SAUDI COUNCIL FOR HEALTH SPECIALTIES

SAUDI BOARD FOR FAMILY MEDICINE

MANUAL FOR TRAINING IN FAMILY MEDICINE

KINGDOM OF SAUDI ARABIA
SAUDI COUNCIL FOR HEALTH SPECIALTIES

SAUDI BOARD IN FAMILY AND COMMUNITY MEDICINE

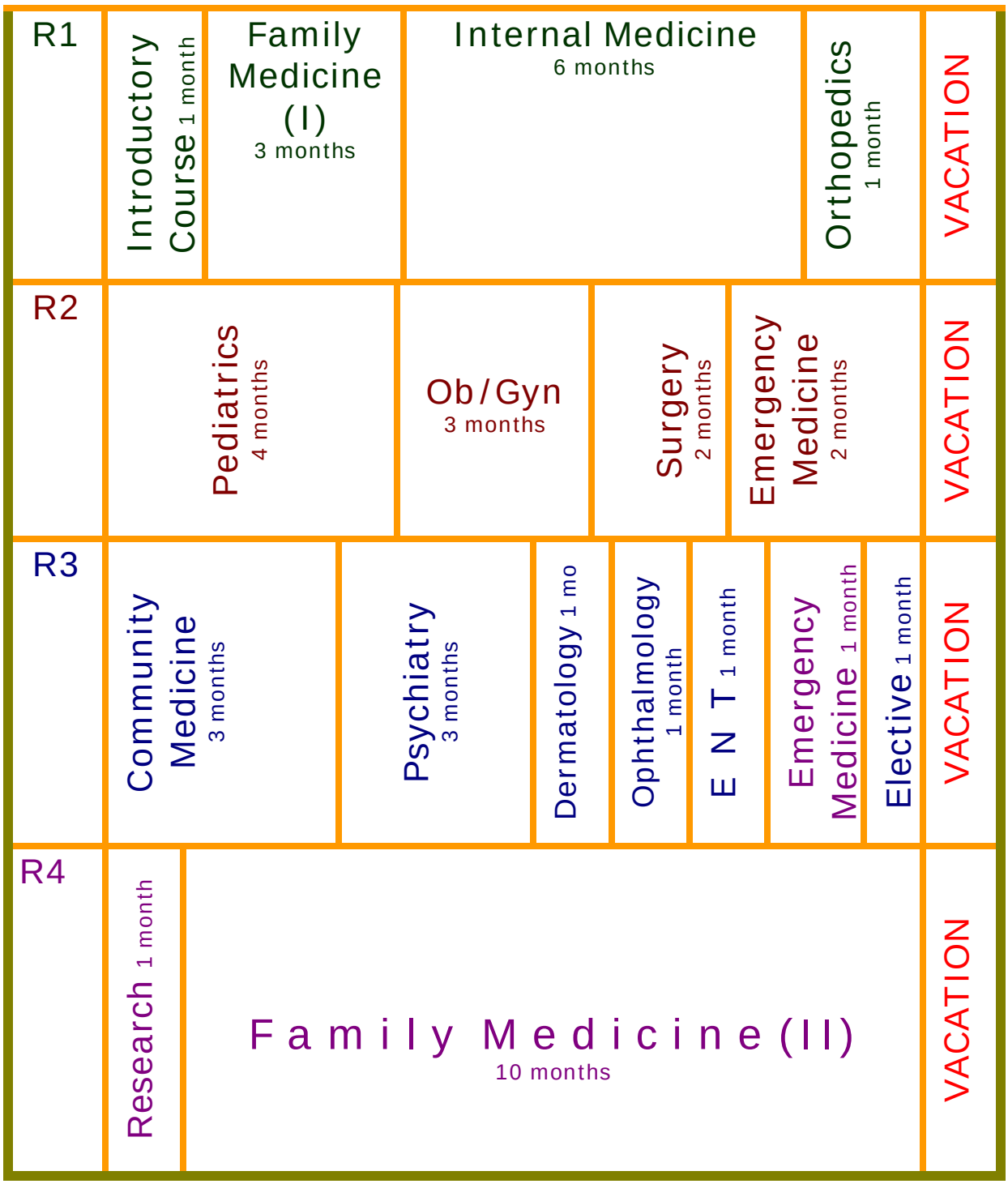
MANUAL FOR TRAINING IN FAMILY MEDICINE

1424 - 2003

C O N T E N T S

TYPICAL SCHEDULE FOR ROTATIONS FOR FAMILY MEDICINE PROGRAMME

	1	2	3	4	5	6	7	8	9	10	11	12



SAUDI BOARD IN FAMILY MEDICINE

INTRODUCTION:

The Kingdom of Saudi Arabia is in great need of very well trained physicians,

Who will work at the level of primary heath care (PHC). The PHC physician is supposed to be the leader of the primary care team in the health centre, at the level of the Directorates of Health Affairs, and at the level of the Ministry of Health. With the wide spread implementation of primary health care programmes, there is an obvious need for higher studies programmes in this specialty. Such programmes will produce competent family physicians who can improve standard of services and training provided, and established a more recognized career structure.

The Aim of the Saudi Board of Family Medicine is to Graduates a Competent Family Physician who should:

1. Adequately and approximately diagnose, manage and treat common problems faced in the primary health care field.

2. Demonstrate the appropriate attitude of a caring physician; dedicated to developing good relationship with patients, families,

and the community, meeting their needs and recognizing their expectations.

3. Provide effective comprehensive and continuing health care for individuals families and the community through the development of excellent problem solving skills.

4. Apply acceptable principles and practices related to health service planning, organization, administration, research, and quality assurance (Q.A.) at the level of the primary health care delivery system.

5. Through a system of referral / or consultation, serve as a point of entry into the secondary / or tertiary health care system, and use these systems effectively and efficiently.

6. Determine the disease patterns of the community and subsequently implement and evaluate the most cost-effective anticipatory care programmes (prevention and/or health education).

7. Promote the autonomy of the individual, the Family and the Community by providing continuous health education aimed at improving health status at these levels.

8. Recognize the social, cultural and psychological factors which influence health and disease and apply principles of medical ethics.

Saudi Board in Family Medicine

Introduction to Family Medicine

Duration: 1 month

Introduction:

It would seem both appropriate and necessary at the very beginning of the

Family Medicine Programme that residents experience an intensive course

focused on the concept and elements of PHC, Family Medicine and Community

Medicine and the distinction between these. This will not only overtake them to

their chosen career and their future role, but also put into perspective the

learning opportunities provided therefore by the entire Saudi Board programme.

The aims of this course are:

To orient the resident of the concepts and methods of the program; to enable

them to appreciate the importance of family and its role in the health care system

and prepare them to what they should expect out of the program and what is

required from them.

Objectives:

At the end of the course, the resident should be able to:

1. Recognize the concepts, principles and elements of PHC and Family and Community Medicine and relate these to the health care in Saudi Arabia.
2. Define the role of Family and Community Medicine in promoting the health of the people.
3. Understand the various aspects of the four year program.
4. Demonstrate an ability to use common principles of communication, relationship and ethics in any professional setting.
5. Show a positive attitude towards the specialty, the profession and other professionals in primary care.
6. State what is expected from him/her in order to succeed in the program, and what she/he should expect out of the program.
7. Understand the various aspects of medical ethics relevant to the practice of medicine.
8. Work as a effective member in primary health care setting

Statement: Encourage self-directed, learner – out Learning and avoid didactic teaching.

Contents: Each session is 2 hours

1. Concepts, principles and methods of PHC and Family Medicine. (3 sessions)
2. Introduction of the residency program, its history, development, content and requirements. (2 sessions)
3. The role of PHC and Family Medicine in promoting the health of the people (2 sessions)
4. The future career of the residents (2 sessions)
5. Introduction to the system of PHC delivery of Saudi Arabia. (1 sessions)
6. Introduction to the role of Family Physician worldwide and in the Kingdom (2 sessions)
7. Introduction to Medical Ethics (5 sessions) [see details of the course]
8. Common health problems in family medicine (7 sessions) e.g hypertension, diabetes mellitus and migraine
9. Medical Consultations: Theory, principles and practice (5 sessions)
10. Communication skills: Principles and practice (2 didactic and 2 practical sessions)
11. Behavioral and social sciences (8 sessions) [see details of the course]
12. Team work and team spirit (2 sessions)
13. Practical assignments (8 sessions) [see the attached questionnaire]
14. The system of primary health care in family medicine. (5 sessions)
    - Medical records (1 session)
    - Referral to secondary care (1 session)
    - Preventive activities
        - health education (1 session)
        - immunization (1 session)

- Maternal and Child Health (1 session)

- Learning how to learn (4 sessions)

Process of Learning:

1. Meeting with teaching staff and trainers to introduce the students to the staff.

2. An open discussion about the programme, its components, process of training and evaluation and to respond to student questions and listen to their views.

3. Lecture with audiovisual aids.

4. Group discussion.

5. Problem oriented seminars.

6. Visits to health centres.

There is a great deal of flexibility in the way this month is conducted as long as a balance between different topics is maintained (i.e the number of sessions per subject).

Evaluation consists of:

1. Continuous assessment (40% attendance, participation, reports)

2. Written examination at the end of the course (60%)

The pass mark is 70% of the aggregate.

Bibliography:

1. John Fry, John Hasler. Primary Health Care, The year 2000.

2. Al-Mazrou Y.Y. Al-Shehri S and Rao M. Principles and Practice of PHC.

3. Barbara Starfield. Primary Care Concept, evaluation and policy 1992.

4. Rakel. Essentials of Family Practice

5. Stott and Davis. Primary Health Care. Bridging the gap between theory and practice.

6. Jarma B. Primary care. Student review 1988.

7. David Morrell. The Art of General Practice Oxford University Press 1991.

8. Frazer R. The clinical methods in general practice.

9. Mc Winniney. Textbook of Family Medicine

10. Murtagh J. General Practice

Journals and Websites:

1. American Family Physician site: www.aafp.org
2. Canadian family Physician
3. American Family Physician Management
4. British Journal of General Practice
5. Family Practice
6. Journal of Family Practice

See also References for Medical Ethics Behavioural Science Courses (Appendix To: Introduction to Family Medicine A and B)

Appendix To: Introduction to Family Medicine

A. THE BEHAVIORAL SCIENCES FOR FAMILY PHYSICIAN

RATIONALE:

The World Health Organization defined health as not merely an absence of disease but as a state of complete physical, mental and social well-being. Therefore the practice of medicine has moved from the biomedical paradigm, which was seeing the health as the absence of biologic damage or injuries, to the biopsychosocial approach. The biopsychosocial approach, deals with the concept of health and illness as related to, or resulted from biological, psychological and social components.

The Family Physician should be equipped with understanding of human bahaviour in health and disease, how people react to illness (illness behaviour), and how this will affect the way he deals with patients.

Also the Family Physician should learn about behavioural therapy within the context of family practice.

OBJECTIVES:

- To help the resident understand and develop the dynamics of the patient-physician relationship, particularly within the medical setting.

- To help the resident develop an understanding of the roles of the family, social, cultural and spiritual context of patients' lives, and to provide some intervention techniques for use where indicated.

- To enable the resident develop an understanding of the roles of individual behaviour on the patients' lives, and to provide some intervention techniques for use where indicated.

- To help the resident acquire skills in professional relationship.

This course is designed to give residents a thorough understanding of the following areas:

- Human behaviour throughout the family life cycle.

- Management of individuals and families who experience life stress issues

- The common behavioural and psychosocial problems seen in family practice e.g., child abuse, and chemical dependencies.
- The effects of acute and chronic illness on individuals and families.

This course content will be covered in the introductory month: Lectures, Seminars Group discussion will be used as a format for instruction.

CONTENTS OF THE COURSE:

1. Human behavior throughout the family life cycle.

2. The effects of acute and chronic illnesses on individuals and families.

3. Illness behaviour.

4. Difficult patient encounter

5. Interpersonal relationship
6. Counseling Skills
7. Stress Management
8. Patient non-compliance

Appendix to: Introduction to Family Medicine B

NB: For better utilization of resources and standardization, this course should be taught at the regional level.

Appendix to: Introduction to Family Medicine
B. ETHICS FOR FAMILY PHYSICIAN

As a practitioner the family physician will provide care for individuals in the context of the family, where his / her ultimate concern must be the welfare of his / her patients. The family physician is required to make health care decisions, sometimes on behalf of his / her patient, Based on both ethical issues and medical parameters.

During training the family physician should be equipped with the ability to understand, comprehend and analyze ethical issues pertinent to common situation at the level of primary health care.

Objectives:

At the end of this course the family physician should be able to:

A. Understand the principles of Islamic medical ethics.

A. Understand his / her role in patient care and doctor patient relationship
in the context of the family.

B.Appreciate the value and dignity of human life.

C. Be committed to ethical practice in each encounter with every patient.

D. Understand the rules and regulations of practicing medicine in Saudi Arabia.

Topics to be covered (10 Sessions)

1. Principles and sources of medical ethics in Islam.
2. Patients and family's rights.
    A. Truth – telling and withholding information
    B. Confidentiality
    C. Informed Consent
3. Patient refusal of treatment
4. Doctor – patient relationship
5. Care of patients with terminal illness
6. Professionalism and doctor – health care professionals relationship.
7. Codes of ethics and Codes of conduct in Saudi Arabia.

