

DUBAI RESIDENCY TRAINING PROGRAMME



SPECIALIST TRAINING PROGRAMME IN GENERAL PAEDIATRICS (2007-8)

Four Year Residency Training Programme

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I. Introduction

Paediatrics is that branch of medicine concerned with the study of infants, children and adolescents in health and disease, their growth and development, and their opportunity to achieve full potential as adults.

Successful training programmes require commitment and dedication from all stakeholders—the residents, the trainers and the sponsors. The resident in particular, must be dedicated to the acquisition of knowledge and experience in Child Health practice and his or her personal development of a caring, responsible and patient oriented behaviour pattern. He or she must be committed to the development of professional responsibility, self-directed learning and professional improvement. The Office of Postgraduate Dean through the Continuing Education Department (CED) will be responsible for the overall administration of the programme. Al Wasl Hospital and the Dubai Hospital are the two training institutions that have declared the interest and commitment to provide the training. DOHMS is the sponsoring body.

II Mission

The mission of the programme is to develop and produce specialists in Paediatrics who have the knowledge, skills and attitudes necessary to manage the complete spectrum of conditions that arise in the care of infants, children and adolescents in health and disease. As well, the programme strives to develop individuals who practice the profession humanely, with the highest of ethical standards and integrity and will contribute to the Community in the areas of education and research as well as providing excellent clinical care.

III. Principles:

- The programme provides organized education with guidance and supervision sufficient to facilitate the resident's professional and personal development while ensuring safe and appropriate patient care.
- Educational quality and patient care quality are conducted to enhance rather than interfere with each other.
- The balance of assignments and support are maintained so that the programme does not rely on residents to meet patient care needs at the expense of effective and accountable education.
- The focus is on the development of clinical skills, proper behaviours and attitudes, scholarship and professional competencies.
- Hospital, ambulatory and community settings are utilised proportionately to reflect the importance of caring directly for adequate numbers and kinds of patients.
- Residents are assigned progressively greater responsibility for patient care throughout the period of the residency, consistent with individual capabilities, maturity growth in clinical experiences, knowledge, skills and overall competence.
- There are regular evaluations, feedback, and review of performances of resident, programme and institution.

IV. Goals and Objectives

The goals and objectives may be summarized as follows:

- Physicians completing the Program will have special education and expertise and leadership skills in the field of Paediatrics and as well as in health care delivery, education and research.

- Have a broad educational experience in Paediatrics to understand infants, children and adolescents in health and in sickness, and deal effectively with their physical, mental, emotional and social problems.
- Be capable of independently providing high quality clinical care and education in all aspects of Paediatrics.
- 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

General Educational Objectives

A paediatrician is a specialist trained in the profession of health and in the diagnosis and treatment of a broad range of diseases involving children based on a sound knowledge of normal growth and development and of the wide range of clinical conditions encountered in infants, children, and adolescents. On completion of the educational programme, the graduate physician will be competent to function as a consultant paediatrician in the essential roles and key competencies of paediatricians, i.e. - medical expert/clinical decision-maker, communicator, collaborator, manager, health advocate, scholar and professional. This requires the physician to have acquired these knowledge, skills and attitudes through coordinated learning experiences. This will include practical clinical experiences and formal educational activities. The resident will have acquired a degree of independent responsibility for clinical decisions and an understanding of the nature of the relationships between a referring physician and a consultant clinical paediatrician. Following certification in Paediatrics, the resident will be prepared for independent practice.

A broad educational experience in Paediatrics is essential if residents are to understand infants, children and adolescents in health and in sickness, and if they are to deal effectively with their physical, mental, emotional and social problems.

Educational objectives of such a basic and fundamental nature, relating to all or many aspects of Paediatrics, are classified under the headings of the Essential Roles and Key Competencies of Paediatricians, which encompass knowledge, skills, and attitudes.

The resident will demonstrate a variety of personal attributes, which are relevant to the broad range of clinical work with paediatric patients and their families. These important attributes, which apply in all paediatric settings, are described below and are not repeated for each special area. For certain clinical fields, specific additional points regarding attitudes are incorporated within the appropriate section.

Residents must demonstrate the knowledge, skills and attitudes relating to gender, culture and ethnicity pertinent to Paediatrics. In addition, all residents must understand the necessity to incorporate gender, cultural and ethnic perspectives in research methodology, data presentation and analysis.

Essential Roles and Key Competencies

1. Medical Expert/Clinical Decision-Maker

Paediatricians 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 professionals, and the community. The role of medical expert/clinical decision-maker is central to the function of paediatricians and draws upon the competencies included in the roles of scholar, communicator, health advocate, manager, collaborator, and professional. In this role, the resident will demonstrate diagnostic and therapeutic skills for ethical and effective patient care.

1.1 Knowledge of normal body structure and function as expressed in a bio psychosocial model of human development.

The resident will understand the normal human anatomy, physiology and psychology with emphasis on physiological and psychological changes during growth and development.

1.2 Knowledge of disturbed body structure and function.

The resident will understand the patho-physiological and psychological processes underlying departures from normal. The resident should therefore be able to recognise, diagnose and manage:

- the normal healthy state,
- the natural course of paediatric problems, variations in and deviations from the normal.

1.3 Knowledge of promotion and maintenance of optimal functioning in biological and psychological aspects.

This will include knowledge of therapy in its broadest sense, to include life-style, dietary, nutritional, physical and drug therapies. The resident will demonstrate the ability to access and apply relevant information to clinical practice.

1.4 Interviewing and communication skills.

The resident will be able to establish a professional relationship and to interact with the patient (infant, child or adolescent) and parent, guardian or other caregivers in order to obtain a history, conduct a physical examination and provide ongoing care. The paediatric resident will establish an atmosphere of open communication appropriate to the situation and will convey interest, sensitivity, empathy and support.

1.5 History taking skills.

The resident will be able to obtain and record a complete history including:

- Identifying data and date of contact,
- Reasons the patient was brought for or sought medical help (chief complaint),
- The important symptoms in sufficient detail to provide a clear picture of the clinical problem(s) - history of present illness,
- All other important information from the past history, prenatal history, developmental history, medications, allergies, review of systems, family history, and social history.

1.6 Physical examination skills.

The resident will carry out an efficient, orderly physical examination, demonstrating sensitivity to the patient's needs, modified according to the patient's age, gender and problem, and record this information by regions or systems.

1.7 Problem Solving and Decision Making.

The resident should demonstrate the ability to correlate, evaluate, prioritise and synthesise information, including the relevant ethical issues, acquired by interview, history taking and

physical examination. The resident should recognise and define problems (formulation) and generate a differential diagnosis and problem list.

The resident will be able to demonstrate the ability to manage problems by:

- Appropriate application of knowledge derived from critical appraisal of the literature,
- Formulation of a problem oriented plan of management,
- Generating a rational plan of diagnostic and therapeutic measures with use of information on cost benefit ratios,
- Interpretation and modification of a plan of management with explanation and ongoing communication with parents and child,
- Participating suitably in multi-disciplinary group discussion, initiating or facilitating as required,
- Maintaining confidential information as appropriate,
- Evaluating and modifying management plans by periodic reassessment of the patient's progress,
- Ensuring proper recording of care and its effectiveness,
- Participating in medical quality assurance activities to review quality of care issues in provision of health care.

1.8 Consultation Skills

The resident should demonstrate effective consultation skills in presenting well-documented assessments and recommendations in written and/or verbal form in response to a request from another healthcare provider, with respect to patient care, education and legal opinions.

