## POSTGRADUATE INSTITUTE OF MEDICINE UNIVERSITY OF COLOMBO

# PROSPECTUS

## MD EMERGENCY MEDICINE

## AND

## **Board Certification in Emergency Medicine**

## 2013

## Specialty Board in Emergency Medicine Board of Study of Multi-Disciplinary Study Courses

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#### 1. Description, Nomenclature and Associated Agencies of the Degree Programme

- 1.1 Name of the Degree Programme MD Emergency Medicine
- 1.2 Full Title MD Emergency Medicine with Board Certification
- 1.3 University University of Colombo, Sri Lanka
- 1.4 Faculties and Institutes Postgraduate Institute of Medicine, Colombo
- 1.5 Departments, External Resources and Associated Agencies Board of Study in Multi-Disciplinary Study Courses Specialty Board in Emergency Medicine Ministry of Health Ceylon College of Physicians College of Surgeons of Sri Lanka College of Anaesthesiologists of Sri Lanka College of Paediatricians of Sri Lanka College of Obstetricians and Gynaecologists of Sri Lanka Sri Lanka College of Otorhinolaryngologists and Head and Neck Surgery Sri Lanka College of Psychiatrists Sri Lanka Society of Study of Pain Sri Lankan Society of Critical Care and Emergency Medicine Australasian College of Emergency-Medicine World Federation of Emergency Medicine Poison Centre, Sri Lanka Alfred Centre, Monash University, Melbourne, Australia Other overseas Emergency Medicine Centers of excellence

#### 2. Mission, Justification and Proposed Outcome

2.1 The Mission

The mission of this endeavor is to ultimately produce " a lead clinician capable of providing medical care in any emergency situation, independent of the location and

effectively lead and safely manage common acute problems, with confidence, and competent to make decisions under pressure of time to save lives, even in a mass scale, whilst preventing further injury".

#### 2.2 Justification

The tsunami in 2004 was a significant impetus for initiating emergency training in Sri Lanka. This highlighted the need for the development of a coordinated emergency response from trained personnel, especially at a national level. In this context, to date, various activities have taken place, for example, establishment of emergency ambulance services and emergency call numbers in some cities (e.g. Colombo), inauguration of a new ministry for disaster management, higher focus for training in emergency care (CPR programmes) for all categories of staff including doctors, nurses, and ambulance men, initiation of disaster management training centers, and construction of dedicated emergency care units.

In Sri Lanka, most seriously ill patients are admitted to hospitals through OPDs (Out Patient Departments). With the current enthusiasm, there had been several pilot programmes too to improve emergency care provided in OPDs. For example, establishment of ETUs (emergency treatment units), PCUs (Preliminary Care Units), and Accident Centres (Colombo NHSL). Despite above, our medical officers serving in OPDs are often non specialists. Yet they are expected to handle patients needing emergency care, first hand, within a poorly organized and ill equipped environment. The Ministry of Health has attempted to improve this situation by the appointment of VP/OPDs.

There is no lead clinician (a specialist) who is trained to coordinate all the above activities and also be in the forefront of emergency clinical management i.e. prehospital care, patient transport and emergency care in hospital on admission.

Emergency Medicine, an accepted specialty in many developed countries involves emergency management of critically ill medical, surgical/trauma, paediatric and gynaecology and obstetrics patients. These specialists are specifically trained for above through a specialist training programme similar to other clinical specialties. This has resulted in safer emergency care, more efficient hospital throughput, better use of scarce hospital resources and the development of a system of care for trauma and emergency patients.

The International federation for Emergency Medicine (IFEM) defines the specialty of Emergency Medicine as "a field of practice based on the knowledge and skills required for the prevention, diagnosis, and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioural disorders; it further encompasses an understanding of the development of pre-hospital and inhospital medical systems and the skills necessary for this development".

#### 2.3 Proposed Outcome

The training programme leading to board certification will result in an Emergency Physician who is a lead clinician capable of providing medical care in any emergency situation, independent of the location and effectively lead and safely manage common acute problems, with confidence, and competent to make decisions under pressure of time to save lives, even in a mass scale, whilst preventing further injury.

#### **3.** Training Outcomes at the end of the Programme

The programme is designed to provide the type of training that would equip the final product to deal with all health care related matters in the field, and in the Outpatient Departments/Emergency Treatment Units/Preliminary Care Units. Once stabilized with emergency care, it would also be their responsibility to refer these patients to appropriate specialists, without delay for further management. It is expected that thus trained Emergency Physicians would be up-to-date in competency to lead rescue teams under any circumstance, triage patients for maximum benefit and transport them to appropriate health care institutions safely.

The curriculum has incorporated a myriad of training activities that need to be undertaken over the full period of training. The four year period of local training (three years of pre MD and one year of post MD training) provides the basic foundation which would be amplified and reinforced during the one year training abroad. The stint abroad would also provide exposure to some of the technologies currently unavailable in Sri Lanka. It would also provide the trainee with an opportunity to be exposed to the most modern forms of Emergency Care and methods of patient transport as well as providing all necessary amenities to embark on a good research endeavour.

From a logistical point of view, the ultimate aim is coverage of all areas of the country with these highly trained and specialized Emergency Physicians, resident whilst on duty at Emergency Units of all Provincial and Teaching Hospitals with readiness to respond to needs outside hospital for disaster management and provision of leadership for rescue teams.

#### 4. Training Content and Curriculum

Whilst in developed countries, the training period of an Emergency Physician is considered to be of approximately 4 years duration, in Sri Lanka this would be approximately 5 years as there are no accredited Emergency Medicine Units in Sri Lanka at present and hence the training necessary will have to be gained as specific ' components' in other specialty units.

#### 4.1 The Curriculum

This is a Competency based model. The syllabus outline is prepared under 10 themes namely, (1) basic clinical skills, (2) diagnosis, management and prevention, (3) use of basic science in the practice of medicine, (4) moral reasoning and clinical ethics, (5) self awareness, self care and personal growth, (6) the social and community contexts of health care, (7) problem solving, (8) lifelong learning (9) effective communication (10) Subject Specific competencies (Annex 1).

#### 5. Selection Process for the Training Programme and Guidance for Trainees.

Applications shall be invited by public circular at regular intervals (usually annually) by the Director of the Postgraduate Institute of Medicine from medical officers in the state and non-state sector fulfilling the following *'eligibility criteria'* to sit the 'Selection' Examination for enrolment for the in-service training programme.

The number of placements available for training would be indicated in the public advertisement that calls for the selection examination. Recruitment of any candidate from overseas (non citizens) will be according to the prevailing rules and regulations of the Postgraduate Institute of Medicine at the time and will not encroach upon the above quota.

#### 5.1 Eligibility criteria

A medical degree registered with the Sri Lanka Medical Council

Satisfactory completion of internship acceptable to the Sri Lanka Medical council

Satisfactory completion of one year of post internship in medical practice in a University/Public Sector Institution/Non State sector in Sri Lanka acceptable to the PGIM as at the date of closure of applications.

#### 5.2 The Selection Examination

This examination conducted by the PGIM is designed to test the basic knowledge in relevant Anatomy, Clinical Chemistry, Physiology, Pathology and Pharmacology, Clinical Measurement and Disaster Medicine. The maximum number of attempts a candidate could participate is unlimited. This examination consists of a single best answer paper, an essay paper and 1 hour Objective Structured Practical Examination (OSPE) examination.

#### 5.2.1. Single Best Answer paper

This is a **2** hour single best answer question paper of 60 questions. Each question has 5 plausible responses out of which one is the best answer.

# Candidates obtaining a score of 50% or more in the Single Best Answer paper will proceed to complete the selection examination.

The remaining components of the selection examination are;

#### 5.2.2. 3 hour Essay paper

6 compulsory questions from areas of study depicted above i.e. Anatomy (includes imaging), Clinical Chemistry, Physiology, Pathology and Pharmacology, Clinical Measurement and Disaster Medicine.

#### 5.2.3. 1 hour OSPE examination

Includes 20 stations and each OSPE is of 3 minutes duration. This is designed to test data interpretation skills using basic knowledge in the above subject areas.

Examination component	Marks allocation	Marks obtained by the Candidate
Single Best Answer paper	100	Х
3 hour essay paper	100	Y
1 hour OSPE	100	Z
Final Mark %	100	(X+Y+Z)/3

#### 5.2.4. Marking grid (Selection examination)

Candidates obtaining a final aggregate mark of 50% (150/300 marks) **AND** a minimum mark of 50% (50/100 marks) for the Single Best Answer paper **AND** a minimum mark of 50% (50/100 marks) for the Essay paper **AND** a minimum mark of 50% (50/100 marks) for the OSPE examination in the Selection Examination will be enrolled on merit for Emergency Medicine training rotations offered by the Specialty Board in Emergency Medicine.

Selection will be done based on merit to fill the number of slots indicated in the circular calling for applications.

The selected candidates would be provided with full and comprehensive details of the training programme, the portfolio and stipulated training rotations. These would be available at the PGIM for perusal by the prospective candidates prior to the allocation meeting.

#### 5.3 *Guidance through the Training Programme*

Once the selection is made, the candidate would come under the general purview of the Specialty Board in Emergency Medicine.

Each candidate would be allocated to Trainers nominated by the Specialty board in Emergency Medicine from among a variety of specialists in the country and would be guided by them right throughout the training programme.

#### 6. Training Programme Details and Structure

#### 6.1 *Orientation courses*

The selected candidates may follow the orientation courses listed below preferably within the first year of training and obtain certification from the PGIM in association with other contributing academic agencies. All orientation courses constitute of lectures, practical classes, video and interactive sessions, hands on training, simulations and assessments stipulated by the course organizer.