Process of Teaching:

All these sessions should be conducted in a problem-based and case- based, self – directed format. The trainees should be provided with a background reading materials and this will form the basis for discussion during the sessions. Lecturing should be kept to the minimum.

Evaluation:

Modified Essay Case – based questions and the end of the course.

Bibliography:

NB: This course should be taught at the regional level.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN FAMILY MEDICINE (I)

Duration: 3 months (first Year)

Pre-requisite: Introduction to Family Medicine

INTRODUCTION:

Early introduction of the resident in Family Medicine Programme to the specialty is important. This rotation will take place during the first two years of the programme. The resident will be introduced to clinical and non-clinical problems in a primary care setting. He will learn approaches to problem solving and management in this setting.

AIMS:

Aims of the rotation:

A. To introduce the resident to the specialty of Family Medicine at an early stage.

B. To help trainee to acquire communication, interviewing and relationship skills.

C. Introduce residents to clinical problem-solving in a primary care setting.

D. Provide comprehensive care for individuals, families and the community.

OBJECTIVES:

By the end of the rotation the trainee is expected to:

1. Properly communicate with and interview patients attending the clinics.

2. Establish good relationship with patients' families' and the community and to meet their needs and expectations as far as possible.

3. Understand and deal with the physical, psychological and social dimensions of the patient's problem.
4. Demonstrate appropriate clinical skills in respect to diagnosis and management of problems commonly presented in a primary care setting.

5. Show ability in health promotion programmes, including health education, maternal and child care and immunization.

6. Understand the organization of primary health care in relation to other levels of care.

7. Show a positive attitude towards the specialty, the profession and other professionals in primary health care and teamwork.

PROCESS OF TRAINING:

During this period the resident will be assigned to a primary health care centre with a trainer. It is preferable that training takes the form of a one-to-one relationship between the teacher and the trainee.

INDUCTION PERIOD:

The first two weeks of the assignment will be devoted to knowing and understanding the atmosphere in which the resident is going to work. This includes knowledge about the health centre, its organization, personnel and methods of teaching and instruction.

CONSULTATION:

The resident will learn, at this stage, the basis of consultation, interviewing and communication skills. He will be referred to the current appropriate

literature on the consultation and asked to produce a model for his / her own personal consultation process.

CLINICAL COMMITMENT:

The resident will work in the health centre under close supervision of the trainer. This should take the form of one-to-one teaching.

TEACHING WILL INCLUDE:

- Clinical tutoring
- Case-presentations and discussion
- Group discussion
- Clinical and non-clinical assignments – follow up of a group of families (family study).
- Individual and group feedback.
- Observation of consultations of senior residents and trainers
- Daily clinical work. (7 clinical sessions)

PREVENTIVE MEDICINE AND PUBLIC HEALTH.

The residents will be introduced to all the preventive activities at the training health centre or any other affiliated centre. This will include maternal and child care, health education and other preventive activities.

The supervision should be as follow:

1. The trainer should be available for the trainees and supervise them very closely for the first two to three week.

2. The supervisor will then be available during the seven clinical sessions to respond to the trainees calls and referrals of the trainees (Residents in R4 can help in the supervision).

EVALUATION:

1. Continuous Assessment (40%)

This will be based on the evaluation of tutors during the period of the competence and performance of the trainee. It should cover the following:

- Attendance and participation

- Assessment of theoretical knowledge, and attitudes
- Assessment of clinical skills
- Assessment of assignments
- Assessment of organizational and management abilities.
- A log book of the cases and activities should be provided by the trainee and reviewed periodically by the trainer.

The residents will be given a feedback in formal session throughout the rotation and areas of strengths and weakness should be discussed.

Satisfactory performance in the continuous assessment in mandatory before the candidate is allowed to sit for the final examination.

2. Final Examination (60%)

This will take the form of:

- Written examination (20%) [MCQ: Problem-based]
- Clinical examination (40%)
- This will take the form of OSCE with 10-15 Stations and at least 2 consultations with patients that will be evaluated by the trainers.

Bibliography:

1. Conn, Rakel and Johnson. Family Practice 1995.
2. Goroll. Primary Care Medicine. An Office Management of Adult Patient.
3. Rakel. Textbook of Family Practice
4. Taylor. Family Practice
5. Murtagh J. General Practice
6. Pendelton. The Consultation
7. Paul Freeling. The doctor – patient relationship.
8. Michael Mcad. Tutorials in General Practice.
9. Farser. Clinical Methods. A General Practice approach 1992.

10. McWinney. Textbook of Family Medicine

11. Bibliography for the course: Introduction to Family Medicine and Family Medicine I.

12. Fowel G. Preventive Medicine in General Practice. Oxford Series.

13. Geofrey Rose. The Strategy of Preventive Medicine

14. Sloane. Essentials of Family Medicine

A TYPICAL WEEK DURING FAMILY MEDICINE (I) ROTATION

	AM	PM
Saturday	Morning Activity (1 hour) Clinic	Clinic
Sunday	Case Discussion Clinic	Mentor (1 hour) Clinic
Monday	Feedback (1 hour) Clinic	HDRC
Tuesday	Case Presentation (1-1/2 hour) Clinic	Activities (Tutorials)
Wednesday	SDL	Feedback (1 hour) Clinic
Thursday	Clinic	

SDL: Self Directed Learning
HDRL: Half-Day Release Course
Number of Clinics: 7-8 per week

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN INTERNAL MEDICINE

DURATION: 6 Months

Introduction:

After their graduation, Family Physicians will be exposed to a variety of acute and chronic medical problems that they should be able to deal with and treat effectively. It should be ensured that all graduates are able to fulfill the responsibilities for medical care of doctors of first and continuing contact.

Objectives:

At the end of the rotation, the trainee should acquire knowledge, skills, and attitudes and demonstrate competence in:

1. Taking a proper clinical history.
2. Performing proper physical examination
3. Diagnosis and management of commonly faced clinical problems including the indication for referral.
4. Dealing with common medical emergencies, e.g. M.I., diabetic ketoacidosis, severe acute asthmatic attack and GIT bleeding.
5. Continuing care of chronic conditions, e.g. diabetes and hypertension.
6. Diagnosis and management of common clinical problems in the elderly.
7. The changes in the normal range of laboratory values and other investigations including medical imaging.
8. Understanding factors associated with absorption, metabolism, excretion of drugs.
9. Understanding hazards of drug treatment, drug interactions and new advances in therapeutics relevant to internal medicine
10. Ability to use the Ophthalmoscope to examine the fundi.

11. Use of office clinical measurements such as peak flow meter, inhalers and nebulizer.

12. Reading and interpreting ECG.

13. Use of sphygmomanometer.

14. Aspiration of joints.

15. Beside Microscopy, e.g. in U.T.I.

16. Exhibiting appropriate attitudes to the care of people and manifest these attitudes in the doctor – patient relationship.

17. Ability to read and interpret common radiological investigations.

The Process of Training:

1. A sufficient time for formal teaching is needed by the trainees, particularly induction arrangements at the beginning of the rotation.

2. Every trainee should work under close supervision of senior staff till the trainee acquires enough knowledge and competence to work more independently.

3. A balance between the service work and the protected time for postgraduate medical education should be maintained.

4. The half-day release course held weekly as part of the Family Medicine training organized by the concerned Department of Family and Community Medicine should be attended regularly by the trainees.

5. A greater community element of the training is needed. Opportunities to work in outpatient clinics should be provided. A multidisciplinary approach to caring for some physical illness, showing the role of nurses, social workers and physiotherapist is very useful.

6. On-call duties should be an average of one every three to four nights (4-7 calls per month).

The residents are full time with the Department of Internal Medicine and participate in the service and educational activities of the department except for the weekly half-day release course.

Learning Situation:

1. Inpatients/Grand rounds.

2. Outpatient clinics.

3. Emergency.

4. Continuing medical education (CME) activities.

Structure of Internal Medicine Rotation:

In order to achieve the above aims, Family Medicine residents will spend the six months rotation in Internal Medicine as follows:

1. Three months in a general medical unit. (if this available)

2. Two months in a specialized unit relevant to Family Medicine. Preferably, if residents are given a choice, they should spend these two months in two of the following units (cardiology, endocrinology, pulmonary, gastroenterology). (4 weeks each)

3. There should be more out patient training during the whole rotation and in addition one month should be spent in outpatient clinics as a full time. (at least 2 months after the beginning of the rotation in internal medicine).

Evaluation:

The Department of Internal Medicine in collaboration with the Department of Family and Community Medicine will assess the resident according to the following criteria:

1. Continuous assessment. 30%

2. Final clinical examination.

    a. Written exam 20% (The candidate should score 60% of this mark)

    b. Clinical examination 50%

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the rotation by the senior staff with whom he worked.

Satisfactory performance in the continuous assessment is mandatory before a candidate is allowed to sit the final examination.

Bibliography:

1. Isselbacher, et al. Harrison's Principles of Internal Medicine. McGraw Hill Book Company.

2. Goroll, et al. Primary Care Medicine. An office Management of the Adult Patient.

3. Rakel Textbook of Family Practice Saunders

4. Taylor. Textbook of Family Medicine.

5. Current Textbook of Medical Diagnosis and Treatment.

6. Ham RJ, Sloane PD, eds. Primary Care Geriatrics: A Case-Based Approach. 2nd ed. St. Louis: Mosby Year Book, 1992.

7.Kumar.Medicine

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN PEDIATRICS

DURATION: 4 Months

INTRODUCTION:

Pediatric problems represent a large proportion of primary health care. The family physician should be competent in initial assessment and management

of the common Pediatric problems with emphasis on problem that are more prevalent at the primary care level.

OBJECTIVES:

At the completion of this rotation, the trainee should be able to:

1. Illustrate the important norms of physical, intellectual, emotional and social development and assess the growth development of children at different ages.

2. Diagnose common deviations from normal.

3. Diagnose and manage the following conditions:

A. Acute conditions threatening life (e.g. infections like meningitis, acute respiratory disorders, acute abdomen, accidents and acute bronchial asthma).

B. Conditions which, if not recognized early can lead to disability or premature death (e.g. respiratory infections, jaundice, congenital malformation, epilepsy and malignant disease).

C. Common conditions (e.g. feeding problems, sleep problems, respiratory infections, diabetes and enuresis).

D. Handicaps and their supervision (e.g. congenital handicaps).

E. Chronic pediatric conditions (e.g. chrome diarrhea , Epilepsy)

4. Identify the effect of disease of children on the family.

5. Organize, plan, conduct and evaluate a well baby clinic (screening, records, and immunizations).
6. Provide the preventive measures and activities in Pediatrics (immunization, health education).

7. Take a proper history and perform a proper physical examination of new born infants, toddlers, children's and adolescents.

8. Effectively prescribe for children in terms of dose, route, expected side effects and interactions.

9. Identify and appropriately use other agencies that can provide care for children (e.g. secondary care and social services).

10. Perform with skill those technical procedures common in Primary Care Practice (see skill list below).

Process of Training:

1. Attachment to one of the units, where, he or she is expected to have full responsibilities for in and out patient care under the direct supervision of the senior registrar or the consultant of that unit.

2. Active involvement in the on-call rota. The range should be at least 7 on calls per month including one week end.

3. Adequate attendance participation and attendance in the departmental activities, e.g. handover round, case presentation, journal clubs, etc. (at least 80% of the activities)

4. Preparation of material to be discussed in a tutorial with a senior staff at least once every two weeks.

5. Performing and assisting in the common technical procedures e.g. (LP, intubation, use of nebulizer).

6. Attendance of the weekly half day activities in the Department of Family and Community Medicine.

Learning Situation:

1. Inpatient/Grand rounds.

2. Outpatient clinics.

3. Accident and Emergency.

4. Continuing Medical Education (CME) activities.

Structure of Rotation:

- 2 months in inpatient general pediatrics unit.

- 1 month in outpatient general pediatrics clinics.

- 1 month in accident and emergency.

Evaluation:

The Department of Pediatrics in collaboration with the Department of Family and Community Medicine will assess the resident according to the following criteria.

1. Continuous assessment 30%

2. Final clinical examination
   a. Written exam 20% (The candidate should score 60% of this mark)

   b. Clinical examination 50%

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the course if their performance is unsatisfactory up to that time.

Satisfactory performance in the continuous assessment is mandatory before a candidate is allowed to sit the final examination.

LIST OF SKILLS TO BE LEARNED:

1. Plot height, weight and head circumference and interpret

2. Bladder catheterization and supra pubic aspiration

3. Newborn resuscitation

4. Lumbar puncture

5. Venesection

Calculate maintenance and fluid and electrolyte requirements

Bibliography:

1. Vangham/Makay/Behrman. Nelsons Textbook of Pediatrics.

2. David Hull. Essential Pediatrics. Churchill Livingstone (Latest edition).

3. Leon Polanay. Community Pediatrics. Churchill Livingstone (Latest edition).

4. Henderickse. Pediatrics in the tropics. Oxford U. Press.

5. Ebrahim. Pediatric Practice in Developing countries. McMillan Trop Comm. Health Manual 1981.

6. Rakel P. Essentials of Family Practice. Saunders.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN PSYCHIATRY

DURATION: 3 Months

Introduction:

The rotation in Psychiatry should help the family physicians to acquire knowledge, skills and attitude that will enable them to provide a broad range of services and to enable them to make clinical decisions related to common psychiatric problems encountered in the PHC setting as well as to refer when necessary.

