"This prospectus is made under the provisions of the Universities Act, the Postgraduate Institute of Medicine Ordinance, and the General By-Laws No. 1 of 2016 and By-Laws No. 2 of 2016 for Degree of Doctor of Medicine(MD) and Board Certification as a Specialist"

# POSTGRADUATE INSTITUTE OF MEDICINE
# UNIVERSITY OF COLOMBO, SRI LANKA

## Prospectus

## DOCTOR OF MEDICINE (MD) AND BOARD CERTIFICATION IN GERIATRIC MEDICINE

*(To be effective from the year 2017)*

## Board of Study in Medicine & Specialty Board in Geriatric Medicine

*BOM Approved – 09.01.2016*
*Senate Approved – 10.08.2016*
*Council Approved – 19.08.2016*

## Contents

## 1. Nomenclature

- Full title: Doctor of Medicine in Geriatric Medicine & Board Certification in Geriatric Medicine
- Abbreviated title: MD in Geriatric Medicine
- University: University of Colombo
- Faculty/ Institute : Postgraduate Institute of Medicine

Departments: Specialty Board in Elderly Medicine which is under the purview of Board of Study (BOS) in General Medicine.

## 2. Background and justification/introduction

The successful completion of training in the MD program in Geriatric Medicine will entitle the trainee to be eligible for Board Certification by the Postgraduate Institute of Medicine as a Specialist in Geriatric Medicine. At present there is no local programme to train a specialist in Geriatric Medicine. As Sri Lanka is a fast ageing nation in the region, the Ministry of Health has identified the need for the development of Geriatric Medicine in the country and this is the first program to be launched by the PGIM for specialization in the field of Geriatrics. The objective of the training program is to ensure that the trainee gains adequate knowledge, skills and attitudes which will enable him/her to manage age-related problems in elderly patients with multiple pathologies and sensitive emotional needs with the utmost competence and care. The trainee is expected to acquire the professional skills to be an effective leader, committed team player and a manager in the provision of health care for elderly persons including health maintenance in the older patient. The trainee is expected to acquire competence necessary to design and conduct research, critically appraise published research and be committed to the practice of evidence-based medicine and continuing professional development.

### 2.1. The role of specialist in Geriatric Medicine

The specialist in Geriatric Medicine that we envisage will lead a multidisciplinary team in providing optimal and quality care according to nationally accepted standards with sensitivity to socio-cultural values and norms and the maintenance of ethical standards. The specialist should provide leadership to one's own team and advocacy and advice to other sectors and services, in both hospital and community settings. The services of the specialist will include provision of hospital and community care.

Specialists in Geriatric Medicine are those with expertise in the diagnosis and management of acute, chronic, complex and multisystem disorders in elderly patients. They conduct a comprehensive assessment of a patient's problems (biomedical and psychosocial). They are competent to provide coordinated care to assist multidisciplinary teams to optimize health outcomes and work in the community, in community based-clinics and in hospitals. The

specialist adopts a scientific approach to the patient as a whole person which includes detailed knowledge of social background, home-based resources, pathophysiology, diagnostics and therapeutics for a broad range of health problems. Their breadth and depth of knowledge make them ideally suited to provide high quality consultant services across a wide spectrum of health and disease. These competencies place them in a unique position to give clinical expertise, teach, advocate and promote healthy ageing and for rights of the elderly in society, and conduct research, particularly where health problems are caused by frailty affecting multiple organ systems requiring integration of multidisciplinary expertise. They provide community and hospital-based care for the elderly.

## 3. Eligibility for entry into the training programme

Prospective applicants who intend to join the MD (Geriatric Medicine) training programme must satisfy the following requirements to be eligible to sit for the selection examination:

1. Hold a medical degree registered with the Sri Lanka Medical Council (SLMC).
2. Complete an internship recognized by the SLMC.
3. Complete one year work experience in Sri Lanka, after internship.
4. Have six (6) months of experience in general medicine as an intern house officer, and/or six (6) months of experience as a full-time medical officer (consecutively or in total), with both in-ward and out-patient care, with first-on-call commitments, under the supervision of a full-time specialist, in general medicine or in cardiology, dermatology, gastroenterology, nephrology, neurology, respiratory medicine, or rheumatology.
5. Produce a medical certificate from a specialist physician to confirm general mental and physical fitness.
6. Comply with any other PGIM regulations.
7. A candidate with a certificate of completion of specialist training from a foreign country may be exempted from the Medicine Selection Examination, provided this is in accordance with the prevailing general regulations of the PGIM. However, such candidate should comply with requirements 1, 2, 5 and 6 above to be eligible to enter the program.

## 4. Selection Examination

The selection examination for MD Geriatrics programme will be the MD Medicine Selection Examination (refer to prospectus for MD (Medicine) for further details). The candidates will be required to indicate their interest in training in MD Geriatrics at time of application for the Selection Examination. They will be selected according to the merit at the performance of the MD Medicine Selection Examination.

## 5. Number to be admitted

The number to be admitted from the candidates who qualify shall depend on the requirements of the Ministry of Health and the training facilities available, as determined by the BOS.

## 6. Introduction to the program

Once a trainee is selected for training at the Medicine Selection Examination, the training programme consists of the following 4 stages:

- Stage 1: registrar training (pre-MD training)
- Stage 2: the MD examination
- Stage 3: senior registrar training (post-MD training)
- Stage 4: Pre-Board Certification Assessment

(Refer to section 9)

The completion of the stages 1-2 of this programme leads to the award of the degree of Doctor of Medicine (MD) in Geriatric Medicine, whereas the completion of the stages 3-4 leads to board certification in Geriatric Medicine. The minimum total duration of the programme is 5 years. This includes the MD (Medicine) in Geriatric Medicine Examination and the Pre-Board Certification Assessment (PBCA).

## 7. Outcomes and Competencies

### 7. 1 Training outcomes at the end of the programme

At the end of the training, the trainee is expected to achieve the following outcomes;

- Provision of care for older people in different settings, including hospitals, residential care facilities, and the community
- Conducting research in Geriatric Medicine
- Training of medical officers, healthcare workers and caregivers in different aspects of Geriatrics
- Fostering team work
- Practicing and promoting positive attitudes towards caring for older people
- Developing managerial and advocacy skills
- Promoting active healthy ageing
- Adhering to correct principles of ethical and legal issues in Geriatric Medicine

### 7.1.1 Provision of care for older people in different settings, including hospitals, residential care facilities, and the community

- To assess, diagnose, treat, and manage acute and chronic illnesses in older people
- To apply principles of internal medicine to the health problems of frail older people with complex co-morbidities
- To discern whether and when to request diagnostic tests and how to interpret results
- To be familiar with the principles of palliative and end of life care
- To recognize the special needs of older people from culturally and linguistically diverse backgrounds
- To offer comprehensive geriatric assessment to elderly patients through the multidisciplinary health and social care team
- To manage the frail elderly (using the domains of physical, mental and social frailty) and plan out further management strategy for follow up
- To organize rehabilitation and follow up of patients after acute and chronic medical conditions
- to organize and give leadership to outreach clinics in the community to screen and assess health issues of the community-based elderly in liaison with medical officers of health and primary care providers
- To provide necessary advice and expertise to daycare centers, elderly homes, nursing homes and houses where the frail elders need care as and when necessary

### 7.1.2 Conducting research in Geriatric Medicine

- To initiate formation of research teams and carry out research projects that would help to provide better care for the elderly in the local setting
- To be conversant with the Information technology including research methodology and data analysis in order to carry out useful clinical research related elderly care

### 7.1.3 Training of medical officers, healthcare workers and caregivers in different aspects of Geriatrics

- To contribute to the education of medical officers, students and other health care workers and to further develop the field of e Geriatric Medicine
- To plan and implement programmes for capacity building of personnel involved in care of the elderly which includes trainees in Geriatric Medicine to doctors, paramedical personnel and caregivers
- To guide community healthcare providers on Geriatric Medicine issues

### 7.1.4 Fostering team work

- Work within teams that provide assessment, rehabilitation, and care of older patients
- To effectively lead the multidisciplinary team providing care, to organize smooth uninterrupted services according to the stipulated management plan

- To liaise and communicate effectively with other clinicians for referrals both ways (to receive referrals as well as to refer for sub specialty care)
- To establish and maintain cordial and respectful relationships with other professional colleagues
- To network effectively with the general practitioners who provide continuing services to a population of people whom they have been following up and organize clinical meetings where they are updated on provision of better services
- To liaise with relevant authorities at all levels for the development and provision of resources to promote increased awareness about elderly health issues of general population in the interest of improving elder health in the community

**7.1.5 Practicing and promoting positive attitudes towards caring for older people**

- To provide care that encompasses concern, companionship, comfort and compassion
- To reinforce good attitudes towards the elderly in keeping with the valued traditions of our rich culture in respecting the elders
- To be sensitive to the spiritual and cultural needs of the elderly
- To promote respect towards the elders, enhance their capabilities and recognize their contribution for a better society

**7.1.6. Developing managerial and advocacy skills**

- Promote strategies for healthy ageing and organize their implementation
- Understand and acknowledge the importance of social, cultural and economic factors that contribute to illness and vulnerability
- To advocate to policy makers regarding all issues concerning the elderly including caregiver impact
- To advocate and establish liaison with other agencies such as social services, housing, voluntary agencies and the private sector involved in the provision of services for elders

**7.1.7 Promoting active healthy ageing**

- To organize health promotion and disease prevention activities for the elderly in liaison with primary care providers and community leaders
- To promote the dissemination of knowledge on healthy ageing

**7.1.8 Adhering to correct principles of ethical and legal issues in geriatric medicine**

- To understand the basic principles and practice ethics in the care of the elderly
- To have a sound knowledge of the legal issues regarding elders' rights, care of the elderly and end-of-life situations.