- Emergency Life Support (ELS)–2 day course
- Advanced Life Support (ALS)–2 day course
- Advanced Trauma Life Support (ATLS)–2 day course
- Advanced Paediatric Life support (APLS)–3 day course
- Emergency Radiology for Emergency Physicians–2 day course
- Neonatal Life Support–1 day course
  - Any other courses as directed by the Specialty Board in Emergency Medicine such as,
- Echocardiography
- Ultra Sound Scan
- Bronchoscopy
- Communication skills workshop
- Research methodology workshop
- Audit workshop
- Child protection

#### 6.2 Duration of the degree course

Total duration of the program will be 5 years as following.

#### Pre-MD Training

3 years structured clinical training

Post-MD Training

- 1 year training abroad
- 1 year training locally as a Senior Registrar in Emergency Medicine

#### 6.3 Clinical training (See table 2)

Hospital based clinical training will commence immediately after successful completion of the selection examination for MD Emergency Medicine. The clinical training period shall be a total of 3 years in Sri Lanka subject to satisfactory incourse assessments by the PGIM appointed trainers. (Annex 2)

#### 6.4 *Completion of pre MD training programme*

The candidate should submit evidence supportive of satisfactory completion of the above hospital based training(1-3 years); the portfolio, and satisfactory peer team ratings (PTR form C Annex 3).

#### 6.5 Year 4 and 5 Senor Registrar in Emergency Medicine

The two year Senior Registrar period will commence immediately after successfully completing the MD Emergency Medicine examination. This will be for a one year period of training abroad and one year of training under supervision in Sri Lanka (in an OPD, ETU or an Emergency Center). The candidate should demonstrate a minimum of 80% attendance in each segment of clinical training.

#### 6.6 *Research Project leading to a research paper*

Successfully carrying out a research project, directly relevant to Emergency Medicine, is a mandatory requirement that needs to be fulfilled to be eligible to appear for the Pre-Board Certification Assessment (PBCA).

The Research Project could be undertaken at any time, either in Sri Lanka or abroad. It should be a prospective study, observational or interventional.

All aspects of the study have to be assessed and deemed to be satisfactory by the Specialty Board of Emergency Medicine *before embarking on the proposed study*. Towards that end, a comprehensive project proposal has to be submitted to the Specialty Board of Emergency Medicine and approval obtained, prior to commencing the study including recruitment of patients and data collection.

Help from the members of the Specialty Board in Emergency Medicine may be obtained before submitting the finalized project proposal to the Specialty Board of Emergency Medicine. The draft proposal should be allinclusive and detailed with all relevant particulars including ethical clearance. The trainer could be any of the tutors or recognized specialists by the Specialty Board in Emergency Medicine.

All projects would need informed written consent and interventional studies have to be registered with the Sri Lanka Clinical Trials Registry.

The project, once completed, should be accepted by a two member panel of examiners appointed by the Specialty Board in Emergency Medicine. The examiners would assess the project based on the following marking scheme:-

Title, Introduction and Literature Survey	10 marks
Objectives	10 marks
Method	20 marks
Results	20 marks
Discussion	20 marks
Conclusions	05 marks
References	05 marks
Overall presentation of the project	10 marks
TOTAL	100 marks

A minimum mark of 50 per cent is necessary for the project to be accepted by the Specialty Board in Emergency Medicine.

After such acceptance it is preferable to present it at a National or International Scientific Meeting and subsequently published. The trainee has to provide documentary proof of presentation and publication of the research project to the Specialty Board in Emergency Medicine. This documentation could be in the form of a signed letter from the Scientific Congress or the journal concerned.

Any paper or publication could have more than one author and several trainees may be co-authors. However, only one trainee could submit the paper as his/her own research project.

#### 6.7 *Clinical Audit*

As a part of foreign training, it is preferable for the trainees to do a comprehensive Clinical Audit and formally present it at the hospital where they are working. This is in addition to the prescribed Research Project. Documentary evidence of such an audit presentation can be provided to the Specialty Board in Emergency Medicine. This venture is a form of training that would be most useful when such audits have to be carried out or supervised in the Sri Lankan setting when the trainee returns to Sri Lanka.

#### 6.8 Portfolio

The Portfolio is an important tool for assessment of trainee performance and learning processes. The "Portfolio Method" will be used as an assessment criterion for the training programme in Emergency Medicine. It is a key document in the assessment of the trainee during the training programme.

The fundamental basis of Portfolio maintenance is Reflective Practice, which is an important tool in postgraduate training.

Reflective practice consists of;

- focused self-assessment
  - reflecting on experience
- reflecting on strengths, weaknesses and areas for development
- design of own strategies that leads to improvement in practice

Using such a process, there is improved training by self-identification of strengths and weaknesses, which is expected to promote deep learning, documentation of what the trainee already knows, identify areas for improvement and seek help in planning further learning. This approach promotes self-directed learning and critical thinking skills.

The objective of maintaining a Portfolio is (a) to help the trainees to record their training in brief so that the experience acquired can be assessed and deficiencies identified and remedied and (b) to help trainers and assessors to evaluate the overall training and provide guidance in areas where it is needed.

The Portfolio should consist of documentation of all aspects of training and learning experienced by the trainee. This should include;

- Log book of stipulated practical procedures
- Case records (minimum of 10)
- Exposure to new technologies (A minimum of 5).
- Details of Continuing Professional Development activities (A minimum of 5)
- Records of Scientific Presentations made (A minimum of 5).
  - Case Based Discussions (CBD) (A minimum of 5).
  - Regular reflective entrees on all aspects of patient care and professional training
  - A record of individual activity-based entrees on the trainee's own experience
  - Voluntary work especially involving natural disasters
  - Any other professional activity (e.g. Clinical Audit)

The portfolio should be maintained in separate sections to conform to the above format. Entries in the Portfolio should be made by the trainee at the time of acquiring the skill and authorized by the trainer.

The trainee is expected to keep it updated regularly. The trainers will use the portfolio to assess the progress of the trainee and to provide a feedback at the end of each segment of training. The trainers are expected to assess the level of competencies in different areas of training and provide advice and assistance to the trainees to achieve the expected levels of skills empowerment.

It is the responsibility of the trainees and the trainers to ensure that the entries in the Portfolio are authentic and made regularly. It is essential to provide the trainee with accurate feedback about their performance during the training period.

The Specialty Board in Emergency Medicine expects the Trainee and the Trainers to make the best use of the Portfolio in order to achieve the objectives of the training programme. The portfolio should be kept as a ring binder document which will allow easy insertions by the Trainee.

The completed portfolio should be submitted at least 8 weeks before the MD Emergency Medicine examination for the purpose of assessment. It will be assessed by a panel of two examiners appointed by the Specialty Board in Emergency Medicine. The panel will sit at a formal discussion with the trainee and evaluate the portfolio over a period of 30- 45 minutes. At this portfolio viva *voce* the performance of the trainee will be marked by examiners using the rating scale given in table 1.

Table 1 Rating Scale for the assessment of portfolio viva vocé

Failure	7	30%
Borderline	8	40%
Pass	9	50%
Good pass	10	60%
Excellent pass	11	70%

#### 7. Evaluation of process

Each completed section of the clinical training programme should be followed by the submission of a confidential in-course assessment report by the trainer. The templates for

trainee assessments are provided as Annex 2 at the end of this document. These reports should be received by the PGIM within one month of completing the relevant section of training.

7.1 In course assessment [constitutes 10% of marks of the MD Emergency Medicine examination]

This is a collated mark of scores given by PGIM appointed trainer/s for each segment of clinical training during the first 3 years (adjusted to the duration of each clinical appointment).

The trainee should complete, with 80% attendance, the registrar grade or equivalent medical officer appointments designated by the PGIM as detailed in table 2 below. Marks will be assigned by the PGIM recognized trainers/tutors (in confidence), independently, for Knowledge (100), Skills (100) and Attitudes and Behaviour (100) shown by the candidate during each training period.

Clinical appointment	Duration (months)	Knowledge (100)	Skills (100)	Attitudes/ Behaviour (100)	Total (See the calculation below)
Year 1					
Anaesthesia	3	Х	Y	Ζ	А
ICU (Multi-disciplinary)	3				В
General Medicine	3				С
Obstetrics & Gynaecology	3				D
Year2					
General Surgery	3				Е
General Paediatrics	3				F
Paediatric ICU	1				G
ENT	1				Н
Eye surgery	1				Ι
Cardiology	1				J
Neurosurgery	1				К
Radiology	1				L
Year3					
Forensic Medicine	1				М
Psychiatry	1				Ν
ETU	3				0
Acc.Ser.(Trauma+Burns) NHSL	3				Р

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Toxicology	1		Q
Total	33 months		

Calculation of the overall mark for in-course assessments.

[(X + Y + Z)/3]/33x3 = X

(3 is the duration of the clinical appointment in months) Similarly calculate Overall mark for continuous assessment = S [A + B + C + D + E + ....] x 10%

<u>The onus of ensuring that these reports are sent in time to the PGIM is entirely on</u> <u>the trainee</u>. He or she should liaise with the trainers and make sure that the reports are received by the PGIM in time. This includes local as well as foreign training. A mark of 50% will be a satisfactory evaluation result. A continuous assessment mark of 39% or less would be considered an adverse report and may need an additional period of trainee specific training prescribed by the Specialty Board in Emergency Medicine. At the second evaluation the maximum mark to be awarded is 40%.

Suitable and appropriate action will be taken by the Specialty Board in Emergency Medicine according to the General Regulations and Disciplinary Code of the PGIM in the event of the receipt of an unsatisfactory or adverse progress report at any stage of training.

Satisfactory Progress Reports are a mandatory requirement to qualify for the MD Emergency Medicine examination and Pre–Board Certification Assessment (PBCA).

#### 8. MD Emergency Medicine Examination (100 marks)

#### 8.1 Eligibility criteria

- a. Satisfactory completion of the **3 yr** clinical training with 80% attendance
- b. Obtaining a minimum collated in-course assessment mark of 50% for the 3year clinical training period
- c. Obtaining a minimum mark of **50%** at the Portfolio assessment

#### 8.2 Components of the MD Emergency Medicine Examination

This examination constitutes of 6 components as following.

