Student Name:

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Registration number:

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STUDENT WORKBOOK and PORTFOLIO

Professorial Appointment in Medicine

Faculty of Medicine

Sabaragamuwa University of Sri Lanka

STUDENT WORKBOOK

AND

PORTFOLIO

Professorial Appointment in Medicine

Department of Medicine
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First Edition 2022

THIS BOOK IS BASED ON THE PORTFOLIO AND WORKBOOK PIONEERED IN THE FACULTY OF MEDICINE, UNIVERSITY OF COLOMBO

Department of Medicine

Faculty of Medicine

Sabaragamuwa University of Sri Lanka

Student details

Name _____

Index No _____

Batch _____

From _____ **to** _____

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Preface

Dear student,

Welcome to the Prof Unit in Medicine. We are very pleased to have you with us as students and hope you will enjoy your learning during this period. Our goal for you is, to be a good doctor, who is competent, caring and compassionate. In order to achieve this, we expect you to be totally involved in the care of the allocated patients, and in general, to be responsible for the providing care for the patients in ward as same as the staff working in ward. This in contrasts with the conventional term of 'taking histories from patients', we want you to 'provide caring, for patients while learning from them'.

We have developed this Workbook to guide you during your final year. It is a joint effort by the consultants in the Teaching Hospital Ratnapura and the academic staff of the Department of Medicine. You will benefit immensely if you follow the self-directed learning and assignments given in the Workbook. It will guide you to our teaching programme and continuous assessments.

Best wishes!

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CHAPTER 1

INTRODUCTION

Welcome to the 'Professorial Medicine Appointment'. By the time you start the Professorial Appointment, you would have completed most, if not all, of your theoretical contents and have completed clinical clerkships in General Medicine and most specialties such as Neurology, Dermatology, Cardiology, Rheumatology, Pulmonology, Gastroenterology, Nephrology, Endocrinology, Oncology, Sexually Transmitted Diseases, Radiology, Geriatrics and Palliative Medicine. The Professorial Medicine Appointment is your last one in Medicine. On its completion you ought to be confident and ready to face the 'final' examination and the internship which follows.

During this appointment you need to work as a main character coordinating and overseeing the care for the allocated patents. You need to spend time speaking with the patient and examining him or her. You must collect information from the patient and the relatives without breaking confidentiality. You must then analyze the information gathered and arrive at a tentative list of diagnoses or explanations to the patient's condition. You are expected to obtain consent from the patient to proceed with the physical examination. You are advised to do a comprehensive physical examination. On completion of this, you are ready to develop your hypotheses that would explain the patient's presentation and physical signs. You may then assist the medical team in further evaluating, investigating and managing the patient. You should take part in every aspect of clinical care from admission to the discharge including arranging investigations, talking to relatives, documentation, clinical decision making, allaying anxiety and health education.

Each ward has a team with a consultant physician in charge, Senior House Officer (SHOs)s, intern medical officers, nursing staff and junior staff members. Some units have trainee specialists known as Senior Registrars.

You are encouraged to ask questions and clear your doubts from any of the members of the staff mentioned above. We are expected to be able to work as a house officer under supervision by this stage of clinical training.

At the end of the professorial clinical appointment, students should be able to

1. work in a responsible manner for the wellbeing of the patient assigned to him/her and work independently as a house officer under supervision.

2. interview and obtain comprehensive histories, perform a systematic physical examination and elicit physical signs.

3. analyze the clinical information competent to state and arrive at a reasonable clinical differential diagnosis,

4. plan for investigating the patient, interpret routine laboratory tests, radiological, electrocardiography and other tests

5. describe common diseases, their pathophysiological basis, clinical presentations, treatment and prognosis.

6. describe an appropriate plan of management and reason out the basis for them

7. state indications, limitations, patient preparation, consenting process and undesirable effects of common diagnostic and therapeutic procedures

8. work as a part of the team managing medical emergencies commonly seen in medical wards and emergency medical unit

9. demonstrate empathy and maintain higher standards of ethics

10. communicate well with patients from different social and cultural backgrounds and with their families with particular reference to giving information, obtaining consent and breaking serious news

11. write case notes, daily status, referrals, discharge summaries, clinic notes and prescriptions.

12. know the support provided by the health system, the social service sector and informal carers towards provision of care for patients in hospital and in the community

During the Professorial Appointment students will undergo a minimum of 2 days of working as a ‘shadow house officer’.