## 8. Content Areas

The modules and teaching content are as follows.

| | Module | Content |
|---|---|---|
| 1 | Scientific Basis for Geriatric Medicine | Ageing physiology, biology, pathophysiology (frailty, impaired homeostasis), pharmacology in old age, rational prescribing, drug adverse effects, poly-pharmacy, social gerontology, epidemiology of ageing and demographic transition and population structure |
| 2 | Introduction to core areas in Geriatric Medicine | Geriatric history taking skills, communicating with old patient, geriatric syndromes- dementia , delirium, falls, immobility, incontinence, instability, physical examination of elderly, sleep disorders, comprehensive geriatric assessment and multidisciplinary team working |
| 3 | Core areas in General Medicine (Other common conditions in old age) | Cardiovascular problems-hypertension, heart failure, ischaemic heart disease, arrhythmias, peripheral vascular disease<br>Renal disease chronic renal impairment, calculi, acute renal impairment, urinary tract sepsis<br>Respiratory disease like asthma, chronic obstructive pulmonary disease, bronchiectasis, Interstitial lung disease<br>Neurological problems- stroke, Parkinson's disease, other neurodegenerative disorders, metabolic and endocrine problems- diabetes and complications, osteoporosis, thyroid dysfunction etc<br>Rheumatologic problems- osteoarthritis, rheumatoid arthritis, vasculitis, polymyalgia rheumatic, visual and hearing impairment, sensory impairments, ulcers and wounds.<br>Pre-operative assessment of frail older people<br>Tissue viability<br>Gastroenterology, liver, continence |
| 4 | Ethical and legal issues /Professionalism | Ethical issues in geriatric practice, principles of medical ethics, advanced directives, power of attorney, legal enactments in Sri Lanka related to elder care , evidenced-based medicine, end of life care, palliative care, euthanasia, assisted hydration and nutrition, withdrawing and withholding treatments, other medico- legal issues (eg. assessment of mental capacity) |
| 5 | Community Geriatrics and Public Health | Health promotion concept, multi-s sector approach to geriatric care, multidisciplinary team in clinical practice, home care, ambulatory care, organizing elderly care through community participation |
| 6 | Mental health | Common mental health issues in elderly: depression, dementia, delirium, anxiety and other psycho-geriatric issues |

| | | |
|---|---|---|
| 7 | Rehabilitation | Basic principles of rehabilitation, team care approach, management of disability- psychological, physical, hearing etc<br>Rehabilitation after acute and chronic medical illnesses and post -surgery, falls management and mobility enhancement |
| 8 | Healthy ageing and healthy life style | Nutritional problems in old age , exercise, tai-chi , smoking cessation, alcohol avoidance, balanced diet , recreation and spiritual wellbeing, mindfulness and active ageing |
| 9 | Palliative care/ oncology | Cancer management in old age, pain management, chronic illness and palliative care principles. |
| 10 | Critical care | Management of geriatric emergencies in acute setting, management of severely ill old patient in intensive care environment, atypical presentation of illness in old age. |

## 9. Structure of the Training Programme

Once the trainee is selected following the MD medicine selection examination, the pre MD training will consist of 2 ½ years out of which one year will be General Medicine, one year of short appointments and 6 months of Geriatric Medicine training. The post MD training will be for one year locally and 18 months overseas followed by the Pre Board Certification Assessment.

The completion of stages 1-2 of this programme leads to award of the degree of MD in Geriatric Medicine, while completion of stages 3-4 leads to Board Certification in Geriatric Medicine.

### 9.1 Clinical appointment schedule for Pre MD training (Stage 1)

General Medicine - 12months
Geriatric Medicine - 6 months
Specialty clinical appointments -12 months

## 10. Learning Activities during Pre-MD Training

- Registrar training in general medicine, which will be carried out by one supervisor, who is a specialist physician, over a period of 12 months. Registrar training in short appointments, which will be carried out by one supervisor at a time, over a total period of 12 months. The short appointments are as follows:
    - 8 weeks each in cardiology, neurology, psychiatry and rehabilitation medicine
    - 4 weeks each in dermatology, endocrinology, gastroenterology, nephrology, and respiratory medicine

- 6 months in a Geriatric Medicine unit under the supervision of general physicians with a special interest in elderly care

- The learning outcomes of these appointments will be focused on achieving the overall outcomes and learning objectives listed in Section 7. These may be developed and changed from time to time, with regard to changing practices and needs. The candidate will be given a Portfolio at the commencement of the training programme, and it will reflect the prevailing expectations for each appointment.

### 10.1 Types of learning activities

The learning activities during the pre-MD training programme will be as follows:

1. Full-time, hands-on training in the clinical settings in the General Medicine and short appointments, with both in-patient and out-patient work, which includes second-on-call in general medicine, a minimum of 1-in-3 on-calls after regular hours, during public holidays and weekends, under the supervision of the trainer (consultant of the unit). In the in-patient setting, the registrar is responsible for the initial assessment and periodic reassessment of each allocated patient, the institution of emergent, urgent and early management, the conduct of the ward rounds, attending to referrals, the performance of practical procedures appropriate to the patient and relevant to the training, the liaison with other units as appropriate, the maintenance of basic ward organization and efficiency, the practice of appropriate infection control and other patient- and staff-safety procedures, the teaching of medical students and allied healthcare staff/students, the liaison with patients' family members, relatives and bystanders, and the assistance of the trainer in the carrying out of clinical duties, including the conducting of clinical examinations of medical students/graduates and postgraduate trainees. In the out-patient setting, the registrar is responsible for the care of out-patients, including clinic patients, and assisting the trainer in running the clinics efficiently. This training will provide the trainee with the opportunity to receive experiential learning in his/her future work setting in a contextually appropriate manner.
2. Regular ward-based teaching sessions, such as ward classes, case discussions, journal/book clubs and multi-disciplinary meetings, which are organized and/or recommended by the trainer and the Board of Study.
3. Academic teaching, such as academic events conducted by the CCP, Sri Lanka Medical Association and other regional or national clinical or professional societies/associations/colleges.
4. Library-based and web-based learning, including textbooks, manuals, periodicals and scholarly journals.

### 10.2 Scholarly reading/writing

We believe that the specialist physician must be capable of scholarly communication with his/her professional peers. The ability to write effectively in the English language in the style appropriate for scholarly medical journals of an international standard is a must. It will enable the specialist physician to share important facets of his/her professional experience with his/her peers, which is an obligation to one's profession as well as a source of self-satisfaction and recognition by peers.

The Geriatric Medicine registrar is required, and encouraged, to regularly read scholarly medical journals of international standard, such as *Ceylon Medical Journal* ('CMJ'), *New England Journal of Medicine* ('NEJM'), *CME Geriatric Medicine, The Gerontologist, Journal of American Geriatric Society, Clinics in Geriatric Medicine, European Geriatric Medicine Journal, Age and Ageing.* He/she is encouraged to spend about one to two sessions per week 'scanning' these journals for a few important and/or interesting articles, and reading these selected articles fully, if possible at a regular, dedicated time slot in the week. He/she is encouraged having easy and ready access to two dictionaries: an English dictionary (unless his/her general command of English is excellent) and a medical dictionary (such as Stedman's, Butterworth's or Oxford).

This will help achieve several objectives simultaneously: improvement in English literacy (which is essential for obtaining an overseas training placement), familiarization with scholarly writing, updating of medical knowledge, improvement in the quality of patient care and enhanced self-satisfaction.

The programme will support the trainee to achieve these objectives and assess him/her in the following ways:

a) By encouraging the trainee to carry out regular reading as indicated above, through the trainer's supervision, and by assessing this behavior at the in-service training assessment.
b) Programme would be supported by regular training workshops in scholarly writing and publishing, both through the PGIM and the CCP, as well as regional medical faculties and the SLAGM and SLMA.
c) By assessing each trainee's scholarly writing skills, through the Casebook or alternative forms of assessment duly approved by the Board.

## 11. Training Units and Trainers

Accredited by Specialty Board and BOS

## 12. Monitoring progress during pre-MD training

The Portfolio guidelines provided to the registrar at the commencement of training will be used to guide the registrar regarding training requirements, progress achieved, and

discussions regarding the training carried out with the trainer. In addition, the trainee will also need to compile a Casebook based on the clinical experience gathered during the first 24 months of the pre-MD training programme.

### 12.1 The Portfolio (including RITA, WBA and Portfolio viva)

The portfolio (Annex 1) will be maintained by the trainee from the point of entry into the programme until the exit. All entries must be made by the trainee through his/her own initiative, with all necessary details (e.g., patient's BHT number, date and time of teaching/learning activity) and duly and promptly certified by the relevant trainer.

The portfolio will provide documentary proof of learning in the professional setting, such as logs of:

a. common and rare medical conditions, both acute and chronic, seen and managed by the trainee.
b. practical procedures undertaken in accordance with Miller's pyramid.
c. unusual, interesting, instructive or problematic cases or experiences (including discussions with trainer) in the professional setting, in relation to clinical work, administrative or managerial work, and organizational work.
d. presentations, teachings and readings related to clinical work.
e. attendance at formal teaching/learning activities, including teaching sessions, multi-disciplinary sessions, meetings and conferences.

The portfolio will provide documentary proof of workplace-based assessment (WBA), including:

a. Case-based discussions (CBDs) in general medicine and Geriatric Medicine (at least 5 per 18 months).
b. Acute care assessment tools (ACATs) at post-casualty ward rounds and ETU admissions in general medicine and Geriatric Medicine (at least 5 per 18 months).
c. Directly-observed procedures (DOPs).
d. Peer team rating (PTR) assessment (1 each as registrar in general medicine and senior registrar and 1 as Registrar during Geriatric Medicine training).

The portfolio will provide space for the documentation of reflective logs, with a view to encouraging reflective practice.

The portfolio will provide a documentary record of continuous assessments, including:

a. Quarterly self-assessments.
b. Quarterly trainer-trainee discussion on the trainee's progress.
c. Record of in-service training assessments (RITAs) and the learning agreements generated at them. Each registrar in Geriatric Medicine will undergo 3 RITAs (with the

trainer and an external supervisor at each RITA), the first at the end of the first six months, and the second at the end of the second six months third at the end of Geriatric Medicine training. The registrar must obtain a minimum mark of 60% in the third RITA, or if he/she fails to do so, shave a fourth RITA in the fourth six months and obtain a minimum of 60% in it. Registrars who fail to obtain a minimum of 60% in both second and third RITAs are not eligible to sit the MD examination and will be referred to the Board of Study in Elderly Medicine for appropriate remedial action.

d. A Portfolio viva at the end of the last six months of the Geriatric Medicine appointment, which is called the Geriatric Medicine Registrar Portfolio Viva. This will be held with the trainer and an external supervisor (similar to the RITA assessment), and will take approximately 30 minutes. The purpose is to make an overall assessment of the general medicine appointment, identify areas that require further attention, and suggest strategies to address these areas. A clear record of the findings of the assessment and the suggested and agreed actions will be made in the Portfolio, and it is up to the trainee to carry out the agreed actions. There is no 'pass' or 'fail' for this viva, but the record made at the viva will be taken into consideration at the PBCA Portfolio viva to ensure that any identified gaps in training are addressed by the time of board certification.

## 12.2 Case Book

### 12.2.1 The Casebook, and options for exemptions

The trainee must submit a Casebook consisting of 5 case histories, at the completion of 30 months of the registrar training. The 5 cases must consist of 3-4 cases of Geriatric Medicine and 1-2 cases in the finer specialties. Trainees will be provided with the latest guidelines on the preparation of the Casebook, at the commencement of the registrar training (Annex 2).

The case reports must be written out in the format prescribed in the guidelines, duly corrected and approved by the relevant trainer, and submitted along with the fulfillment of any other requirements outlined in the guidelines. In general, we recommend following the formatting and style for case reports prescribed in *Ceylon Medical Journal,* except for the limit on the word count.

The guidelines also provide details of obtaining exemptions for case histories in the Casebook on account of published work, such as case reports, research papers and research letters, in peer-reviewed journals (both in print format and online). An exemption for 1 case is given for each published case report, and an exemption for 2 cases for each original publication; such case reports or research publications must be based on work carried out during the registrar training period. Please note that unpublished work (i.e., free paper presentations or lectures at conferences or meetings) or work published as abstracts or in conference/meeting proceedings do not qualify for such exemption.