Objectives:

By the end of this three months rotation, the trainees are expected to be able to:

1. Take a proper psychiatric history and conduct a proper mental status examination.

2. Recognize and manage patients with psychiatric complaints, and properly and timely refer those who need referral.

3. Recognize, assess, manage and follow-up chronic psychiatric conditions commonly dealt with in PHC settings including psychiatric emergencies

4. Identify social, economic, cultural factors affecting the aetiology, course and management of psychiatric and behavioural problems.

5. Recall the role of other professionals involved in the care of patients with mental disorders, e.g. psychologist, social worker and agencies involved in such care and be able to utilize their expertise.

6. Demonstrate an understanding of the role of preventive medicine in psychiatry and the role of the teachings of Islam in psychiatric and psychological disorders.

7. Recognize the importance, indications and application of common modalities of psychotherapy.

8. Competently make early diagnoses of problems in childhood development and within vulnerable groups.
9. Perform effective counseling and behavioural modifications appropriate to a primary care setting.

10. Understand the importance of rehabilitation in psychiatry.

Process of Training:

1. In psychiatry, there is particular need for professional supervision including local discussion between family physician course scheme organizers, trainers and consultant psychiatrists to clarify many issues related to training.

2. The resident shall be attached to a unit where he/she should work under close supervision until his/her consultant trainer is satisfied that he/she has the knowledge and ability to work more independently.

3. A sufficient time for formal teaching is needed by the trainees, particularly induction arrangements at the beginning of the rotation.

4. Participation in departmental activities, e.g. grand rounds, lectures, tutorials, journal clubs, etc.

5. Preparing material of relevance to primary care to be discussed and presented in the form of a tutorial at least once a week.

6. The half-day release course held weekly on one afternoon by the Department of Family and Community Medicine should be attended regularly by the trainees.

7. A greater community element of the training is needed. Opportunities to work in outpatient clinics and a multi-disciplinary approach to caring for patients should be emphasized.

Learning Situation:

1. OPD clinics.

2. Accident and emergency.

3. CME activities.

4. Inpatient grand rounds.

5. A multidisciplinary approach to caring for mental illness in PHC is particularly important, so that joint training sessions with nursing and social workers colleagues are of particular value for trainee family physicians.

Basic Knowledge:

1. Normal and abnormal psychological growth and development across the life cycle, and variants.

2. Recognition of interrelationships among biologic, psychologic and social factors in all patients.

3. Reciprocal effects of acute and chronic illnesses on patients and their families.

4. Factors that influence adherence to a treatment plan.

5. Family functions and common interactional patterns in coping with stress.

6. Awareness of one's own attitudes and values, which influence effectiveness and satisfaction as a physician.

7. Stressors on physicians and approaches to effective coping.

8. Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality and issues quality of life.

Mental Health Disorders:

1. Disorders principally diagnosed in infancy, childhood or adolescence
    a. Mental retardation
    b. Learning disorders
    c. Motor skills disorders
    d. Communication disorders
    e. Attention deficit and disruptive behavior disorders
2. Delirium, dementia, amnestic and other cognitive disorders
3. Substance-related disorders, e.g. alcohol, amphetamines, opioids, etc.
4. Schizophrenia and other psychotic disorders
5. Mood disorders
    a. Major depressive disorder
    b. Dysthymic
    c. Bipolar disorders, including hypomanic, manic mixed and depressed
6. Anxiety disorder
    a. Panic attack
    b. Phobias
    c. Obsessive/compulsive disorder
    d. Generalized anxiety disorder
7. Somatoform disorders
    a. Somatization
    b. Pain
    c. Hypochondriasis
8. Eating disorders

a. Anorexia nervosa

b. Bulimia nervosa

9. Sleep disorders

    a. Insomnia

    b. Hypersomnia

    c. Narcolepsy

    d. Parasomnias

10. Adjustment disorders

    a. Depressed mood

    b. Anxiety

    c. Mixed anxiety and depressed mood

    d. Disturbance of conduct

11. Personality disorders

12. Problems related to abuse or neglect

Evaluation

The Department of Psychiatry in collaboration with the Department of Family and Community Medicine will assess the resident according to the following criteria.

1. Continuous assessment	30%
2. Final clinical examination	
a. Written exam	20% (The candidate should score 60% of this mark)
b. Clinical examination	50%

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the course if their performance is unsatisfactory up to that time.

Satisfactory performance in the continuous assessment is mandatory before a candidate is allowed to sit the final examination.

Bibliography:

1. AC Markus, C Murry Parkes, P Tomson, M Johnston. Psychological Problems in General Practice. Oxford. Oxford University Press. Walton Street, Oxford OX26 DP. 1989.

2. Rees. A New Short Textbook in Psychiatry. Hodder and Stoughton.

3. Goldberg, et al. Psychiatry in Medical Practice, Routlege.

4. Gelder M. Oxford Textbook of Psychiatry. Oxford University Press.

5. Royal College of General Practitioners. Primary Care for People with Mental Handicaps.

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8. Primary Care Clinics in Office Practice: Mental Health, Stuart, MR and Liberman JA III (Eds) 26 32 6/1999.

Web sites:

1. American Psychiatric Association: www.psych.org
2. American Psychological Association: www.apa.org
3. he@lth; Mental Health Touches (Everyone): www.athealth.com
4. Psychwatch. Com; The; Online Resource for Professionals in Psychology and Psychiatry:
   Psychwatch. Com; The; Online Resource for Professionals in Psychology and Psychiatry: www.psychwatch.com

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN OBSTETRICS AND GYNAECOLOGY

DURATION: 3 Months

Introduction:

The Obstetrics/Gynaecology practice occupies a central position in whole-family care. A significant proportion of problems dealt with in primary care practice is related to the discipline of Obstetrics and Gynecology. The family physician should be competent in initial assessment and interim management of all these cases and in the overall management of common Obstetrical and Gynaecological problems.

Objectives:

At the end of the training, the resident should be able to:

1. Provide quality antenatal care including the promotive and preventive aspects.

2. Undertake the initial management of common and life-threatening problems during pregnancy.

3. Identify high risk patients, apply proper intervention and arrange an appropriate referral.

4. Provide health education during pregnancy, child birth and care of the newborn.

5. Recall the methods by which congenital malformation of the fetus may be detected.

6. Manage common conditions for which pregnant women are admitted to hospital e.g. premature labour, preeclampsia, multiple pregnancy, fetal growth retardation, antepartum haemorrhage, and maternal disease.

7. Manage normal delivery.

8. Demonstrate an understanding of the management of other abnormalities of labour e.g. shoulder dystocia, breech, twins and multiple pregnancies.

9. Train mothers on how to establish and maintain breast feeding.

10. Plan management of physical and psychosocial problems of the mother in postnatal period e.g. puerperal depression.

11. Plan arrangements needed for home confinements.

12. Use of accurate and detailed records in all aspects of obstetric care and recognize the value of such records in clinical audit.

13. Take a gynaecological history, carry out a full and appropriate examination and conduct appropriate investigations.

14. Advise, investigate and where appropriate refer patients with problems relating to infertility.

15. Manage common problems relating to menstruation.

16. Manage patients suffering from infections of the genital tract, including sexually transmitted disease.

17. Plan management of the menopause.

18. Counsel couples in child spacing and assist in family planning clinics.

19. Describe the steps required for the early diagnosis of neoplasia of the genital tract and the Family Physician's role in management.

20. Apply preventive methods in Obs/Gyn.

21. Perform technical procedures commonly practiced in primary care (see the skill list below).

Process of Training:

The clinical rotation in obstetrics and gynaecology is designed to provide a set of learning experiences in the hospital in order to foster the acquisition of the competencies required for the practice of the discipline with special emphasis on conditions common in primary care, whenever possible.

The resident must work on a full-time basis as a member of the obstetrics/gynaecology team, participates in the service and educational activities of the department and develops good interpretational skills in

dealing with patients. The resident must meet all the objectives and be available for all the requirements of rotation.

The system of admitting room experience (in out-patient, referral and antenatal clinics), in-patients experience (in the obstetrics and gynaecology wards, labour wards and operating theaters) and follow-up experience (in the referral or consultant clinics), provide an excellent opportunity for continuity of patient care which is essential to the practice of primary health care.

Learning Situation:

1. In patient.
2. Out-patient Clinics (ANC and Gynaecology Clinics).
3. Delivery room
4. Emergency
5. Continuing Medical Education (CME) activities

Content of Training:

Areas of knowledge expected to be taught in the course of the rotation.

- Normal antenatal care: diagnosis, establishing dates, screening, assessment of progress, patient education.
- Identification of high risk pregnancy; with proper management and referral.
- Normal labor and delivery.
- Medical problems during pregnancy i.e. diabetes and thyroid disease.
- Genetic counseling.
- Problems of labor and delivery i.e. obstructed labor, infections, fetal distress, postpartum and intrapartum bleeding.
- Obstetric emergencies.
- Ectopic pregnancy.
- Abortion and antenatal bleeding.
- Preterm labor and premature rupture of membranes.
- Hypertension of pregnancy, pre-eclampsia, and eclampsia.

- § Indications for cesarean section, and other assisted delivery procedure (e;g ventouse and forcepse)

- § Postpartum care and follow up.

- § Breast feeding, child spacing and sexual advice.

Evaluation:

The Department of Obstetrics and Gynaecology in collaboration with the Department of Family and Community Medicine will assess the resident according to the following criteria.

1. Continuous assessment 30%

2. Final clinical examination
   a. Written exam 20% (The candidate should score 60% of this mark)

   b. Clinical examination 50%

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the course if their performance is unsatisfactory up to that time.

Satisfactory performance in the continuous assessment is mandatory before a candidate is allowed to sit the final examination.

LIST OF SKILLS TO BE LEARNED:

1. Obtaining vaginal and cervical cytology

2. Colposcopy

3. Cervical biopsy, polypectomy

4. Cryosurgery/ cautery for benign lesions

5. Microscopic diagnosis of urine and vaginal smears

6. Dilatation and Curettage

7. Limited ultrasound examination and interpretation

8. Management of labor

9. Pudendal and local anaesthesia

10. Induction of labor

11. Neonatal resuscitation

12. Assistance in cesarean section

Bibliography:

A. Obstetrics:

1. Brews and Holland. Manual of Obstetrics. Churchill London.

2. De Swiet, M. (et al) Manual Disorder in Obstetric Practice. Black well Scientific Publications, Oxford.

3. Pritchard, J.A. and MacDonald, P.C. Williams Obstetrics Crafts, New York.

B. Gynaecology:

1. Jones. H.W., Jones G.S. (Ed): Novak's Text Book of Gynaecology, Williams and Wilkins, Baltimore.

2. Tindall, V.R., (Ed): Jeffcoate's Principles of Gynaecology, Butterworth, London.

3. J.C. Mclure and J.K. Lewis. Post-graduate Obstetrics and Gynaecology.

4. David N. Danforth, J.B. Lippincott. Obstetrics and Gynaecology.

5. Women's sit right problems in General Practice. Oxford Series.

General:

1. Gorol. Primary Care medicine.
2. Rakel Saunders, Text Book of Family Practice.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN SURGERY

Duration: 2 months (6 weeks in General Surgery and 2 weeks in Urology)

Introduction:

The rotation in Surgery should help the family physicians to acquire knowledge, skills and attitude that will enable them to provide a broad range of services and to enable them to make clinical decisions related to common surgical and orthopedic problems encountered in the PHC setting.

Objectives:

By the end of this 2 months rotation, the trainees are expected to:

1. Be able to recognize and manage common surgical problems and emergencies which may need referral to a surgeon (part of this is covered during rotation in emergency care).

2. Be competent to perform minor surgical procedures, e.g. incision of abscesses, circumcision, banding of internal hemorrhoids, suturing, dressing, and removal of foreign bodies.

3. Acquire basic knowledge of anaesthesia used in different surgical procedures in a PHC setting and its complications, e.g. local anaesthesia and interaction with drugs.

4. Understand how patients are managed pre-and pos-operatively, e.g. explaining to patients about surgery, taking consent, dressing and cleaning wounds, etc.

5. Be involved in management related to mutilating surgical procedures like total colectomy, total gastrectomy, mastectomy, amputation and RTA, especially for psychological consequences.

Process of Training:

1. The resident is to be attached to a unit where he / she should work under close supervision by senior staff till he acquire enough knowledge and the ability to work more independently.

2. Participation in departmental activities, e.g. grand rounds, lectures, tutorials, journals clubs, etc.

3. Performing and assisting in common surgical procedures under the direct supervision of a consultant or senior registrar and taking full responsibility at in-patient and out-patient care.

4. Residents should be given opportunities to perform minor surgical procedures, particularly those done in out-patient under local anaesthesia.