CHAPTER 2

WORK NORMS

At a given time, the responsibility of clinical care of patients in the two wards lies with the consultant(s) in charge. He/she is also responsible for a major component of bedside teaching. Students will study in one ward for 4 weeks in male or female wards and swap each ward to gain a wide spectrum of experience.

The patient allocation, clerking and daily states

The patient allocation should be done by the students themselves and supervised by the monitors. You must write your name in the BHT to indicate 'ownership'. You are expected to have the current histories and details of examination etc. of all patients allocated to you.

A detailed history, examination findings and daily status should be recorded on an A4 paper and kept in your possession. We encourage you to use the 'SOAP' format (S – subjective, O – objective, A – assessment, P – plan) to write the daily states of the patient in your notes.

Your daily schedule

You are expected to come in by 0730 hours or earlier, see your patients, complete daily status and trace investigations for the ward teaching sessions. The register will be marked by 0800 hrs. Those students allocated to do venepuncture and function as Assistant House Officers (AHO) are expected to be in the wards by 0700 hrs.

Clinical teaching will happen during the ward round and as a large group classes or case-based discussions by the members of the academic staff for each group. The latter is done either during morning or afternoon sessions. Other teaching activities for the appointment are as listed below.

- Revision of history taking systems examination – during the first week of appointment
- Session on communication skills and ethics
- Combined ward classes, case-based discussions by consultant in charge of a ward in RTH or a senior academic staff member or the Professor of Medicine
- Nursing classes on Saturday on selected topics. This will be a combined class for both batches (ie those in male and female wards).
- Exam-oriented teaching sessions (variable)

You are expected to return to the ward in the afternoons to continue clerking new patients allocated to you, completing the afternoon ward rounds of your patients, examining interesting

patients in the ward and observing or participating in ward activities. Students should be present in the ward till 8.00 pm. You are expected to be actively involved in all aspects of patient care including being aware of the latest results of investigations, referrals, monitoring of seriously ill patients and maintaining their charts. You should meet the relatives and be aware of the social background of your patients and their ability to continue treatment after discharge.

Work times for students – 8.00 a.m. to 12.00 p.m., 2.00 p.m. to 4.00 p.m., and 6.00 p.m. to 8.00 p.m. on weekdays. You are required to be in the ward from 8.00 a.m. to 12.00 p.m. on Saturdays (except for assistant (shadow) house officer and special assignments).

All patient case histories must be completed on the day of admission. Complete case histories as given in 'Structure of case histories' (see below) must be available for inspection at any given time. Assistant house officers which we conduct in the 4th year, are expected to remain beyond normal duty hours.

Attendance

Attendance to teaching activities and ward work is compulsory. Absence from the appointment without prior notice is strongly discouraged. If you are unwell, a message must be forwarded through the monitor to the consultant in charge of your group. The patients under your care should be handed over to a colleague. If you need leave, this must be approved in advance by your consultant. If you are absent for more than 3 days without a valid medical certificate, you are liable to be "repeated". Leave for social events (e.g., parties) will be granted only under exceptional circumstances.

Behaviour, dress code, equipment and patient safety

You should be courteous, show empathy and be always kind to your patients. Please adhere to the faculty dress code. A name tag with the first and last names is mandatory. Basic equipment to carry to the ward includes a stethoscope, torch, tape, tendon hammer, toothpicks and cotton wool should be available with you when examining patients. Please refrain from re-using toothpicks and cotton wool. Ensure that you properly wash your hands before and after examining each patient.

Recommended books and references

Each of the four student groups must have at least one textbook each, a book on clinical methods and a formulary (e.g., BNF). These must be available during the ward rounds. We encourage you

to access sites on the internet and learn while in the ward. However, avoid using phones and other electronic devices during ward rounds or teaching sessions, unless you are requested to do some searching as a part of teaching by the consultant or the ward teacher.

The recommended books are given below

1. Basic Textbooks
    - Kumar and Clark's Clinical Medicine 10th Edition. Adam Feather, David Randall, Mona Waterhouse. Elsevier.
    - Davidson's Principles and Practice of Medicine 23rd Edition. Stuart H. Ralston, Ian Penman, Mark W J Strachan, Richard Hobson. Elsevier.

2. Handbooks
    - Oxford Handbook of Clinical Medicine (Oxford Medical Handbooks) 10th Edition. Ian Wilkinson, Tim Raine, Kate Wiles, Anna Goodhart, Catriona Hall, Harriet O'Neill. Oxford University Press.
    - Oxford Handbook of Emergency Medicine (Oxford Medical Handbooks) 5th Edition. Jonathan P. Wyatt, Robert G. Taylor, Kerstin de Wit, Emily J. Hotton. Oxford University Press.