All requests for such exemptions must be made in writing to the Board of Study, with all relevant documents as indicated in the guidelines, well in advance of the deadline for the submission of the Casebook. Please note that letters of approval of such exemptions (which are given after the Board of Study has met and approved the exemption) must be submitted along with the Casebook on time.

The procedure for the assessment of the Casebook, including correction and resubmission, is given in the guidelines.

## 13. MD in Geriatric Medicine examination

### 13.1 General aspects

A trainee must fulfill the following requirements to be eligible to sit the MD examination:

- Satisfactory completion of the 36-month pre-MD training programme, with documentary proof of same, including the satisfactory evaluation from all respective trainers (altogether 14 trainers). (Annex 1)
- Satisfactory performance at the RITA.
- Submission of the Casebook or approved exemptions for cases.
- Submission of the up-to-date, completed Portfolio.
- Any other requirements laid down by the PGIM.

The MD examination consists of 3 components: the written component, the clinical component and the viva voce component. The written component is carried out first, and only candidates who obtain a minimum of 50% will be allowed to proceed to the other two components. Candidates who pass the written component (with a minimum of 50%) also receive a limited exemption from having to sit the written component again, so that any candidate who fails in the MD examination may be allowed to re-sit the clinical and viva voce components of the following MD examination/s without having to re-sit the written component. These exemptions are described later.

### 13.2 Examination components

#### 13.2.1 The written component

The written component has the following 4 subcomponents:

**13.2.1.1 Paper 1: Structured essay questions (SEQ).** This Paper consists of 5 SEQs to be answered in 2 hours. Each question will be marked by 2 independent examiners, out of100Marksand awards 200 marks.

It examines the following: core knowledge in medicine and Geriatric Medicine. There will be 2 SEQs from General Medicine two from Geriatric Medicine and one from finer specialties.

**13.2.1.2 Paper 2: Case histories.** This Paper will have 10 questions with equal marks, and is 2½ hours long, and awards 150 marks.

It examines the following: ability to synthesize and analyze information; ability to differentiate between important and non-essential information; interpret pertinent data in order to develop a differential diagnosis for common clinical problems; ability to diagnose atypical presentations of common diseases; and ability to recognize and manage life threatening diseases.

**13.2.1.3 Paper 3: Data interpretation.** This Paper will have 15 questions with equal marks, in 2½ hours, and awards 150 marks.

It examines the following: ability to interpret diagnostic tests; ability to use and interpret investigations in a patient's context; analyze clinical pictures, graphs, ECG and radiological images (except CT, MRI & X-rays); and problem solving exercises.

**13.2.1.4 Paper 4: Slide interpretation.** This Paper consists of 20 projected slides with equal marks, conducted over 1 hour, and awards 100 marks.

It examines the following: ability to recognize signs, appearances and other visual images (including pathology specimens and radiology imagining); diagnostic skills; and background knowledge about the illustrated conditions.

The questions in the written component overall will be blue-printed (see Annexure 6 for the plan). The weightage of the overall marks is as suggested in the above: i.e., SEQs 200 + Case histories 150 + Data interpretation 150 + Slide interpretation 100 = 600, brought down to the final 100 (SEQs 30 , Data interpretation 25%, Case histories 25%, slide interpretation **20 marks**

**To pass the written component, the candidate must obtain a minimum of 50% of this final 100.**

### 13.2.2 The clinical component

The clinical component consists of the following 4 subcomponents: the long case; the short cases; the observed history-taking /communications component.

#### 13.2.2.1 The long case: (Geriatric long case)

The long case will consist of 1 patient, who will be allocated to a candidate for 45 minutes, during which the candidate must take a history, perform a relevant physical examination, and be ready to carry out a comprehensive holistic discussion with two examiners (who are specialist physicians in general medicine) over 20 minutes.

The domains marked will be: data gathering (30%), data interpretation (20%), plan of management (30%), and relevant background knowledge (20%). The mark allocated (independently by the two examiners) will be graded over Clear fail (<40%), Bare fail (40-49%), Bare pass (50-59%) or Clear pass (>60%).The total mark is 100%.

The following aspects will be assessed: Data gathering (history, examination, key findings); analysis of data and approach to a diagnosis; plan of management (comprehensive); and knowledge relating to disease, pathogenesis, treatment, prevention etc.

**13.2.2.2 The short cases:**

This subcomponent consists of 5 Stations: cardiovascular system (1 patient); respiratory system (1 patient); abdomen (1 patient); nervous system (1 patient); and other systems (2 patients from any of: endocrine system, musculoskeletal system, dermatology, fundoscopy). Each Station will last 10 minutes and have two examiners, one of whom is a specialist physician in general medicine and the other is the relevant finer specialist (in the case of the abdomen station, this may be either a gastroenterologist or a nephrologist, irrespective of whether the case is a gastroenterological, nephrological or haematological case; in the case of funduscopy in the other systems' station, it may be a neurologist or a general physician).

The mark allocated (independently by the two examiners) will be graded over Clear fail (<40%), Bare fail (40-49%), Bare pass (50-59%) or Clear pass (>60%). The final total mark is 100%.

The domains examined will be: methodical, systematic, sequential technically perfect technique of examination; eliciting of signs and their absence correctly; interpretation; and patient welfare and comfort and professionalism.

**13.2.2.3 The observed history-taking and communication stations:**

This subcomponent has 2 stations, each with a patient or surrogate, lasting 20 minutes each, and observed by two examiners who are specialist physicians in general medicine. One station will assess history-taking skills, and the other will assess communication skills. The candidate will interact with the patient/surrogate for 14 minutes, followed by a 1 minute-rest, followed by 5 minutes of questioning by the examiner/s.

The mark allocated (independently by the two examiners) will be graded over Clear fail (<40%), Bare fail (40-49%), Bare pass (50-59%) or Clear pass (>60%). The final total mark is 100%.

***The observed history-taking station*** will assess for the following competencies: permission and explanation; open-ended questions; explore presenting complaint; chronological

information; questioning to make a tentative diagnosis; comprehensive (eg. Past/treatment/family/social/occupational histories); tone of voice, non-verbal cues; and thanking the patient.

***The communication station*** will assess for the following competencies: permission and explanation; explore present understanding; tone of voice, non-verbal cues; explanation in simple language; pauses and paces interview; checks understanding; and thanks patient and concludes.

### 13.2.3 The viva voce component

The viva voce component will be of 40 minutes duration, and will be with 2 panels of examiners with each panel having 2 examiners. Each panel will examine a candidate for 20 minutes. The viva will assess the following 4 areas: (a) management of emergencies (b) ethical reasoning in clinical practice (c) knowledge of current literature and recent advances (d) management of chronic diseases.

It will have a structured format; written, standardized scenarios will be given to candidates. Candidates will be tested using predetermined questions and the expected answers will be determined before the examination, with some flexibility allowed.

The mark will be allocated independently by the four examiners. The final total mark is 100%.

## 13.3 Criteria for passing the MD examination

The marking grid for the long case, short cases, observed history-taking, communication skills, and viva voce components will be as follows:

| | |
|---|---|
| Highly unsatisfactory: | 0-29% |
| Clear fail: | 30-39% |
| Bare fail: | 40-49% |
| Bare pass: | 50-59% |
| Clear pass: | 60-69% |
| Excellent: | 70-100% |

The weightage of the component in the final 100 marks is as follows:

- written component: 30%
- clinical component: 50% (long case: 25%, short cases: 25%)
- observed history taking/communication skills: 10%
- viva voce component: 10%.

**The criteria to pass the MD Examination are as follows:**

- **Overall mark must be 50% or more.**
- **And minimum of 50% in the written component.**
- **And minimum of 50% in the clinical component.**

### 13.4 Candidates who fail the MD examination

Candidates who fail the MD examination will be reverted back to their previous post, pending the next available MD examination. The Board of Study will conduct a counseling session for failed candidates after each MD examination, to offer guidance and advice of a general nature. **Exemption from written component:** Candidates who obtain a minimum of 50% in the written component will be allowed to attempt the clinical and viva voce components on four consecutive attempts or over two years from the date of passing the written component with the mark, whichever expires first.

For details regarding re-sitting the examination and counting the number of attempts, etc., please see *PGIM General Regulations and Guidelines*. The maximum number of attempts at the MD clinical and viva components, which must be taken together, is 6. Candidates who have used up 5 of these attempts unsuccessfully will be referred by the Board of Study for mandatory retraining under a consultant physician, as per these regulations.

For details regarding exemption from the written component, please see Section 11.1.1

## 14 Post MD Training

### 14.1 Post MD Training -Learning activities

The senior registrar training in Geriatric Medicine in Sri Lanka will be for a period of one year, and will be provided in a training unit recognized for this purpose by the Board of Study in Medicine. The full period of one year will be supervised by one supervisor/trainer. This will be followed by the mandatory overseas training period, which is for another 18 month.

### 14. 1.1 Portfolio (Annex 2)

The Portfolio will document evidence of learning in the following areas:

- Log of difficult cases and rare medical conditions managed by the trainee.
- Log of experience relating to organizational, administrative, ethical and advocacy issues relating to patients and ward work.
- Log of practical procedures.
- Reflective practice.
- Workplace-based assessment, including 2 CBDs, 2 ACATS, DOPS and 1 PTR assessment.
- Organizing training activities for registrars.
- Log of CPD activities attended.

### 14.1.2 Research project

At the end of this activity, the trainee should:

1. Know the basic steps involved in clinical research or audit.
2. Be able to plan and complete a clinical research project, with due appreciation of the need for scientific validity and ethical principles, and within organizational and financial constraints.
3. Be able to effectively communicate the findings of clinical research to the profession.

#### 14.1.2.1 Timeline

***First quarter (of the senior registrar year):*** submit the research project proposal to the Board of Study in Medicine through the trainer (supervisor), and obtain approval for the proposal.

***Second and third quarters:*** obtain necessary pre-requisites (eg, ethics clearance, funds, permission from hospital committees) and collect data.

***Fourth quarter:*** analyze data and write up the research project report, and submit same to the Board of Study through the trainer.

At the Board of study, the project proposals and reports will be examined and approved, where appropriate, by the committee of regional advisors before they are forwarded to the Board of Study in Medicine.

#### 14.1.2.2 Details

***The research question:*** The project should be on a clinically relevant question that can be researched within the time available (eg, data gathering should be completed in a maximum of 6 months and funding required should not be impractical).

***The research project proposal:*** This should include an introduction with justification; literature review; methods section; plan for data gathering (including study instruments); plan for data analysis; any pilot studies (if necessary); budget and proposed funding sources; a discussion of ethical issues (and ethics clearance, if already obtained) and permission issues; a timeline; bibliography (Annex 3). The proposal submitted to the Board of Study should be already recommended by the trainer and the committee of regional advisors.

***The project report:*** This should include, in addition to the above, any alterations or amendments to the above; the results; discussion; recommendations and conclusions; and documents pertaining to funding, ethics and permissions. The project report must be accepted and approved by the Board of Study (Annex 4).

The Board of Study in Medicine will provide support to the trainee in the following manner:

a. The supervisor/trainer and regional advisor will guide the trainee on a regular basis and also on demand (Annex 5).
b. The PGIM will conduct regular (6-montly), part-time research methodology workshops.

c. The trainee will be actively encouraged and permitted to participate in workshops/meetings organized by other organizations (eg, SLMA, the universities) that deal with research methodology, writing up papers, obtaining funding, making budgets etc.

