following presenting problems:

- Red eye
- Blurred vision & diplopia
- Eye pain
- Photophobia
- Loss of vision
- Eye discharge
- Tearing
- Visual field defects
- Floaters
- Hyphema
- Proptosis
- Strabismus

2. Fundamental knowledge of the following conditions:

a. Related to eye emergencies:

- Eye injuries (lid lacerations, conjuctural injuries, corneal abrasion, perforating eye injuries, chemical contamination, orbital echymosis and fractures)
- Corneal F.B.
- Angle closure glaucoma
- Intraocular & orbital infections
- Iridocyclitis
- Retinal haemorrhage
- Retinal detachment
- Sudden loss of vision

b. Related to the Eyelids and the Lacrimal apparatus:

- Stye and chalazion
- Blepharitis
- Entropion
- Ectropion
- Trichiasis
- Dacrocystitis
- Nasolacrimal duct obstruction

c. Related to the conjuctive & Cornea:

- Conjunctivities (Viral, bacterial, allergic, kerato conjunctivitis, chemical, Ophthalmia neonatorum, trachoma).
- Pterygium
- Pinguecula
- Keratitis and corneal ulcers
- Corneal opacities and keratopathy

d. Related to other eye structures:

- Hypopion
- Synacchia
- Cataract
- Refractive errors
- Glaucoma
- Retinopathy (Hypertension - Diabetes)
- Retnitis pigmentosa
- Optic Neuritis
- Optic atrophy
- Tumors (retinoblastoma)

3. Competency in performing the following clinical skills:

- Visual acuity testing and colour vision
- Visual perimetry
- Tonometry
- Flouroscein staining
- Removal of superficial F.B.
- Epilation
- Stye drainage
- Excision of the chalazion

DEPARTMENT OF PSYCHIATRY

GENERAL TRAINING OBJECTIVES

Duration: The residents will spend two months in various sections of psychiatric department during 1st & 2nd year and one month equivalent during 3rd residency year.
General learning guidelines: The family physician should be able to provide appropriate psychiatric care to children, adolescents, adults, as well as geriatric population. So by the end of the psychiatric rotation, he/she should be able to achieve the followings:

1. Perform adequate psychiatric assessment, through obtaining an accurate psychiatric history, conducting proper medical state assessment, physical examination, and the complementary social, psychological, & biological investigations.
2. Learn and practice the art of getting the psychiatric history through "the psychiatric interview' with special emphasis on the doctor patient relationship in this peculiar field of medicine. He/she should be able to elicit the psychopathological phenomena with particular awareness to the cultural colouring of the symptoms.
3. Understand the nature of the psychiatric illness as an outcome of an interaction between particular stresses (psychological, social, or physical), against the individual's constitution (physical and psychological).
4. Postulate the differential diagnosis, and plan of management, taking into account the personality constitution, and the social environment.
5. Be familiar with psychiatric presentation of physical illness, physical presentation of psychiatric illness, and psychiatric complications of physical problems.
6. Understand the principles of psychiatric treatment, both psychological and physical. He/she will be encouraged to practice supervised counselling, supportive psychotherapy and behaviour therapy programs.
7. Learn the psychopharmacology of psychotropic medications commonly used in psychiatry, with special emphasis to the side effects of these drugs.
8. Recognize high risk cases that needs referral to the hospital e.g. patients with suicidal risk, those who are potentially dangerous to the others, and or to avoid adverse social circumstances etc.,).

Specific learning guidelines:
- Methods of psychiatric assessment
- Psychopathology
- Coping with stress and psychological defense
- The neuroses: anxiety states, obsessive compulsive disorder, and hysteria.
- Effective disorders
- Schizophrenia
- Paranoid states
- Organic psychiatry
- The concept of somatisation
- Psychological treatment
- Physical treatments used in psychiatry e.g.

a. Electro Convulsive Therapy (E.C.T.)
b. Psychotropic drugs (Neuroleptics, Antidepressants, Minor tranquilizers and related drugs).
c. Psychosurgery (theoretical introduction).