- 8.2.1 In-course assessment **10%** clinical training 3 years (Evaluated according to the marking grid already given)
- 8.2.2 Short Answer Questions **25%** 3 hour paper

10 compulsory questions incorporating core knowledge expected of an emergency physician and marked according to a pre-determined marking grid.

8.2.3 Clinical Interpretation (OSPE) 20% 1 hour

20 OSPE stations (each lasting 3 minutes) and up to 10 stations may be marked by a single examiner after direct observation according to a predetermined marking grid. In other stations there shall be no examiners and the candidate is expected write down the answer to questions based on a "spot" which will be corrected later.

8.2.4 Short Clinical Cases **25%** 6 cases

This constitutes a combination of (a) scenario-based assessment, (b) simulation- based assessment, (c) a play-back of actual video, (d) warm cases [previous day's admissions] (e) Equipment assembly and (f) a standardized patient.

Each case shall last 10 minutes with one examiner and will be marked according to a pre-determined marking grid.

8.2.5 Portfolio 10%

Two examiners shall objectively assess the portfolio independently. The Interview shall be a minimum of 30 minutes. (The student shall appear with a copy of his/her portfolio before a two member examiner panel and face questions).

8.2.6 Structured Viva 10%

2 stations (20 minutes each)

2 viva examiners for each station

This session will focus on acute case scenarios

8.2.7 Pass mark

To pass the examination should score 50% or more of the total aggregate AND

A score of 40% or more for at least 4 of the 6 components

Failed candidates should appear for the whole examination. In such situation portfolio marks will not be carried to subsequent examinations. A candidate shall be allowed six number of attempts at the MD Emergency Medicine examination within 8 years of the *first attempt*.

#### 9. Pre- Board Certification Assessment (PBCA)

The PBCA will consist of a specified form of assessment

9.1 Eligibility to sit for the PBCA

All the following criteria have to be accomplished to be eligible to appear for the PBCA.

- Provision of satisfactory Progress Report for the training period abroad.
- Provision of satisfactory Progress Report for the local training period as an Assistant Emergency Physician.

- Documentary evidence of successful completion of the Research Project.
- Successful completion of the MD Emergency Medicine examination.
- Obtain a satisfactory score through the PGIM Peer Team Rating (PTR) system

#### 9.2 Details of PBCA

This will constitute

a. Portfolio viva covering the 2 years of post MD training.

A trainee must obtain a minimum of a 'Pass' grade to be eligible for Board Certification. A trainee whose portfolio is rated as 'Borderline' or 'Fail' will be advised by the panel of examiners on how the portfolio could be improved to achieve a 'Pass'. In such a case, the necessary corrections and amendments have to be made by the trainee and the portfolio submitted to the same panel of examiners for a second evaluation. If a 'pass' is not obtained, a third evaluation by the same panel of examiners will become necessary.

The completed portfolio, its satisfactory assessment by the Board of Study and a minimum pass grading at the pre-Board Certification assessment is necessary for the trainee to be eligible for Board Certification.

b. Twenty minute self prepared presentation by the candidate to the Specialty Board in Emergency Medicine indicating a self evaluation of the training received and the trainee's vision for the future development of patient care services in Sri Lanka and further career development. This should be acceptable to the BOS.

#### **10. Requirements to be eligible for Board Certification**

Successful completion of the pre-board certification assessment.

#### 11. Method of Delivery and Learner Support System

Text book and journal oriented theory knowledge, theory and practical knowledge of special equipment, patient oriented discussions, tutorials, small group discussions, cyber learning etc.

#### **Recommended Journals**

- The Journal of Emergency Medicine Elsevier (The Official Journal of the American
- Academy of Emergency Medicine)
- American Journal of Emergency Medicine
- European Journal of Emergency Medicine (The Official Journal of the European Society for Emergency Medicine)
- Annals of Emergency Medicine (The Official Journal of the American College of Emergency Medicine)
- Emergency Medicine Australasia

Recommended Text books

- <u>Emergency Medicine</u> (Latest edition) Anthony FT Brown, Michael D, Cadogan eds. London, Hodder Arnold
- <u>Textbook of Adult Emergency Medicine</u> (Latest edition) Peter Cameron, George Jelinek, Anne-Maree Kelly, Lindsay Murray, Anthony FT Brown, John Heyworth eds. Edinburgh, Churchill Livingstone
- <u>Oxford Hand Book of Accident and Emergency Medicine</u> (Latest edition) JP Wyatt, RN Illingworth, CE Robertson, MJ Clancy, PT Munro eds. Oxford, Oxford University Press
- <u>Text book of Paediatric Emergency Medicine</u> (Latest edition) Peter Cameron, George Jelinek, Ian Everitt, Gary Browne, Jeremy Raftos. London, Churchill Livingstone

#### **12. Training Settings, Units and Educational Resources**

Teaching will be done by Trainers approved by the Specialty Board in Emergency Medicine and resources such as wards, clinics, intensive care units, special care baby units, operating theatres, skills laboratories, information technology facilities and libraries will be used as learning methods and tools. Regular case discussions, Journal Clubs and audit meetings will be held.

#### **13. Details of Trainers**

The current panel of Board Approved Trainers who are Board Certified Consultants with MD or those with foreign qualifications and are eligible for Privileges of Board Certification (in relevant specialties) with employment in the Ministry of Health or the Universities would carry out the training locally. Foreign training would be carried out by recognized Consultants in centers of excellence. All trainers would provide an honorary service for which no payment will be made by the University or the PGIM.

## Annex 1 The Curriculum

The expansion of the curriculum under each theme is based on the following format;

#### 1. THEME

#### 1.1 Educational Outcomes (broad objectives)

- 1.1.1 *Competencies* 
  - 1.1.1.1 Specific objectives

Content areas

An outcome constitutes a collation of *competencies* under which specific objectives and content areas are described.

#### 1. BASIC CLINICAL SKILLS

- 1.1. Provide good medical care in any emergency situation
  - 1.1.1. *Demonstrate basic clinical skills* 
    - 1.1.1.1. Acquire proficiency in taking a focused history From patient, from patient's family, caregivers and other professionals
    - 1.1.1.2. Acquire proficiency in physical examination General examination, system examination
    - 1.1.1.3. Acquire proficiency in mental state examination In relation to psychiatric disorders, in relation to organic disorders

#### 1.1.2. Demonstrate commonly used procedural skills

1.1.2.1. First aid

Airway management, vascular access, oxygen delivery systems, bag and mask ventilation, needle or surgical cricothyroidotomy, fracture immobilisation

1.1.2.2. Demonstrate proficiency in cardiopulmonary resuscitation

Basic life support, advanced life support, use of a defibrillator, use of laryngeal mask, endotracheal intubation and confirming its position, rapid sequence intubation, principles of cerebral resuscitation in brain illness and injury.

1.1.2.3. Understand equipment uses and their pitfallsCapnography, pulse oxymetry, ECG, ventilators, non invasive ventilators

- 1.2. Able to rescue, resuscitate and maintain life support in any emergency situation, independent of the location utilizing the resources available.
  - 1.2.1. Demonstrate ability to triage, rescue, and safely transport victims in any disaster, natural or otherwise
    - 1.2.1.1. Disaster situations in mass scale Trauma, poisoning, floods/drowning, radiation, chemical disaster
    - 1.2.1.2. Emergency department on routine service Adult, paediatric
    - 1.2.1.3. Understand triage

Definition, its philosophy, various triage scales

1.2.1.4. Initiate relevant Vital signs measuring and monitoring Clinical vital signs, non invasive electronic monitoring, invasive

monitoring

1.2.1.5. Recognise the need and provide safe transportation for critically ill patients

By road, by air

- 1.2.2. Demonstrate ability to recognise life-threatening illness or injury and apply basic principles of stabilization to the early management of these entities.
  - 1.2.2.1. Recognise and initiate first aid for airway obstruction

Cyanosis, stridor, hypercarbia, oro-pharyngeal airway, nasal airway, endotracheal intubation, laryngeal mask/ pharyngeal mask airway, cricothyroidotomy

- 1.2.2.2. Provide rapid intravenous access and fluid/blood administration. Peripheral, central
- 1.2.2.3. Obtain a focused history and examination From patient, from relative or by standees, from referring doctor
- 1.2.2.4. Offer a prioritized differential diagnosis

To formulate initial management, for further investigation

- 1.3. Able to request, and safely transport patients where necessary to obtain emergency radiological investigations and interpret findings
  - 1.3.1. Understand the place of radiology in a variety of emergency situations 1.3.1.1. Aware of basics

Physics, safety issues, safe doses of radiation, complications (including contrast induced)

1.3.1.2. Aware of the issues surrounding special circumstances
 Pregnancy and shielding, the unstable patient – monitoring and transfer

1.3.2. Understand the indications, techniques and interpretation of common studies 1.3.2.1. Plain radiology

Trauma series, chest, abdomen, limbs, spine, thoracic, lumbosacral, skull, soft tissue

- 1.3.2.2. Contrast radiology Angiography
- 1.3.2.3. Computed tomography Brain, cervical spine
- 1.3.2.4. Magnetic resonance imaging Brain, spine
- 1.3.2.5. Nuclear medicine

Ventilation/ perfusion scans, bone scans

1.3.2.6. Ultrasound

Focused Assessment using Sonography in Trauma (FAST), assessment of peritoneal cavity, pleural cavity, pericardial space, assessment of the abdominal aorta and IVC, vascular access, echocardiography in life support, lung ultrasound

### 2. DIAGNOSIS, MANAGEMENT AND PREVENTION

- 2.1. Effectively leads and safely manages common acute medical problems
  - 2.1.1. Demonstrate the capacity to differentiate and treat common acute problems.
    - 2.1.1.1. Develop existing clinical and examination skills and apply them in clinical practice to develop a differential diagnosis and provisional management plan