## 15. Assessment: local senior registrar training

The assessment consists of the following:

- The research project report, which must be approved by the Board of Study in Medicine.
- A portfolio viva, at the end of the local training. This is known as the Geriatric Medicine Senior Registrar Portfolio Viva.
- The supervisor's/trainer's confidential appraisal/report (Annex 6).

## 16. Overseas Training

### 16.1 Overseas training in Geriatric Medicine

The learning objectives of the overseas training are the fulfillment of the overall learning objectives listed in Section 6. The Board of Study in Medicine considers the overseas training opportunity as an important, indispensable component in the training of a postgraduate trainee to the level of proficiency and overall performance that the Sri Lankan public has the right to expect from consultant physicians serving its healthcare needs. In particular, some of the unique characteristics of this learning activity include the following:

- Receiving first-hand, hands-on experience in the manner modern specialist medicine is practiced in centers of excellence in developed countries.
- Gain experience in the use and institution of the latest knowledge and methods, which the trainee can then use and institute as appropriate in the local setting.
- Acquire skills and develop attitudes and confidence in the adoption of patient-centered healthcare and multi-disciplinary team work, which are major needs for Sri Lanka's health care system in the twenty-first century.
- Be able to adapt to the rapid changes in the field of general internal medicine in the coming decades.

The overseas senior registrar training will be for a period of 18 months, and will be carried out in an overseas training center approved for that purpose by the Board of Study.

The trainee should have completed the following requirement before embarking on overseas training:

- Completion of at least 6 months of local training as a senior registrar.
- A satisfactory report of work from the local trainer for the period completed up to that point. (Annex 7)

The trainee must obtain the approval of the Board of Study for the overseas training appointment before embarking on it. The application for the approval must contain the following information:

- The appraisal of the local trainer for the period of senior registrar local training, which must indicate that the trainee is ready to embark on overseas training. The relevant appraisal form is in the Portfolio; however, if the trainee is embarking on overseas training before the completion of local training, a separate appraisal form must be used, which can be obtained from the PGIM.
- The profile of the overseas training unit.
- The job description of the contract offered to the trainee by that unit.
- The offer of job from that unit.

The appraisal of the overseas training will consist of quarterly appraisals by the overseas trainer, in the prescribed form.

## 17. Eligibility for Pre-Board Certification Assessment (PBCA)

The conditions that must be met to apply for the PBCA are as follows:

1. Completion of the required training (Stages 1-3), with satisfactory appraisals from all relevant trainers. This shall include satisfactory completion of Flexible Pre-Board Certification Training Options where appropriate.
2. Approval of the research/audit project report.
3. Submission of the completed Portfolio.
4. Any other requirements that may be prescribed by the PGIM.

### 17.1 Pre-Board Certification Assessment (Annex 8)

#### 17.1.1 Format of PBCA

The PBCA will consist of the following components:

1. A brief ***presentation*** of the overseas or flexible training experience. This shall be made to a panel of 03 examiners appointed by the Board of Study from amongst its membership, and should normally be about 15 minutes long, and will be followed by ***discussion*** by the panel for 15 minutes. The purpose of this assessment is to:
   i. Assess the overseas or flexible training experience.
   ii. Assess the trainee's future vision.

2. A ***portfolio viva.*** This shall be with a panel of 03 examiners appointed by the Board of Study. It will last 30 minutes and will:
   i. Examine the overall adequacy of the training experience, including learning in the professional setting, workplace-based assessments, fulfillment of learning agreements, and actions taken following self-appraisals and previous appraisals.

Any reflective logs and records of reflective practice will also be considered (although not mandatory).

ii. Examine the adequacy of the fulfillment of any learning agreements and the commitment to personal and professional development.

The overall decision of the panel/s will be one of the following categories:

- Successful.
- Unsuccessful, followed by counseling and re-sitting the PBCA after a minimum period of 3 months. If the trainee is successful at this sitting, the date of board certification will be backdated to the date of the first PBCA. If the trainee is unsuccessful at this attempt as well, then a further training (in a unit selected by the Board of Study) of a minimum of 6 months will be prescribed, followed by another PBCA, in which case the date of board certification will the date of the passing PBCA. A trainee who in unsuccessful in such PBCA can be required to re-do further trainings (minimum period of 6 months each) and re-sit PBCAs, provided the trainee can complete the requirements for board certification within the maximum period allowed in *PGIM General Regulations and Guidelines*.

## 18. Board certification

A trainee who has successfully completed the Pre-Board Certification Assessment is eligible for Board Certification as a Specialist in Geriatric Medicine on the recommendation of the Board of Study in Medicine and Specialty Board in Geriatric Medicine.

## 19. Recommended Reading

### Text Books

**1.** KUMAR, P. J., & CLARK, M. L. (2002). *Kumar & Clark clinical medicine*. Edinburgh, Saunders.
2.GAWANDE, A. (2014) *Being mortal : medicine and what matters in the end.* New York : Metropolitan Books, Henry Holt and Company.
3. BIGGS, S. et al.( 2003) *Social Theory, Social Policy and Ageing*. Open University Press
4. BOWKER, L. et al. (2006) *Oxford Handbook of Geriatric Medicine* . Oxford University Press.
5. FINCH, C.E. et al. eds. (2001) *Handbook of the Biology of Aging*. Academic Press Inc.
6. GRIMLEY EVANS, J. et al. (2003) *Oxford Textbook of Geriatric Medicine*. Oxford University Press.
7. STUART-HAMILTON, I. (2006) *The Psychology of Ageing: An Introduction*. 4th Ed. London Jessica Kingsley
8. TALLIS, R.C. and FILLIT,H.M. (eds) ( 2002*). Brocklehursts' Textbook of Geriatric Medicine and Gerontology*. 6th Ed. Edinburgh: Churchill Livingstone.
9. WOODFORD, H. (2007) *Essential Geriatrics*. Radcliffe Publishing Ltd.
10. WOODS, B. and CLARE, L. (eds) (2008) *Handbook of the Clinical Psychology of Ageing*. 2nd Ed. Wiley Blackwell.
11. BURNS, A., LAWLOR, B. and CRAIG, S. (2003) *Assessment Scales in Old Age Psychiatry.* 2nd Ed. London, Taylor and Francis 2003 ISBN 1-84-1841684
12. BURNS, A., DENNING, T. and LAWLOR, B*. (*2002) *Clinical Guidelines in Old Age Psychiatry.* London, Martin Dunitz. ISBN 1-84184-029-7
13. HODGES. J.R. (2007) *Cognitive assessment for clinicians*. 2nd Ed. Oxford University Press. ISBN 978-0192629760
14. LINDESAY, J., ROCKWOOD K., and MACDONALD, A. (2002) *Delirium in Old Age*. Oxford University Press. ISBN: 0192632752
15. BURNS, A., O'BRIEN, J., and AMES, D. (2005) *Dementia.* London, Hodder Arnold . ISBN: 0340 81203 6
16. CHEW-GRAHAM, C.,A., BALDWIN, R., and BURNS, A. (2008) *Integrated Management of Depression in the Elderly*. Cambridge University Press. ISBN: 978-0521689809
17. GOONARATNA, C. and BALASOORIYA, A. (eds) (2011) *Medicine in the Elderly: Volume* 1. Ananda Press. ISBN 978-955-53646-0-7
18. ATAPATTU, P.M., and GOONARATNA, C. (eds) (2012) *Medicine in the Elderly: Volume* 2. Ananda Press. ISBN 978-955-53646-0-7

19. DENING, T., and THOMAS, A. (eds) (2013) *Oxford Textbook of Old Age Psychiatry.* 2nd Ed. Oxford University Press.

20. RAI and MULLEY. (2007) *Elderly Medicine: A Training Guide*. ISBN 02043103025

### Websites

1. http://www.bgs.org.uk/Age and Society
2. http://www.americangeriatrics.org/

## 20. Contributors

| | |
|---|---|
| Dr. Lalith Wijayaratne | Consultant Rheumatologist |
| Dr Achala Balasuriya | Consultant Physician |
| Dr Dilhar Samaraweera | Consultant Physician |
| Dr Piyusha Atapattu | Consultant Physician and Senior lecturer in Physiology |
| Dr Aindralal Balasuriya | Consultant Community Physician and Senior lecturer in community medicine |
| Dr PandukaKarunanayake | Consultant Physician |
| Dr. Udaya Ranawake | Consultant Neurologist |
| Dr. Padma Gunaratne | Consultant Neurologist |
| Dr Asoka Jayasena | Consultant Otorhinolaryngologist |
| Prof Antoinette Perera | Professor of Family Medicine |
| Prof. Sarath Lekamwasam | Professor of Medicine |
| Prof Saroj Jayasingha | Professor Of Medicine |
| Professor M S A Perera | Senior Professor of Family Medicine |
| Professor Sarath Lekamwasam | Senior Professor of Medicine |

**Annex 1**

**Progress report - For pre-MD training**

Name of Trainee:
Hospital : Trainer:
Period from : to

---

**Performance:** Above Average : A Adequate : B Poor : C

**Clinical Skills**

| | |
|---|---|
| History taking and examination | |
| Diagnosis and treatment planning (Multidisciplinary approach) | |
| Patient management | |
| Laboratory skills | |

**Academic Skills**

| | |
|---|---|
| Theoretical knowledge | |
| Knowledge of current literature | |
| Participation in academic activities | |

**Communication Skills**

| | |
|---|---|
| Demonstrate appropriable communication skills with patients ,parents and others caregivers | |

**General Conduct**

| | |
|---|---|
| Responsibility and conscientiousness | |
| Punctuality | |

**Comments on particular weaknesses and suggested remedies:**

Date:

Signature of Trainer:

## Annex 2

## Portfolio

This portfolio provides a framework for you to gather evidence of the acquisition of the necessary knowledge, skills and attitudes to be a consultant physician (which are encompassed in the outcomes and learning objectives, listed in section 6 of the *Prospectus)*.

This framework consists of 7 sections (of which the first 6 are recommended by the PGIM), namely:

1. Subject expertise
2. Teaching experience
3. Research and audit
4. Ethics and medico-legal issues
5. Information technology
6. Lifelong learning
7. Reflective practice

The evidence you record in this portfolio will be used to assess you at the PBCA, which will use this framework.