5. Preparing material of relevance to primary health care to discussed with senior staff and presented in a form of tutorial once a week.

6. A balance between the service and training should be maintained.

7. The half-day release course held weekly in one afternoon by the Department of Family and Community Medicine should be attended regularly by the trainees.

8. A log book should be maintained by the resident and signed by a senior staff on the activities he attended and skills he performed.

Learning Situation:

1. Out-patient clinics

2. Day Surgery

3. Accident and emergency

4. Academic activities (Journal Clubs, Tutorial etc.)

5. In-patient / Grand – rounds

Surgical skills to be acquired during the rotation:

- Rapid assessment of an acutely-ill patient.
- Suturing and laceration repair.
- Incision and drainage of superficial abscesses.
- Biopsy and removal of superficial masses
- Wound debridement and wound management.
- Local anaesthesia techniques
- Nasogastric tube insertion
- Fine needle aspiration.

Contents of Training:

- Preoperative evaluation and management.

- Acute abdomen in children and adults.
- Hemorrhoids and other ano-rectal problems like fissures and abscesses, etc.
- Gall bladder disease.
- Approach to patients with neoplasms of the chest, breast, abdominal cavity and gastro-intestinal tract, etc.
- Trauma and wound management.
- Varicose veins.
- Postoperative care
- Prostatic disease
- Management of burn
- Peripheral vascular disease
- Urinary stones

Evaluation:

The Department of Surgery in collaboration with the Department of Family and Community Medicine will assess the resident according to the following criteria.

1. Continuous assessment 30%

2. Final clinical examination
   a. Written exam 20% (The candidate should score 60% of this mark)

   b. Clinical examination 50%

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or

part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the course if their performance is unsatisfactory up to that time.

Satisfactory performance in the continuous assessment is mandatory before a candidate is allowed to sit the final examination.

Bibliography:

1. Rakel, Saunders Textbook of Family Practice.
2. Primary Car Medicine, Office Evaluation and Management of the Adult Patient. Goroll et al 3rd Edition.
3. Minor Surgery, A Test and Atlas, 2nd Edition 1993, J.S. Brown.
4. Oxford Handbook of Clinical surgery, 1990. G.R. MacLatchie.
5. General Surgery at the District Hospital, 1988. john Cook et al. WHO.
6. System of Orthopedics and Fractures A. Graham Apley.
7. An Introduction to the Symptoms and Signs of Surgical Diseases Normal L. Browse.
8. Minor surgery in General Practice. Information Folder. Royal College of General Practitioners.
9. Surgical procedures in primary care. Bull M.J.V. and Gondenir P. 1995 Oxford University Press.
10. Brian A. Maurice, Surgery for General Practitioners. Turnbridge Weils, Kent U.K. Castle House Publication (LTD), 1989.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN ORTHOPAEDICS

Duration: 1 month

Orthopedic problems represent a sizeable workload in primary health care setting.

The Family physician is required to deal with these problems efficiently and competently.

The goal is to help the trainee to identify patients with orthopedic problems who can be managed in primary health care setting and those who require specialist care.

Objectives:

By the end of the rotation, the trainee is expected to:

- Acquire basic knowledge in orthopedic problems.
- Be able to recognize and manage common orthopedic problems and emergencies.
- Demonstrate proper understanding and application of diagnostic and therapeutic technical skills in relation to orthopedic problems.
- Be able to recognize and manage common fractures, their diagnosis, proper management and prompt referral to the specialist.
- Be able to perform orthopedic examination and interpret its findings.
- Recognize the role of radiological investigation in the diagnosis of orthopedic problems.
- Be able to apply casts and plaster of pairs to common fractures.
- Recognize the importance, indications and applications of physiotherapy, occupational, and rehabilitation therapy in orthopedic problems.

Process of Training:

1. The resident is to be attached to a unit where he / she should work under close supervision by senior staff till he acquires enough knowledge and the ability to work more independently.
2. Participation in departmental activities, e.g. grand rounds, lectures tutorials, journal clubs, etc.
3. Performing and assisting in common surgical procedures under the direct supervision of a consultant or senior registrar and taking full responsibility at in-patient and out-patient care.
4. Residents should be given opportunities to perform minor surgical procedures, particularly those done in our patient under local anaesthesia.

5. Preparing material of relevance to primary health care to be discussed with senior staff and presented in a form of tutorial once a week.

6. a balance between the service and teaching should be maintained.

7. The half-day release course held weekly in one afternoon by the Department of Family and Community Medicine should be attended regularly by the trainees.

8. A log book should be maintained by the resident and signed by a senior staff on the activities he attended and skills he observed and / or performed.

Content of Training:

- Proper history taking in orthopedic practice.
- Proper orthopedic examination.
- Arthritis
- Bursitis and tendonitis
- Carpal tunnel syndrome
- Common fractures and soft tissue syndrome
- Low back pain
- Shoulder pain
- Cervical pain
- Congenital hip dislocation (CHD)
- Osteomyelitis
- Septic arthritis
- Aspiration and injections of joints and bone

Skills to learn:

- Complete joint and spine examination
- Appropriate use and interpretation of X-rays in orthopedic problems.

- Bandaging of sprained joint.
- Safe transport of orthopedic trauma.
- Safe and effective splinting of fracture.
- Aspiration and injection of joint.

Evaluation:

The Department of Orthopedics in collaboration with the Department of Family and Community Medicine will assess the residents according to the following criteria.

This will take the form of continuous assessment during the rotation including a clinical examination (either a clinical examination or OSCE)

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the rotation by the senior staff with whom he worked.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN DERMATOLOGY

DURATION: 1 Month

Introduction:

A significant proportion of problems dealt with in primary health care practice is related to the specialty of Dermatology.
The family physician should be competent in initial assessment and interim management of these cases and in the overall management of common dermatologic problems.

He/she should also be familiar with the contribution of specialists and subspecialists in dermatology, so that he will make appropriate referrals.

Objectives:

At the end of the rotation, the resident should be able to:

1. Diagnose, assess and manage acute and chronic Dermatological conditions commonly dealt with in primary health care settings with timely and appropriate referrals for conditions that need special procedures equipments or expertise (e.g. hypothyroidism, DM, vitamin deficiency). These should include:

    a. Pruritus

    b. Urticaria

    c. Purpura

    d. Pigmentation Disorders

    e. Acne

    f. Contact Dermatitis

    g. Eczematous Dermatitis

    h. Scabies and Pediculosis

    i. Alopecia

    j. Psoriasis

    k. Fungal skin infection

    l. Manifestation of Systemic Disease

    m. Cutaneous Leishmaniasis

    n. Dry skin

    o. Pyoderma and Cellulitis

    p. Warts, Viral infection and bacterial infection

    q. Insect bites

r. Sexually transmitted disease

s. Neoplasm of the skin

t. Photo sensitivity disorder

2. Independently perform Dermatological procedures which are common in primary care practice (see list of skills to be learned)

3. Describe the social, economical, and cultural factors affecting skin problems.

4. Give appropriate advice on promotive, preventive and rehabilitative aspects of skin diseases.

5. Use of topical agents in dermatology including steroids.

6. Recognize serious conditions and perform appropriate and timely referrals.

Process of Training:

The resident will work full time with the Department of Dermatology and participate in the services and educational activities of the department.

Evaluation:

The Department of Dermatology in collaboration with the Department of Family and Community Medicine will assess the residents according to the following criteria.

This will take the form of continuous assessment during the rotation including a clinical examination (either a clinical examination or OSCE)

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the rotation by the senior staff with whom he worked.

LIST OF SKILLS TO BE LEARNED

1. Diagnostic:
   - Biopsy
   - Scraping
   - Skin testing techniques
2. Therapeutic:
   - Acid Cauterization
   - Electrodesiccation and curettage
   - Cryosurgery
   - Punch biopsy
   - Excision of skin lesions
   - Intra-lesional injection of steroid
   - Incision and drainage
   - Treatment of ingrowing nails
   - Ultraviolet light therapy

Bibliography:

1. Goroll et al. Primary Care Medicine. An Office Management of the Adult Management of the Adult patient.
2. Rakel, Saunders. Text Book of Family Practice.
3. Graham – Brown. Lecture notes in Dermatology.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN OPHTHALMOLOGY

DURATION: 1 Month

Introduction:

Eye diseases represent an important proportion of problems dealt with in primary health care practice.

The family physician should be competent in initial assessment and interim management of these cases and in the overall management of common ophthalmology problems.
He should also be familiar with the contribution of specialists and subspecialists in ophthalmology, so that he will make appropriate and timely referrals.

Objectives:

At the end of the course, the resident should be able to:

1. Assess and manage acute and chronic ophthalmological conditions commonly dealt with in primary health care settings. These should include:

    a. Red Eye

b. Impaired vision

c. Eye pain

d. Common Visual disturbance

e. Cataract

f. Glaucoma

g. Exophthalmos

h. Retinopathy due to systemic diseases

i. Abnormal ocular mobility (especially in children)

j. Ocular emergencies (eye trauma, burns or corneal ulceration)

Describe the common ophthalmologic condition seen in primary care setting

2. Select suitable cases for referral, work-up or both.

3. Independently perform ophthalmological procedures which are common in primary care practice and acquire the skills of appropriate usage and handling the essential ophthalmology examination instruments:

   - Direct battery hand-held ophthalmoscope
   - Hand-held flash light for ophthalmic exam
   - Snellen's chart - Tumbling E. for adult
   - Allen's figures for children
   - Pin hole disc
   - Corneal foreign body removal
   - Visual field examination.

4. Perform proper funduscopic examination with the use of a direct ophthalmoscope and recognize difference between normal appearance and major abnormalities, e.g. Papilloedema, Cupping nerve head, Diabetic retinopathy, Hypertension and Retinal detachment, etc.

5. Describe the social, economical, and cultural factors affecting ophthalmology problems.

6. Recognize serious condition and perform appropriate and timely referral.

7. Give appropriate advice on promotive, preventive and rehabilitative aspects of eye diseases.

Process of Training:

The resident will be a full time with the Department of Ophthalmology and participate in the services and educational activities of the department. The following break down is suggested:

- 2 weeks in General Screening Clinic
- 1 week in Pediatric Eye Clinic
- 1 week in Refractive Errors Clinic

Evaluation:

The Department of Ophthalmology in collaboration with the Department of Family and Community Medicine will assess the residents according to the following criteria.

This will take the form of continuous assessment during the rotation including a clinical examination (either a clinical examination or OSCE)

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the rotation by the senior staff with whom he worked.

Bibliography:

1. Gorol et al. Primary care medicine. An Office Management of the patient.

2. Rakel, Saunders. Text Book of Family Practice.

3. Calbert I Philips. Basic Clinical Ophthalmology.

4. Gardiner. ABC of Ophthalmology.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN OTOLARYNGOLOGY (ENT)

Duration: 1 month

Introduction:

A significant proportion of problems dealt with in primary health care practice is related to the specialty of E.N.T.

The family physician should be competent in initial assessment and interim management of these cases and in the overall management of common E.N.T. problems.

He should also be familiar with the contribution of specialists and subspecialists in E.N.T. so that he will make appropriate referral.

Objectives:

At the end of the rotation the resident should be able to:

1. Recognize, assess and manage acute and chronic E.N.T. conditions commonly dealt with in primary health care settings. These should include.

- Impaired Hearing, balance disorders and hearing aids.
- Otitis (otitis media, external)
- Sinusitis
- Pharyngitis

- Rhinitis
- Chronic and nasal congestion and discharge
- Dizziness
- Epistaxis
- Hoarseness of voice and disorders of voice.
- Smell and taste disturbances
- Stomatitis
- E.N.T. Malignancies
- E.N.T. emergencies (such as stridor, trauma and other air way obstruction problems).
- Congenital defects

2. Take a proper ENT history.
3. Select suitable cases for workup and / or referral.
4. Demonstrate awareness of social, economical, and cultural factors affecting ENT diseases.

Skills to be learned:

- Appropriate ENT examination
- Ear wax removal
- Nasal packing for control epistaxis
- Removal of foreign body from nose and external ear.
- Observation of tracheotomy and care patient with tracheotomy.
- Audiogram interpretation.

Evaluation:

The Department of Otorhinolaryngology (ENT) in collaboration with the Department of Family and Community Medicine will assess the residents according to the following criteria.

This will take the form of continuous assessment during the rotation including a clinical examination (either a clinical examination or OSCE)

The candidate should score 70% aggregate to pass the rotation. Those who will fail at the end-of-rotation examination will be referred to the local supervising committee to recommend whether they will repeat the rotation or part of it or only sit for another examination. This decision should be made in collaboration with the concerned departments.

The residents will be appraised twice during the rotation by the senior staff with whom he worked.

Bibliography:

1. Goroll et al. Primary Care Medicine

2. Rakel, Saunders. Text Book for Family Practice.

3. William, David, Diseases of the Nose, Throat and Ear, Saunders de Weese.

4. William, David Text Book of Otolaryngology, Saunders de Weese.

5. ABC of ENT problems. BMJ

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN EMERGENCY MEDICINE

DURATION: 2 Months (during junior residency and 1 month (during R3)

Introduction:

During practice, Family Physicians may be exposed to a variety of medical emergencies. Family Physicians should be competent in initial assessment and interim management of emergencies in all age groups and in the overall management of common emergencies. He/she should also be familiar with the contribution of hospital emergency services, so that he will make appropriate referrals. The aim of this rotation is to enhance the resident's knowledge and skills of emergency health care.