General examination, systems examination, paediatric/neonatal examination, trauma survey

- 2.1.1.2. Distinguish age specific anatomical and physiological differences Neonatal, infant, paediatric, pregnancy, elderly
- 2.1.1.3. Recognise and be prepared to intervene, in any age group, specific emergency situations listed in section 10

All causes of shock, all causes of hypoxia, all causes of poisoning

- 2.2. Make decisions under pressure of time to save lives, even in a mass scale
  - 2.2.1. *Pre-hospital management under variable circumstances* 2.2.1.1. Patient care

Assessment, first aid, triage

2.2.1.2. Modes of transport

By road, by air

2.2.1.3. Clinical procedures

Airway, CPR, haemorrhage control, splinting, spinal immobilisation, defibrillation, vascular access

2.2.1.4. Retrieval

Inter-hospital transfer, intra-hospital transfer, timing of transfer

- 2.2.2. In-hospital transport
  - 2.2.2.1. Effectively manages time to achieve best outcomes for all In the x ray room, in OT/ ICU
- 2.3. Take responsibility to ensure continuity of care
  - 2.3.1. Hands over appropriately
    - 2.3.1.1. Identify important issues for handover

History, examination findings, ongoing management, continuation of therapies

2.3.1.2. Keep adequate medical records of

Clinical findings, therapies given, existing problems, anticipated management issues, ongoing therapies

2.3.1.3. Ensure

Hand over between competent similar ranking officers, patients are informed of the changing doctors

- 2.4. Demonstrate ability to recognise risk, prevent or mitigate its effects and manage situation safely
  - 2.4.1. Recognise high risk areas, dangers and prevent further injury
    - 2.4.1.1. For self and rescuers

Continuing environmental dangers

2.4.1.2. For victims/ patients

Effects of injury, secondary factors such as hypoxia

2.4.1.3. For bystanders

Environmental issues

2.4.1.4. Prescribe safely to minimize error and adverse events

Risks of sedatives, risks of respiratory depressants, risks of drug induced allergy, risks of drug interactions

2.5. Understand Medico-legal issues in Emergency Medicine practice

- 2.5.1. *Conscious over the duty of care* 
  - 2.5.1.1. Of the doctor

General Medical Council Guidelines, Sri Lanka Medical Council Guidelines

2.5.1.2. Of the hospital

Ministry of Health Circulars, Free Health Care Policy of Sri Lanka

2.5.2. Works to minimise medical errors

Negligence, systems vs. team and individual failure, preventability, root cause analysis

2.5.3. Aware of appropriate documentation

Medical record components, authenticity for record keeping

- 2.5.4. Understand the principles governing End of life care
  - 2.5.4.1. Medical care Palliative care
  - 2.5.4.2. Documents Death certificates, living wills
  - 2.5.4.3. Brain death Advance directives, coroner
  - 2.5.4.4. Understand the need to refer for organ donation The time constraints of organ retrieval
- 2.5.5. Aware of Forensic issues surrounding hospital admissions Forensic evidence, chain of evidence, drugs and alcohol testing

#### 3. USING BASIC SCIENCE IN THE PRACTICE OF MEDICINE

- 3.1 Provide comprehensive assessment of the undifferentiated patient.
  - 3.1.1 Demonstrate fundamental knowledge of basic sciences applied to emergency medicine
    - 3.1.1.1 Develop an understanding of clinical management issues when applied to acute care situations

Supportive care, definitive care

- 3.1.1.2 The assessment and immediate treatment of common emergencies Subject specific emergencies, trauma
- 3.1.1.3 Demonstrate the capacity to prioritize attention to those patients with

more urgent conditions

Triage, neurological deterioration, uncontrolled haemorrhage, dysrhythmias/infarction affecting cardiac output, poisoning

#### 3.1.2 Recognise physiological and biochemical derangements

- 3.1.2.1 Aware of normal physiological patterns and biochemical patterns Age/ Sex adjusted physiological ranges, Age/ Sex adjust biochemical parameters
- 3.1.2.2 Able to interpret physiological and biochemical abnormalities Recognise limitations of investigations and normal ranges
- 3.1.2.3 Recognise life threatening physiological and biochemical derangements Hypoxia, hypovolaemia, hypoglycaemia, hypotension, hyperkalaemia, hypothermia
- 3.1.3 Learn to recognise own limitations in the provision of emergency care
  - 3.1.3.1 Personal skill

Handled before, needs support

3.1.3.2 Staff skill

Numbers available, ranks/ competence, common vs. rare problem

3.1.3.3 Facilities available Assisting services, equipment

#### 3.1.4 Understand the principles of trauma management.

3.1.4.1 Demonstrate basic trauma management skills

Initial assessment using the ABC approach, full spine immobilization, understand principles of wound care

3.1.4.2 Demonstrate wound care

Basic wound care techniques, basic wound closure techniques, wound dressings

3.1.4.3 Aware of the needs of special wounds

Puncture wounds, bites and stings, blast injury, de-gloving injury, amputations, infected wounds

#### 4. MORAL REASONING AND CLINICAL ETHICS

4.1 Show ability to impose moral reasoning and apply clinical ethics

- 4.1.1 Understand professional behaviour and probity
  - 4.1.1.1 Professional attributes

Patient autonomy, do no harm, equity

4.1.1.2 Maintain privacy and confidentiality

Managing inappropriate attendees, entitled information for police via road traffic act, disclosure in the public interest

#### 4.1.2 Show ability to obtain Informed consent

4.1.2.1 Capacity to consent

Children and adolescents, intellectually disabled, mentally ill, sedated or on the influence of drugs

4.1.2.2 Validity

Implied consent, verbal consent, written consent

4.1.2.3 Refusal to consent

Patient autonomy, safeguarding patient interest when unable to consent, obtaining legal authority for life saving procedures (e.g. blood transfusion for a Jovial Witness)

4.1.2.4 Capable of mounting

Do Not Resuscitate and advanced directives

- 4.1.3 Carry out event reporting without delay
  - 4.1.3.1 Child abuse

Medical issues, legal issues, social issues

4.1.3.2 Domestic violence

Medical issues, legal issues, social issues

4.1.3.3 Infectious diseases

Infection control, isolation/ quarantine, dealing with contacts, dealing with immune-suppressed

- 4.1.3.4 Violent injuries Medical issues, legal issues, social issues
- 4.1.3.5 Coroner Inquest ordering
- 4.1.3.6 Impaired practitioner Medical issues, professional issues
- 4.1.3.7 Medico-legal reports Dealing with police requests, to courts, to insurance

#### 4.1.4 Maintain career and professional development

- 4.1.4.1 Assist others develop through learning CME
- 4.1.4.2 Assessment and appraisal Methods of appraisal and assessment
- 4.1.5 Capable of appropriate patient disposition 4.1.5.1 Discharge

Check list

- 4.1.5.2 Referral Through telephone, in writing
  4.1.5.3 Follow-up Return visits
- 4.1.5.4 Leaving against medical advice Recording the event and reasons
- 4.1.6 Capable of Crisis management
  - 4.1.6.1 Deceased patients

Needs for inquest, informing relatives

- 4.1.6.2 Victim management Medical issues, legal issues
- 4.1.6.3 Violence Recognition of violent behaviour, impending violence, underlying causes, prevention, seclusion, physical restraint, pharmacological restraint, post violence
- 4.1.6.4 Child and elder abuse Neglect, failure to thrive, physical abuse, sexual abuse, psychological abuse

#### 5. SELF-AWARENESS, SELF-CARE AND PERSONAL GROWTH

- 5.1 Clearly recognise and perform to achieve the objectives of Emergency Medicine as a profession
  - 5.1.1 Understand principles of Emergency Medicine
    - 5.1.1.1 Definitions and background Emergency Medicine, Emergency Department, Emergency Physician
    - 5.1.1.2 History of Emergency Medicine Global, Sri Lankan

#### 5.1.2 Demonstrate the capacity to work in multi-professional teams

- 5.1.2.1 Understand clearly the roles and responsibilities of other team members Recognise and respect competencies and diverse roles of team members, participate effectively inter-professional meetings, respect team ethics including confidentiality, demonstrate leadership where appropriate, the importance of the emergency department as the link between the general population and the health care system
- 5.2 Able to review clinical practice, indentify areas for change and implement change through provision of guidelines
  - 5.2.1 Effectively carry out clinical audits related to Emergency Medicine practice 5.2.1.1 Understand clinical audit
    - Design, objectives, data collection and interpretation, implement

improvements in practice

- 5.2.2 Able to conduct research to acquire new knowledge
  - 5.2.2.1 Understand Research methodology
    Sample size, choice of research method, enrolment/ consent, randomization, bias, concealment, validity, gold standard, planning
    5.2.2.2 Understand Evidence based medicine
    - Evidence generation, evidence interpretation, evidence application
- 5.3 Ability to maintain efficient administration
  - 5.3.1 Understand role as an administrator
    - 5.3.1.1 Team work concept Responsibility, leadership, delegation, organization structure, planning, communication
    - 5.3.1.2 Supervision Enhance productivity, quality improvements

#### 6. THE SOCIAL AND COMMUNITY CONTEXTS OF HEALTH CARE

6.1 Understand the role of situations unique to Emergency Medicine:

#### 6.1.1 Death Notification

- 6.1.1.1 For sudden unexpected death Critical illness, intoxicated patients
- 6.1.1.2 Environmental illness / injury Injury prevention, media
- 6.1.1.3 Out–of–hospital Personal Disaster
- 6.1.1.4 Language barrier Use of interpreter

#### 6.1.2 Perform allocated tasks

- 6.1.2.1 Manage time on the shop floor within the shift Working smart
- 6.1.2.2 Meet clinical deadlines Prioritisation