### 1. SUBJECT EXPERTISE

In this section, you will be gathering evidence for the acquisition of knowledge and skills in General Medicine and Geriatric Medicine  This acquisition will be built on the significant level of knowledge and skills that you had already acquired as part of your training and preparation for the MD Geriatric Medicine examination.  Therefore, such evidence must demonstrate a more advanced level of achievement than what was demonstrated in *Portfolio for Stage 1*.  This evidence is categorized under the following headings:

1. Advanced reading on important general medicine topics, followed by presentation (e.g., coronary artery disease, cerebrovascular accident, falls, dementia, incontinence, general palliative care, critical care medicine).
2. Advanced reading on medical and Geriatric problems important in Sri Lanka, followed by presentation (e.g., osteoporosis, frailty, Parkinson disease, syncope and dizziness, atrial fibrillation and gait disturbance and balance in old age).
3. Experience in rare, new or difficult clinical problems (e.g., multisystem atrophy, complicated dementia management, heart failure and chronic kidney disease and assessment of cognitive impairment  in community setting)

### 1.1 Advanced reading on general medicine topics:

| Topic/problem | Sources of information | Presentation: time, place, audience | Trainer's signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### 1.2 Advanced reading on topics important in Sri Lanka:

| Topic/problem | Sources of information | Presentation: time, place, audience | Trainer's signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### 1.3 Experience in rare, new or difficult clinical problems:

| Problem | Sources of information and solution/s | Trainer's signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 2. TEACHING EXPERIENCE

You are advised to gain extensive experience in doing clinical, bedside teaching as preparation for your future work as a consultant Geriatrician. This should mainly be for medical students and doctors (intern house officer, post-intern medical officers and registrars), but should also include students in other categories such as nursing, physiotherapy, pharmacy, etc. This will help you to build a wide repertoire of knowledge and teaching skills, as well as give you an important insight into the levels of knowledge of colleagues in various fields and at different levels; this is extremely important for your work as a team leader.

During your teaching, you should make every effort possible to ensure that the teaching is useful and appropriate to their level (i.e., you should aim your teaching to your audience), that it is student-centered and student-friendly, and that they have correctly understood what you had taught.

Some of the activities logged here may overlap with those in sections 1.1 and 1.2 above; this is quite acceptable.

| Date | Audience | Topic | Your reflective thoughts on the teaching event… | Trainer's signature |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 3. RESEARCH AND AUDIT

As a senior registrar in general medicine, it is mandatory that you carry out and complete a research or audit project during the local training period. Details of this task, known as the research/audit project, is given in the *Prospectus,* in section 13.3.3. In this section of the portfolio, you are required to maintain an activity log pertaining to your work in the research/audit project.

**Activity log:**

| Date | Action taken | Result/s, or future action planned | Trainer's signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 4. ETHICS AND MEDICO-LEGAL ISSUES

In this section, you will have an opportunity to identify and reflect on your experience relating to ethical issues in clinical practice and clinical research, as well as expand your knowledge on medico-legal issues. Although these two components are lumped together (as per PGIM requirements), it is important to note that they are not really the same; they continue to be lumped together because medical ethics was traditionally taught by university departments of forensic medicine.

With regard to medico-legal issues, you are advised to find out the latest position on important aspects such as writing a death certificate, statutory requirements where patients are found to have undergone physical and/or mental abuse (e.g., elder abuse) etc.

**Activity log (medico-legal issues):**

| Topic/issue explored | Date | Source of information | Trainer's signature |
|---|---|---|---|
| Writing the cause of death in a death certificate | | | |
| Statutory requirements: Elders act 2009 | | | |
| Statutory requirements: abuse of women | | | |
| Statutory requirements: elderly abuse | | | |
| | | | |

You will doubtless come across numerous occasions when ethical issues became central to the problems your team had to face. Traditionally, medical ethics has been considered under the 4 topics of autonomy, beneficence, non-maleficence and justice, and a fifth topic, viz. vulnerability, has also come into prominence. However, these topics/issues have come up during discussions of medical ethics in the West, and it is possible that you will have to experience other issues as well.

It is important that we develop the skill to *identify* ethical issues when they arise, *update* ourselves on the current thinking on what our responses should be to them, *explore* the issues so that we can also think broadly on them, and *reflect* on our personal experience so that we can deal with them better in the future. Throughout these steps, it is important that we also *discuss* these issues with our colleagues, especially senior, experienced colleagues, so that we can learn from each other's experiences (including mistakes!).

**Activity log (ethical issues):**

| Issue | Sources of information | With whom did you discuss? | What are your reflections? | Trainer's signature |
|---|---|---|---|---|
| | | | | |
| | | | | |
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## 5. INFORMATION TECHNOLOGY

In this section, you should gather evidence of learning and proficiency on IT skills relevant to your clinical practice. This may include skills such as searching for information on the Internet, keeping yourself up to date on new developments (both nationally and internationally), and presentation skills. This section encourages you to *identify* your requirements as they arise in your work, *take* meaningful, effective steps to address them, *incorporate* what you have learnt into practice, and *share* this knowledge with others.

**Activity log:**

| Requirement | Date | Source of information | Change to practice | Trainer's signature |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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## 6. LIFELONG LEARNING

**Participation in conferences and meetings:**

| Name/date of conference/meeting | New learning and/or changed practice | Trainer's signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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## 7. REFLECTIVE PRACTICE

| |
|---|
| *What was the event/experience that stimulated your reflection?* |
| *What was unusual or unexpected about the event/experience?* |
| *Why do you think this unusual or unexpected thing happened?* |
| *What can we learn from this?* |
| *If a similar situation arose again, how can we handle it better?* |

**Contents of the Portfolio**

The MD portfolio shall have sufficient evidence to confirm that the trainee has made the above achievements during the training programme.

**1. Details of the trainee**

Name:
Permanent address:
E-mail address:
Contact phone numbers:
Date of registration as a PGIM trainee:
Date of passing the MD (Medicine) Examination:

***This book contains information that is very important to a doctor who is training to serve as a consultant physician in the future. In case this book is lost and found, please return it to the owner above, or contact the owner, or please return it to:***
***Postgraduate Institute of Medicine, 160 Nandadasa Kodagoda Mawatha, Colombo 07 (telephone +94 11 2696261 or +94 11 2697758).***

**2. Evidence to be included**

The portfolio should contain evidence for the following.

- CPD programmes (lectures, seminars, clinic, and meetings academic sessions) attended. Details of venue, date, time, speaker, organizing body and a short account of what the trainee learnt should be recorded
- Abstracts of papers presented or copies of publications
- Copies of reports written certified by the supervisor
- Copies of letters of reference certified by the supervisor
- Evidence of having followed extra training programmes
- Information technology
- Audits

**3. Details of the training**

Stage 1 of your training programme (pre-MD training or registrar training):

1. An outline of the weekly *training and work plan*
2. A *log of your experience,* and *reflective practice*
3. eg
    a. Common medical emergencies
    b. Diagnostic and therapeutic problems
    c. Interesting or difficult clinical problems

4. *Practical procedures* performed,
5. *Academic activities* attended, *presentations* made and undergraduate
6. Critical evaluation of interesting or important articles read
7. The record of workplace-based assessments:
    a. Mini-Clinical Examinations (mini-CEx): a minimum of 6.
    b. Case-Based Discussions (CBDs): a minimum of 4.
    c. Acute Care Assessment Tools (ACATs): a minimum of 4.
    d. Directly-Observed Procedural Skills (DOPS)
    e. Peer Team Rating (PTR)
8. Special comments (both positive and negative), summaries of quarterly appraisals (self-appraisals and trainer's appraisals), photocopies of Record of In-service Training Assessments (RITAs) and the learning agreements developed following them.
9. Outcome of the Geriatric Medicine Registrar Portfolio Viva.

**IMPORTANT:** Please note that it is *your* responsibility to take the initiative in filling out the relevant parts of this Portfolio. Your trainer will certify each entry only once you have taken the initiative on them.

**4. Examples**

**SUMMARY OF STAGE 1 TRAINING**

| *Appointment* | *Dates* | *Signature and frank of trainer* |
|---|---|---|
| General medicine 12 months Geriatric medicine | 1-6 months | |
| | 7-12 months | |
| | 6 months | |
| Cardiology 8 weeks | | |
| Neurology 8 weeks | | |
| Respiratory medicine 4 weeks | | |
| Rheumatology 8weeks | | |
| Dermatology 4 weeks | | |
| Psychiatry 8 weeks | | |
| Gastroenterology 4 weeks | | |
| Nephrology 4 weeks | | |
| Endocrinology 4 weeks | | |

**CARDIOLOGY**

During the cardiology appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as echocardiography, stress tests, tilt table testing), *and provide 1-in-3 second-on-call for cardiology up to 8 pm on working weekdays (with the cardiology medical officer first-on-call and cardiology senior registrar third-on-call).* The registrar will be exposed to the common and important cardiology problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems

The workplace-based assessment in cardiology will be the following:

- Mini-CEx (minimum 2) on complex valvar heart disease, non-valvar structural heart disease, or pericardial disease.
- CBDs (minimum 2) on ischemic heart disease, chronic heart failure, or cardiac arrhythmias.
- ACATs (minimum 5) on acute left heart failure, cardiogenic shock, acute coronary syndrome, tachyarrhythmia, bradyarrhythmia, or cardiac tamponade.
- DOPs (minimum 2) on cardiac pacing or pericardiocentesis.

**DERMATOLOGY**

During the dermatology appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as punch biopsy, phototherapy, cryotherapy, cauterization). The registrar will be exposed to the common and important dermatology problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in dermatology will be the following:

- Mini-CEx (minimum 2) on examination of patients with leprosy, vasculitis or psoriasis.
- CBDs (minimum 2) on leprosy, bullous disorders or psoriasis.
- DOPs (minimum 2) on skin scraping, nail clipping, Tzank smear etc.

**ENDOCRINOLOGY**

During the endocrinology appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as dynamic tests, retinal photography, foot care sessions, DEXA scans). The registrar will be exposed to the common and important endocrinology problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in endocrinology will be the following:

- CBDs (minimum 2).

**GASTROENTEROLOGY**

During the gastroenterology appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as endoscopy, ERCP, therapeutic

procedures), *and provide 1-in-3 second-on-call for gastroenterology up to 8 pm on working weekdays (with the gastroenterology medical officer first-on-call and gastroenterology senior registrar third-on-call).* The registrar will be exposed to the common and important gastroenterology problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in gastroenterology will be the following:

- Mini-CEx (minimum 2) on nutrition assessment and prognosis assessment chronic liver disease patient.
- CBDs (minimum 2).
- ACATs (minimum 2) on upper gastrointestinal disease bleeding, hepatic encephalopathy or acute colitis.

**NEPHROLOGY**

During the nephrology appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as CKD counselling, transplant meeting), *and provide 1-in-3 second-on-call for nephrology up to 8 pm on working weekdays (with the nephrology medical officer first-on-call and nephrology senior registrar third-on-call).* The registrar will be exposed to the common and important nephrology problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in nephrology will be the following:

- CBDs (minimum 2) on nephrotic syndrome, AKI, RPGN or CKD.
- ACATs (minimum 2) on dialysis prescription.
- DOPs (minimum 2) on internal jugular and/or femoral vein access.

**NEUROLOGY**

During the neurology appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as clinical neurophysiology, neuroradiology meetings, neurorehabilitation), *and provide 1-in-3 second-on-call for neurology up to 8 pm on working weekdays (with the neurology medical officer first-on-call and neurology senior registrar third-on-call).* The registrar will be exposed to the common and important neurology problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in cardiology will be the following:

- Mini-CEx (minimum 2) on epilepsy, spinal cord disease, cranial nerve disease, cognitive impairment, or space-occupying lesion.
- CBDs (minimum 2) on acute central nervous system (CNS) infection, peripheral neuropathy, or chronic encephalopathy.
- ACATs (minimum 3) on stroke, subarachnoid hemorrhage, acute CNS infection, epileptic status, or impending respiratory failure.