1.9 The resident should recognise personal limitations and demonstrate a willingness to call upon others with special expertise and make referrals where appropriate.

1.10 Technical Skills.

The resident must demonstrate knowledge and skills required for the safe and efficient practice of the following procedures.

- Intravenous access and blood-drawing
- Umbilical venous and umbilical arterial catheterisation
- Arterial puncture
- Suture of a one-layer laceration, simple wound closure
- Cardiopulmonary resuscitation (newborn and child)
- Tracheal intubations (newborn and child)
- Lumbar puncture
- Bladder catheterisation and/or suprapubic aspiration
- Gastric tube placement (oro or nasogastric)
- Intraosseous insertion, chest tube placement and thoracentesis as demonstrated in either a patient or model

The resident should also have knowledge and proficiency of the specific technical skills as outlined in the Syllabus below

2. Communicator

To provide humane high quality care, paediatricians establish effective relationships with patients, other physicians and other health care professionals. Communication skills are

essential for the functioning of a paediatrician and are necessary for obtaining information from, conveying information to patients and their families and establishing therapeutic relationships with patients and families. Furthermore these abilities are critical in eliciting patients' and/or families' beliefs, concerns and expectations about their illnesses, and for assessing key factors impacting upon patients' health.

2.1 Communication Skills

The resident will be able to demonstrate the ability to:

- Listen effectively and obtain and synthesise relevant history from patients, families and communities,
- Communicate effectively and discuss appropriate information with patients and families and all members of the interdisciplinary health care team,
- Educate patients, families and health care professionals in formal and informal educational settings,
- Present the patient's problem(s) clearly, concisely and correctly, in the following ways:
 - verbally, in the clinical setting or formal presentation
 - in a written medical record (in standard/problem oriented form) or consultation report

2.2 The resident will demonstrate caring and empathy for patients and their families, and especially for those individuals who are vulnerable.

2.3 The resident will pay close attention to the impact of such factors as age, gender, disability, ethno-cultural background, social support, and emotional influences on a patient's illness.

2.4 The resident will demonstrate respect for individual patients, families, colleagues and for their value systems which may be different from the resident's own values.

2.5 The resident will demonstrate an appreciation of the parents' perspective of and concerns for a child's health and the impact of a child's illness on family relationships.

2.6 The resident will demonstrate a willingness to communicate effectively with patients and families and all members of the interdisciplinary team.

2.7 The resident will demonstrate an ability to support and counsel a child (and his/her family) with chronic illness and/or impending death and provide bereavement counselling.

3. Collaborator

Paediatricians work in partnership with others who are appropriately involved in the care of children and adolescents. It is therefore essential for paediatricians to be able to collaborate effectively with patients, their families and a multidisciplinary team of expert health professionals for provision of optimal patient care, education, and research.

3.1 The resident will demonstrate a capacity to establish and maintain a productive and responsible relationship with young patients and families, and a capacity to establish and maintain cooperative interpersonal relationships with a multi-disciplinary team and thus contribute effectively to other interdisciplinary team activities.

4. Manager

Paediatricians function as managers when they make every day practice decisions involving resources, co-workers, tasks, policies, and their personal lives. They do this in the setting of individual patient care, practice organisations and in the broader context of the health care system. Thus paediatricians require the abilities to prioritise and effectively execute tasks through teamwork with colleagues, and make systematic decisions when allocating finite health care resources. As managers, paediatricians take on positions of leadership within the context of professional organisations and their National health care system.

4.1 Provision of Health Care

The resident will be able to demonstrate the knowledge of various forms of health care provision and to work effectively and efficiently in a healthcare organisation, including the following:

- An understanding of the importance of the families' (parents' and child's) involvement in the provision of health care to the child,
- The role of a paediatrician in the provision of preventive and therapeutic health care, based on sound scientific evidence,
- The importance of shared responsibility for health care provision in a multidisciplinary setting,
- The advantages, disadvantages and relative costs of preventive and therapeutic health care programmes,
- The advantages, disadvantages and relative costs of care in different settings, including an appreciation of the various forms of health care provision, including hospitals, ambulatory clinics, private offices, home care, chronic care and rehabilitation facilities,
- The avoidance of unnecessary investigation and/or hospitalisation.

The resident should exhibit knowledge of the relative advantages and disadvantages and the impact on the child and the family of such forms of care.

4.2 Quality Assurance includes:

- Knowledge of the definitions and role of audits, quality improvement, risk management, occurrence / incident reporting, and complaint management in a hospital and ambulatory setting,
- Knowledge of cost/benefit ratios of diagnostic and therapeutic interventions, cost-containment and efficacy, effectiveness and efficiency as they relate to quality assurance,
- a willingness to participate in cost-containment and quality assurance programmes.

4.3 The resident will demonstrate an awareness of the need to continually balance professional, personal, institutional and social commitments.

4.4 The resident will demonstrate open-mindedness to the consideration of alternative health care practices.

4.5 The resident will demonstrate an awareness of cost and cost effectiveness of various forms of paediatric care, and the ability to utilise resources effectively and to allocate finite health care resources widely.

4.6 The resident will demonstrate an awareness of the social, societal and governmental aspects of health care provision as applied to the paediatric age group.

4.7 The resident will demonstrate an ability to utilise information technology to optimise patient care, life-long learning and other activities.

5. Health Advocate

Paediatricians recognise the importance of advocacy activities in responding to the challenges represented by those social, environmental, and biological factors that determine the health of children and adolescents within society. They recognise advocacy as an essential and fundamental component of health promotion that occurs at the level of the individual patient, the paediatric population, and the broader community. Health advocacy is appropriately expressed both by the individual and collective responses of specialist physicians in influencing public health and policy.

5.1 The resident will demonstrate an appreciation that the health care needs of children are distinct from those of adults.

5.2 The resident will encourage promotion of active family involvement in decision-making and continuing management of the child.

5.3 The resident will demonstrate the ability to contribute effectively to improved health of patients and communities.

5.4 The resident will identify the important determinants of health that affect children and adolescents. This includes the ability to recognise, assess, and respond to the psychosocial, economic, societal and biologic factors influencing the health of those served.

6. Scholar

Paediatricians engage in a lifelong pursuit of mastery of Paediatrics. They recognise 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/housestaff, patients, and other health professionals.

6.1 The resident will recognise the importance of self-assessment of professional competence and acceptance of the responsibility for self-directed learning as a life long goal, to develop, implement and monitor a personal continuing education strategy. Learning should incorporate critical appraisal and evaluation of medical and other relevant literature.

6.2 The resident will maintain a questioning and inquisitive attitude towards medical information and an appreciation of the necessity for ongoing research to develop new knowledge.

6.3 The resident will facilitate the education of patients, housestaff/students and other health care professionals and contribute to development of new knowledge.

7. Professional

Paediatricians have a unique societal role as professionals dedicated to improving the health and well being of children and adolescents. Paediatricians are committed to the highest

standards of excellence in clinical care and ethical conduct, and to continually perfecting mastery of their discipline. Paediatricians are committed to delivering highest quality care with integrity, honesty and compassion.