#### 6.1.3 Demonstrate ability liaise with community

6.1.3.1 Effectively deliver information To the patient and family, general practitioner, community agencies, diseases prevention, media 6.1.4 *Demonstrate ability to refer appropriately* 

6.1.4.1 Within hospital staff and specialists Intensive care unit, ambulance staff, operating theatre, wards, pharmacy

#### 7. PROBLEM SOLVING

- 7.1 Demonstrate ability to teach
  - 7.1.1 Informally on the shop floor
    7.1.1.1 Bed-side
    Demonstration, simulation, case discussion
  - 7.1.2 In specified circumstances in a more formal setting

7.1.2.1	Teacher led
	Lectures, tutorials
7.1.2.2	Student led
	Promote self directed learning, case scenarios

- 7.1.3 Demonstrate ability to Select and perform simple audit projects
  - 7.1.3.1 Understand the audit cycle To monitor care delivery, to improve care quality

#### 7.2 Demonstrate ability to resolve common events

- 7.2.1 Aware of the issues surrounding each scenario and involves necessary personnel
  - 7.2.1.1 Deceased patients
    - Police, coroner
  - 7.2.1.2 Violence and agitated behaviour Police, psychologists, social workers
  - 7.2.1.3 Victim management Police, counsellors
  - 7.2.1.4 Child and elder abuse Child protection authority, social worker, guardians, parents
  - 7.2.1.5 Sexual abuse Counsellor, police
  - 7.2.1.6 Neglect
  - Quality assurance unit
  - 7.2.1.7 Psychological abuse Psychologists, psychiatrists

#### 8. LIFELONG LEARNING

8.1 Understand the principles of critical appraisal and research methodology and apply these to acute care situations

#### 8.1.1 *Audit and clinical outcomes*

8.1.1.1 Clinical Audit

Critical review of current practice and comparison against predefined standards, identification of key features of clinical practice allowing relevant lessons to be learnt, identify areas in which knowledge could be improved or is deficient, suggesting the need for research

8.1.1.2 Research Interventional studies, observational studies

#### 8.1.2 *Critical appraisal*

8.1.2.1 Portfolio management

A log of procedures carried out, reflective practice, teaching experience, research and audit involvement, information technology use, ethics and medico-legal issues, professional development activities, peer, patient, community feed back

- 8.1.3 Information management
  - 8.1.3.1 Management of databases Confidentiality, data retrieval
  - 8.1.3.2 Records room Filing systems, document retrieval, storage, security

#### 9. EFFECTIVE COMMUNICATION

- 9.1 Understand modes and methods of effective Communication
  - 9.1.1 With colleagues
    - 9.1.1.1 Referral writing
    - 9.1.1.2 Summarizing
    - 9.1.1.3 Report writing

#### 9.1.2 With Patients and Caregivers

- 9.1.2.1 Use of lay language
- 9.1.2.2 Use of interpreter
- 9.1.2.3 Breaking bad news

#### **10. SPECIFIC COMPETENCIES**

There shall be 3 levels of competencies described in this segment of the curriculum to avoid conflicts of management with that of the specific subject specialist. These competencies shall be;

- A Knowledge + Recognition + Referral B – Knowledge + Recognition + Initial Management + Referral C – Knowledge + Recognition + Management ± Seek advice
- 10.1 Capable of managing emergency clinical scenarios at presentation
  - 10.1.1 Resuscitation (B)
    - 10.1.1.1 Understand the situations in need of resuscitation To normalise physiology, to normalise biochemistry, to achieve normothermia
    - 10.1.1.2 Skilled to conduct effective resuscitation Adequate oxygenation, adequate tissue perfusion, pharmacologic support
    - 10.1.1.3 Post arrest care

Neurological care, maintenance of tissue perfusion, preventing secondary injury, monitoring and effectively managing multi-organ injury, basic skills of non invasive mechanical ventilation, basic skills of invasive mechanical ventilation

- 10.1.2 Recognise and manage different types of shock (B)
  - 10.1.2.1 Cardiogenic shock Myocardial infarction, cardiac dysrhythmia
  - 10.1.2.2 Distributive shock Anaphylactic shock, septic shock
  - 10.1.2.3 Obstructive shock Pulmonary embolism, coarctation
  - 10.1.2.4 Hypovolaemic shock Haemorrhagic shock, dehydration
- 10.1.3 Indentify causes of Coma and institute initial management (B)
  - 10.1.3.1 Aetiology
    - Hypoxia, hypoglycaemia, poisoning, trauma, seizures
    - 10.1.3.2 Initial management Airway, cerebral perfusion, intra cranial pressure
    - 10.1.3.3 Continuing care Monitoring, appropriate investigation, appropriate referral
    - 10.1.3.4 Brain death Criteria, confirmation

- 10.2 Able to assess and offer initial management for major Trauma
  - 10.2.1 Understand principles of management (B)
    - 10.2.1.1 Recognise circumstance leading to major trauma
      - High speed road collision, death of another individual in the same accident
    - 10.2.1.2 Understand mechanisms of injury Direct impact, explosion, hypoxia, haemorrhage
    - 10.2.1.3 Understand scoring systems Injury Severity Score, Glasgow Coma Scale
  - 10.2.2 Capable of mounting Advanced Trauma Life Support (ATLS) (B)
    - 10.2.2.1 Primary survey (ABC approach) Airway maintenance with cervical spine control, breathing and ventilation, circulation and haemorrhage control, disability (rapid
    - assessment of neurological function), exposure to allow full examination 10.2.2.2 Resuscitation phase Rectification of problems identified in primary survey, further practical procedures

such as insertion of chest tube, urinary catheter, NG tube

10.2.2.3 Secondary survey

Head to toe examination to identify other injuries, investigations: radiography and imaging, look for occult injuries

10.2.2.4 Definite care phase

Fracture stabilization, emergency operative intervention, transfer to appropriate units for further management

- 10.2.3 Understand specific initial management issues in trauma (B)
  - 10.2.3.1 Head Injury

Monitoring, reducing level of consciousness, raised ICP, cervical spine

10.2.3.2 Chest Trauma

Flail chest, haemothorax, tension pneumothorax, oesophageal rupture, ruptured diaphragm, lung contusion, pulmonary aspiration, cardiac tamponade, aortic injury

- 10.2.3.3 Abdominal Trauma Ruptured viscera, ruptured internal organs such a liver, spleen etc, kidney trauma, internal haemorrhage
- 10.2.3.4 Pelvic and genito-urinary trauma
  - Bladder injury, urethral injury, testicular trauma
- 10.2.3.5 Spinal Injury

Airway, spinal immobilisation, cord injury, spinal shock

10.2.3.6 Maxillo-facial Trauma

Dento-alveolar fractures, Le Fort facial fractures, nasoethmoidal fractures, zygomatic fractures, orbital 'blow out' fractures, t-m joint dislocation

10.2.3.7 Extremity trauma

Compartment syndrome, crush syndrome

- 10.2.4 Understand orthopedic management principles (B)
  - 10.2.4.1 Type of Fractures Simple, oblique, spiral, comminute, crush, wedge, burst, impacted, avulsion, hairline, green stick, pathological, stress, fracture dislocation
    10.2.4.2 Fracture immobilisation Type of casts, cast associated problems
  - 10.2.4.3 Deformity

Displacing, angulations, rotation

10.2.4.4 Dislocations

Neurovascular compromise, pain relief

- 10.2.4.5 Compound fractures Classification, management
- 10.2.4.6 Soft tissue injuries Sprains strains direct must
- Sprains, strains, direct muscle injuries, haematomas 10.2.4.7 Physiotherapy

Rest, ice, compression, elevation, exercise, formal therapy

- 10.3 Ability to assess and institute initial management of burns
  - 10.3.1 Understand principles of burns care (B)
    - 10.3.1.1 Evaluation Surface area, deep vs. superficial burns, fluid management, pain relief, supportive care
    - 10.3.1.2 Early management special issues Inhalational burns, thermal burns, electrical burns, chemical burns
    - 10.3.1.3 Burns wound care General, gunshot injuries, blast injuries, escharotomy
- 10.4 Ability to assess and institute initial management of muscular-skeletal conditions
  - 10.4.1 Understand etiology based need for urgent action (B)
     10.4.1.1 Upper limb
     Neurological, muscular, vascular, trauma
     10.4.1.2 Lower limb & Pelvis

Neurological, muscular, vascular, trauma

- 10.5 Capable of assessing and instituting initial management of Spinal conditions
  - 10.5.1 Ability to distinguish etiologies (B)
    - 10.5.1.1 Infectious Poliomyelitis, transverse myelitis
      10.5.1.2 Vascular Thrombosis

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10.5.1.3 Trauma

Cervical spine fractures, vertebral injury, spinal cord injury

- 10.5.2 Recognise and manage effects of Spinal cord injury (B)
  - 10.5.2.1 Assessment

Transverse spinal cord syndrome, acute central cervical cord syndrome, acute anterior cervical cord syndrome

- 10.5.2.2 Prevention
  - \* Secondary spinal cord damage
- 10.5.2.3 Management

Autonomic nervous system effects, spinal shock

- 10.6 Assess and institute initial management of Vascular Emergencies
  - 10.6.1 Able to recognise and institute immediate management (B)
    10.6.1.1 Arterial Acute ischemia, vascular injury, thrombosis/ embolism
    10.6.1.2 Venous Venous obstruction, venous thrombo embolism
- 10.7 Assess and institute initial management of abdominal conditions

#### 10.7.1 Manage undifferentiated abdominal pain (B)

- 10.7.1.1 Understand surgical aetiologies Appendicitis, cholecystitis, pancreatitis, peptic ulcer disease, tumours, obstructions, renal calculi, testicular torsion, acute urinary retention
- 10.7.1.2 Understand gynaecological aetiologies Ectopic pregnancy, pelvic inflammatory disease, ruptured/ torsion ovarian cyst
- 10.7.1.3 Understand medical aetiologies Diabetic ketoacidosis, aortic dissection, pneumonia, myocardial infarction, porphyria
- 10.7.2 Manage Haematemesis / malaena (B)
  - 10.7.2.1 Resuscitate