3. Clinical science
    - Hutchison's Clinical Methods: An Integrated Approach to Clinical Practice (Hutchinson's Clinical Methods) 24th Edition. Michael Glynn, William M Drake. Elsevier.
    - Macleod’s clinical examination Macleod's Clinical Examination 14th Edition. J. Alastair Innes, Anna R Dover, Karen Fairhurst. Elsevier.
    - Talley and O'Connor's Clinical Examination - 2-Volume Set 8th Edition. Nicholas J Talley, Simon O’Connor. Elsevier.

4. Reference textbook
    - Oxford Textbook of Medicine, Volume 1 - 4. 6th Edition. John Firth, Christopher Conlon, Timothy Cox. Oxford University Press. Harrison's Principles of Internal Medicine, Twentieth Edition (Vol.1 & Vol.2) 20th Edition. J. Larry Jameson, Anthony Fauci, Dennis Kasper, Stephen Hauser, Dan Longo, Joseph Loscalzo. McGrawHill Education.

SUPPLEMENTARY READING (OPTIONAL)

- British Medical Journal
- New England Journal of Medicine
- Lancet
- Ceylon Medical Journal
- Journal of Ceylon College of Physicians
- Sri Lanka Medical Journal and Medical Journals of Galle, Jaffna, Jayewardenepura and Anuradhapura.
- Medscape – free website
- UpToDate – paid website
- Medicine journal

CHAPTER 3

WORK SCHEDULE

Self-directed learning at the bedside

The most effective learning resource is the patients in the ward. Speak to them, examine them and learn from their stories. Take a comprehensive history and formulate a tentative list of problems and analyze them to arrive at a differential diagnosis before examining the patient or checking the hospital notes. The examination will enable you to refine this list and come to a most probable diagnosis or a differential diagnosis giving clinical reasoning. Investigations that are available will help you to further narrow down the differential diagnosis, prognosticate and assess for risk factors. After going through this exercise, read about the topics (either textbooks or reliable web-based resources) and ask yourself a few questions. These are the sort of questions you will be asked during the Final MBBS.

- What are the clinical features of the diseases the patient has?
- Did I ask for all the symptoms?
- On what criteria should the diagnosis be made?
- What is the pathogenesis of the symptoms?
- What is the underlying pathology?
- How do we investigate?
- What is the sensitivity and specificity of a test?
- How should we treat the patient?
- Have the ward doctors followed the appropriate guidelines?
- What is the prognosis?
- Is the patient aware of the illness?
- What are his/her ideas, concerns and expectations?
- What does the patient think of the origins of the illness?
- Are there any ethical issues in the management of this patient?
- What are the principles of communication when discussing the diagnosis, investigations and treatment with the patient?
- What are the social circumstances of the patient?
- Whether there are special skills needed to care the patient at home after discharge?

Ward classes by consultants

This is usually a bedside teaching session, done each day by the consultant and an important component of your learning. It may take the format of discussions during a ward round or a more detailed class after the ward round. These tend to focus on clinical decision-making, practical skills, integrating existing knowledge and synthesizing solutions to real-life clinical problems.

The monitor is encouraged to maintain a log of the teaching done so as to avoid unnecessary repetition. It will also ensure that as many topics are learnt during the appointment.

Ward classes by extended faculty

These sessions are usually conducted by the teachers who are consultants of the Ministry of Health. Until independent professorial units are established, bedside teaching during ward rounds will be mainly done by the staff of the consultants of the THR.

Case-Based Teaching (CBT)

The previous terminology was Clinical Lecture Demonstrations (CLDs). The whole 'batch' of students will be attending the CBL organized by the clinical departments.

Students are expected to attend the clinical meetings of the Ratnapura Clinical Society in THR. Students are expected to participate any of the online teaching programmes organized by professional collages and or associations.

Short case teaching sessions

A special short case teaching session will take place during the appointment. The objectives of this session are to evaluate the clinical skills of the students and familiarize them with examination conditions.

Acute Medicine teaching sessions

These sessions will take place in small groups. Hands-on practical training will be provided on basic and advanced life support. Students will also be exposed to the management of medical emergencies in a "simulated environment". Students will also be expected to make presentations on medical emergencies seen during their ETU rotations in with a critical analysis discussion on the observed management.