Objectives:

At the end of this rotation, the resident should be able to:

1. Recognize, assess and manage emergency conditions, whether personally or by referral.

2. Recognize the social, economic and cultural factors affecting the causation and management of emergencies.

3. Diagnose and manage emergencies commonly met in primary care practice including history taking, physical examination, investigation and management.

4. Triage and offer interim management of other emergency presentations.

5. List and discuss the possible causes of presenting symptoms and signs in emergency situations, giving priority to life threatening causes that are dangerous to health or lifestyle and those which are the more possible.

6. Make appropriate assessments in emergency presentations, carry out and order appropriate investigations and make reasonable interpretations of the results.

Attitudes:

The resident should develop attitudes that encompass:

1. An ability to communicate effectively and compassionately with patients and families.

2. A capacity to work quickly and efficiently to assess the patient according to the urgency of the patient's problem.

3. An ability to work effectively with other health care professionals as team members.

Knowledge:

1. Early intervention

    a. Pre-hospital emergency care

    b. Understanding of emergency medical system concepts and disaster medicine

2. Time management in emergencies

    a. Prioritization and triage

    b. Stabilization for transport

    c. Principles of simultaneous triage of multiple trauma patients or patients with serious medical illness

    d. Efficient resource utilization

        1. Immediate access to consultants

        2. Rapid access to information

3. Assessment and management of

    a. Trauma

    b. Neurologic emergencies

    c. Psychiatric emergencies
    d. Burns

    e. Violent patients

    f. Obstetric and gynecologic emergencies

4. Recognition and treatment of acute life threatening situations (critical care)

    a. Acute respiratory problems, including airway management

    b. Life-threatening arrhythmias

        1. Asystole

        2. Ventricular tachycardia

        3. Ventricular fibrillation

        4. Bradycardia

        5. Supraventricular tachycardia

    c. Cardiac arrest

    d. Ischemic heart disease (acute myocardial infarction, cardiogenic shock, unstable angina)

    e. Cardiovascular pharmaceuticals and their use

    f. Resuscitations

    g. Acid/base imbalance

    h. Shock (hypovolemic, restrictive, neurogenic, cardiogenic, septic, etc.)

    i. Infectious disease emergencies, including meningitis

5. Diagnostic interpretation

    a. Electrocardiograms

    b. Roentgenographic identification of emergencies situations, including cervical spine injuries, chest x-ray, acute abdominal series, head computed tomography

    c. Monitors

6. Environmental exposures

    a. Envenomation (bites and stings)

    b. Poisonous plants

c. Inhalations

d. Hypersensitivity reactions/anaphylaxis

7. Toxicologic emergencies

a. Poison control centers

Skills:

All the residents should successfully PASS A COURSE ON CPR AND ATLS during the programme or within 3 years. This is a pre-requisite for setting the final certifying exam.

Other Skills Include:

1. Airway management techniques
2. Initiation of vascular access
3. Artificial circulation
4. Reduction, immobilization and traction techniques in fractures/dislocations
5. General and specific treatments of poisoning and overdoses
6. Treatment protocols

Process of Training:

During the rotation the residents will work as full time in the Emergency Unit. They are to participate in the service and educational activities of the unit during the two months block rotation.

Evaluation:

Assessment will be undertaken according to the following criteria:

1. Continuous assessment.

This will take the form of confirmation assessment during the rotation including a clinical examination (either a clinical examination or OSCE)

Residents will be appraised twice during the rotation be the senior staff with whom he work.

Satisfactory performance in the continuous assessment is mandatory before a candidate is allowed to sit the final examination.

2. Final clinical and oral.

This should take the form of OSCE

70% is the pass mark

<u>NOTE:</u> Residents should be free to attend the weekly Half-Day Release Course of the Family Medicine Residency Training Program.

Bibliography:

1. The Committee on Trauma, American College of Surgeons. Early Care of the Injured Patient. W.B. Saunders, 1989.

2. To M.T., Saunders C.E. (eds) Current Emergency Diagnosis and Treatment. Appleton and Large, Publisher. New York, California, 1990.

3. Norman Lawrence, Joanna Watts. Handbook of emergencies in General Practice. Oxford University Press 1989 (or latest edition).

4. A.J. Mould, P.B. Martin. Emergencies in General Practice.

5. Rosemary J. Norton and Barbra M. Philip. Accidents and emergencies in Children, 1992.

6. W. Earle, Wilkins. Emergency Medicine.

7. American College of Emergency Physicians. Core content for emergency medicine Ann Emerg Med 1991; 20:920-34.

8. Rosen P, Barkin RM, Braen GR, eds., et al. Emergency medicine: concepts and clinical practice. 3rd ed. St. Louis: Mosby Year Book, 1992.

9. Taylor AS. Emergency medicine educational objectives for the undifferentiated physicians. Emerg Med 1994; 12:255-62.

ROTATION IN ELECTIVE

Duration: 1 month

Introduction:

Elective by definition "permits a choice". Therefore, resident will choose the subject according to his / her need and / or interest among the clinical rotations either those who already have specified training time or not.

The aim of the elective will be to help the resident in selecting topics which will further enhance their training in a specific subspecialty for future career.

This should be decided upon by the resident in consultation with his / her tutor and coordinator of programme. The Residency Training Committee can be enrolled if there is a dispute.

Contents:

Specific cannot be determined for each elective rotation. However, the following guidelines should be observed.

1. The discipline should be relevant to Family Medicine

2. The elective should be in one of the clinical rotations related to Family Medicine.

3. The elective could be used all in one specialty period or could be split to a maximum of two specialties.

4. Approval of the training committee of the programme is mandatory.

Learning Situations:

Should be appropriate to the chosen elective rotation and should be decided by the program Director/Supervisor

Evaluations:

The resident will be assessed by the department concerned according to the following criteria:

1. Continuous assessment 40%
2. Final Clinical Examination 50%

The pass mark is 70% aggregate.

The residents will be appraised twice during the course.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN COMMUNITY MEDICINE

Duration: 12 weeks (see details of courses)

Introduction:

The rotation in community medicine should enable the family physician to provide comprehensive health services to the individuals and families in the community and to diagnose community health problems through the necessary clinical, epidemiological knowledge and skills, and research. The PHC physician is also expected to be able to plan for health services and provide promotive, preventive and rehabilitative services in addition to the curative services. It is important to take note of the following points:

1. Health is defined as a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity. (i.e. not all health problems are seen in the PHC centre).

2. Since the family physician deals with existing problems, while the epidemiologist starts by identifying populations at risk, then, neither of them can work alone and the family physician should be familiar with the essential applied epidemiology.

3. An understanding of the distribution and determinants of a disease and its natural history are essential for achieving prevention, control and comprehensive health care.

4. The family physician in PHC should be able to describe the health status of the community in order to know the necessary actions to improve health of the population.

Specific Objectives:

Specific objective are laid out for each component of the Community Medicine rotation.

Components of Community Medicine Rotation:

There are two major components of Community Medicine Rotations:

A. Epidemiology and biostatistics which include:

	Duration in Weeks
1. Biostatistics	2
2. Epidemiology	2

3. Research Methodology 2

B. Community Health Related Issues and Problems which include:

1. Maternal and Child Health 1

2. Environmental and Occupational Health 1

3. Health Education 1

4. Community Nutrition 1

5. Health Care Management 1

6. Care of the Elderly 1

Process of Training:

1. A sufficient time for formal teaching is indeed particularly at the beginning of the rotation

.

2. The resident should be exposed and be familiar with the different promotive, preventive and rehabilitative services provided by different health and health- related sectors.

3. Participation in health education activities directed to the patient, family and community.

4. Involvement in research or study.
5. the residents should have the chance to know the common communicable disease in the community and methods of their prevention, control, and management

6. The residents should be involved in planning for the health services when possible.

7. The resident should be given practical sessions on the following:
    - Design of epidemiologic studies.
    - Calculating and interpreting vital statistics.
    - Epidemiology of communicable disease.
    - Services related to occupational and environmental health.
    - The practical steps of investigation of epidemics.
    - Principles and methods of disease surveillance.
    - Health planning.
    - Identification of at risk groups and provision of appropriate continuous services to them.

Learning situation:

1. CME activities (lectures, seminars, workshops and symposia)
2. Field visits and practical sessions.
3. Applied research.
4. Visits to relevant health and health- related sectors.

Evaluation:

A. Continuous Assessment which may take the following format:

1. Punctuality Active Participation
2. Projects, exercise and reports
3. Assignments (e.g. production of health education materials)

This will be done for each individual course separately and will carry 40% of the marks.

B. Final Evaluation

There will be a written examination and will carry 60% of the marks:

1. For Epidemiology Biostatistics and research methodology at the end of the First 6 weeks.
2. For Community Health related issues and problems course at the end of the second 6 weeks.

The pass mark is 70% aggregate.

Those who fail the end-of-course examination will attend the course in the year following. In the event of a second failure or more, the candidate will be required to take a remedial course with the permission of the Training Committee.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN COMMUNITY MEDICINE

A. Biostatistics

This 3 months rotation will constitute the following

DURATION: 2 weeks

Rationale:

Medicine and public health are becoming increasingly quantitative. Facing situation of uncertainty is a common feature in the daily practice of medicine and in health care delivery. Biostatistics provides the concepts and methods necessary for the handling for quantitative material and in making decisions in face of uncertainty. Furthermore, recent research in medical and allied health sciences relies to a great extent on statistical methodology, and as a result, statistics is increasingly pervading the literature. This reliance is expected to grow in the future.

Aims:

1. To equip the resident with the basic knowledge of descriptive statistics, inferential statistics with emphasis on biomedical application.

2. To train the resident in the understanding, handling and evaluating of quantitative material and proper application of statistical concepts and tools in the disciplines of medicine and public health.

3. To develop the skill of logical thinking, an ability for quantitative reasoning and for the evaluation of numerical evidence.

4. To establish the foundation needed for the subsequent courses and training in different residency programs and for future research work and dissertation.

Objectives:

At the end of the course, the resident should be able to:

1. Organize data collection, code and edit data and prepare data for the computer.
2. Apply the concepts and procedures of descriptive statistics in presenting data and results.

3. Select and employ the proper statistical methods to perform simple statistical tasks.

4. Identify those situations where the consultation of the biostatistician is needed and intelligently communicate with him.

Contents:

In all of the following, theorems and methods will be stated without mathematical proofs. However, it will be shown through simple examples how they work. Practical medical and public health applications do constitute the major art and the main emphasis in this course. All applications will be illustrated using computer. The contents are as follows:

1. Introduction to statistics and brief historical notes on the evolving of various branches of the discipline of statistics and biostatistics.

2. Types and nature of biological variables and the descriptive methods by frequency distributions, graphs, fractiles and other measures of central tendency and dispersion.

3. The basic concept of probability distributions, population parameters and sample statistics with emphasis on the binomial, and the normal probability distributions.

4. Sampling techniques and sampling distributions.

5. Estimation of population means.

6. Chi-square test of goodness of fit, independence and homogeneity.

7. Non-parametric and distribution-free statistical methods with emphasis on the need, advantages, and disadvantages of their uses and the details of the sign test, the median test, Mann-Whitney, Kruskal-Wallis one-way ANOVA, and the Spearman rank correlation.

Methods of Instruction:

1. Didactic lectures.

2. Seminars, tutorials and group discussions.

3. Practical Sessions using computer.

B. ROTATION IN EPIDEMIOLOGY

DURATION: 2 Weeks

Rationale:

Management of health problems encountered by the family physician requires understanding, comprehension and application of proper epidemiological methods. The family physician should also be able to apply epidemiological methods to study the diagnosis of health problems and the monitoring of health status and program effectiveness for individuals, families and the community.

Aims:

To enhance the resident's knowledge of the basic concepts and principles of epidemiology and its understanding and the skill of the application of these basic concepts in the study of various health problems and the control of acute and chronic diseases. In conjunction with the course in research methodology, this course should also help the resident in the selection of his research topic.

Objectives:

At the end of the course, the resident should be able to:

1. Describe the natural history of communicable & non-communicable diseases in the community.

2. Analyze multifactorial disease etiology.

3. Identify the sources of health information and the relevant data needed for the health of the community.

4. Calculate the vital statistics and other indicators of community health.

5. Identify and calculate measures of morbidity and mortality.

6. Describe the disease in the population by person, place and time.

7. Recognize the concept of screening and apply its principles and methods in the identification and control of diseases in a community.

8. Identifying and describe the different types of health surveys and apply the relevant ones in diagnosis of community health problems.
9. Describe the design and uses of different epidemiological studies in health and disease and as a research tool in community health.

10. Identify and describe the role of epidemiology in the planning, implementation and evaluation of health programs and evaluation of health services.