7.1. The resident will demonstrate knowledge of Medical Ethics including:

- Basic knowledge of the principles of medical ethics including: "best interest" of the child, autonomy, beneficence and non-maleficence, confidentiality, truth-telling, justice, respect for persons, conflict of interest, advanced directives and end-of-life care, and resource allocation.
- Knowledge of and ability to obtain informed consent.
- Knowledge of ethical decision-making process.
- Knowledge of required communication skills.
- Knowledge of child development and family theory that is applicable to paediatric medical ethics.
- Knowledge of the legal and ethical codes of professional behaviour and the obligations of a physician that apply to paediatrics including: notification of coroner, reporting of suspected child or sexual abuse, public health issues with respect to infections.

7.2 The resident will demonstrate tolerance for ambiguity and uncertainty and the possibility of error in ethical decision-making; flexibility and willingness to adjust appropriately to changing circumstances.

7.3 The resident will demonstrate trustworthiness (honesty, confidentiality) with respect to patients, families and colleagues.

7.4 The resident will demonstrate recognition of personal limitations and a willingness to call upon others with special expertise.

7.5 The resident will demonstrate a willingness to accept peer and supervisor reviews of professional competence.

7.6 The resident will demonstrate an appreciation of the moral and ethical implications of various forms of patient care and research.

VI Administrative Structure

1 Programme Director

The programme director is senior physician for the overall conduct of the Residency Programme. The Residency Programme Director is responsible to the Chair of the Department of Paediatrics and to the Postgraduate Dean and is a member of the Postgraduate Education Committee.

2 Programme Site Co-Director

The Programme Site Co-directors are responsible for the day to day functioning of the Residency Program at each institution participating in the Programme. The Programme Site Co-directors are responsible to the Programme Director. There must be active liaison between the Programme Director and the Programme Co-directors.

3. Residency Programme Committee

The Residency Programme Committee assists the Program Director in the planning, organisation, and supervision of the Programme. The Residency Programme Committee must meet regularly, at least quarterly, and keep minutes. It is chaired by the Programme Director who is its executive officer.

This committee includes

- a representative from each participating institution,
- the Programme Site Co-Directors
- a representative of each major component of the program
- representatives of Residents in the Programme, nominated and elected by their peers in the programme.

4 Responsibilities of the Programme Director

The responsibilities of the Program Director, assisted by the Residency Programme Committee include:

- development and operation of the Programme such that it meets the standards of accreditation for a specialty program in Paediatrics.
- 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 Committee.
- maintenance of an appeal mechanism.
- 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 Programme 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 Programme 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 programme

Further to those responsibilities listed above, the Programme 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 Programme Director is responsible to the residents to train them well in a humane atmosphere.

The Programme Director reports to the Postgraduate Dean.

VI Programme Sites

The Residency Programme in Paediatrics will utilize the following sites:

- Dubai Hospital, Dubai
- Al Wasl Hospital, Dubai
- Other hospitals or institutions recognized for training by the Accreditation Committee of the Postgraduate Medical Education Committee

VII 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 programme that included at least two months of Paediatrics.
- 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.

VIII. Number of Posts and Duration of Programme

The number of posts in the Paediatrics Residency Programme is 8. This number reflects the available resources at the programme sites and the need within the community for those successfully completing training in the Residency Programme.

IX. Programme Structure

Residents will enter the program having received a broad foundation in several aspects of general medicine and surgery during their internship year. The Pediatric Residency Programme will include experiences in core general pediatrics and in the various pediatric subspecialties, in both in-patient and ambulatory settings. To ensure an adequate breadth of training, maximum experience in any one subspecialty or discipline is limited over the four years. The resident will learn to set his/her own educational goals and will be given the opportunity for clinical and research elective experiences in the fourth year. Research activities will be encouraged and supported throughout the entire four years. Clinical faculty directed classroom learning will occur on a weekly basis, and attendance will be mandatory; and, time will be protected from clinical duties to facilitate attendance.

1 Core Rotations

The program will provide a strong base for comprehensive pediatric knowledge through general inpatient pediatrics, critical care, neonatology, and a wide variety of subspecialty rotations over the first three years. The final year will include 16 weeks of electives of which up to two months can be dedicated to completion of a research activity, at the discretion of the Program Director. The elective period may be within or outside the country. DOHMS will however not have financial responsibilities for outside programmes.

The final year will be spent in a senior supervisory capacity, with responsibility for education and supervision of more junior trainees. While in this capacity, the resident will report directly to a staff pediatrician. (see over leaf)

2 Electives

Sixteen weeks of the final year will be elective study

The resident will be encouraged to choose an elective experience in any area of Paediatrics in which he/she is interested. Electives will be pursued in the UAE and meet the following requirements:

- An educational program is delineated
- Patient population is appropriate in quality and quantity
- Supervising staffs are available and have sufficient background and Expertise to ensure

that the educational goals, objectives, and/or curricular content can be met.

- The elective institution has a commitment to the education of residents.
- The usual Pediatric Residency evaluation is adhered to.

3 Research

The resident will be required to define a topic of interest, and to plan and complete a research project over the course of his/her training. This work should be begun no later than year two. A block of 4 weeks allocated to Research each year. The research project will be part of evaluation in year 4

4 Formal Educational Activities

All residents are required to participate in the academic half-day program. This program will take place weekly throughout the year and will consist of seminars on pertinent topics in Pediatrics to augment their clinical learning. The residents will be excused from ward or outpatient duties at this time. In addition to this, the resident will be expected to contribute in a scholarly manner to the scheduled rounds and journal clubs on a regular basis in each rotation.

5. Rotations in Paediatrics

PGY-1: In-patient wards (22), Neonatology (10), Emergency Medicine (4), Community Outpatient Practice Experience (4), Pediatric Surgery (8)

PGY-2: In-patient wards (16), Neonatology (8), Emergency Medicine (4), Ambulatory Pediatrics :OPD (6),Thalassemia (2),Nephrology(4),Neurology (4) Research (4)

PGY-3: In-patient wards (8), Neonatology (4), Emergency (4), Ambulatory Pediatrics (4), Cardiology (4), Endocrinology (4), Hematology (4), Oncology (4), Gastroenterology (4), Clinical Genetics (4), Research (4)

PGY-4: In-patient wards (8), Neonatology (6), Emergency (4), PICU (4), Ambulatory Pediatrics (6), Research (4), Subspecialty electives (16)

(Number of weeks/yr listed in parentheses;

**Ambulatory Pediatrics is OPD;PICU: IS CRITICAL CARE)

6. Vacation and Conference Leave

Each year will include four weeks of vacation and one week of study/conference leave that may be taken at any time in the program with the approval of the Program Director and the Supervisor of the affected rotation. To support research activities, any resident with approved posters or abstracts will be encouraged to present their work at the appropriate meeting.

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.

7. Night Call

To optimize experienced-based learning, the resident will be required to take part in on-call duties. This is a maximum of 7 calls a month. Residents are permitted to go home at 11 am the following morning, but are encouraged to stay for pedagogic activities. Meals are provided when on-call

X Evaluation of Resident Performance

1. Format

The ultimate responsibility for compiling the Final In-Training Evaluation Report of the resident lies with the Programme Director. During each rotation of the programme the resident will be supervised and evaluated by the rotation supervisor directly or by the members of the rotations teaching faculty as 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. Knowledge will be assessed by a formal written exam and oral exam set by the rotation supervisor as well as by direct observation of resident performance in clinical situations. Formal examination and assessment will occur annually.

Clinical 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 (when applicable) 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.

2. In-training assessments

Monthly assessments: Resident performance is evaluated by rotation supervisors every month. Written and verbal feedback is provided at the end of every rotation.