Replete volume, seek assistance

- 10.7.3 Manage anal pain and rectal bleeding
  - 10.7.3.1 Recognise and seek appropriate advice Complications of haemorrhoids, anal fissure, anorectal abscess, venereal proctitis
- 10.7.4 Assess and institute initial management of Urological conditions Sexually Transmitted Disease

- 10.8 Capable of providing appropriate and safe use of anaesthetics and pain relief in the Emergency **Department** 
  - 10.8.1 Institute therapies, understanding the limitations in the Emergency Department (B)
    - 10.8.1.1 Local Anaesthetic Techniques
      - Local infiltration, peripheral nerve blocks
    - 10.8.1.2 Safe Conscious Sedation Analgesics, sedatives
    - 10.8.1.3 General anaesthetic techniques Induction agents, muscle relaxants, inhalational agents
    - 10.8.1.4 Pain management Acute pain, chronic pain, pain scores, methods, drugs, route of administration, adjuncts
- 10.9 Capable of recognition and initial management of Ophthalmological conditions
  - 10.9.1 Understand approach to eye problems (B)
    - 10.9.1.1 History taking
    - Ascertain time and speed of onset 10.9.1.2 Examination

Visual acuity, pupils, eye movements, direct assessment, sub-tarsal examination, visual fields, funduscopy

- 10.9.1.3 Able to use Snellen chart, ophthalmoscope, slit lamp
- 10.9.2 Evaluate specific eye conditions (B)
  - 10.9.2.1 Able to do a presentation specific focussed examination Red eye, painful eye, sudden visual loss
  - 10.9.2.2 Evaluation of External eye conditions Blepharitis, dacryocystitis, conjunctivitis, keratitis, corneal abrasions, amblyopia, ocular burns
  - 10.9.2.3 Evaluation of Anterior pole disorders Glaucoma, uveitis
  - 10.9.2.4 Evaluation of Posterior pole disorders Retinal detachment, vitreous haemorrhage, retinal haemorrhage, optic neuritis
  - 10.9.2.5 Evaluation and management of A penetrating eye injury, a blunt eye injury, corneal trauma, contact lens problems
- 10.10 Capable of recognition and initial management of conditions involving the Ear and throat

10.10.1Understand approach to ear problems (B)10.10.1.1Skills

	Auroscopic examination, clinical hearing tests
10.10.1.2	Ear ache
	Causes and management, perichondritis
10.10.1.3	Ear discharge
	Causes and management- otitis media, otitis externa, mastoiditis,
	CSF otorrhoea, ear bleeding
10.10.1.4	Sudden Deafness
	Causes and management
10.10.1.5	Sudden onset Tinnitus
	Causes and management
10.10.1.6	Vertigo
	Causes and management
10.10.1.7	Facial Palsy
	Causes and management
10.10.1.8	Ear Trauma
	TM perforation, temporal bone fractures, FB in ear
10.10.1.9	Procedures
	Aural toilet/wick insertion, ear syringing

10.11 Capable of recognition and initial management of conditions involving the nose

10.11.1	Understand approach to nose problems $(B)$
10.11.1.1	Skills & procedures
	Examination of nose, reduction of nasal bone fractures, nose packing,
	removal of FB
10.11.1.2	Sinusitis
	Investigation and management
10.11.1.3	Epistaxis
	Causes and management
10.11.1.4	Nasal obstruction
	Causes and management
10.11.1.5	Rhinorrhoea
	Causes and management, CSF rhinorrhoea, allergy
10.11.1.6	FB in Nose
	Presentation and management
10.11.1.7	Nasal bone trauma
	Fracture facial bones, septal haematoma
10.11.2	Understand approach to throat problems $(B)$
10.11.2.1	Skills & procedures
	Examination of pharynx, indirect laryngoscopy, tracheostomy, fibre-
	optic laryngoscopy, bronchoscopy
10.11.2.2	Infections
	Tracheitis, tonsillitis, laryngitis, epiglotitis, peri-tonsillar abscesses,
	retropharyngeal abscess
10.11.2.3	Air way obstructions/ stridor
	Infections/ Ludwig's angina, foreign body, tumours, trauma
10.11.2.4	Bleeding from throat

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	Haemoptysis, post adeno tonsillectomy bleeding
10.11.2.5	Foreign bodies
	Nasal, aural, upper airway, pharyngeal

10.12 Capable of recognition and initial management of conditions involving Head and Neck

10.12.1	Understand approach to head and neck problems & dental disease $(B)$
10.12.1.1	Recognition and initial management of

- Facial pain, headaches, neck swelling and facial swelling, head and neck injuries/tracheal injuries/laryngeal, dysphagia- causes and management
- 10.12.1.2 Procedures Oesophagoscopy, NG feeding, drainage of neck abscess

10.12.2 Capable of recognition and initial management of dental emergencies (B)

10.12.2.1	Trauma to teeth
	Fractures, avulsion, classification and management
10.12.2.2	Bleeding from an extraction socket
	Bleeding diathesis
10.12.2.3	Acute tooth pain
	Pain relief, antibiotics

10.13 Capable of recognition, initial management and early referral of Obstetric emergencies

10.13.1	Understand approach to obstetric problems $(B)$
10.13.1.1	Clearly describe
	Normal pregnancy, high risk pregnancy
10.13.1.2	Recognise complications of pregnancy
	Hyperemesis gravidarum, miscarriage, septic abortion, HELLP syndrome, ante partum
	haemorrhage, fevers, post partum haemorrhage, pelvic infection, mastitis and breast abscess
10.13.1.3	Recognise complications of labour
	Foetal distress, premature labour, premature rupture of membranes, complications of delivery, poor progress of labour, prolapsed cord, rupture/ inversion of uterus, retained products of conception
10.13.1.4	Medical complications of pregnancy
	Pre-eclampsia and eclampsia, epilepsy, thrombo-embolic disease, disseminated
	intravascular coagulation, diabetes crisis, heart disease
10.13.1.5	Drugs in pregnancy
	Terotogenicy, foetal effects, placental barrier, lactation
10.13.1.6	Trauma in pregnancy
	Foetal injury, placental abruption, uterine rupture, amniotic fluid

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#### embolism

10 14	Canable of	of recognition	and initial	management	of G	vnaecological	emergencies
10.14	Capable	JI IECOgintion	anu mnuai	management	UI U	ynaecological	emergencies

10.14.1	Understand approach to Gynecological problems (B)
10.14.1.1	Vagina and vulva
	Vaginitis, ulcers, foreign body, Bartholin abscess
10.14.1.2	Uterus
	Dysmenorrhea, dysfunctional uterine bleeding, tumors
10.14.1.3	Ovaries
	Cysts, tumors
10.14.1.4	Infections
	Pelvic inflammatory disease, herpes simplex
10.14.1.5	Contraception
	Complications, post-coital
10.14.1.6	Sexual assault

10.15 Capable of recognition and initial management of Cardiology conditions

10.15.1	Understand patho-physiology and clinical approach to following cardiac
	related diseases (B)

- 10.15.1.1 Acute coronary syndromes
- 10.15.1.2 SVT, AF
- 10.15.1.3 VT, frequent VE
- 10.15.1.4 Bradyarrhythmias
- 10.15.1.5 Cardiac arrest
- 10.15.1.6 Shock syndromes
  - Cardiac, Hypovolaemic, Septic, Distributive
- 10.15.1.7 Hypertensive crises
- 10.15.1.8 Pericardial effusion and tamponade
- 10.15.1.9 Critical valvular lesions MS, AS, MR, AR
- 10.15.1.10 Pulmonary oedema
- 10.15.1.11 Severe pulmonary hypertension
- 10.15.1.12 Aortic dissection
- 10.15.1.13 Cardiac syncope
- 10.15.1.14 CVA in a cardiac patient on anticoagulants

10.15.2	Understand following	management	issues	in	relation	to	all	conditions
	listed in 10.15.1 above	( <i>B</i> )						

- 10.15.2.1 Related symptoms / signs of each clinical entity
- 10.15.2.2 Patho-physiological correlates
- 10.15.2.3 Components of a quick history and rapid physical examination
- 10.15.2.4 'Point of care' testing
- Timing, Interpretation
- 10.15.2.5 ECG

Diagnostic features, risk stratification

- 10.15.2.6 Telechest
  - Diagnostic features, risk stratification
- 10.15.2.7 2D Echo
- Diagnostic features, risk stratification
- 10.15.2.8 Routine investigations to be done stat
- 10.15.2.9 Immediate management:

First aid – do's and don'ts, making the patient comfortable (pain relief, psychological support, positions etc), therapies to limit pathophysiological process, therapies to limit complications, detection of complications and management, methodology for monitoring during acute phase

- 10.15.2.10 Planning definite management for the next 6 hours
- 10.15.2.11 Methodology of transfer/ transport to a tertiary care centre Precautions, arrangements at receiving centre, knowledge of centres which provide definitive therapy and contact method
- 10.15.3 Demonstrate a selection of essential competencies necessary to effectively manage emergency cardiac conditions (B)
  - 10.15.3.1 Ability to obtain a focussed cardiac history
  - 10.15.3.2 Ability to perform a focussed cardiac physical examination
  - 10.15.3.3 Understand the indications and appropriate use defibrillator/ cardioverter
  - 10.15.3.4 Ability to obtain a standard 12 lead ECG and interpret its findings
  - 10.15.3.5 Ability to interpret a telechest
  - 10.15.3.6 Ability to perform a 2D Echocardiogram and interpret Aortic dissection, pericardial tamponade, MS, AS, AR, MR, myxoma, LV function, severe pulmonary hypertension, (toe – optional)
  - 10.15.3.7 Ability to interpret a thoracic CT
  - 10.15.3.8 Ability to perform a pericardiocentesis
  - 10.15.3.9 Ability to initiate external pace making (trans-venous pacing optional)
- 10.16 Capable of recognition and initial management of Respiratory emergencies