**PSYCHIATRY**

During the psychiatry appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as electroconvulsive therapy sessions, psychotherapy sessions). The registrar will be exposed to the common and important psychiatry problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in psychiatry will be the following:

- Mini-CEx (minimum 2) on mental state examination and cognitive impairment assessment etc.
- CBDs (minimum 2) medically unexplained symptoms, substance use or depression etc.

**RESPIRATORY MEDICINE**

During the respiratory medicine appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as bronchoscopy, medical thoracoscopy, lung function tests, and chest ultrasound), *and provide 1-in-3 second-on-call for respiratory medicine up to 8 pm on working weekdays (with the respiratory medicine medical officer first-on-call and respiratory medicine senior registrar third-on-call).* The registrar will be exposed to the common and important respiratory medicine problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in cardiology will be the following:

- Mini-CEx (minimum 2) on chronic breathlessness, hemoptysis, or pulmonary fibrosis.
- CBDs (minimum 2) on tuberculosis, drug-induced hepatitis, lung cancer, occupational lung disease, or lung disease in systemic disease.
- ACATs (minimum 2) on massive hemoptysis and ICU referrals.

**RHEUMATOLOGY**

During the rheumatology appointment, the registrar will be required to attend regular ward rounds, clinics and ancillary sessions (such as procedure sessions). The registrar will be exposed to the common and important rheumatology problems, both acute and chronic, during these activities, and will receive bedside teaching as well as small group discussions on these problems.

The workplace-based assessment in cardiology will be the following:

- Mini-CEx (minimum 2) on regional examinations (neck, shoulder, hand, low back, or knee), or clinical assessment tools etc.
- CBDs (minimum 2).
- DOPs (minimum 2) on knee joint injection, knee joint aspiration, or trigger finger injection.

## GENERAL MEDICINE REGISTRAR TRAINING

**Work plan of the Unit and regular learning activities in the Unit and Hospital:**

| *Monday* | *Tuesday* | *Wednesday* | *Thursday* | *Friday* | *Saturday* | *Sunday* |
|---|---|---|---|---|---|---|
| | | | | | | |
| *Lunch time* | | | | | | |
| | | | | | | |

**Medical emergencies personally managed by the trainee (minimum 10):**

| *Patient's name & BHT number* | *Emergency and date of presentation* | *Outcome, lessons learnt and source of learning* | *Trainer's signature* |
|---|---|---|---|
| | | | |
| | | | |

**Diagnostic problems encountered by the trainee (minimum 10):**

| *Patient's name & BHT number* | *Diagnostic problem* | *Outcome, lessons learnt and source of learning* | *Trainer's signature* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Therapeutic problems encountered by the trainee (minimum 10):**

| *Patient's name & BHT number* | *Therapeutic problem* | *Outcome, lessons learnt and source of learning* | *Trainer's signature* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Difficult clinical problems encountered by the trainee (minimum 5):**

| *Patient's name & BHT number* | *Nature of the clinical problem* | *Outcome and lessons learnt* | *Trainer's signature* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Unexpected scenarios in the clinical setting (minimum 3):**

| *Give a brief description of the scenario, and the unexpected issue. Give the time & place.* | *Give a brief description. What happened? What went right? What went wrong? What could you do differently if there was a 'next time'?* | *Trainer's signature* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Basic practical procedures:**

The trainee must be able to correctly and confidently perform the following practical procedures, and to effectively train intern house officers to do them:

| *Procedure* | *Can correctly and confidently perform it (trainer's signature)* | *Can effectively train intern house officers to do it (trainer's signature)* |
|---|---|---|
| Giving IM and SC injections | | |
| Venipuncture and obtaining blood samples correctly | | |
| Inserting an IV cannula aseptically, *and* maintaining it | | |
| Setting up an IV infusion correctly | | |
| Giving an IV drug correctly | | |
| Inserting a NG tube, checking it and maintaining it | | |
| Inserting a urethral catheter and maintaining it | | |
| Nebulization | | |
| Peak flow rate measurement | | |
| Training inhaler technique for a dry powder inhaler | | |
| Training inhaler technique for a metered dose inhaler | | |
| Maintaining a fluid balance chart | | |
| Using a glucometer | | |
| Obtaining a 12-lead ECG | | |
| Medical handwashing | | |
| Setting up a blood transfusion *and* monitoring it | | |
| CPR (BLS) | | |
| Lumbar puncture | | |
| Pleural fluid aspiration | | |
| Ascitic fluid aspiration | | |

**Practical procedures (appropriate models may not be available):**

| *Procedure* | *Describes (trainer's signature)* | *Does on model (trainer's signature)* | *Does on patients (trainer's signature)* |
|---|---|---|---|
| ET intubation | | | |
| CPR (ALS) | | | |
| Insertion of femoral line | | | |
| Insertion of central venous line (subclavian or IJ) | | | |
| Gastric lavage | | | |
| Insertion of PD catheter | | | |
| Hemodialysis prescription | | | |
| Knee joint aspiration and intra-articular injection | | | |
| Pleural biopsy | | | |
| Liver biopsy | | | |
| Renal biopsy | | | |
| Artificial ventilation of a patient | | | |
| Arranging the safe transfer of a patient out of the ward | | | |
| Arranging the safe transfer of a patient out of the hospital | | | |

**Academic activities (regional, national or international) attended (minimum 3):**

| *Event, date and venue* | *Three key new things learnt, which can be applied to practice* | *Trainer's signature* |
|---|---|---|
| | | |
| | | |

**Satisfactory presentations to postgraduate audiences (minimum 5):**

| *Event, date and venue* | *Topic of presentation* | *Trainer's signature* |
|---|---|---|
| | | |
| | | |

**Medical literature that made an impact on the trainee-Unit's practice (minimum 6):**

| *Citation* | *Impact or change produced* | *Trainer's signature* |
|---|---|---|
| | | |
| | | |

**Teaching undergraduate students (medicine or allied health sciences) (minimum 6):**

| Date | Audience | Topic | Trainer's signature |
|---|---|---|---|
| | | | |
| | | | |

**Special comments (commendations, endorsements, warnings, reprimands):**

| Date | Comment | Trainer's signature |
|---|---|---|
| | | |
| | | |

**Quarterly self-assessments:**

| *Number & date* | *Statement following self-assessment* | *Outcome of trainer-trainee discussion* | *Trainer's signature* |
|---|---|---|---|
| | | | |
| | | | |

**Summary of RITAs:**

| *RITA number & date* | *Mark* | *Summary of learning agreements developed* |
|---|---|---|
| | | |
| | | |

**Geriatric Medicine Registrar Portfolio Viva:**

*Date:* *Name/signature of external supervisor:*

| |
|---|
| *Brief summary of findings, both positive and negative:* |
| *Learning agreements agreed by the trainee:* |
| *Action suggested:* |

**Annex 3 : Guidelines for the preparation of the Casebook**

**Introduction**

1. The trainee must submit a Casebook consisting of 5 case histories, 3 months prior to the MD examination (i.e., when half the Geriatric appointment-time has been completed). The 5 cases must consist of 3-4 cases in Geriatric medicine and 1-2 cases from the finer specialties. The cases must be from institutions recognized by the Board of Study in Medicine to which the candidate was attached for training. It is mandatory to have the case records corrected and certified by the relevant supervisor/trainer. Trainees will be provided with the latest guidelines on the preparation of the Casebook at the commencement of the registrar training.
2. The case reports must be written out in the format prescribed below, duly corrected and approved by the relevant supervisor/trainer, and submitted along with the fulfillment of any other requirements outlined in the guidelines. In general, we recommend following the formatting and style for case reports prescribed in *Ceylon Medical Journal,* except for the limit on the word count. Further advice regarding the preparation of the Casebook is given in the Prospectus (see Section 9.2).
3. The guidelines for obtaining exemptions for case histories in the Casebook on account of published work are as follows:
    a. Published work that may qualify for exemption are case reports, case series, original papers on audit or research, and research letters, in peer-reviewed journals (in print format and/or online format).
    b. In case of papers with multiple authorship, the first (principal) author will receive credit for the paper. If the candidate is not the principal author he/she should submit a letter from the chief investigator regarding his/her contribution to the paper before he/she can be given 'credit' for the paper by the evaluators, and the decision of the Board of Study shall be final.
    c. An exemption for 1 case is given for each published case report or case series, and an exemption for 2 cases for each original publication (including each research letter).
    d. Such case reports or research publications must be based on work carried out during the registrar training period.
    e. Please note that unpublished work (i.e., free paper presentations [either oral or poster] or lectures at conferences or meetings) or work published as abstracts or in conference/meeting proceedings do not qualify for such exemption.
    f. The published articles in print/bound form (in the case of print format) and printouts (in the case of online formats) must be submitted.
    g. All requests for such exemptions must be made in writing to the Board of Study in Medicine, with all relevant documents as indicated in the guidelines, well in advance of the deadline for the submission of the Casebook. Please note that letters of approval of such exemptions (which are given after the Board of Study in Medicine has met and approved the exemption) must be submitted along with the Casebook on time.
4. A copy of the submitted Casebook should be retained by the candidate. The Casebook should either be handed over personally or sent under registered cover, to the Senior

Assistant Registrar/ Examinations, on or before the stipulated date together with the payment of the relevant assessment fee.

5. The procedure for the assessment of the Casebook, including correction and resubmission, is given below. The Casebook will be returned to the trainee for corrections, if any, after one month. The trainee is expected to re-submit the corrected Casebook at least four months before the scheduled MD Medicine Examination.
6. The exemptions for submitting a casebook are as follows:
    a. Candidates who sat for the MD (Medicine) examination when mandatory submission of a casebook was not a requirement.
    b. Candidates who were unsuccessful at the MD (Medicine) examination whose casebooks have already been accepted at a previous examination.
7. Assessment: The Board of Assessors will be nominated by the Board of Study in Medicine. If the assessors find that the case record book is not satisfactory and requires further modification, it will be sent back to the candidate for re-correction/modification. The revised case book must be submitted at least four months prior to the MD Medicine Examination. Resubmitted Casebooks will be assessed by all the assessors and a final decision taken. Their decision will be final, and the candidate will not be allowed to sit for the MD Medicine Examination if it is rejected again.

**Assessment of the Casebook:**

The case book would demonstrate the following abilities in the trainee:

1. Ability to write up a case record
2. Ability to read the literature on the topic
3. Ability to use knowledge gained from the literature to discuss problem areas, eg., values of various investigations, diagnosis and differential diagnosis, points of interest in initial management, particular form of therapy carried out with reasons, alternate forms of therapy available and arguments for or against the use of such, treatment, points needing particular emphasis in other forms of therapy used in patient management that one has managed patients continuously with adequate skill from admission to discharge and rehabilitation.

The trainee, therefore, should select a variety of clinical problems preferably with possible different methods of management in each case which would enable adequate discussion. Five selected cases in Medicine should be presented as critical commentaries and not simply as a summary of the particular case. Short commentaries should analyse the clinical presentation and diagnosis and be critical of the management based on the specific problems in the case and should include a relevant literature survey.