MRCPCH & ARAB BOARD In-Training Exams: All residents write the MRCPCH & ARAB BOARD In-Training Exam each summer.

OSCE: All residents participate in one Objective Structured Clinical Exam per year. These exams may use simulated patients or parents to test specific residency objectives. The exam concludes with a teaching session, discussing the correct responses. Exam scores are subsequently tabulated and distributed.

Observed History and Physical Examinations: Each resident is assigned to a consultant or senior specialist registrar, to complete an observed history and physical examination. Cases are appropriate to the level of training. Feedback is given immediately after. Each year, the resident is assigned to a different physician.

Weekly quizzes: Through an email response system, residents are quizzed on a specific topic taught during the week

3 Feed-back

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 and in conjunction with the completion of the End Rotation In-Training Evaluation Form. Examples of formats for the End Rotation In-Training Evaluation Form appear in the appendix. There should also be regular feedback to residents on an informal basis. As well, a rotation specific case log will be maintained by the resident and signed by the given faculty involved with the particular case. The Programme Director will inspect this periodically by the rotation supervisor and discussion around the cases will occur to ensure progress in the area of patient management.

4 Standards

The resident and the Programme Director are ultimately responsible for the candidate's successful progress through and completion of the Programme. The Programme Director will review each rotation evaluation and any concerns will be reviewed with the resident. As well, rotation supervisors and site 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 Programme for two months in any one year, the resident will be invited for counselling by the Programme Director and the resident's progress reviewed. Such a resident is allowed to continue with the Programme at the discretion of the Programme Director and based on the recommendation of an Ad Hoc group of the tutors and the involved rotation supervisors.

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 the Programme Director after consultation with the Residency Programme Committee and the involved resident.

At the end of Year 4, a resident must successfully complete each component of an examination that consists of a comprehensive written examination, a clinical examination and an OSCE. This is a requirement for completion of the programme.

If a resident fails to successfully complete the Final Examination a re-sit examination will be arranged within one month of the first attempt. If the resident fails to pass the re-sit examination review with the Programme Director will be undertaken. The resident will be required to complete another year in the Programme prior to attempting the exam again. Only one additional year may be spent in the programme and a resident cannot be certified as having successfully completed the programme if they do not pass the Final Examination even if they pass the Part 2 of either the Arab Board for Specialization or the MRCPCH.

5. National Examinations

To maximize the portability of the residency training, British, U.S. and Arab Board exams will be a part of the training process. The end of the first year of residency will be marked by the DCH and USMLE

Residents completing their second year will write MRCPCH Part I, and Arab Board for Specialization Part 1 should be completed following the third year, and by the completion of fourth year, Arab Board Part 2, MRCPCH Part 2, MRCPCH should be completed.

Should a resident be dissatisfied with their assessment at any point in the programme they are encouraged to review the issues with the involved rotation supervisor or the Programme Director. If satisfactory resolution cannot be obtained the resident has the right to lodge a formal complaint with the Programme Director, the Residency Programme Committee or the Postgraduate Dean. The complaint will then undergo the process as outlined in Residents' Handbook.

6. The Certificate

On satisfactory completion of the entire programme of specialist training, the Programme Director will notify the Postgraduate Dean and a certificate of completion of training will be issued. The authorized signatories on the certificate will be the Programme Director, Director General/Assistant Director General (MA) and Postgraduate Dean

XI. Evaluation of the Programme

1. Residency Programme Committee

The Residency Programme Committee under the leadership of the Programme Director will be responsible for the ongoing evaluation of the programme. This will include an assessment of the strengths and weaknesses of the programme and recommended improvements. As well, all residency education sites, including elective experiences will be assessed and evaluated. The resident will evaluate all rotations on the final day of the rotation, by completing a rotation evaluation form. All faculty involved in a specific rotation will be evaluated by the resident on the last day of the rotation and the Residency Programme Committee should also undertake a periodic formal evaluation of all of the teaching faculty affiliated with the programme. Discussion regarding the programme will occur at all Residency Programme Committee meetings and a formal evaluation of the programme accompanied by a report should occur on a yearly basis.

2. Internal Review

The internal review is intended as a mechanism to assist the sponsor (DOHMS) in maintaining the quality of Residency Programme and provide the Programme Administrators with information about the strengths and weaknesses of the Programme, so that necessary corrective measures may be taken.

The Postgraduate Dean should initiate the internal review and the team should include: a Programme Director from another Programme, 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 Programme. A series of interviews should take place with the Programme Director, teaching staff, members of the resident group, and with the Residency Programme 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 programme and the degree to which it fulfils its Goals and Objectives.

The written report of the internal review should include the strengths and weaknesses of the Programme 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 Programme Director, and members of the Residency Programme Committee.

Internal Review should take place every two years

3 External Review

If possible, the Programme should undergo an external review periodically. The frequency of this process would generally be every 4 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 team should include: a representative of an accrediting body in Paediatrics, a Programme Director from another Paediatrics programme 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 programme.

The external review committee would generate a report that should include the strengths and weaknesses of the programme and specific recommendations for continued development and improvements. This report should be submitted to the Postgraduate Dean, the chair of the department, the Programme Director, and members of the Residency Programme Committee.

XII Textbooks & Resources

Suggested texts and resources are meant as a guide only. It is recognised that learning materials will be individualized based on need and learning style.

- Cochrane Collaboration, "The Cochrane Library" Oxford University Press, Update Software- 2001.
- Essentials of Caffey's Paediatric X-Ray Diagnosis, 2nd Edition. Silverman, Kuhn.
- Forfar & Arneil's Textbook of Paediatrics, 5th Edition, AGM Campbell & N. McIntosh
- Infectious Diseases of the Foetus & Newborn Infant, 5th Edition, Remington & Klein
- Nelson Textbook of Paediatrics 16th Edition, Behrman et al
- Neonatal-Perinatal Medicine: Diseases of the Foetus & Infant, AA Fanaroff & RJ Martin
- Paediatric Kidney Disease Vol 1 & 2, Edelman
- Paediatric Nephrology, 3rd Edition. Holliday, et al.
- Smith's Recognizable Patterns of Human Malformation
- Textbook of Neonatology, 5th Edition, JM Rennie & NRC Robertson
- Canadian Paediatric Society www.cps.ca
- American Academy of Paediatrics www.aap.org
- On-line CME (AAP) www.pedialink.org
- Neonatology www.neonatology.org
- Harriet Lane Links www.med.jhu.edu/peds/neonatology/poi

XIII. References

- Policies and Procedures for Certification and Fellowship, Royal College of Physicians and Surgeons of Canada, January 2001
- General Standards of Accreditation, Royal College of Physicians and Surgeons of Canada, September 2006
- General Information Concerning Accreditation of Residency Programs, Royal College of Physicians and Surgeons of Canada, September 2006
- Specific Standards of Accreditation for Residency Programs in Pediatrics, Royal College of Physicians and Surgeons of Canada, 2006
- Objectives of Training and Training Requirements in Pediatrics, Royal College of Physicians and Surgeons of Canada, 2006
- Ezimokhai, M., 'Specialist Training Program in Obstetrics and Gynaecology', Five Year Programme. UAE University, 1999, 2004, 2005
- Smith, JR. Specialist Training Programme in Obstetrics and Gynaecology, Draft, UAEU, November 2001.
- Dawson, K, Gururaj, A. Residency Programme in Paediatrics. (FMHS, UAEU) Undated.
- Program Requirements for Residency Education in Paediatrics, ACGME (Accreditation Council for Graduate Medical Education) July 2001.
- Uduman S. Residency Programme in Paediatrics ,DOHMS 2005

APPENDIX 1

Programme Resources

The two hospitals, Dubai and Al Wasl are utilized for training by the program. These are tertiary care medical centres formally accredited by the Arab Board for Medical Specialization. Each has a library and has on line access to the stock in the main Library at Rashid Complex.