The residents are expected to present cases twice weekly in the ward rounds, and to attend two supervised clinical sessions weekly in the outpatient department. This aims to provide the resident with the necessary skills needed to reach an accurate diagnosis of common psychiatric disorders, and to postulate an appropriate plan of management.
During this two month rotation, the residents will be subjected to the areas of psychiatric subspecialities, namely:
- Child and adolescent psychiatry
- Psychogeriatrics
- Alcohol and drug addiction
- Community psychiatry, and day hospital
- Rehabilitation and mental handicap
- Liaison psychiatry (with special emphasis on assessing the suicidal risk).

The aim of the clinical training in these areas is to provide the resident with enough knowledge and skills to diagnose and treat the common psychiatric problems in the appropriate areas. And to know the scope of psychiatric services for the referred cases.
The clinical training includes:
1. Attending one ward round and two supervised outpatient clinics weekly.
2. During two month rotation, they should also be subjected to the following areas:
- Psychosexual disorders
- Personality disorders
- Eating disorders
- Suicide and parasuicide
- Factitious disorders
- Sleep disorders
- Psychiatric problems in relation to women (associated with menstruation, pregnancy, childbirth and perpurium).

Resident Log-Book

Cases, Seminars, Rounds, Journal Clubs, etc personally presented			
NO	Date	Educational Activity	Teaching Staff Name & Signature

Confidential assessment of educational needs –learning with PUNs and DENs

Fill in each column for each consecutive consultation and then review after an appropriate number of consultations (say 100). Photocopy the pages a

Date	Patient ID			The PUN	Define area for improvement, development or change	Class KC/KN/S/A
	No	Age	Sex			

The discovery page (Richard Eve)

Clinical diary for reflective practice

Fill in each column for consecutive consultations and review after around 50 consultations. Photocopy the pages as needed.

Date	Patient or meeting	Issue	Idea for learning

Process page

The education plan

Define personal DEN / Practice development plan etc	Action taken	Date action completed

Family Medicine Residency Program
Clinical ROTATION Evaluation

Resident Name: (optional)__________________Rotation__________________________

This Form is designed to provide resident feedback to Program Administrators concerning strengths and areas to improve in the variety and organization of clinical exposures provided in the different clinical rotations of the Family Medicine Program. The forms will be given to the rotation supervisor of each rotation at the end of the rotation. Please feel free to be candid and objective. All comments will not be traceable to the resident completing the form by the immediate supervisor.

Rank the following statements on a scale of 1 to 7 on whether you agree or disagree with them as they pertain to this rotation (1= strongly disagree; 7 = strongly agree)

Evaluation Scale:	Could not Judge	Strongly Disagree						Strongly Agree
Organization of the Rotation								
The overall workload of the rotation was appropriate (please make a comment in comments section as to if workload was too light or too heavy)	0	1	2	3	4	5	6	7
Patient Rounds were run in an efficient manner balancing teaching with patient care needs	0	1	2	3	4	5	6	7
The amount of scut in the Rotation was appropriate	0	1	2	3	4	5	6	7
The clinical material I saw provided a good exposure to the field of practice of the rotation	0	1	2	3	4	5	6	7
I was given clinical responsibilities appropriate for my level of training (please make a comment in comments section as to whether too much or too little was expected of you)	0	1	2	3	4	5	6	7
Teaching								
The academic activities of the division provided good learning opportunities	0	1	2	3	4	5	6	7
There was adequate access to internet resources and books if I needed to look something up	0	1	2	3	4	5	6	7
The bedside teaching was very good	0	1	2	3	4	5	6	7
I received my evaluation before the rotation ended	0	1	2	3	4	5	6	7
I received feedback about my performance throughout the rotation	0	1	2	3	4	5	6	7
Organisation								
There was adequate space for me to complete my work	0	1	2	3	4	5	6	7
The supervising staff were available for back up and consultation if needed	0	1	2	3	4	5	6	7
The rotation was arranged in such a way that I was able to attend other Teaching Activities	0	1	2	3	4	5	6	7
Resident – Faculty Interactions								
I felt that my contributions to the department's clinical activities were valued	0	1	2	3	4	5	6	7
My opinions were respected and I felt like a member of the team.	0	1	2	3	4	5	6	7
Overall								
Overall this rotation allowed me to meet most of the rotation specific educational objectives	0	1	2	3	4	5	6	7