**Format of the cases:**

1. SUMMARY

2. CASE RECORD should include –Name of Hospital, Name of Consultant, Case No., Ward, BHT, Name, Age, Address, Date of Admission, Date of discharge/death, Presenting complaint, Subsidiary complaint, History of complaint, Relevant past medical history, family, social, history; Examination findings.

HISTORY & EXAMINATION: 15 MARKS

Enumerate problems in order of priority: Include initial diagnosis (clinical) with reasons and personal, social and other problems relevant to the patient, Investigations carried out, Diagnosis after investigations with reasons for investigation and explanation for any normal/abnormal findings.

DIFFERENTIALDIAGNOSIS ANDINVESTIGATIONS: 15 MARKS

Plan for further management: (include medical and other social/psychological support in managing the patient).

Outcome.

Plan for rehabilitation and for follow- up in your institution and in the community.

MANAGEMENT: 15 MARKS

DISCUSSION: 25 MARKS

(This is a discussion similar to that seen in the Discussion of Case reports in the medical journals)

(a) Brief review of the subject giving references.

(b) Discuss critically clinical diagnosis giving reasons and other related problems you have

identified and why this case was chosen.

( c ) The value of various investigations giving reasons (including cost effectiveness )

( d ) Management: Discuss aspects which need special emphasis, eg. Ventilation, monitoring antibiotics, steroids etc., and discuss deficiencies in the available facilities.

( e ) Discuss plans for rehabilitation and follow up both ideal and practical – and problems faced by the patient and the doctor.

( f ) If there are new ideas on the management of these problems in the literature mention if and quote source..

PRESENTATION, ORIGINALITY, STYLE OF WRITING: 20 MARKS

Use size A4 paper (one side only). Typewritten, double spaced with 1½ inch margins on either side. Illustrations (Photographs) are encouraged. The case books should preferably be bound. It should have a title page, table of contents at the beginning. In the case of the candidate submitting published work, reprints should be submitted for evaluation in a bound form.

BIBLIOGRAPHY – 10 MARKS(References as for the *Ceylon Medical Journal*.)

**Evaluation:**

The candidate should obtain a 60% total for the case book with not less than 50% for any single case. Those obtaining less than 60% will be asked to resubmit the case book with the modifications required. If the total mark obtained is less than 50% after resubmission, that candidate will be not allowed to sit the MD par II examination. Candidates scoring between 50 and 60% on resubmitting the books will be considered by the Board of Study in consultation with their supervisors as to the candidates' eligibility to sit the exam.

Published case reports or papers that are submitted in lieu of case records as described earlier will not be evaluated under this scheme, as they would already have been peer reviewed.

## Annex 4 Guidelines for submission of the research proposal

**Section 1**

1. Name of trainee
2. Name(s) of supervisor(s)
3. Training centre

**Section 2**

1. Project title
2. Background and justification
3. Objectives of study
4. Research plan
    a. Design
    b. Setting
    c. Method(data collection?)should come after sampling
    d. Sample size and sampling techniques
    e. Outcome measures
    f. Statistical analyses and plan of presentation of results
    g. Ethical considerations
    h. Work plan and time lines
5. References
6. Funding for study
7. Signature of trainee

**Section 3**

Recommendation of supervisor(s)

| | |
|---|---|
| Signature of Supervisor 1 | Signature of Supervisor 2 |
| Date | Date |

**Section 4**

Date of submission to PGIM

| | |
|---|---|
| Date of approval by BOS | Signature of Secretary BOS |

**Annex 5**
**Guidelines for submission of the evaluation report by reviewers**

Name of Trainee:
**Training Centre:**
**Supervisor:**
**Name of Reviewer:**
Designation: Official Address:
Tel//Fax:……
Email: ……
**Title of Project:**
……
……

**The two reviewers appointed by the BOS shall use the following guideline and marking scheme to assess the project proposal of the candidate**

1. **Title and Introduction:** Rationale (Justification) – problem identified and quantified. Hypothesis and expected outcome, impact and relevance of the study.
   Comments:
   ……
   **Marks (10):** ……..

2. **Literature Review:** Adequacy (evidence of a systematic search for related. similar, relevant studies)
   Comments :
   ……
   **Marks (10):** ……..
3. **Objectives:** Clearly defined . Relevant and stated in measurable terms.
   Comments :
   ……
   **Marks (10):** ……..

**Method:** Appropriate study design to address the objectives with clear detailed description of subjects, sampling technique and sample size, interventions, data collection and management. The study should be, internally valid and reproducible. Where specific details are available in the literature, reference should be made to the original papers, and comments kept to a minimum. If modifications have been made to the published techniques, these should be described in full. Appropriate statistical tests planned should be mentioned and ethical issues addressed
Comments:
……
……

**Marks (30)** : ……..

5. **Ethical considerations/institution from where ethical approval will be /has been obtained:**
   Comments:
   ……
   ……
   **Marks (10)** : ……..
6. **References:** According to the Vancouver system and relevant to the study. Properly documented in the Bibliography and appropriately cited in the text.
   Comments:
   ……
   **Marks (10)** : ……..

**Recommendation of reviewer:**

- Is the project proposal acceptable? Yes / No
- If No, What corrections are required? ( Attach a separate sheet of paper if necessary)
  ……
  ……

Additional Comments: ……
**Total Marks (80)** : ……..
**Signature: …….. Date:**

**Recommendation of the BOS:**
**……**
**Signature of Chairperson/Secretary: ……**
**Date:……**

**Annex 6**

**Progress reports on research activities**

To be forwarded by the supervisor to the BOS at 6 , 12, 18 and 24 months of Stage 1 of training

1. **Name of trainee:**
2. **Training Centre:**
3. **Supervisor:**
4. **Title of project:**
5. **Description of work carried out to date:**
   ***(To be filled in by trainee): Brief description of progress in conducting the research project and dissertation writing***

---
---
---
---
---
---

Supervisor's comments

6. **Is the work on schedule**? Yes / No
7. **Progress in dissertation writing**: satisfactory / unsatisfactory
8. **Constraints** (if any):
9. **Recommendation of supervisor**:

Signature: Date:

**10. Recommendation of the BOS:**

Signature of Secretary: Date:

## Annex 7 Progress report for post MD training

**NAME OF TRAINEE:** **SPECIALTY:**

**PERIOD OF TRAINING:**

**HOSPITAL AND UNIT:**

**NAME OF THE SUPERVISOR:**

| | Excellent | Good | Average | Poor |
|---|---|---|---|---|
| Theoretical knowledge | | | | |
| Clinical decision making | | | | |
| Clinical skills | | | | |
| | | | | |
| Ability to cope with emergencies and complications | | | | |
| Thinks independently and rationally | | | | |
| Seek appropriate consultations | | | | |
| Ability to follow instructions | | | | |
| Quality of documentation | | | | |
| Dedication to work | | | | |
| Professional attitudes | | | | |
| Reliability | | | | |
| Availability/punctuality | | | | |
| Communication skills | | | | |
| Doctor-patient relationship | | | | |
| Relationship with colleagues | | | | |
| Relationship with other staff | | | | |
| Supervises and help juniors | | | | |
| Teaching of medical students/junior staff | | | | |
| **Other Comments:** | | | | |

**Signature of the Supervisor:**

**Date:**

## Annex 8: Trainer's appraisal for the senior registrar overseas training

**FORMAT FOR PROGRESS REPORT ON TRAINEES - POST MD (STAGE 5 - OVERSEAS TRAINING)**

**NAME OF TRAINEE:** **SPECIALITY:**

**PERIOD OF TRAINING:**

**HOSPITAL AND UNIT:**

**NAME OF THE SUPERVISOR:**

| | Excellent | Good | Average | Poor |
|---|---|---|---|---|
| Operative skills | | | | |
| Ability to cope with emergencies and complications | | | | |
| Thinks independently and rationally | | | | |
| Seek appropriate consultations | | | | |
| Ability to follow instructions | | | | |
| Quality of documentation | | | | |
| Dedication to work | | | | |
| Professional attitudes | | | | |
| Reliability | | | | |
| Availability/punctuality | | | | |
| Communication skills | | | | |
| Doctor-patient relationship | | | | |
| Relationship with colleagues | | | | |
| Relationship with other staff | | | | |
| Supervises and help juniors | | | | |
| Teaching of medical student/junior staff | | | | |
| **Other Comments:** | | | | |

**Signature of the Supervisor:**

**Date:**

**Annex 9**

**Pre-Board Certification Assessment (PBCA)**

To be board certified as a Specialist in Geriatric Medicine in order to practice independently in Sri Lanka, on completion of the in-service training before and after post MD training in Geriatric Medicine, all trainees should go through a Pre-Board Certification Assessment (PBCA), which would be equivalent to the Specialty Certification Examinations in UK and other countries. This requirement was implemented in 2011 through PGIM Director's Memo No: AC/03/2011 dated 16.06.2011.

The format of PBCA is based on adoption of the following broad outcomes for specialist training in Geriatric Medicine:

1. Subject expertise
2. Teaching
3. Research and audit
4. Ethics and medico-legal issues
5. Information technology
6. Life-long learning

**Assessment tool**

The PBCA is based on assessment of a portfolio maintained by the trainee during the period of pre and post-MD training. The contents of the portfolio should encompass all of the above learning outcomes and contain evidence of achievement of these outcomes by the trainee. Although some of these may have been evaluated before the MD examination, the portfolio assessed at the PBCA should mainly contain evidence of achievements during pre and post-MD training, both local and overseas. All sections need not be of equal weight – for example, the section on Subject Expertise may be much more detailed than the others.

**Contents of portfolio**

The contents of the portfolio should be divided into sections according to the outcomes stated above, followed by a final section that contains evidence of reflective practice.

The following list sets out the type of evidence that may be relevant to each section. The details should be determined by each Board.

1. Subject expertise:
    - progress reports from supervisors (essential, should be according to prescribed format)
    - Supervisor feedback on communication skills

- Log of procedures carried out
- Results of any work-place assessments conducted
- Evidence that the trainee has acquired the essential knowledge, skills and competencies related to the Geriatric Medicine, identified by the speciality board, and monitored with regular assessments throughout the period of post-MD training, e.g.mini-CEX, case-based discussions, direct observation of practical skills

2. Teaching
    - Undergraduates
    - Postgraduates
    - Ancillary health staff
3. Research and audit relevant to geriatric medicine
    - Dissertations / theses
    - Research papers published or accepted for publication
    - Abstracts of presentations
    - Clinical audit
4. Ethics and medico-legal issues
    - Completed professionalism observation forms (from integrated learning component of professionalism strand)-
5. Information Technology
    - Participation in training programmes / workshops
    - Evidence of searching for information and application of findings in practice
6. Life-long learning
    - Participation in conferences and meetings
7. Reflective practice
    - narration of at least one learning event experienced by the trainee, in relation to each of the above outcomes, with reflection on what and how the trainee learned from this experience

**Portfolio assessment**

The portfolio should be reviewed at least every 6 months by the local supervisor(s), with regular feedback to the trainee on how the portfolio may be improved. When the trainee is eligible for PBCA, 3 copies of the completed portfolio should be submitted to the PGIM Examinations Branch.