Al Wasl Hospital is a large general hospital with active paediatric and obstetric services including Level 3 neonatal intensive care units. There is a paediatric surgical service and Paediatric Emergency Room and outpatient clinics. It contains the main regional centres for centre for Paediatric haematology-oncology, Thalassaemia and Clinical Genetics.

Dubai Hospital is a general hospital with active adult and paediatric medical and surgical services including adult and neonatal intensive care units. It has a busy ER department and polyclinic, and also provides general paediatric services and special interest services in paediatric nephrology and gastroenterology.

Both sites are actively involved in the undergraduate Medical Education Programme.

Departmental Profiles:

Department of Paediatrics Al Wasl Hospital:

This facility has a total of 88 beds, distributed as follows, SCBU 34, In-patient Wards 46 and Paediatric Intensive Care Unit 8. General paediatric services are provided by all the consultants and in addition there are sub-specialty services in Paediatric Haematology, Cardiology, Neurology, Pulmonology, Clinical Genetics, Neonatology and Surgery. Intra-departmental facilities for EEG, ECHO and Audiometry are available. All the Specialists are trained and experienced clinical teachers.

Staff Complement:

Consultants	8
Haematologist	1
Paediatric Cardiologist	2
Paediatric Neurologist	1
Clinical Geneticist	1
Neonatologist	3
Senior Specialist Registrars	11

Paediatrics Department, Dubai Hospital

This facility has a total of 60 beds, distributed as SCBU 20 and In-patient Wards 40. General paediatric services are provided by all the consultants and in addition there are sub-specialty services in Paediatric Nephrology, and Paediatric Oncology.. All the Specialists are trained and experienced clinical teachers.

Staff Complement

Consultants General Paed	3
Consultants Neonatology	2
Senior Specialist Registrars	6

APPENDIX 2

Syllabus

This syllabus is based on the major systems and classifications of paediatric illness. They are not subspecialty-based objectives. Objectives are listed once in the most appropriate category, rather than repeated under each relevant section.

Knowledge of embryology, anatomy and pathophysiology refers to that which is relevant to common paediatric disorders.

1. ACUTE CARE (Critical Care / Emergency Paediatrics)

1.1 KNOWLEDGE

- Pathophysiology of altered consciousness, shock, respiratory failure and principles of mechanical ventilation
- pathophysiology of cardio respiratory arrest
- Role of nutrition and fluid management in the critically ill patient
- principles, techniques and limitations of invasive and non-invasive cardiorespiratory monitoring
- Principles, role, and logistics of interhospital transport of critically ill infants and children
- Determination of brain death and principles of organ donation
- Management of the child with special needs / technology dependence.

1.2 SKILLS

- Recognition of the critically ill child and stabilization and / or transfer of the critically ill child
- Airway management and cardiorespiratory resuscitation
- Access and care for indwelling catheters
- Manage a child with a tracheotomy tube including replacement of the tube.
- Management of unexpected death

The following technical procedures, in addition to those listed in (1.10):

- Foreign body removal - eye/nose
- Perform and interpret oximetry
- Assess the traumatized eye
- C-spine immobilization
- Immobilisation of acute injury including fractures
- Gastric lavage
- Eye irrigation, and the use of dilating drops, topical fluorescein, topical anaesthetics

1.3 PROBLEMS

- Cardio respiratory arrest
- Foreign body inhalation
- Shock
- Acute vomiting
- Respiratory failure
- Acute dehydration
- status epilepticus
- sepsis
- coma
- electrolyte imbalance

- near drowning
- apparent life-threatening events (ALTEs)
- poisonings and drug overdoses
- multiple trauma
- burn management
- head injury
- child abuse

2. ADOLESCENT HEALTH CARE

2.1 KNOWLEDGE

- normal development: cognitive, psychological, peer relations, parent-adolescent relations
- adolescents and society: influencing factors, heterogeneity, sub-cultures
- health needs and health problems
- normal adolescent behaviour
- intervention principles
- laws and resources in adolescence
- normal adolescent gynaecology

2.2 SKILLS

- Gynaecological and pelvic examination and specimen procurement
- breast examination
- assessment of testicular size

2.3 PROBLEMS

- eating disorders: anorexia nervosa, bulimia
- behavioural problems: risk taking, delinquency
- gynaecological problems and disorders of menstruation
- pregnancy issues, contraception, sexually transmitted diseases
- alcohol, drug, tobacco and other substance use and abuse
- sexual abuse
- chronic diseases and compliance to therapeutic regimen
- sexuality: male/female issues

3. ALLERGY AND IMMUNOLOGY

3.1 KNOWLEDGE

- the normal host defences and immune response
- variations in normal immune response with age
- pathophysiology of immunodeficiency states and autoimmune disease
- basic diagnostic laboratory techniques involving the immune system
- pathophysiology of allergic disorders
- pharmacotherapy and immunotherapy of allergic disorders
- Indications for and limitations of skin testing, RAST testing and challenge testing

3.2 SKILLS (included in other sections)

3.3 PROBLEMS

- Recurrent infections and immunodeficiency syndromes
- Seasonal and non-seasonal rhinitis
- Anaphylactic shock

- Insect stings
- Urticaria /angioedema
- Serum sickness
- Drug allergy
- Food allergy

4. CARDIOVASCULAR SYSTEM

4.1 KNOWLEDGE

- The anatomy, hemodynamic and electrophysiology of the normal heart and the common congenital and acquired paediatric heart diseases
- The foetal circulation and changes in circulation at birth
- Indications for, limitations, benefits, costs and hazards of:
 - a. Electrocardiogram
 - b. Chest x-ray
 - c. Echocardiogram and Doppler
 - d. Diagnostic and interventional cardiac catheterisation and angiography
 - e. Radionuclide studies
 - f. Exercise ECG
 - g. Holter monitor
 - Pre- and post-operative needs of the paediatric heart patient, and long-term complications
 - The incidence and recurrence risk for congenital heart disease
 - Appropriate use of medications commonly used in the treatment of heart disease

4.2 SKILLS

- Record and interpret reliably an electrocardiogram in all age groups
- Interpret a chest X-ray with respect to heart size, contour and pulmonary vascularity

4.3 PROBLEMS

- Common forms of cyanotic and a cyanotic congenital heart disease
- Cardiac murmurs
- Congestive heart failure
- Syncope
- Cardiac arrhythmia
- Chest pain
- Cor pulmonale (Pulmonary hypertension)
- Endocarditis, Myocarditis, and Pericarditis
- Kawasaki disease
- Rheumatic fever and RHD

5. CLINICAL PHARMACOLOGY

5.1 KNOWLEDGE

- Mechanisms of action of drugs in relation to their ability to correct a pathophysiologic state
- Pharmacokinetics in infants and children
- Placental transfer and breast milk excretion of drugs
- drug interactions