Contents:

1. Epidemiological definitions and concepts.

2. Multifactorial etiology of disease.

3. Measurement of disease frequency in human population.

4. Morbidity and mortality statistics and their distribution by person, place and time.

5. Natural history of disease and levels of prevention.

6. Investigation and control of an outbreak of a communicable disease.

7. Screening and disease control.

8. Vital statistics and health information.

9. Epidemiological studies.

10. Community diagnosis and health survey.

11. Role of epidemiology in health care and health service organization.

Minimum Requirement:

Sixteen – 2 hour sessions.

Methods of Instruction:

1. Lectures/discussions.

2. Seminars.
3. Small group discussions.
4. Assigned readings and class presentations.

Bibliography:

A/Books

1. Mausner & Kramer Basic Textbook: Epidemiology. An introductory text, 1985 edition.

2. Lillienfeld & Lillienfeld. Foundations of Epidemiology.

3. Assigned readings from other textbooks and journals.

4. MacMahon & Pugh. Principles of epidemiology.

5. Abramson Survey methods in Community Medicine Churchill, Livingstone 1990.

6. Medical Epidemiology by R.S. Greenberg, SR Daniels, WD Flunders, J Weley, JR Boring III. 3rd Edition, Large Medical Bookds, McGraw Hill 2001.

7. Epidemiology in Medicine, by C,H, Hennekens, J.E. Buring Little Brown and Company Publication, Boston, 1987.

8. Parker's textbook of Preventive and Social Medicine.

B/Journals

1. American journal of Epidemiology.

2. International Journal of Epidemiology.

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN COMMUNITY MEDICINE

C. RESEARCH METHODOLOGY

DURATION: 2 Weeks

Rationale:

Resident in Family Medicine should be trained in Research Methodology to prepare them for their future career. Research is a strong tool at all levels of

the health system. Applying the research can be used to improve patient's care.

Aims:

To offer the resident knowledge in basic research methodology and help him to choose his research project.

Objectives:

At the end of the course, the residents should be able to:

1. Describe the various types of health – related research.
2. Complete the various steps necessary for the preparations of a good research proposal.
3. Prepare a complete health – related research proposal.
4. Analyze and interpret the results.

Contents:

1. Introduction to health research.
2. Methods of literature review.
3. Basic steps of hypothesis formulation
4. The pilot study.
5. Various types of studies.
6. Data coding and analysis
7. Interpretation of results.
8. Report writing.

Minimum Requirements:

32 lectures or lecture equivalents.

Methods of Instructions:

- Lecturers
- Group exercises
- Skills of using computer
- Self-directed learning

Evaluation:

Evaluation includes successful writing of the proposal of research project. This should be supervised by one of the trainer and finally approved according to the regulations of approval of research project (see appendix.....)

Bibliography:

1. Reigelman R. K. Studying a study and testing a test. How to read the medical literature. Little Brown and Company Boston , 1986.

2. Abramson J.H. survey methods in Community Medicine Epidemiological Studies Program Evaluation. Churchill Livingstone, 1990.
3. Calnan J. Coping with research. The complete Guide for Beginners William Heinemann Medical Books, London, 1990.

SAUDI BOARD IN FAMILY MEDICINE

D. ROTATION IN MATERNAL AND CHILD HEALTH

DURATION: 1 Week

Rationale:

Mothers and children constitute a high proportion (approximately 65%) of the population of the Kingdom of Saudi Arabia and there is a need to reduce the mortality and morbidity rates in this group. family physicians in Saudi Arabia should be responsible for researching, planning, organizing and providing appropriate health care for mothers and children, and be able to provide

nutritional and genetic counselling for the whole family and the community they serve.

Aims:

To provide the theoretical and practical experience in the areas of Maternal and Child Health (MCH), Nutrition and Genetics, necessary for a family physician.

Objectives:

At the end of the course, the resident should be able to:

1. Describe the theoretical basis for practical intervention in the areas of genetics, conception, pregnancy, lactation, infant feeding, growth of children and interrelationships of mother and children.

2. Assess the health needs of mothers and children, identify available MCH resources and plan, organize and evaluate MCH services at health center.

3. Recognize nutritional requirements of the mother during pregnancy and lactation and how to prevent nutritional disorders.

4. Demonstrate awareness of the prevalence and characteristics of common genetic disorders and of the agencies available to assist individuals and families with possible or proved genetically based problems.

5. Define priorities in maternal and child health care.
6. Plan, organize, and run an effective maternal and child health clinic appropriate to the needs of the community.

7. Describe the duties of the personnel in an MCH clinic.

8. Undertake a nutritional assessment.

9. Manage the problems of mothers, expectant mothers and children within the capabilities and resources of a MCH clinic.

10. Provide genetic counseling to the parents in regard to genetic problems commonly occurring in the community.

Contents:

1. Priorities in MCH care and the risk approach.

2. Delivery of MCH services in the context of Family Medicine and primary health care.

3. Primary health care approach to the management and prevention of infectious diseases of childhood and the principles and teachings of immunization.

4. Growth, development, and growth monitoring.

5. Diarrheal diseases, oral rehydration, interaction of nutrition and infection.

6. Disabilities and handicapped child in the community.

7. School health services.

8. Detection, management and referral of high risk obstetric cases in a primary health care unit.

9. Child spacing, methodology and the Islamic approach.

10. Nutrition of the infant, and the child of the mother during pregnancy and lactation. Food fortification.

11. Evaluation of nutritional status in children and during pregnancy

12. Assessment of MCH Programs.
13. Common genetic disorders.

14. Genetic counseling and community resources.

15. New advances in MCH.

Methods of Instruction:

Lectures, seminars, group discussions, assignments, and exercises. Visits will be arranged when feasible to appropriate community facilities.

Bibliography:

1. Ibrahim G.J. Pediatric Practice in Developing Countries, MacMillan.

2. David Morley. Pediatric Priorities in the Developing World, MacMillan.

3. Maurice King. Primary Child Care, MacMillan.

4. Cicily Williams & Jelliffe D. Mother and Child Health, Oxford University Press.
5. WHO. Immunization in Practice, Oxford.
6. Hutchison and Cockburn. Practical Pediatric Problems, Sixth Edition.
7. Ebrahim G.J. Practical Mother and Child Health, MacMIllan.
8. Brown. Antenatal Care.
9. Danhoe. Fundamental Obstetric and Gynaecology.
10. McDonald. William's Obstetrics, 1991 Edition.

SAUDI BOARD IN FAMILY MEDICINE
COMMUNITY MEDICINE ROTATION

E. Environmental Health/Occupational Health

Learners Level: R3

RATIONALE:

The interaction between man and his environment need to be very well understood by the Family Physicians in order to provide good quality care. This care will include management of the environment on the part of the patient and the community if we are to provide a life-style that is conducive to health.

The Kingdom of Saudi Arabia is industrializing rapidly. It is imperative that the Family Physicians have a practical working knowledge on the range of occupational hazards in the Kingdom and how to recognize, evaluate, control, and treat them.

AIMS:

To reinforces and expand the resident's knowledge, attitude and skills of environmental and occupational health.

SPECIFIC OBJECTIVES:

By the end of the course the residents should be able to:

4. Explain the importance of the environment to the health and well-being of individuals and families.
5. Recognize environmental health hazards.
6. Describe preventive and remedial measures.
7. Define the process of providing statutory control of the environment.
8. state the concepts and functions of occupational health services.
9. Explain how occupational health programs are planned at company, regional and national levels.
10. List the statutory rights and obligations of employers and employees.
11. Outline the methods of assessments of the working environment.
12. Describe the different methods of control of occupational hazards.

CONTENTS:

1. Man and his environment: The reciprocal relationship.
2. Environmental health control program.
3. Environmental pollution: Air, water, and soil.
4. Urbanization and industrialization.
5. Solid (domestic and industrial) waste disposal.
6. Liquid (domestic and industrial) waste disposal.
7. The food industry (processing, transportation, storage, distribution, the food chain).
8. Environmental measures in the control of communicable diseases and role of health education.
9. Occupational health as a discipline, concepts, functions and occupational health programs.
10. Review of rural/urban occupations and the possible hazards.
11. Health and work environment monitoring.
12. The role of the Family Physician in occupational health.
13. Rights and obligations of employees.
14. Rights and obligations of employers.
15. Problems of immigrant workers.
16. Accidents, accidents analysis and rehabilitation.
17. Sickness absence records and analysis.

METHODS OF INSTRUCTION:

Lecture – discussions
Problem-solving Exercises
Group Discussions
Field visits whenever possible.

BIBLIOGRAPHY:

A/Book

1. Purdom P.W. Environmental Health.
2. Hubson W. The Theory and Practice of Public Health.
3. Willey Pacey A. (ed). Sanitation in developing countries.
4. E.J. Calabrese. Methodological approaches to deriving environmental and occupational health standards.
5. ILO, Geneva, Encyclopedia of Occupational Health and Safety.

Schilling R.F, Occupational Health Practice.

6.

B/Journals

1. American Journal of Public Health.
2. Archives of Environmental Health.
3. Journal of Occupational Medicine
4. British Journal of Industrial Medicine.

SAUDI BOARD IN FAMILY MEDICINE

F. ROTATION IN HEALTH EDUCATION

DURATION: 1 Week

Rationale:

Health Education should be an integral part of comprehensive health services. Effective health education offers the best methods of encouraging people to take the necessary steps to prevent and control many physical, psychological and social disorders.

Aims:

To enable the resident to apply the principles and techniques of health education in health practice.

Objectives:

At the end of the course, the resident should be able to:

1. Recognize the need for health education for individuals, families, groups and the community.

2. Apply the principles and techniques of health education.

3. Appreciate the importance of social-cultural factors in health education.

4. Choose and apply appropriate methods of health education in specific situations.

Contents:

1. Local beliefs, values, attitudes and practices as related to health educational needs.

2. Principles and techniques of health education.

3. Preparation and use of health educational aids.

4. Planning, implementation and evaluation of health education.

Methods of Instruction:

Lectures, problem oriented seminars, group discussions, role playing, use of audiovisual aids, demonstrations and practical sessions.

Bibliography:

1. Child to Child Today. A news letter, spring 1988.

2. Education for Health. Manual on Health Education in Primary Health Care. World Health Organization. (Health Education).

3. Dickens M., McBath J.H. Guidebook for speech Communication. New York H.B. Jovanovich Inc. 1973, 29-33.

4. Hanlon J.J., Pickett G.E. Public Health. Administration and Practice. Times Mirror/Mosby college Publishing, St. Pouis – Toronto, 1984; 13-21.

5. Hilton D. Story Telling for Health Teaching.

SAUDI BOARD OF FAMILY MEDICINE

G. NUTRITION

Duration: One Week

NUTRITION:

On rationale:

Nutrition plays a major role in both health promotion and disease prevention, in addition to being a therapeutic toll in the treatment of medical, surgical and emotional illness. Physicians should develop the skills necessary to assess nutritional status and provide nutrition therapy.

Attitudes:

The resident should develop attitudes that recognize the following:

A.) Nutrition is an integral part of:

1. Health promotion and disease prevention. Mortality and morbidity could be significantly reduced through primary prevention targeting dietary risk factors throughout the life cycle.

2. Medical treatment of disease-nutritional status has a large impact on the ability to respond to medical interventions.

3. Diagnosis and appropriate management of disorder.

B.) Dietary intake is influenced by a variety of patient factors, including:

1. Culture (family, community, ethnicity, religion)

2. Socioeconomic (ability to purchase food, living situation)

3. Psychosocial and mental health (depression, anorexia, dementia, bulimia)

4. Knowledge

5. General health lifestyle (co-morbid conditions, diseases, habits)

C.) Nutrition consultants should be utilized when appropriate to help provide counseling for at-risk patients.

Knowledge:

The resident should develop knowledge of:

A. General principles of nutrition, including:

1. The roles of dietary components, carbohydrates, fats, proteins, vitamins, minerals, water and fiber.

2. Nutritional content of foods.

3. Dietary recommendations, e.g., dietary guidelines and food pyramid.

B. Nutritional Assessment:

1. Medical / social history and physical examination.

2. Anthropometrics (height / weight. Body mass index [BMI], head circumference, body-fat distribution)

3. Ordering and evaluating laboratory tests (inpatient) and (outpatient)

Recognize nutrition related diseases

C. Nutritional issues of different stages of the life cycle.

1. Infancy – e.g., breastfeeding, bottle-feeding, adding solids, allergy prevention.

2. Children – e.g. Picky eating, pica, snacks

3. Adolescents – e.g., healthy choices, eating orders

4. Adults – e.g, portion size habits, convenience foods

5. Pregnancy – e.g. weight gain, folic acid, iron, calcium.

6. Lactation – e.g, nutritional needs, support, counseling.

7. Elderly – e.g. psychosocial issues, co-morbid conditions, swallowing disorders.

D. The role of nutrition in the prevention and treatment of specific diseases:

1. Cancer
2. Cardiovascular disease
3. Dental disease
4. Diabetes
5. Gastrointestinal disorders
6. Hematological disorders
7. Hypertension
8. Liver disease
9. Obesity
10. Osteoporosis
11. Renal disease

E. Use of dietary supplements, including:

1. Vitamin and mineral deficiency, toxicity, and recommended intakes
2. Guidelines for herbal, alternative and other supplements, including drug interactions, safety and efficacy.
3. Evidence-based nutrition resources and signs quackery

E. Preventing and recognizing and treating food borne illness

G. Allergies and food intolerance

H. Physical activity and sports

1. Recommendations for health and weight loss

2. Nutritional needs for various levels of activity (i.e. elite atheletes) and for different ages

3. Hydration

Skills:

The resident should develop skills in:

B. Integrating nutrition assessment and intervention assessment and intervention into the medical history, review of systems, physical examination, laboratory evaluation and plan of care.