Adapted from McGill Paediatric Residency Forms

Family Medicine Residency Program
Clinical Rotation FACULTY Teaching Evaluation

Resident Name: (optional)___________________Rotation___________________________

This Form is designed to provide resident feedback to Program Administrators concerning strengths and areas to improve in the quality of training by providing an assessment of teaching staff in the Family Medicine Program. The forms will be given to the resident at the end of each rotation. Please feel free to be candid and objective. All comments will not be traceable by the faculty in question to the resident completing the form.
Rank the following statements on a scale of 1 to 7 on whether you agree or disagree with them as they pertain to this rotation (1= strongly disagree; 7 = strongly agree) Please Rate the Faculty Member's teaching style and capacity to function as a role model.

Clinical Teaching Faculty: ________________ Rotation: ________________
(Note: Use a separate sheet for each supervising Faculty Member)

	Could not Judge	Strongly Disagree		.				Strongly Agree
Medical Expert								
Up–to-date in area of practice, scientific and clinical knowledge	0	1	2	3	4	5	6	7
Promotes development of trainee's judgement and decision making	0	1	2	3	4	5	6	7
Supervised the teaching of procedural skills	0	1	2	3	4	5	6	7
Communicator								
Role model for effective & compassionate communication with patients & families	0	1	2	3	4	5	6	7
Clear written communications documentation	0	1	2	3	4	5	6	7
Collaborator								
Role model for care in interdisciplinary setting	0	1	2	3	4	5	6	7
Respectful interaction with trainees/ other colleagues in clinical situations	0	1	2	3	4	5	6	7
Provided appropriate graded responsibility to the resident during the rotation	0	1	2	3	4	5	6	7
Manager								
Role modeled the use of health care resources cost effectively	0	1	2	3	4	5	6	7
Organization of work and time management	0	1	2	3	4	5	6	7
Health Advocate								
Role-modeled just advocacy for his/her individual patients	0	1	2	3	4	5	6	7
Scholar								
Promoted critical appraisal skills in teaching and clinical work	0	1	2	3	4	5	6	7
Enthusiasm for and effectiveness at teaching	0	1	2	3	4	5	6	7
Professional Role modeled and promoted the values of:								
The highest levels of integrity and honesty	0	1	2	3	4	5	6	7
Sensitivity to and respect for diversity	0	1	2	3	4	5	6	7
Compassion and Empathy	0	1	2	3	4	5	6	7
Recognition of own limitations	0	1	2	3	4	5	6	7
Application of the principles of medical ethics to clinical situations	0	1	2	3	4	5	6	7

Comments

Adapted from McGill Paediatric Residency Forms

DEPARTMENT OF HEALTH AND MEDICAL SERVICES
PRIMARY HEALTH CARE
PROFESSIONAL DEVELOPMENT OFFICE
POSTGRADUATE TRAINING PROGRAM OF FAMILY MEDICINE
COMPETENCIES FOR YEAR ONE