- Modifications of drug dosage required in altered pathophysiologic states (renal failure, liver failure)
- Therapeutic drug monitoring
- The cost of commonly used drugs; choice of drugs with respect to availability of drug plans; issues related to compliance

5.2 SKILLS (included in other sections)

5.3 PROBLEMS

- Adverse drug reactions
- Drug toxicity and overdose
- Management of acute and chronic pain
- Drug withdrawal

6. DEVELOPMENT AND BEHAVIOUR

6.1 KNOWLEDGE

- Normal and abnormal development - gross motor, fine motor, language, personal-social and behavioural biological and psychosocial factors affecting development and behaviour
- Understanding of and interpreting psychological and education testing

6.2 SKILLS

- Assessment of psychomotor development
- Counselling parents on normal growth, development and behaviour with provision of anticipatory guidance
- Counselling of parents regarding developmental and behavioural concerns with attention to available community support and resources

6.3 PROBLEMS

- Developmental delay and mental retardation
- Pervasive developmental disorders/autism spectrum disorders
- Common behavioural problems
- Crying infant, infantile colic, sleep disorders, nightmares and night terrors
- Learning disabilities
- Attention deficit hyperactivity disorders
- School avoidance

7. ENDOCRINOLOGY AND METABOLISM

7.1 KNOWLEDGE

- The normal anatomy, and embryology and physiology of the endocrine glands
- Normal physical growth
- Physiology of normal and abnormal puberty
- Disorders affecting the endocrine gland, producing underactivity or overactivity
- Indications and interpretation of endocrine tests
- Pharmacology of commonly used drugs and hormones

7.2 SKILLS

- Bedside measurement of glucose
- Orchidometry

7.3 PROBLEMS

- Growth retardation/short stature
- Hypoglycaemia
- Ambiguous genitalia
- Early/late sexual development
- Thyroid disease
- Pituitary disorders
- Diabetes mellitus, diabetic ketoacidosis
- Diabetes insipidus
- Inappropriate ADH secretion
- Adrenal disease
- Hypo-/hypocalcaemia
- Hyperlipidemias

8. GASTROINTESTINAL, HEPATIC AND BILIARY SYSTEMS

8.1 KNOWLEDGE

- Normal and abnormal development of the gastrointestinal tract, liver and pancreas
- Physiology and function of the gastrointestinal tract including liver, biliary tract and pancreas, in normal and abnormal states
- Pathophysiology of liver failure
- Indications for diagnostic tests and procedures including: endoscopy, plain abdominal X-rays, upper gastrointestinal and small bowel x-rays, contrast enema, abdominal ultrasound and CT scan, radionuclide scan
- Indications for and interpretation of liver function tests

8.2 SKILLS

- Interpretation of abdominal X-rays

8.3 PROBLEMS

- vomiting and regurgitation
- abdominal pain (acute/chronic)
- diarrhoea (acute/chronic)
- inflammatory bowel disease
- malabsorption
- constipation / encopresis
- intestinal bleeding
- jaundice
- Liver enlargement
- liver dysfunction/failure
- abdominal masses
- dysphagia

9. GENETICS AND TERATOLOGY

9.1 KNOWLEDGE

- modes and molecular basis of inheritance
- application of cytogenetics
- indications and limitations of prenatal diagnosis
- indications and limitations of screening programmes for genetic disease

- principles of assessment of dysmorphism and syndrome identification
- application of molecular diagnosis
- common presentations of inborn errors of metabolism
- embryological basis of malformation
- environmental factors in foetal development

9.2 SKILLS

- construction and interpretation of a pedigree
- ability to provide genetic counselling to a family / individual with a known genetic or inherited disorder, or referral to appropriate source

9.3 PROBLEMS

- the dysmorphic child
- exposure to a possible teratogen
- approaches to and initial investigations of suspected inherited metabolic diseases
- common genetic syndromes (e.g. Down syndrome, Turner syndrome, Fragile-X)

10. RENAL and GENITOURINARY SYSTEM

10.1 KNOWLEDGE

- normal and abnormal development of the genitourinary tract including the external genitalia
- clinical presentation of acute and chronic glomerular diseases and tubular disorders
- indications for, advantages and risks of investigative techniques: IVP, voiding cystourethrograms, renal scan, renal ultrasound, urodynamics, renal angiography, renin studies and renal biopsy
- pathophysiology of renal failure
- indications and complications of dialysis and renal transplantation
- renal transplantation
- fluid and electrolyte requirements in normal and abnormal states
- normal mechanisms of acid-base balance
- indications for and interpretations of renal function tests

10.2 SKILLS

- interpret common abnormalities seen on urine microscopy

10.3 PROBLEMS

- enuresis
- incontinence
- disorders of the male and female external genitalia
- circumcision
- haematuria
- proteinuria
- urinary tract infection
- hydronephrosis
- acute and chronic renal failure
- hypertension
- abdominal and pelvic mass
- congenital structural anomalies of the urinary tract
- renal stones

- vesico-ureteral reflux
- undescended testes
- swollen or tender testis

11 HAEMATOLOGY AND ONCOLOGY

11.1 KNOWLEDGE

- development, structure and function of the formed elements of the blood and blood-forming organs including the changes in normal values with age.
- physiology of factors responsible for haemostasis and thrombosis
- indications for and interpretation of common haematological tests
- pathophysiology of alterations in morphology or quantity of formed elements in the blood
- principles underlying transfusion and hypertransfusion of blood and blood products
- pathophysiology of neoplasms including the acute leukaemias
- characteristics and principles of investigation of the acute leukaemias and common tumours of childhood
- social, familial and personal effects of childhood cancer
- techniques for safe administration of chemotherapy
- common side effects of chemotherapy and radiotherapy and their management
- management of the immunocompromised oncology patient
- late effects of cancer therapy
- principles of palliative care

11.2. SKILLS

- counselling families faced with life-threatening illness/chronic childhood illness

11.3. PROBLEMS

- pallor / anaemia
- bleeding
- purpura and petechiae
- lymphadenopathy
- cytopenia
- hepatosplenomegaly
- indications and complications of splenectomy
- acute complications of haemoglobinopathies and red cell disorders

12. INFECTIOUS DISEASES

12.1. KNOWLEDGE

- characteristics, epidemiology and pathogenicity of common infectious agents and conditions
- mechanisms of host defence and infection
- pharmacology of anti-microbial agents and interpretation of sensitivity tests for antibiotics
- antimicrobial resistance
- control of communicable diseases, including: prevention and immunization
- prevention of congenital and perinatal infections
- nosocomial infections and infection control

12.2. SKILLS

- tuberculin skin testing - perform and interpret

- procurement of appropriate specimens for diagnosis of infections

12.3. PROBLEMS

- common infectious diseases (viral, bacterial, fungal, parasitic, protozoan infections)
- infection in the immunocompromised host
- fever without focus
- fever of unknown origin
- perinatal / congenital infections
- HIV Infection
- occult bacteraemia
- life-threatening infection
- infectious issues relating to travel and immigration

13. NEONATAL / PERINATAL MEDICINE

13.1 KNOWLEDGE

- foetal growth, development and physiology including the role of the placenta
- aspects of pregnancy, labour and delivery which affect the neonate
- effect of maternal systemic disease on the fetus and newborn
- demographic, medical and psychosocial factors which influence
- perinatal mortality and morbidity (the high-risk pregnancy)
- process of neonatal adaptation to extrauterine life
- neonatal growth, nutrition, metabolic problems, feeding problems
- aspects of drug therapy unique to the newborn
- general principles of care of the newborn: skin, warmth, feeding
- problems encountered in the follow-up of the high-risk neonate
- newborn screening