C. Assessing the nutritional status.

D. Counseling patients and family members about specific nutritional needs related to stages of the life cycle and or disease.

E. Counseling patients on safe lifestyle approaches to weight management and balancing caloric intake and physical activity.

F. Advising patients about appropriate use of and, when needed, prescribing vitamin mineral and other dietary and botanic supplements.

G. Collaborating with registered dieticians and certified diabetes educators, and referring patients to community nutrition resources, including internet sites.

Process of Learning:

The implementation of these curriculum guidelines should be longitudinal and integrated into patient care, didactic conferences, and experiential learning activities.

Nutritional status of the patient should be an integral part of case presentation, staffing rounds and other clinical activities. Qualified nutrition professionals should teach nutrition and mentor residents. All faculty should model and teach nutrition and make it easy to integrate nutrition information into patient care. This should use a problem-oriented approach in learning either through real cases from the clinic or hypothetical cases and simulations. Didactic sessions should be kept to the minimum.

Resources:

1. Physician's curriculum in clinical nutrition – A competency based approach for primary care, Kansas City, MO: Group on Nutrition Education, society of Teachers of Family Medicine, 1995.

2. Manual of Clinical diabetics, 5th Edition, Chicago IL: The American Diabetic Association, 1996.

3. Mahan LK and Escott-Stump S. Krause's Food, nutrition and diet therapy, 10th edition, Hardcourt, Brace and Co, 1999.

4. Modern nutrition in Health and Disease, 9th Edition, Williams and Wickins, 1999.

5. Medical Nutrition and Disease, Blackwell Science Inc. 1996

Web Sources:

1. Americans Diabetic associations: www.eatrigth.org.

2. Tufts University Nutrition Navigator, A Rating Guide to Nutrition Websites: www.navigator,tufts.edu.

3. Arbor Nutrition Guide: www.arborcom.com

4. National Center for Complementary and Alternative Medicine: www.nccam.nih.gov

5. Office of Disease Prevention and Health Promotion: www.odphp.osophs.dhhs.gov

6. USDA Centre of Nutrition Policy and Promotion: www.usda.gov/c

SAUDI BOARD IN FAMILY MEDICINE

H. ROTATION IN HEALTH CARE MANAGEMENT

DURATION: 1 Week

Rationale:

Sound organization and administration are crucial to the efficient delivery of health services to a community. There is thus a need for future family physicians to acquire theoretical and practical knowledge of management.

Aims:

To enable the residents to have an understanding of the principles of management in order to fulfill their management and supervisory role in the future.

Objectives:

At the end of the course, the resident should be able to:

1. Describe and perform the role of the leader of a health team.
2. Prepare a management plan of the available and potential resources.
3. Evaluate the management of primary health care services.
4. Demonstrate managerial capabilities in primary health care setting

Contents:

1. Principles of management in relation to planning, implementation and evaluation.

2. Understand team work principle

3. Effective management of equipments, drugs, money, time, space and paperwork.

4. Budget and resources management.

5. Managing primary health care services and community programs.

Methods of Instruction:

2. Lectures.

3. Small group discussions.

4. Exercises.

5. Role playing.

6. Field visits (with exposure to different management systems)

Bibliography:

1. Blanchard K., Johnson S. The One Minute Manager. Berkley Books, New York (Arabic).

2. Edmonds L. The Politics of Prevention. Johns Hopkins Magazine, July 1989; 89-93: 126-127.

3. Hanlon J.J., Picket G.E. Managing Organization, p. 171-187. Times Mirror/Mosby College Publishing.

4. The role of the Physician in the Primary Health Care Center (FAMCO protocol).

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN COMMUNITY MEDICINE

I. CARE OF THE ELDERLY

DURATION: 1 Week

Rationale:

Improvements in social conditions and in health care are accompanied by larger populations of the elderly, and social change can greatly affect their mental and physical well being. The family physician should have an appropriate background since he/she will be involved in planning and carrying out the care of this increasing proportion of the population.

Aims:

To help the resident understand the process and problems of ageing and the problems and management of those experiencing degenerative disorders and terminal illnesses.

Objectives:

By the end of the course, the resident should be able to:

1. Briefly describe the epidemiology of ageing.
2. Understand the main theories of ageing.
3. Describe the main psychological changes in the aged.
4. State and briefly discuss the main problems and difficulties of the ageing people and their comprehensive management.
5. Identify the local, national resources, and agencies available in the community for the care and support of the aged.
6. Be able to propose a plan for community care of the elderly and implementation of the community aspects of geriatric care for a population group.
7. To Assess of the mental and physical status of the elderly.

Contents:

1. The epidemiology of ageing.
2. The ageing process and the physiological changes in the aged.
3. Assessment of the mental and physical status of the aged.
4. Family and community resources for the aged "supportive, preventive, and rehabilitative care".
5. Death and dying, and terminal care.
6. Common problems of the elderly.
7. Planning geriatric care for a population group.
8. Exposure to home care.

Methods of Instruction:

1. Lectures.
2. Group discussions.
3. Visit to elderly home, or patients home.

Bibliography:

1. Green & Anderson. Community Health, 5th edition, Times Mirror/MOSBY, Guege Publishing 1986-Part 2 Section 7, pp. 150 – 173.
2. Keith Thompson. Caring for an elderly relative. A guide to home care, Dunitz 1986.
3. Robert E. Rakel (Ed.). Textbook of Family Practice, 3rd edition 1984, W.B. Saunders, pp. 244 – 279. "Care of the Geriatric Patient".
4. Pocket Consultant – Geriatric.
5. William R. Car of Elderly Clinical Aspects of Aging 4th Edition Williams and Wilkins 1996 Baltimore, USA.
6. Martin A, Gambrill E. e.g. Geriatrics 1986 MTP press.
7. Goroll A, May L, Mulley A. Primary Care Medicine 3rd Edition Boston Lippincott Raven; 1981.
8. Ham R, and Sloane P. Primary Care Geriatrics 2nd Edition. Mosby Year Book 1992.
9. Tierney L, Mcphee S, Papdakis M, Current Medical Diagnosis and Treatment 38th Edition, California Appelton and Louge 1999.

SAUDI BOARD IN FAMILY MEDICINE
RESEARCH PROJECT

Prerequisites: Research Methodology Course/Dissertation

Introduction:

The family physician should be able to conduct basic research and write scientific reports. This is important because for his future career as a health promoted and a leader in his field of specialty. This includes the formulation of hypothesis, objectives, methodology and analysis and writing the data.

Objectives:

At the end of the course the residents should be able to:

9. Identify specific problems to solve.
10. Define the objectives of the project.
11. Scrutinize and criticize medical literature.
12. Describe the methodology.

13. Collect, tabulate, and analyze the data.

14. Write the findings including a scientific discussion.

15. Utilize these findings.

Content:

Planning followed by data collection can begin at any time after the end of the community medicine course block. According to type and size of the problem chosen, the resident, under supervision, will divide his time between:

1. Writing the protocol

2. Reviewing the literature

3. Conducting a field exercise

4. Tabulate, analyze and write the report.

Methods of Instruction:

1. Personal consultation with the supervisor, advisor as well as other experts in the field.

2. Supervised field work.

3. Guided reading and library work.

4. Self learning

5. Problem solving

Rules and Regulations: (See details of regulation of how to Conduct of Research Appendix)

1. Candidates should be encouraged to think of the research subject(s) as early as the time of research methodology course (Community Medicine).

2. An initial proposal on a research subject or more should be submitted to the course coordinator for approval. This should also suggest the name of the Supervisor and Advisor(s).

3. The Regional Training Committee will approve the project as regard to its subject, the supervisor, and the advisor(s). After the approval, the resident can start his project.

4. The final report will be composed of nine parts.

a. Summary

b. Introduction

c. Literature Review

d. Materials and Methods

e. Results

f. Discussion

g. Conclusion
h. References

i. Appendices

5. The final manuscript should be typed and bound in a hard cover and must be submitted at least two months before the date of the final written examination. Copies should be presented, the master copy and 4 photocopies.

Evaluation:

The project will be assessed by two examiners one from within the programmed and one from outside the programme (an external assessor). If the two examiners pass the candidate he will be grades as "Pass". If one examiner fail the candidate project will be assessed by a third independent examiner.

NB. Completion of the research project is a pre-requisite to set for the final fellowship examination [see details in Rules and Regulations (appendix)]

SAUDI BOARD IN FAMILY MEDICINE
ROTATION IN FAMILY MEDICINE (II)

Duration 11 months (1 month is for completion of research project)

Introduction:

Family Medicine provides initial, continuing comprehensive and coordinated care for individuals, families and communities. It integrates current biomedical, psychological and social understanding of health in caring for patient using a holistic approach with a great attention to prevention.

The family physician is required to understand the principles of family medicine, acquire clinical knowledge and skills that will help him to practice as an effective family physician in an ideal setting. He also needs to develop a person-centered approach oriented to the individual, his/her family and their community. This requires a unique consultation process which establishes a relationship through effective communication process.

The Aims of this Rotation are:

A. To develop complement, and consolidate the skills and knowledge acquired by trainees during their undergraduate and hospital-based and Family Medicine based postgraduate experience.

B. To help trainees improve their skills, knowledge and attitudes to become efficient family physician.

C. To help the trainees to make the transition from hospital based medicine to community –based family medicine/primary care.

D. To help the trainees to become effective lifelong evidence-based learners and effective team members.

Objectives:

By the end of this rotation the trainee should:

1. Be able to conduct a consultation with patients in a primary health care setting, establishes a patient's reason for consulting, the nature of his problem, how it affects lifestyle and family, and to establish the management options available.

2. Competently undertake an appropriate physical examination in a primary health care setting.

3. Establish good relationships with patients, families and the community and as far as possible meet their needs and cope with their expectations.

4. Provide effective, comprehensive, and continuing care for individuals, families and the community he is serving.

5. Demonstrate clinical competence in respect to diagnosis and management of acute and chronic problems commonly seen in primary care, recognizing the physical, the psychological and the social domains of problems, and using a holistic approach.

6. Provide and organize promotive and preventive care for individuals, families and a designated population group.

7. Understand and effectively use therapeutics appropriate for a primary care setting and describe actions, interactions and side effects of the commonly used drugs.

8. Be able to record and analyze details of morbidity encountered in primary health care setting.

9. Be able to work as an effective team member in the primary health care setting.

10. Demonstrate skills of self-directed learning, critical thinking and evidence based practice.

11. Define primary health care, describe its features, and recognize how these features developed in the Kingdom of Saudi Arabia differ from those seen in other countries across the world.

12. Understand how health centres are organized and managed.

13. Understand principles of management and quality improvement.

14. Demonstrate, values, attitudes and professional ethics appropriate for family physician.

15. Demonstrate a broad grasp of the Family Medicine/PHC literature.

16. Recognize uncertainty in primary care setting and be able to deal with illness which patients present with in an undifferentiated way at early stage of its development.

17. Demonstrate leadership, team management and supervision skills.

18. Show appropriate attitudes towards the specialty, the profession and the other professional evolved in primary health care setting.

Domains of Training:

Training in Family Medicine will concentrate on the following domains:

- Communications skills and doctor-patient relationship
- Applied clinical practice (knowledge and skills)
- Organizational and management skills
- Professional growth, attitudes and ethics.
- Epidemiology and health of the population.
- Improvement of health care performance

Communication Skills and Doctor-Patient Relationship

In every doctor-patient encounter (consultation), there is an opportunity to learn communication skills and apply principles of doctor-patient relationship.
Good communication skills will enable the family physicians to develop a relationship with their patients and help them to understand their illness, their experience with the illness, their responses and reactions to the illness and their, illness behavior

These skills will be learned primarily during family medicine rotations. This will include the following:

- Understanding of the consultation process pertinent to family medicine and models of consultation and the appropriate use of each model.
- Practicing patient-centered approach
- Understanding and appropriate use of communication skills (both verbal and nonverbal)

- Opportunistic health promotion during the consultation.

- Ability to build effective, sensitive and culturally appropriate relationship with patients, and their families.

Applied Clinical Knowledge and Skilss:

Much of the work of the family physician will include clinical decision-making. This requires that the family physician should learn to be an effective clinician. This should include the following.

- The skills of interviewing and information gathering.

- The skills of physical examination

- Understanding the pathophysiology of common diseases, the skills of diagnostic process and clinical decision- making.

- Critical use of investigation, their interpretation and their relevance to the patients' problem.

- Competency in management of common problems (including un-differentiated illness and emergency care)

- Safe and cost-effective prescribing in concordance with rational prescribing.

- Appropriate use of other expertise and resources available to further complete the management of patient's problems including timely referral and follow-up.