Special classes

- Classes on ECGs and radiology will be held.
- Classes will be held to highlight ethics and communication in clinical practice
- Social, cultural, spiritual and mental health aspects related patient care

Casualty ward experience

The Professorial Unit has a casualty on-take rotation. You will be supervised closely. Attendance is compulsory. On our casualty nights, you are expected to be present in the casualty ward from 2000 hrs until the end of the post-casualty round. You should see the patients as they are admitted and assess them early. Groups consisting of four students each should see patients at the ETU in rotation and accompany them when they are being brought to the casualty ward. In situations where the house officer is busy, you should take the opportunity to assess the patients on admission. This will help you to identify patients requiring immediate attention (i.e., triaging patients using early warning scoring systems). Each student should be familiar with all the admissions whilst being fully responsible for the patients allocated. A post-casualty ward round will be done on the following day morning. Students who are allocated to ETU rotations are expected to monitor the progress of the patients in the short stay ward and review plan.

MICU / ETU

You should be able to assess critically ill patients at the ETU and MICU. The MICU gives you the opportunity to learn about artificial ventilation with regard to indications for ventilation, types of ventilation, problems related to ventilation and understand complications of prolonged ICU care. You should also learn and be able to describe procedures related to routine patient care, such as measurement of central venous pressure, chest physiotherapy, and know about safe transfer to and from ICUs. A roster will be provided for ETU and MICU rotations

Assistant House-Officer scheme

This is a unique scheme for your learning. The objective is to gain confidence to work in a general medical ward, by acquiring basic skills, learning to carry out the duties of a house officer and becoming familiar with ward routines.

A group of 3-4 students will be allocated for a 2-day period to a designated teacher (consultant). You need to contact this consultant before starting the shadow house officer roster. You should 'shadow' the house officer during their ward stays, helping and learning from them. Join in the ward rounds of House Officers, assist and perform clinical procedures and perform tasks such as

setting up IV infusions, IV injections that are permitted, assessing 'daily states' of patients, and observing nursing rounds and other ward procedures

The student should also draw blood samples from patients and observe statutory work such as notification, medical and death certification. You will be expected to remain in the ward after hours and be 'on-call'. The allocated shadow house officer should complete the shadow house officer log section in the workbook and maintain summaries of all the patients clerked during this period.

During or at the end of the allocated period you will be assessed by the consultant based on the work you have done or seen. You must obtain the consultant's signature immediately after completion of the shadow house officer period.

CHAPTER 4

THE CONTINUOUS ASSESSMENT

Marks obtained in this continuous assessment will constitute 20% of the Final MBBS Medicine examination mark. Ward work forms an important component of your assessments. Patients will be allocated consecutively.

Assessments at the end of the 4th Year

Interview Based Portfolio/ Workbook Assessment

- 15 cases each from 1st and 2nd Clinical Medicine Appointments
- 3 to 5 cases from each short appointment

Ten (10) marks will be allocated to an assessment of case scenarios based on workbooks. This will be conducted by the academic staff members of the Department with the assistance of other staff from the Ministry of Health and Faculty.

Assessments during and at the end of the Professorial Appointment

- Assessment of performance of ward work, based on cases allocated to individual students. This will include history-taking skills, physical examination skills, clinical reasoning, formulating a comprehensive plan of management, patient welfare, and knowledge related to the illness etc.)
- Assessment of Communication Skills
- Structured oral examination focusing on emergencies and ethics.
- Objective Structure Clinical Examination (OSCE)

Ten (10) marks will be allocated for Continuous Assessments in Medicine during the Prof. Appointment which will be conducted during or at the end of the Professorial appointment.

Assessment of Ward Work

Attendance

Attendance will be marked every day. Attendance is compulsory. Any absence should be supported by a medical certificate or by obtaining permission from the academic in charge of the ward. Prior permission should be obtained, especially in instances where the event is planned well ahead of time.

Assessment of Patient-Centered Learning

This forms one of the most important components of the programme. Each teacher will give a grading based on the

- familiarity with the patients assigned
- expression of knowledge during rounds
- level of participation during rounds
- general conduct in the ward and
- participation in patient care and in the well-being of the patient

Consultants may also assess you more formally during ward rounds. This could be at the time of a case presentation by you, or by asking a few questions from you to assess what you have learned about your own patient. Questions that could be asked include one or more of the following:

- "Give a summary of the history of your patient"
- "Take a brief history of this patient in order to see if she has migraine"
- "Take a brief history of this patient who presented with acute chest pain"
- "Auscultate the precordium while I observe"
- "Which features indicate that this patient has hepatic encephalopathy?"
- "What are the problems you have identified in this patient?"
- "How have you confirmed a diagnosis of acute kidney injury in this patient?"
- "Talk to the family regarding discharge from hospital and care at home in this patient after stroke"

It is YOUR responsibility to get these assessments completed by each of the supervising consultants during the respective rotations.