The PBCA should take the form of a final, summative assessment of the trainee's portfolio, carried out by 2 (or 3) independent examiners appointed by the relevant Board of Study or Speciality Board and approved by the Senate of the University of Colombo. The 3rd examiner should be from outside the discipline to improve objectivity.

The trainee should be called for an oral examination, during which he/she will be questioned on the portfolio. The trainee may be required to start with a presentation of 10 – 15 minutes, on the post-MD training if the Board of Study deems it appropriate.

The overall assessment should be based on each of the main sections, which should be assessed as satisfactory or not on an overall basis. It is left to the Boards to decide whether to use a rating scale.

If the examiners are of the view that the trainee's performance is unsatisfactory, and the trainee should not be given immediate Board Certification, the examiners must provide the trainee with written feedback on how the portfolio should be improved in order to reach the required standard. The trainee should then re-submit the portfolio within a specified period of time (up to 3 – 6 months), and face another oral examination based on the re-submitted portfolio. If the trainee is successful at this 2$^{nd}$ oral examination, the date of Board Certification should be backdated as done routinely. If unsuccessful again, the date of Board Certification will be the date of passing the subsequent PBCA following further training for a minimum period of six months in a unit selected by the Board of S

**Annex 10**

# POSTGRADUATE INSTITUTE OF MEDICINE

## UNIVERSITY OF COLOMBO, SRI LANKA

## CASE-BASED DISCUSSION

**Study Programme:** **Date of Assessment:**

**Trainee's Name:** **Training Year:** **PGIM Reg. No:**

**Assessor's Name:** **Designation:**

**Brief summary of Case:**

**Setting:** O In-Patient O Out-Patient O Emergency O Other (please specify)

1. **Medical Record Keeping**( O Not Observed)
   1 2 3 / 4 5 6 / 7 8 9
   UNSATISFACTORY SATISFACTORY SUPERIOR

2. **History taking**( O Not Observed)
   1 2 3 / 4 5 6 / 7 8 9
   UNSATISFACTORY SATISFACTORY SUPERIOR

3. **Clinical findings and Interpretation**( O Not Observed)
   1 2 3 / 4 5 6 / 7 8 9
   UNSATISFACTORY SATISFACTORY SUPERIOR

4. **Treatment/management Plan**( O Not Observed)
   1 2 3 / 4 5 6 / 7 8 9
   UNSATISFACTORY SATISFACTORY SUPERIOR

5. **Follow-up and Future Planning**( O Not Observed)
   1 2 3 / 4 5 6 / 7 8 9
   UNSATISFACTORY SATISFACTORY SUPERIOR

6. **Professionalism**( O Not Observed)
   1 2 3 / 4 5 6 / 7 8 9
   UNSATISFACTORY SATISFACTORY SUPERIOR

7. **Overall Clinical Judgment**( O Not Observed)
   1 2 3 / 4 5 6 / 7 8 9
   UNSATISFACTORY SATISFACTORY SUPERIOR

**Rating Scale:** Nine point rating scale is used. Rating of 4 is defined as 'marginal" and conveys the expectation that with remediation that the trainee will meet the expected standards.

**DESCRIPTORS OF COMPETENCIES DEMONSTRATED DURING CBD**

**Medical Record Keeping:** Understood the need for an accurate and appropriate clinical record

**History taking:** : facilitates patient's telling of story, effectively uses questions directions to obtain accurate information needed, responds appropriately to affect, non-verbal cues

**Clinical Findings and Interpretation:** Was able to describe the key issues and their clinical relevance

**Treatment/Management Plan:** Reviewed and understood the significance of appropriate investigations, requested additional information and was able to formulate a treatment/management plan

**Follow-up and Future Planning:** Was able to formulate a plan for future care based on knowledge of potential problems and their severity.

**Professionalism:** Where relevant, knew and followed appropriate standards, guidelines and protocols**.** Selectively orders/performs diagnostic studies, considers risks/benefits

**Overall Clinical Judgment and Clinical care:** Demonstrates an appropriate, systematic and co-ordinate approach to clinical care. The Case-based Discussion encounter takes approximately 30 minutes, including a 10 minute feedback session.

- The trainee discusses the case(s) with their assessor, including their approach, the results, and reflection on what went well and what they would change in similar situations in the future.
- The assessor may prompt for further information when required.
- The assessor makes notes and rates the trainee's performance on the PGIM Case-based Discussion rating form throughout the session. The assessor provides an overall 'competence' rating based on the outcome of the encounter.
- If a trainee receives a rating which is unsatisfactory, the assessor must complete the 'Suggestions for development' section. The form cannot be submitted if this section is left blank.
- Discussion of the case(s) is immediately followed by feedback from the assessor.
- Feedback should focus on the trainee's clinical decision making skills and include comments on what the trainee did well and areas for improvement.
- If any significant areas for development are identified during the session, the assessor and the trainee should devise a remediation plan.

**Strengths**

……
……
……
……

**Suggestions for development**

……
……
……

**Agreed action:**

……
……
……

**Time taken for discussion ◯ minutes** **Time taken for discussion ◯ minutes**

**Assessor Satisfaction with CBD**

LOW 1 2 3 4 5 6 7 8 9 HIGH

**Trainee Satisfaction with CBD**

LOW 1 2 3 4 5 6 7 8 9 HIGH

Comments:……..……..…….
……
……

**Annex 11**

# POSTGRADUATE INSTITUTE OF MEDICINE

UNIVERSITY OF COLOMBO, SRI LANKA

## Acute Care Assessment Tool (ACAT) Form

**Study Programme:** **Date of Assessment:**

**Trainee's Name:** **Training Year:** **PGIM Reg. No:**

**Assessor's Name:** **Designation:**

| Please TICK (✓) to indicate the standard of the trainee's performance in each area | Not observed | Unsatisfactory | | | Satisfactory | | | Above Expected | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Clinical assessment | | | | | | | | | | |
| Medical record keeping | | | | | | | | | | |
| Investigations and referrals | | | | | | | | | | |
| Management of critically ill patient | | | | | | | | | | |
| Time management | | | | | | | | | | |
| Management of Take / Team working | | | | | | | | | | |
| Clinical leadership | | | | | | | | | | |
| Handover | | | | | | | | | | |
| **OVERALL CLINICAL JUDGEMENT** | | | | | | | | | | |

| | |
|---|---|
| Which aspects were done well? | Suggested areas for development? |
| Trainee's Comments | Agreed action |
| **Assessor**<br><br>Signature: | **Trainee**<br><br>Signature: |

ACAT Instructions:

- A different observer for each assessment
- An ACAT should take no longer than 15 minutes, and this includes the feedback given over the different sections of the ACAT assessment forms

The completed ACAT forms should be entered onto the trainee's 'e' portfolio.

| | |
|---|---|
| Clinical assessment | Quality of History and Examination to arrive at appropriate differential diagnoses |
| Medical record keeping | Quality of recording of patient encounters on the take, and including drug and fluid prescriptions |
| Investigations and referrals | Quality of a trainee's choice of investigations, and referrals over a take period |
| Management of critically ill patient | Quality of treatment given to critically ill patients encountered on the take (assessment, investigations, urgent treatment administered, involvement of appropriate colleagues including senior) |
| Time management | Prioritisation of cases and issues within the take, ensuring sickest patients seen first and the patient's most pressing issues are dealt with initially.<br>Recognition of the quality of a colleague's initial clerking to inform how much further detail is needed. A full repeat clerking is not always needed by a more senior doctor. |
| Management of Take / Team working | Appropriate relationship with and involvement of other health professionals |
| Clinical leadership | Appropriate delegation and supervision of junior staff. |
| Handover | Quality of the handover of care of patients from the take to the relieving team. If patients have been transferred to a different area of care then this applies to the quality of the handover to the new team. |
| OVERALL CLINICAL JUDGEMENT | Quality of the trainee's integrated thinking based on clinical assessment, investigations and referrals resulting in the patients' management plan |

**Annex 12**

# POSTGRADUATE INSTITUTE OF MEDICINE

## UNIVERSITY OF COLOMBO, SRI LANKA

## MINI CLINICAL EVALUATION EXCERCISE

**Trainee's Name:** **Training Year:** **PGIM Reg. No:**

**Assessor's Name:** **Designation:**

**Brief summary of Case:**

**Focus:** O Data gathering O Diagnosis O Therapy O Counselling

**1.Medical Interviewing Skills**( O Not Observed)

1 2 3 / 4 5 6 / 7 8 9
UNSATISFACTORY SATISFACTORY SUPERIOR

2.**Physical Examination Skills**( O Not Observed)

1 2 3 / 4 5 6 / 7 8 9
UNSATISFACTORY SATISFACTORY SUPERIOR

**3.Humanistic Qualities/Professionalism**(O Not Observed)

1 2 3 / 4 5 6 / 7 8 9
UNSATISFACTORY SATISFACTORY SUPERIOR

**4.Clinical Judgment**(O Not Observed)

1 2 3 / 4 5 6 / 7 8 9
UNSATISFACTORY SATISFACTORY SUPERIOR

**5.Counselling Skills**(O Not Observed)

1 2 3 / 4 5 6 / 7 8 9
UNSATISFACTORY SATISFACTORY SUPERIOR

**6.Organisation/Efficiency**( O Not Observed)

1 2 3 / 4 5 6 / 7 8 9
UNSATISFACTORY SATISFACTORY SUPERIOR

**7.Overall Clinical Competence**( O Not Observed)

1 2 3 / 4 5 6 / 7 8 9
UNSATISFACTORY SATISFACTORY SUPERIOR

**Rating Scale:** Nine point rating scale is used. Rating of 4 is defined as 'marginal" and conveys the expectation that with remediation that the trainee will meet the expected standards.

**DESCRIPTORS OF COMPETENCIES DEMONSTRATED DURING MINI-CEX**

**Medical Interviewing Skills**: facilitates patient's telling of story, effectively uses questions directions to obtain accurate information needed, responds appropriately to affect, non-verbal cues.

**Physical Examination Skills**: follows efficient, logical sequence, balances screening/diagnostic steps for problem, informs patient, sensitive to patient's comfort, modesty

**Humanistic/Qualitative Professionalism:** shows respect, compassion, empathy, establishes trust, attends to patient's needs of comfort, modesty, confidentiality, information

**Clinical Judgment:** selectively orders/performs diagnostic studies, considers risks/benefits

**Counselling Skills**: explains rationale for test/treatment, obtains patient's consent, educates/counsels regarding management

**Organization/Efficiency**: prioritize, is timely, succinct

**Overall Clinical Competence**: Demonstrates judgment, synthesis, caring, effectiveness, efficiency

### Which aspects of the encounter were done well?

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### Any suggested areas for improvement?

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### Agreed action:

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### Assessor Satisfaction with Mini-CEX

LOW 1 2 3 4 5 6 7 8 9 HIGH

### Trainee Satisfaction with Mini-CEX

LOW 1 2 3 4 5 6 7 8 9 HIGH

Comments:……..……..…….
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Assessors Signature: …… Trainee's Signature: …….