Resident Name--Staff Number-------------

PATIENT CARE	YES	NO	NA
Identifies the purpose(s) of the visit/admission			
Utilizes patient centered interviewing for history collection			
Develops appropriate bio-psychosocial hypotheses which apply to the presenting problem			
Develops a plan of action that attends to salient medical, ethical, spiritual, psychosocial,			
family, cultural and socioeconomic issues			
Presents a provisional and working diagnosis to the patient			
Arranges for follow-up of the current problem which fits the guidelines of current			
standard of care and/or attends to the special needs of the patient			
Handles upper level duties of FP service			
Comments:			
MEDICAL KNOWLEDGE	YES	NO	NA
Demonstrates an investigative and analytic thinking approach to clinical situations.			
Evaluates the presenting problem using a focused investigation which will influence			
management decisions for the visit			
Prioritizes the probable and potential diagnoses to ensure that attention is given to the			
most likely, most serious and most readily treatable options			
Comments:			
INTERPERSONAL AND COMMUNICATION SKILLS	YES	NO	NA
Documentation and Records			
Documentation in medical records is accurate			
Documentation in medical records is complete			
Documentation in medical records is legible			
Follows the SOAP/problem oriented format			
Updates the bio-psycho-social problem list and medication list at each visit			
Colleagues and Supervisors, Consultants, Support Staff			
Demonstrates active listening skills that lead to the ability to gather, relay and process information			
Patients and Families			
Conducts an interview which fosters a nurturing doctor-patient-family relationship			
Conducts an encounter which recognizes the primacy of patient needs and treats the			
patient as an appropriately equal health care partner			
Provides patient/family with clear instructions regarding discharge and follow-up			
Comments:			
PROFESSIONALISM	YES	NO	NA
Demonstrates respect			
Shows integrity, accountability and reliability			

Maintains confidentiality			
Shows appropriate appearance with respect for surroundings and others			
Comments:			
SYSTEMS BASED PRACTICE	YES	NO	NA
Practices cost effective health care that does not compromise quality of care			
Bills the patient fairly and appropriately for services rendered			
Completes medical records in a timely manner (within 24 hours)			
Completes clinic session in a timely manner			
Meets clinic policy for completing messages and handling abnormal labs			
Appropriate documentation and attending involvement for patient visits (coding)			
Adheres to managed care requirements (formularies, etc.)			
Comments:			
PRACTICE BASED LEARNING AND IMPROVEMENT	YES	NO	NA
Uses information technology to support their own education			
Comments:			

Recommendations: --
--
--
--

Evaluated by:
Signature: ---
Name: ---
Designation: --
Date: --

Approved by:
Signature: ---------------------------------------
Name:
Designation
Date: ---

DEPARTMENT OF HEALTH AND MEDICAL SERVICES
PRIMARY HEALTH CARE
PROFESSIONAL DEVELOPMENT OFFICE
POSTGRADUATE TRAINING PROGRAM OF FAMILY MEDICINE
COMPETENCIES FOR YEAR TWO

Resident Name---Staff Number-------------------

Resident continues to meet the competencies identified in Year One	YES	NO	NA
PATIENT CARE	YES	NO	NA
Demonstrates thorough physical examination skills			
Makes informed decisions regarding diagnostic interventions based on			
•patient information/preferences			
•current scientific information			
•clinical judgment			
Performs critical evaluation of data including risk awareness			
Attends to disease prevention and health care maintenance			
Implements the negotiated management plan			
Reviews the bio-psycho-social problem list at each visit and attends to appropriate longitudinal care			
Issues			
Comments:			
MEDICAL KNOWLEDGE	YES	NO	NA
Applies basic and clinical sciences to patient care			
Incorporates epidemiological and social-behavioral sciences to patient care			
Comments:			
INTERPERSONAL AND COMMUNICATION SKILLS	YES	NO	NA
Colleagues and Supervisors, Consultants, Support Staff			
Presentations are concise			
Presentations are relevant			
Is able to elicit appropriate information			
Patients and Families			
Communicates at patient's education level			
Demonstrates respect, sensitivity and responsiveness to full spectrum of patient's diversity			
Inquires into, and discusses sensitive issues which may impact on the execution of the			

negotiated management plan			
Conducts an interview in a manner consistent with the values of family medicine utilizing appropriate verbal and non-verbal skills			
Comments:			
PROFESSIONALISM	YES	NO	NA
Demonstrates compassion			
Demonstrates emotional stability/maturity and appropriate personal health behaviors			
Comments:			
SYSTEMS BASED PRACTICE	YES	NO	NA
Demonstrates appropriate use of diagnostic tests			
Demonstrates appropriate use of referrals/consults			
Demonstrates appropriate use of alternative treatments			
Demonstrates awareness of costs			
Acts as a patient advocate			
Conducts the visit in a time efficient and professional manner			
Comments:			
PRACTICE BASED LEARNING AND IMPROVEMENT	YES	NO	NA
Engages in continuing medical education activities which are influenced by interest, deficiency and need			
Comments:			