10.16.1	Understand approach to respiratory problems and conditions needing
	urgent attention (B)
10.16.1.1	Upper airway obstruction
	Croup, epiglottis
10.16.1.2	Lung parenchymal diseases
	Acute lung injury, pneumonia, ARDS
10.16.1.3	Obstructive airway disease
	Chronic obstructive airway disease, asthma
10.16.1.4	Restrictive lung problems
	Pneumothorax, pleural effusions
10.16.1.5	Miscellaneous
	Disorders of the chest wall, disorders of the mediastinum, sleep
	apnoea

- 10.17 Capable of recognition and initial management of Neurological Emergencies
  - 10.17.1 Understand approach to acute neurological disease and management (B)
    - 10.17.1.1 Syndromes of Cerebro-vascular accident Anterior cerebral artery, middle cerebral artery, poster inferior cerebellar artery syndrome, lacunar syndrome, mid brain, pontine and brainstem syndromes
    - 10.17.1.2 Headache Indications for CT, MRI, migraine, cluster headache, tension headache, raised intracranial pressure, temporal arteritis
    - 10.17.1.3 Cranial nerve paralysis Facial nerve paralysis, other
    - 10.17.1.4 Altered mental state
      - Comas, acute brain syndrome, dementia, memory disorders
    - 10.17.1.5 Seizures
      Status epilepticus, dystonic reactions
      10.17.1.6 Peripheral neuropathies
    - 10.17.1.6 Peripheral neuropathies Guillan barre syndrome, motor neurone diseases, myasthenia gravis, multiple
      - sclerosis, botulism, para-neoplastic disorders
    - 10.17.1.7 Paraplegia
    - 10.17.1.8 Ability to interpret an EEG
- 10.18 Capable of recognition and initial management of Hepatic and Biliary tract Disorders
  - 10.18.1 Understand approach to acute liver disease and biliary tract disease (B)
     10.18.1.1 Biliary obstruction & Infections Cholelithiasis, acute cholecystitis
     10.18.1.2 Liver injury Acute encephalopathy, acute parenchymal liver disease, chronic parenchymal liver disease
- 10.19 Capable of recognition and initial management of poisoning

10.19.1	Understand general and specific approach to poisoning (B)
10.19.1.1	Risk assessment and prediction of toxicity
10.19.1.2	Management issues
	Emesis, gastric lavage, activated charcoal, cathartics, whole bowel irrigation
10.19.1.3	Antidotes Anti-cholinergic, chelating agents, methylene blue, anti-cyanide therapy
10.19.1.4	Analytical toxicology

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	Drug screening
10.19.1.5	Chemical dependency and substance abuse
	Drug abuse, drug dependence, drug withdrawal, tolerance
10.19.1.6	Poisoning with
	Anti-inflammatory agents and analgesics, antimicrobials, autonomic agents, CNS drugs
	and muscle relaxants, cardio-vascular, environmental (plants), GI agents, industrial toxicology (metals, toxic gases)

10.20 Capable of recognition and initial management of Environmental emergencies

10.20.1	Understand approach to medical conditions induced by environmental
	effects (B)
10.20.1.1	Heat
	Heat stroke, heat stress/ exhaustion, drug related hyperthermia
10.20.1.2	Cold
	Hypothermia, frost bite
10.20.1.3	Venomous bites
	Snakes, spiders, hymenoptera (bees, wasps), jelly-fish
10.20.1.4	Aquatic
	Near drowning, decompression illness
10.20.1.5	Electricity
	Electric shock, lightening strike
10.20.1.6	Aviation
	Acute mountain sickness, high altitude cerebral oedema, high altitude
	pulmonary oedema

10.21 Capable of recognition and initial management of acute renal injury

10.21.1	Understand approach to Renal Disease (B)
10.21.1.1	Aetiologies
	UTI, prostatitis, pyelonephritis, rhabdomyolysis, haemolytic uremic syndrome
10.21.1.2	Metabolic effects
	Hyperkalemia
10.21.1.3	Special situations
	Post renal transplant

10.22 Capable of recognition and initial management of Diabetes and Endocrinology related conditions

10.22.1	Understand approach to endocrine disease (B)
10.22.1.1	Diabetes mellitus
	Diabetic ketoacidosis, hypoglycaemia
10.22.1.2	Other

Acute adrenal insufficiency, myxoedema coma, thyroid storm, pan hypopituitarism

- 10.23 Capable of recognition and initial management of Haematological conditions
  - 10.23.1 Understand approach to hematological derangements (B)
     10.23.1.1 Interpretation of haematological symptoms and signs Haematological investigations, anaemia, abnormal haemoglobins, disorders of
    - haemostasis and coagulation
       10.23.1.2 Therapy

       Anti-platelet agents, anti-coagulation, blood transfusion and component therapy, transfusion reactions

       10.23.1.3 Specific issues

       Acute haemolysis, bone marrow suppression, leukaemias/ lymphomas
- 10.24 Capable of recognition and initial management of Infectious Diseases and Sepsis

10.24.1	Understand approach to sepsis and septic shock $(B)$
10.24.1.1	Sampling for cultures
	Blood, sputum, secretions, urine, tissue
10.24.1.2	Staff protection
	Isolation, vaccination, surveillance
10.24.1.3	Therapy
	Rational antibiotics use

10.25 Capable of recognition and initial management of Dermatology

10.25.1	Understand approach to coute dermotologic conditions $(C)$
10.23.1	Chaerstand approach to acute definationagic conditions (C)
10.25.1.1	Acute on chronic
	Acute psoriasis, autoimmune blistering diseases
10.25.1.2	New localized
	Purpuric and papular rashes, contact allergic dermatitis, nodules,
	pustule, candida
10.25.1.3	New generalized
	Redness only, redness with added colour changes within lesions, redness with blistering or pustule changes within lesions, redness with purpura and palpable lesions, diffuse redness and scaly rashes, erythroderma

10.26 Capable of recognition and initial management of Rheumatology

10.26.1 Understand approach to acute rheumatologic emergencies and able to discriminate articular, peri-articular and non articular syndromes (B)

- 10.26.1.1 Aware of initial management of Acute monoarticular arthritis, gout, acute haemoarthrosis, acute polyarthritis, rheumatoid arthritis, systemic lupus erythematosis, psoriatic arthritis, gonococcal arthritis, rheumatic fever, carpal tunnel syndrome, shoulder pain, Baker's cyst
- 10.27 Capable of recognition and initial management of Paediatrics and Neonatology
  - 10.27.1Understand approach to acute pediatric and neonatal diseases (B)10.27.1.1Initial approach

Dealing with children, dealing with parents, special issues, drug doses, immunisation, venous access, intraosseous infusion

- 10.27.1.2 Specific issues Neonatal resuscitation, paediatric life support, choking from a foreign body, anaphylaxis in children, sudden infant death syndrome, neonatal conditions (e.g. jaundice), infantile skin conditions, purpuric rashes, paediatric ENT problems, stridor, acute asthma, acute bronchiolitis, whooping cough, pneumonia, febrile convulsions, funny turns, status epilepticus, UTI, renal failure, poisoning, abdominal pain in children, inguinal and scrotal swellings, the limping child, painful hip, paediatric trauma
- 10.27.2. *Child abuse (B)* 
  - \* Child Protection
- 10.28 Capable of recognition and initial management of acute Psychiatric conditions

10.28.1	Understand approach to acute psychiatric disease and organic disorders
	that may mimic psychiatric disease (B)

- 10.28.1.1 Assessment and management of Aggressive patient, suicidal patient, homicidal / infanticidal patient, acute psychosis
- 10.28.1.2 Severe Depression
- 10.28.1.3 Patient presenting with deliberate self harm
- 10.28.1.4 Borderline personality disorder
- 10.28.1.5 Dissocial personality disorder
- 10.28.1.6 Drugs and Alcohol intoxication and withdrawal
- 10.28.1.7 Delirium
- 10.28.1.8 Acute Stress Reaction
- 10.28.1.9 Post Traumatic Stress Disorder
- 10.28.1.10 Severe side effects to drugs
  - Neuroleptic Malignant Syndrome, serotonin syndrome, acute dystonia
- 10.28.1.11 Panic attacks
- 10.28.1.12 Catatonia
- 10.28.1.13 Acute medical conditions presenting with psychiatric symptoms
- 10.28.1.14 Compassion fatigue
- 10.28.1.15 Managing a person presenting with acute homelessness

- 10.28.2. *Procedures of Compulsory Admission according to mental health Act(C)*
- 10.29 Demonstrate special Skills in
  - 10.29.1 *Crisis intervention* (*c*)
  - 10.29.2 Breaking bad news (C)
  - 10.29.3 *Management of a Dying patient (C)*
- 10.30 Ability to recognise and manage problem based emergencies

10.30.1.1	Acid Base and Ventilatory disorders
	Respiratory acidosis and alkalosis, metabolic acidosis and alkalosis,
	respiratory and metabolic compensation, anion gap
10.30.1.2	Osmolar gap
	Fluid and Electrolytes

#### 10.31 Knowledge in Disaster Medicine

10.31.1	Understand approach to Disasters and management of environmental
	emergencies(C)
10.31.1.1	Defining
	Classification
10.31.1.2	Disaster planning
	Management, mitigation, response, recovery
10.31.1.3	Roles and responsibilities at disaster site
	Incident command structure, medical, ambulance, police, fire
10.31.1.4	Occupational health and safety issues
	Incident site, emergency department
10.31.1.5	Medical response to terrorist incidents
	Chemical weapons, biological weapons, radiation emergencies, blasts