13.2 SKILLS

- neonatal resuscitation and stabilization of critically ill newborn
- initial assessment of the newborn, including APGAR score and gestational age
- recognition of the seriously ill newborn
- management of conventional mechanical ventilation and its complications

13.3 PROBLEMS

- respiratory distress
- prematurity
- cyanosis
- bronchopulmonary dysplasia
- jaundice
- retinopathy of prematurity
- intrauterine growth retardation
- seizures
- asphyxia
- floppy infant
- sepsis
- feeding difficulties / vomiting
- metabolic abnormalities including: hypoglycaemia, hypo / hypocalcaemia
- intraventricular haemorrhage
- surgical problems of the newborn
- anaemia, hypovolaemia, polycythaemia

- bleeding
- apnoea
- drug withdrawal
- congenital anomalies
- birth trauma
- congenital hip dysplasia

14. NEUROMUSCULAR SYSTEM

14.1. KNOWLEDGE

- basic embryology, neuroanatomy and neurophysiology of the central nervous system, congenital malformations and common paediatric neurological problems
- indications for, appropriate use of, and risks/complications of the following investigations:
 - a. Lumbar puncture
 - b. EEG
 - c. Evoked potentials
 - d. nerve conduction studies and electromyography
 - e. skull and spine x-rays
 - f. ultrasound scan of the head and spine
 - g. CT scan
 - h. MRI
 - i. Radionuclide scan of the head and spine
- interpretation of CSF analysis
- pharmacology of drugs used in neurological and neuromuscular problems

14.2 SKILLS (included in other sections)

14.3. PROBLEMS

- congenital malformations of the nervous system including the skull
- neurocutaneous syndromes
- developmental regression
- cerebral palsy
- seizures and sudden loss of consciousness
- breath-holding spells
- headaches
- raised intracranial pressure
- head trauma and sequelae
- comatose child
- cerebrovascular diseases including intracranial haemorrhage and strokes
- weakness and paralysis
- paresthesias
- disorders of peripheral nerves and muscles
- tics
- nystagmus, dizziness and vertigo
- ataxia

15. NUTRITION

15.1 KNOWLEDGE

- recommended nutritional requirements during infancy, childhood and adolescence

- effect of disease states on nutritional requirements
- breastfeeding
- infant feeding
- health implications of restricted diets, fad diets, diets determined by custom or socioeconomic situation
- indications for, physiological basis of and complications of parenteral and enteral nutrition

15.2. SKILLS

- prescribe and manage parenteral and enteral nutrition
- advise on breastfeeding issues

15.3 PROBLEMS

- failure to thrive
- feeding disorders
- obesity
- nutritional deficiencies
- nutritional excesses

16. OPHTHALMOLOGY

16.1 KNOWLEDGE

- basic anatomy, embryology and physiology of the eye, ocular muscles and visual pathways
- aetiology, classification of visual defects in children
- screening procedures for vision
- congenital abnormalities of the eye and ocular muscles
- acquired abnormalities of the eye
- ocular manifestations of systemic diseases

16.2. SKILLS

- measure visual acuity by use of standard visual acuity charts

16.3. PROBLEMS

- congenital blindness
- cataracts/leukocoria
- the red eye
- anisocoria
- proptosis
- ptosis
- strabismus / amblyopia
- abnormal acuity
- papilloedema
- heterochromia of the iris
- nasolacrimal duct obstruction

17. MUSCULOSKELETAL SYSTEM / RHEUMATOLOGY

17.1 KNOWLEDGE

- anatomy, structure and function of bone, joint and connective tissues in normal and abnormal
- physiology of normal bone growth and function
- recognition of non-inflammatory connective tissue diseases, e.g. Marfan's syndrome, Ehlers Danlos syndrome
- mechanisms of immune responses in rheumatic disease
- indications for, and interpretation of laboratory tests on blood and synovial fluid
- principles and applications of physical and occupational therapy for musculoskeletal diseases
- pharmacology of common anti-inflammatory drugs, corticosteroids and immunosuppressive drugs
- effects of chronic rheumatic diseases on physical growth and social development
- common radiographic abnormalities in musculoskeletal diseases

17.2 SKILLS

- interpret bone X-rays including identification of fractures

17.3 PROBLEMS

- common congenital abnormalities
- joint and limb pain
- common fractures, dislocations or injuries
- joint deformities
- septic arthritis and osteomyelitis
- common gait disorders (limp, torsional and angular deformities of lower limbs)
- scoliosis
- acute / chronic arthritis
- systemic rheumatologic diseases, e.g. systemic lupus erythematosus, juvenile rheumatoid arthritis

18. OTOLARYNGOLOGY

18.1 KNOWLEDGE

- embryology, anatomy and pathophysiology of the ear, nose, throat and upper airway
- assessment of hearing
- indications and limitations of diagnostic imaging of the upper airway
- normal and abnormal dentition

18.2. SKILLS

- perform curettage under direct vision of the ear
- interpretation of the tympanogram
- interpretation of upper airway soft tissue X-rays

18.3. COMMON PROBLEMS

- hearing loss
- congenital deformities of ear
- otitis media / otitis externa
- mastoiditis
- epistaxis
- nasal obstruction
- sinusitis

- nasal polyps
- tonsillitis and complications
- retropharyngeal abscess
- cleft lip and palate
- hoarseness and stridor
- voice abnormalities
- upper airway abnormalities
- congenital and acquired neck masses
- facial swelling / asymmetry
- dental caries

19. RESPIRATORY SYSTEM

19.1 KNOWLEDGE

- embryology, anatomy and pathophysiology of lower airways, lung, diaphragm and chest
- pharmacology of drugs used in respiratory diseases
- role of: chest X-ray, bronchoscopy, lung biopsy, lung scintigraphy, sleep studies, apnoea monitors, pulmonary function studies, sweat test, fluoroscopy, and CT scan of the chest

19.2 SKILLS

- interpretation of pulmonary function tests
- demonstrate use of various devices: e.g. spacers, peak flow meters, metered dose inhalers
- interpretation of chest X-rays

19.3 PROBLEMS

- cough, acute and chronic
- haemoptysis
- dyspnoea
- wheezing
- asthma
- cystic fibrosis
- pneumothorax
- pleural effusions
- adult respiratory distress syndrome
- mediastinal and intrathoracic masses

20. SKIN AND ALLIED TISSUES

20.1 KNOWLEDGE

- anatomy and pathophysiology of the skin, hair, nails and mucous membranes
- pigmentary, inflammatory and immune responses of the skin
- pharmacology of commonly used dermatologic medications
- indications for skin biopsy

20.2 SKILLS (included in other sections)

20.3 PROBLEMS

- acne
- eczema and other dermatitides

- infections of the skin
- vesiculobullous eruptions
- papulosquamous eruptions
- alopecia
- pigmentary and vascular disorders of the skin

21. MENTAL HEALTH

21.1 KNOWLEDGE

- pharmacology of psychotropic and anti-depressant medications
- availability of and access to community-based mental health resources
- biological, psychosocial and socioeconomic factors affecting mental health
- indications for hospitalisation

1.2. SKILLS

- recognition of the impact of family function on the mental health of the child
- ability to distinguish between organic and non-organic causes of psychiatric dysfunction