Recommendations: ---

Evaluated by:
Signature: ---
Name: ---
Designation: ---
Date: ---

Approved by:
Signature: ---------------------------------------
Name: --
Designation: ----------------------------------
Date: ---

DEPARTMENT OF HEALTH AND MEDICAL SERVICES
PRIMARY HEALTH CARE
PROFESSIONAL DEVELOPMENT OFFICE
POSTGRADUATE TRAINING PROGRAM OF FAMILY MEDICINE

COMPETENCIES FOR YEAR THREE & FOUR

Resident Name---Staff Number-------------

Resident continues to meet the competencies identified in Year One and Two	YES	NO	NA
PATIENT CARE	YES	NO	NA
Demonstrates timely completion of clinical tasks			
Counsels and educates patients and families			
Demonstrates competency in relevant procedural skills			
Is comfortable handling the ambiguous condition including complex interplay of diseases			
Comments:			
MEDICAL KNOWLEDGE	YES	NO	NA
Uses medical knowledge to prioritize and anticipate high-risk situations			
Critically evaluates medical information and scientific evidence and applies it to clinical decision making			
Understands and manages the limits of medical knowledge as applied to patient care			
Comments:			
INTERPERSONAL AND COMMUNICATION SKILLS	YES	NO	NA
Colleagues and Supervisors, Consultants, Support Staff			
Works effectively as a leader			
Effectively supervises medical students and 1st and 2ed year residents			
Works together with front desk and administrative staff in a manner that fosters mutual respect and facilitates an effectively run the health center			
Works together with colleagues, consultants, and health care team in a manner which fosters mutual respect and facilitates the effective handling of patient care issues			
Works together with the rest of the health care team in a manner which fosters mutual respect and facilitates the effective handling of patient care issues			
Patients and Families			
Maintains familial involvement			
Coaches and assists patients and families through uncertain diagnoses and obscure prognoses			
Comments:			
PROFESSIONALISM	YES	NO	NA
Anticipates and addresses pro-actively conflicts and issues in self-care, medical ethics, and confidentiality			
Demonstrates behaviors that represent values of family practice			
Identifies and addresses deficiencies in self and peer performance			
Prevents personal frustration from having an adverse effect on patient care or collegial communication			
Comments:			
SYSTEM BASED PRACTICE	YES	NO	NA

Collaborates with other health care providers (social services, home health, mental health)			
Completes all tasks of each defined patient care session (including telephone messages, charting, administrative tasks, patient care) in a timely, organized and professional manner			
Comments:			
PRACTICE BASED LEARNING AND IMPROVEMENT	YES	NO	NA
Applies evidence-based medicine to patient care			
Facilitates the learning of students and other health care professionals			
Engages in activities which will foster personal and professional growth (in mind, body, psyche and spirit) as a family physician			
Anticipates and recognizes new curriculum necessary for future practice and advocates for needed reform in medical education			
Comments:			

Recommendations: ---

Evaluated by:
Signature: ---
Name: ---
Designation: ---
Date: --

Approved by:
Signature: -------------------------------------
Name:
Designation:
Date: --

Glossary of abbreviations:

AAFP	American Academy of Family Practice
BNF	British National Formulary
CPD	Continuing Personal Development
CFPC	College of Family Physician of Canada
DOHMS	Department of Health and Medical services
GP	General Practitioner
MOH	Ministry of Health
MCQs	Multiple Choice Questions
MEQs	Modified Essay Questions
PHC	Primary Care
PHCT	Primary Health Care Team
RCGP UK	Royal College of General Practitioners, United Kingdom
SEQs	Short essay Questions
WONCA	World Organization of Family Doctors

References:

American Academy of Family Practice

College of Family Physician of Canada

Royal College of General Practitioners, United Kingdom

World Organization of Family Doctors WONCA