- 10.32 Capable of appropriate use of laboratory investigations for clinical decision making
  - 10.32.1 Understand the basics of laboratory investigation
     10.32.1.1 Patient preparation and sampling venepuncture, finger prick specimen, anticoagulants, serum separation & effects of various procedures, specimen collection for haematology, biochemistry, microbiology, histopathology, urine

analysis, preparation of patients for investigations, specimen processing, safety aspects in specimen collection and detecting problems in specimen collection

- 10.32.1.2 Clinical Biochemistry specimen collection, transport, processing, manual analytical techniques, blood, urineand body fluid analysis in relation to the biochemical tests, enzymes, enzymes in health and disease, markers of heart disease, renal disease, serum electrolytes, mineral metabolism, thyroid disorder, sex hormones and infertility, tumour markers. Assessment of re-productive status, thyroid function tests, calcium, phosphorous, homeostasis and bone, iron status, inborn errors in metabolisms, special diagnostic tests
- 10.32.1.3 Haematology

Normal blood film and bone marrow film, hypochromic microcytic iron deficiency, macrocytic and megaloblastic, haemolytic anaemia and their laboratory investigation, lab g6pd deficiency, hereditary investigations of spherocytosis, thalassaemia and haemoglobinopathy, disorders of white cells- acute leukaemia, myeloproliferative and chronic disorders, paraproteinaemia, urine and protein electrophoresis

10.32.1.4 Microbiology

Normal flora and collection and transport of specimens, respiratory tract infections, gastrointestinal infections, sexually transmitted infections, central nervous system infections, bacteraemia/infective endocarditis, skin and wound infections, urinary tract infections, ENT and eye infections, infection in the compromised host, antibiotics and antibiotic sensitivity testing , choice of appropriate test in an infective disease, sputum- microscopy, culture, identification of pneumococci, faeces-culture of faeces, blood culture-gram stain and subculture, device for maki method, urine - inoculate

10.32.1.5 Histology

Routine and special stains, immunohistochemistry, morphometry, cytology, collection and transport, fixation cytotechnology, special stains in cytology, frozen sections, electron microscopy

- 10.32.2 Select appropriate investigations for emergency use (Point of Care) and long- term management
  - 10.32.2.1 Blood bank serology

Blood grouping, cross matching, direct comb's test, indirect coomb's test, preparation of blood components, antibody screening, antibody identification, genotyping, Rh antibody titres, cold antibody titre, rare blood groups, problems in grouping and cross matching, HLA typing, Serological tests for Hep B, HIV I&II, CMV anti body tests and PCR tests

10.32.2.2 Haematotechnology Preparation of glassware for haematology, measurement of haemoglobin, pcv, red cell & white cell counts, differential count, blood film preparation & staining, ESR, platelet count, bleeding time, APTT and prothrombin time

- 10.32.2.3 Microbiology Hands on experience in laboratory microbiology, immunology and serology including specimen collection, transport and processing
- 10.32.3 Understand sampling errors
  - 10.32.3.1 Clinical biochemistry Identification of laboratory errors, maintenance quality control charts and interpretations, supervising satellite laboratories and night laboratories, collecting procedure, containers
  - 10.32.3.2 Public health microbiology Microbial hazards relating to food, water and sanitation: sampling transportation and identification of microbial agents
- 10.32.4 Understand limitations in interpretation
  - 10.32.4.1 Quality control, assurance & management Accuracy, precision, external quality programmes, internal quality control, West guard rules, Lever- Jennings charts, Youden plots, quality assurance, quality management, RTQC charts, external quality control, ring trials, documentation, laboratory manuals, accreditation, ISO 9002 and ISO 15189
  - 10.32.4.2 Clinical biochemistry Use of automated biochemistry analyzers, Specimen collection and processing for Special biochemical tests & special urine tests, Special biochemical tests & special urine tests
  - 10.32.4.3 Haematotechnology Quality assurance and quality control in haematology, automated haematology analyzers, blood gas machines, identification of laboratory errors, maintain ace quality control charts and interpretations. supervising satellite laboratories and night laboratories
  - 10.32.4.4 Histology Quality control in histotechnology and cytotechnology, processing small biopsies, Specimen mounting and museum techniques

## Annex 2 Personalized assessment form for Trainees

# MD EMERGENCY MEDICINE – POSTGRADUATE INSTITUTE OF MEDICINE, COLOMBO

Emergency Medicine Rotation (Trainer's name)
Hospital / Unit
Name of the Trainee
Year
Duration
Consultant PGIM appointed Trainer

	Please tick as appropriate	Significantly deficient	Below level expected skill	Adequate Performance	Above average performance	Outstanding performance	Maximum mark	Scored mark
	Clinical Skills (100 marks)							
	Clinical Judgment & Management							
1	Clinical assessment of patients, history taking and examination	2	4	6	8	10	10	
2	Rational use of laboratory investigations	2	4	6	8	10	10	
3	Analysis of problems	2	4	6	8	10	10	
4	Summarizing capability with appropriate weightage to problems/issues	2	4	6	8	10	10	
5	Planning clinical management	2	4	6	8	10	10	
6	Ability to cope with emergencies & complications	2	4	6	8	10	10	
7	Understanding of principles underlying the equipment used	2	4	6	8	10	10	
8	Seeks appropriate consultation	2	4	6	8	10	10	
9	Manual skills	2	4	6	8	10	10	
10	Clinical record keeping	2	4	6	8	10	10	
	Total marks for clinical skills (out of 100)							
	Attitudes/Behaviour (100 marks)							

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1	Supervises and helps juniors, and ready to do service equirements	2	4	6	8	10	10	
2	Effectively communicates with patients & relatives	4	8	12	16	20	20	
3	Communicates and works well with persons of other disciplines	2	4	6	8	10	10	
4	Follows instructions of senior colleagues and follows through	2	4	6	8	10	10	
5	Power of expression oral / written	4	8	12	16	20	20	
6	High standard of punctuality ethics, professional attitudes & reliability	4	8	12	16	20	20	
7	Teaches medical students and other staff	2	4	6	8	10	10	
	Total marks for Attitudes/ Behaviour (out of 100)							
	Knowledge (100 marks)							
1	Has sound theoretical background and knowledge	8	16	24	32	40	40	
2	Reads widely in medical literature	4	8	12	16	20	20	
3	Participates actively in academic discussion	4	8	12	16	20	20	
4	Thinks independently and rationally	4	8	12	16	20	20	
	Total marks for Knowledge (out of 100)							

# Comments - ....

#### Do not hand over to the trainee.

Please return to Director PGIM under confidential cover.

Date.....

Signature.....

Designation/ Official stamp

## Annex 3 PTR Form C of PGIM

	nnex 3 PTR Form C of PGI onfidential	М			PTR FORM	
PGIM	PGIM PTR ASSESSI (This form	MENT O is also avai	F REGISTRARS/ SENI lable in Sinhala and Tamil)	OR REG	GISTRARS	
Name of the Trainee	]	Date of a	assessment (DD/MM/YY)	0 1 0	ear trainnig D 2 O 3 O 4 O 5 C	6
	(You	can rema	ain Anonymous)			
Please indicate your	profession by filling in	one of th	e following circles			
O Consultant	O Registrars	0	SHO or HO	0	Other Specify	
O Allied Health Profe	essional O SR	0	Clerical or Secretarial Staff			

Please mark one of the circles for each component of the exercise on a scale of 1 (extremely poor) to 9 (extremely good). A score of 1-3 is considered unsatisfactory, 4-6 satisfactory and 7-9 is considered above that expected, for a trainee at the same stage of training and level of experience. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect at their stage of training and level of experience. You must justify each score of 1-3 with at least one explanation/example in the comments box, failure to do will invalidate the assessment. Please feel free to add any other relevant opinions about this doctor's strengths and weaknesses.

#### THE PTR IS NOT AN ASSESSMENT OF KNOWLEDGE OR PRACTICAL SKILLS

1. Attitude to staff:	Respects and values cont	ributions of other member	rs of the team
O Don't know	010203	040506	070809
	UNSATISFACTORY	SATISFACTORY	ABOVE EXPECTED
2. Attitude to patien	nts; Respects the rights, c	noices, beliefs and confide	ntiality of patients
O Don't know	010203	040 50 6	070809
	UNSATISFACTORY	SATISFACTORY	ABOVE EXPECTED
3. Reliability and pu	nctuality		
O Don't know	010203	040506	070809
	UNSATISFACTORY	SATISFACTORY	ABOVE EXPECTED
4. Communication s	kills: communicates effec	tively with patients and fa	milies
O Don't know	010203	040506	070809
	UNSATISFACTORY	SATISFACTORY	ABOVE EXPECTED
5. Communication s	kills: communicates effec	tively with healthcare pro	fessionals
O Don't know	010203	040506	070809
	UNSATISFACTORY	SATISFACTORY	ABOVE EXPECTED
6. Honesty and Inte	grity, do you have any co	ncerns? O Yes	O No

0	Don't know	010203	040506	070809
		UNSATISFACTORY	SATISFACTORY	ABOVE EXPECTED
8. 14	eadership skills:	Takes responsibility for o	wn actions and actions of	the team
				Careful and the second s
0	Don't know	O 1 O 2 O 3 UNSATISFACTORY	O 4 O 5 O 6 SATISFACTORY	O 7 O 8 O 9 ABOVE EXPECTED
9. 0	Don't know	O 1 O 2 O 3 UNSATISFACTORY SIONAL COMPETENCE	O 4 O 5 O 6 SATISFACTORY	O 7 O 8 O 9 ABOVE EXPECTED

#### Comments about the trainee (BLOCK CAPITALS PLEASE) - Write in English/ Sinhala/ Tamil

Your Signature:

(You can remain Anonymous)

Please return to the supervising Consaltant .

DO NOT return to the Registrar or Senior Registrar.

To supervising Consultant - Please use this information to give a feedback/counsell the trainee and return this

form to Director PGIM under confidential cover. We are very grateful for your independent and honest rating our all trainees.