21.3. PROBLEMS

- mood disorders / depression
- anxiety
- attention deficit and hyperactivity
- conduct disorders, oppositional defiant behaviour
- violent behaviour
- family dynamics and psychological adjustment to family stress
- personality traits
- psychoses
- attempted suicide
- emotional abuse
- adjustment to life stresses
- obsessive compulsive disorders

22. SURGERY

22.1. KNOWLEDGE

- preoperative assessment
- indications for appropriate surgical referrals
- perioperative management, including: fluids, steroids, antibiotics
- principles of peri- and post-operative management, including pain management

22.2. SKILLS (included in other sections)

22.3. PROBLEMS

- hernias
- bowel obstruction
- the acute abdomen
- appendicitis
- acute scrotal pain/abscess

SUPERVISION OF THE RESIDENTS

Policy:

1. Clinical Teaching staff are essential and important to the successful implementation of the Dubai residency training Programme.
2. Clinical Teaching staff are expected to be familiar with the goals and objectives of the programme as well as of the rotation for which they have responsibility.
3. Clinical Teaching staff are expected provide a direct and appropriate level of clinical supervision to all residents during clinical rotations.
4. Clinical Teaching staff are expected to foster an effective learning environment by ensuring that the (a) residents share responsibility for decision-making in patient care under supervision, (b) residents have constructive feedback from the concerning clinical skills at diagnosis and management (c) participation of residents in patient care adds to the effectiveness, appropriateness and quality of care.

Procedures:

1. Clinical responsibilities must be assigned to the residents in a carefully supervised and graduated manner, so that the resident assumes progressively increasing responsibility in accordance with their level of education, ability, and experience.
2. Teaching staff supervision must include timely and appropriate feedback to the residents.
3. The resident's clinical involvement must be in fulfillment of the programme's written educational curriculum.
4. Teaching staff must demonstrate concern for each resident's well-being and professional development.
5. Teaching staff who supervise the residents have overall responsibility for patient care and are the ultimate authority for final decision.
6. Teaching staff schedules must be structured to ensure continuous supervision of residents and availability of consultation.
7. All decisions regarding diagnostic tests and therapeutics, initiated by the residents will be reviewed with the responsible Consultants during patient care rounds.
8. Patients will be seen by the team of residents, interns and medical student and their care will be reviewed with the Consultant at appropriate intervals.
9. The residents are required to promptly notify the patient's Consultant physician in the event of any controversy regarding patient care or any serious change in the patient's condition.
10. In clinics and consultation services, the Consultant or supervising physician must review overall patient care rendered by residents.
11. In the operating theatres, the Consultant or supervising physicians are responsible for the supervision of all operative cases. Consultants supervising physicians must be present in the operating room with residents during critical parts of the procedure. For less critical parts of the procedure, the Consultant or supervising physician must be immediately available for direct participation.

APPENDIX 3

Logbooks

Case Log Book

An example of a Case Log Book page is shown on the next page. The Residency Programme Committee and the teaching staff will review the items that will be kept in the case log periodically. Current suggestions for logbook tracking include:

- Case and round presentations
- Lumbar punctures (diagnostic, therapeutic and chemotherapy)
- IV insertions
- Neonatal intubations
- Attendance at delivery
- Neonatal resuscitation
- Paediatric intubation
- Paediatric resuscitation
- Bone marrow aspiration
- Bone marrow biopsy
- Skin biopsy
- NG tube insertion
- Suprapubic aspiration
- Ventricular taps
- TPN orders-neonatal
- TPN orders – paediatric
- “Bad News” counselling



DOHMS Paediatric Residency Program Clinical ROTATION Evaluation

Resident Name: (optional) _____ Rotation _____

This Form is designed to provide resident feedback to Programme Administrators concerning strengths and areas to improve in the variety and organization of clinical exposures provided in the different clinical rotations of the Paediatric Programme. 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 by the division 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)

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
Logistics								
There was adequate space for me to complete my work	0	1	2	3	4	5	6	7
The secretarial support was good	0	1	2	3	4	5	6	7
The attending 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



DOHMS Paediatric Residency Program

Clinical Rotation **FACULTY** Teaching Evaluation

Resident Name: (optional) _____ Rotation _____

This Form is designed to provide resident feedback to Programme Administrators concerning strengths and areas to improve in the quality of training by providing an assessment of teaching staff in the Paediatric Programme. 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 division 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)

Clinical Teaching Faculty: _____ Rotation: _____

(Note: Use a separate sheet for each supervising Faculty Member)

Please Rate the Faculty Member's teaching style and capacity to function as a role model in the provision of the most competent, compassionate, and professional care to patients in the following domains:

	Could not Judge	Strongly Disagree	→	.	→	→	→	Strongly Agree
Medical Expert								
Up-to-date in area of practice; sound 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 modelled 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



DOHMS PAEDIATRICS RESIDENCY PROGRAM ROTATION IN-TRAINING ASSESSMENT (RESIDENT)

Name:

Program:

Period of Training

FROM:

TO:

Resident: I II III IV V

Site:

Specific rotations included in this evaluation:

	Could not Judge	Strongly Disagree	→	→	→	→	Strongly Agree	
MEDICAL EXPERT								
Basic scientific knowledge	0	1	2	3	4	5	6	7
Basic clinical knowledge	0	1	2	3	4	5	6	7
History & physical examination	0	1	2	3	4	5	6	7
Interpretation & utilization of information	0	1	2	3	4	5	6	7
Clinical judgment & decision making	0	1	2	3	4	5	6	7
Technical skills required in the specialty	0	1	2	3	4	5	6	7
COMMUNICATOR								
Interprofessional relationships with physicians	0	1	2	3	4	5	6	7
Communication with other allied health professionals	0	1	2	3	4	5	6	7
Communication with patients	0	1	2	3	4	5	6	7
Communication with families	0	1	2	3	4	5	6	7
Written communication & documentation	0	1	2	3	4	5	6	7
COLLABORATOR								
Interacts and consults effectively with all health professionals by recognizing and acknowledging their roles & expertise	0	1	2	3	4	5	6	7
Delegates effectively	0	1	2	3	4	5	6	7
MANAGER								
Understands & uses information technology	0	1	2	3	4	5	6	7
Uses health care resources cost-effectively	0	1	2	3	4	5	6	7
Organization of work & time management	0	1	2	3	4	5	6	7
HEALTH ADVOCATE								
Advocates for the patient	0	1	2	3	4	5	6	7
Advocates for the community	0	1	2	3	4	5	6	7
SCHOLAR								
Motivation to read and acquire knowledge	0	1	2	3	4	5	6	7
Critically appraises medical literature	0	1	2	3	4	5	6	7
Teaching skills	0	1	2	3	4	5	6	7
Completion of research/project	0	1	2	3	4	5	6	7
PROFESSIONAL								
Integrity & honesty	0	1	2	3	4	5	6	7
Sensitivity & respect for diversity	0	1	2	3	4	5	6	7
Responsibility and self-discipline	0	1	2	3	4	5	6	7
Communicates with patients with compassion	0	1	2	3	4	5	6	7
Recognition of own limitations, seeking advice when needed	0	1	2	3	4	5	6	7
Understands and applies principles of ethics clinical situations	0	1	2	3	4	5	6	7
GLOBAL EVALUATION OF COMPETENCE AND PROGRESS	Incomplete	1	2	3	4	5	6	7
	0							