Training Centre are encouraged to help the residents to development and maintenance of essential procedural skills that are appropriate for the care of patients at the primary health care level. (e.g. aural toilet, intra lesional injections, and minor surgery).

Organization and Management:

The family physicians, wherever, he practice will need to learn and apply principles of management and organizational skills. This will include the following as a minimum:

- principles of management

- principles of total quality management

- principles and application of audit

- use of personal, organizational and time management skills in practice.
- team work and team leadership
- monitoring, supervision and health care activities.
- documentations and medico-legal aspects.

Learning these will enable the future family physician to work effectively and efficiently in a health centre/family practice setting.

The Learning Process will include:

b. Revision of the principles learned during the community medicine/public health courses in a tutorial form{(random case analysis).

c. Problem solving and case-based discussions (random case analysis and discussion)

d. Preparing and conducting a practical audit

e. Case studies in different aspects of management and presentation by resident.

f. Exposure to different health centres with different organizational and management styles.

g. Exposures to practice examples of the use of information technology in patient and practice management.

The trainee is required to conduct a practical audit of one or more of the activities in a primary care centre and should produce a written report on this activity, guided by one of the trainers.

Professional Development, Attitudes and Ethics:

The future family physician is required to be a life-long learner to improve his professional performance and he also need to acquire the appropriate professional attitudes and find a great attention to professional ethics.

Professional Development:

It is a process of life-long learning which enables the professionals to expand and fulfill their professional potentials. In a primary care setting it has to be

selective purposeful, patient-centred and educationally effective. This means that the trainee should be:

- Aware of the learning styles in general and his style of particular.
- Able to assess his/her learning needs.
- Able to work-up a plan for professional learning
- Able to achieve his/her learning needs and evaluate his/her learning process.

To be Effective Continuing Professional Developmental has to be:

- Patient – centered
- Evidence –Based
- Based on actual learning needs and for problems.

It can take several approaches such as:

- peer review
- audit
- active learning
- role – play
- video-recording and feedback

Professional Attitudes:

This will include learning about

- Being aware of own capability and values
- Justifying and clarifying personal behaviors
- Being aware of the mutual interaction of work and private life and striving for a good balance between them.
- Respect of religious and appropriate social and cultural values.

Professional Ethics (Islamic Medical Ethics)

This should include learning about:

- Character and conduct of a Muslim physician
- Patient's rights in Muslim community (e.g. consent)
- The duty of care
- Ethical issues related to doctor-patient relationship
- Ethics of professional relationship
- Analysis of ethical dilemma
- National code of conduct and code of ethics.
- Research ethics

Care for a Defined Population:

As a future family physician the trainee should see himself/herself as a resource for a defined population for whom he/she provides health care. This means that he should learn the following:

- Understanding the dynamics of the population he services.
- Understanding the epidemiology of the health related problems in the community.
- How to assess and evaluate the heath of the population.
- How to prioritize activity and program conduction.
- Plan, implement and evaluate the preventive activities provided for the population. This will include: immunization, maternal and child health, health education and environmental health.

Learning Situations and Process of Training:

- ### The Consultation:

  Every encounter with patients is a learning experience. The trainee should utilize these opportunities to improve his understanding of patients, their, clinical problems, diagnostic skills, and management abilities.

- ### Morning Activities:

This 45-60 minutes session per day is devoted to the discussion of cases seen by the trainee. It can be conducted at the beginning of the session for the previous day cases or at the end of the morning session. Discussion may include random cases or problem cases (cases that are brought by trainees for discussion)

- Random Case Analysis:

  Two hours per week will be allocated for discussion of cases randomly selected by the trainer. These sessions can be conducted for an individual trainee or a group of trainees.

- Problem Case Analysis:

  The trainee has the opportunity to discuss problem cases with the trainee during the clinical sessions, the morning activities or the tutorial sessions.

- Study of a Family

  Early in the Family Medicine II rotation, each resident is required to choose a family (preferably with a reasonable size and different age ranges) to study. He should study the family from all aspect (physical, social and psychological), understand the family dynamics, and at the end of the rotation he is required to write a complete account of that family under the supervision of the trainer. Home visits to the family is encouraged.

- Case Presentation:

  The trainer will ask the trainees to present cases for the group. This should be conducted once per month per trainee.

- Tutorial and Seminars:

  In these sessions the trainee will be actively involved to present, discuss, and give feedback. It can include review of clinical topics, discussion of cases, problem-based sessions and evidence – based medicine practical sessions and should be organized as a two hours weekly sessions.

- Assessment of the Performance of the Trainee.

  It is helpful and necessary for the trainee to monitor his own progress and to continually evaluate his own performance. Criticism should

always be regarded as a constructive mean for improvement. The various forms and methods of formative (continuous) assessment are as below.

5. Direct Observation:

The trainer will observe your consultation and assess your performance and discuss with you. The various methods for improvement. This can take place at any consultation, but preferable done at lest twice per month.

6. Tutorials:

This time is dedicated for discussion of topics important to your learning needs are jointly decided by you and your trainer.

7. Video Consultations:

If the facilities for video recording is available they should be utilized. Observing your own consultation will help you to improve your communication and clinical skills. The constructive feedback given by your colleagues and your trainer will be very valuable. This should be done at least five times during this rotation.

8. Feedback Sessions:

A feedback from the trainer on one-to-one basis will be given at least twice per month and preferably on weekly basis. This will help the trainee to improve his/her performance.

9. Presentation of the Audit Study:

10. Presentation of the Family Study:

11. Log Book:

The trainee is required to log the cases he encounter during the clinical sessions that will be used for educational purposes.

Assessment at the end of the rotation:

The format for assessment is an OSCE test that should include the following:

- Formal Assessment of 2 consultations conducted by the trainee with two different patients: (15%) through direct observation
- Data interpretation (10 data) [10%]
- MEQ: Two MEQ questions (5%)

Distribution of Marks:

- Continuous Assessment 70%

- Final Assessment 30%

Appraisal of the resident performance should be done every three months and his evaluation should be satisfactory to set for the end of rotation assessment.

A TYPICAL WEEK IN FAMILY MEDICINE ROTATION (R4)

	AM	PM
Saturday	Morning Activity Clinic	Clinic
Sunday	Case Discussion Clinic	Mentor Clinic
Monday	Research *	HDRC

Tuesday	Case Presentation / Clinic	Activities
Wednesday	SDL	Feedback / Clinic
Thursday	Clinic	

SDL: Self Directed Learning
HDRL: Half-Day Release Course

* To meet the supervisors of research.

HALF DAY RELEASE COURSE (HDRC)

Residents in the family medicine program should attend a weekly half-day course. They are to be released form their commitments in hospital rotations, during this time.
The aim is to identify further learning needs of the trainee and help them to acquire the necessary skills and knowledge.

OBECTIVES:

1. To keep family medicine trainee in close contact with their specialty, especially during the hospital rotations.

2. To help trainees to acquire up-to-date knowledge and enable them to exchange information and experiences with their colleagues and trainers.

3. To discuss issues that are important to the specialty, that are not covered in hospital rotations, e.g., practice management, self

promotion, critical appraisal and Evidence Based Medicine, Holistic approach; Bio-psychosocial aspect of health problems and diseases.

4. To help trainees acquire skills important for family physicians, e.g. problem solving, team work, consultation skills, negotiation skills, presentation skills.

5. To help family medicine trainees manage their stress and socialize with their colleagues of various levels.

GUIDELINES FOR HDRC:

- Main Theme (60-80% of sessions): Presentations by trainees, small groups and workshops facilitated by trainers. These should be presented in a family medicine, problem solving oriented way information given should be evidence based as much as possible.
  N.B. To assure maximum benefit of these sessions, it is preferred that the trainer presents a closing conclusion (5-10 minutes) at the end of the session.

- Occasionally (20-40% of sessions):

  - Mini-symposia (presentation divided among 2-3 residents.

  - Presentation by trainers.

  - Research presentations of graduate family physicians.

  - Guest speaker presentations (they should be family medicine oriented).

  - Elective sessions (based on learning needs of the trainees).

- Open Activity: Family medicine trainees face stressful challenges during the residency program, and research has shown them to suffer a considerable degree of burnout. Allowing 1-2 sessions/year of HDRC to be an open activity in which both trainees and trainers gather socially might help in reducing stress.

- Elective Sessions: These sessions aim at improving certain skills of residents in an enjoyable way. Residents are divided into small groups according to their interest. They can be repeated, in order to allow those who have several interests or learning needs to attend. Priorities should be based on trainees' needs. Examples: power point and other computer skills, how to write a report, medical uses of the Internet …. ect.

Contents of Presentations:

1. Each program should have at least a yearly program (preferably a 4-year guide) on essential subjects that will be covered by the end of the training period. This aims at trying not to miss essential subjects and avoiding repetition of subjects. However this should not lead to a rigid schedule. Based on this guide a bi-annual schedule is developed with flexibility in choosing subtitles based on relevant and more pressing issues, recent updated information and interests of residents. The schedules should allow also accommodate:

- Journal Clubs: These should be presented in an "Evidence Based" Approach. They aim at keeping trainees updated and teaching them critical appraisal skills.

- Consultation Skills: Which can be covered as a group of lectures as well as discussions in the form of "MEQ" scenarios during small group discussions.

- Update Sessions: On outbreaks e.g. SARS, Rift Valley River, and recently released evidence based guidelines.

- Making use of International Days: e.g. international day of AIDS Asthma, Breast Feeding.

2. Welcoming Session: This should take place during October aiming to orient newcomers to this
course, a feed back session can be conducted at the same session.

3. Presentation Skills: If these are not covered elsewhere (N.B.: some programs give a course on educational methods during the introductory course).

4. Feed-back Sessions: A minimum of 2 feedback sessions per year on HDRC should be conducted. All trainers and trainees must be involved. Discussion is directed towards contents, attendance and evaluations of trainees. Small group may give better outcomes from this session especially if trainees are not supervised since presence of supervisors can affect their free expression of opinion. A brief questionnare could also be given to the trainees one week before the session and discussed during the session.

Awards: During feedback sessions, certificates or complementary gifts can be given to those with perfect attendance and high marks.

REGULATIONS:

- A trainer should supervise each trainee during the preparation of the presentation.

- This supervisor should attend the presentation with the trainee.

- For each session a minimum of 3 trainers / assistant trainers should attend and their names are to be posted on the schedule.

TRAINEES ATTENDANCE:

- Each trainee must attend a minimum of 75% of the sessions. If absence of trainee exceeds 25% in the 1st 6 months of the academic year, a warning letter is to be sent to him / her.

- Trainees who continue to attend < 75% with no acceptable excuse may be prevented from being promoted to the next residency level. This is decided upon by the training committee.

EVALUATION:

The HDRC carries 20% of the total academic year marks.

Distribution of Marks:

- 70% for trainees presentation evaluation

    < 50% main supervisor

    < 30% other trainers

    < 20% trainees

- 30% for attendance:

    1. If absence is < 10% ⟶ full mark i.e., 30%
    2. If absence is 10 – 19% ⟶ mark 20%
    3. If absence is 20 – 25% ⟶ mark 10%
    4. If absence is > 25% ⟶ mark is 0.

SUPERVISOR EVALUATION

Dear Supervisor,

Kindly fill in this Evaluation Form for the Resident assigned to you in the Monday Afternoon Activity.

Then kindly leave it in HDRC Coordinator's pigeon-hole (Mail Box).

Thank you.

Supervisor's Name: _____

Lecture Title : _____

Resident's Name: _____

Date of Lecture: _____ /_____ / _____ G _____ / _____ /_____ H.

ITEM	SCORE (1 min. to 10 max)
1. Arranging to meet with you at sufficient time before the presentation.	
2. Meeting you regularly	
3. Keeping appointments with you	
4. Respecting your advices, and actually doing your recommended modifications.	
5. Adequate number of references	
6. Using up to date references (recent articles, EBM.)	
7. Presentation Skills (over all)	
8. Proper use of A.V., Aids, including clarify of slides, proper spelling	

9. Proper preparation of educational methods as workshops, MCQ's....		
10. Preparing an Arabic Educational Pamphlet		
11. Do you wish to add other areas covered by the resident? (Please Specify):		
TOTAL 100 (If item 10 not filled) of 110 (if item 10 filled)	Mark	(%)

Please don't fill below:

Main Supervisor: _____% x 50/100 _____

Other Trainers: _____ % x 30/100 _____

Candidates (Trainees) _____ % x 20/100 _____ Total: _____

HDRC EVALUATION FORM

Name: ..... Date .....H.....G.....

Presentation Title: ..... Presenter: .....

	ITEM	1-10	COMMENTS
Presentation	Title, introduction: stimulating, shows importance of subject, good outline of contents		
	Body: Important points highlighted, information new, important, selective, relevant examples		
	Audio-visual aids: Clear slides, not crowded, no spelling mistakes		
	Conclusion reached, clear message, summary		
	Effective use of education aids eg. MCQ's, Handouts, video, small groups, new ideas....		
	Update information, not textbook information, Evidence based....		
Sp	Clear voice and language		

	Eye contact equal and appropriate to all audience, Gestures, body language, proper grooming.		
	Self confident, good control of discussion, good time management		
	Discretionary		
Total			

1 = poor

10 = excellent