Shadow house officer scheme

During or at the end of the allocated period of shadow house officer work you will be assessed by the consultant based on the work you have done or seen. You may be asked a few questions, and the consultant may inquire about your work from the House Officers, nurses or the rest of the team. It is your responsibility to obtain the consultant's signature immediately after completion of the shadow house officer period.

Case Histories

You must write your name in the BHT to indicate ownership. A detailed history, examination findings and daily state should be recorded on an A4 paper and kept in your possession. We encourage you to use the 'SOAP' format (S – subjective, O – objective, A – assessment, P – plan) to write daily states relevant to the patient's illness in your notes. All case histories should be endorsed by the consultant during the ward rounds. The endorsed case histories should be filed and available during the end of appointment viva. Un-endorsed histories would not be accepted. You are expected to have the current histories of all patients allocated to you. You are encouraged to clerk any patient in the ward in order to have a varied collection of case histories. Cases should be filed and will form your own portfolio. It could serve as a guide for revision. The first page of the file should have an index giving the case number and main problems the patient had (e.g., Type 2 diabetes mellitus with ischemic heart disease).

Each case history should include the following

- History followed by a short discussion on the likely diagnoses
- Examination findings followed by a narrowing down of diagnoses mentioned in the previous section
- Summary of the case (i.e. how you would present the important features to an examiner or consultant)
- Investigations available to you at the time of taking the history and examination
- Discussion of differential diagnosis
- Problem list which includes medical, psychological and social problems
- Plan of management with at least one reference to a published guideline or Evidence-Based Medicine
- Daily status while in the ward with investigation results in red and their reference ranges
- Plan on discharge

- Discharge summary of the patient. This should be written on a photocopy of a blank 'diagnosis card' given to patients
- The prescription given to the patient
- A brief explanation of medical problem and treatment in an easily understandable form in the patient's native language

The Workbook and Portfolio

The Workbook and Portfolio form an important part of your guide to your learning, and continuous assessments. Procedures, medical emergencies, laboratory work and casualty experience must be logged in this book.

We have included a Reflective Learning form to help you to engage in reflective practice. You are expected to complete at least one for each of the following sections: case histories, medical emergencies and diagnostic/therapeutic procedures. The form for reflective practice in case histories should be countersigned by a member of the academic staff. Please ensure that the Reflective Learning forms are filled out individually. The shadow house officer log should be completed during the rotation and should detail the activities carried out during this period.

Please arrange with the Consultant Chemical Pathologist/ Consultant Haematologist and chief laboratory technician for a case-based demonstration. No more than 7 students will be accommodated at each demonstration. The signature of the Consultant Chemical Pathologist/ Consultant Haematologist should be obtained. The laboratory session will include a demonstration of:

- Urine analysis
- Blood films
- Blood counts

Observed history taking

The student will take a history from an assigned patient while being observed by a teacher. This will take place in the 2nd week of your appointment. The objective is to evaluate and identify the deficiencies in the student's skills in taking a systematic, focused history and processing information.

The student will spend 10 minutes taking a history from an assigned patient while being observed by the teacher one-to-one:

- Greeting the patient, self-introduction, explaining what is going to be done, and obtaining consent
- Open-ended questions / Rapport / Non-verbal communication
- Use simple language
- Analyze symptoms to arrive at a diagnosis or to identify the problems faced by the patient (most important!)
- Comprehensive history covering review of systems, past medical history, family history, social history etc.)
- Time management
- Conclusion of the interview including thanking the patient

At the end (after 10 minutes), the teacher will ask a few questions for 2 minutes focusing on what could be the diagnosis and the reasons for arriving at the particular diagnosis.

Communication Skills

How you explain an investigation, an illness, obtain consent for a test or promote change in behaviour will be assessed. This assessment will be in Sinhala or Tamil. A 10–15-minute formative assessment will be conducted to assess these skills. (See Appendix)

Ethics

At least one class will be held to reflect on ethical issues relevant to clinical practice. Students are expected to incorporate ethical reasoning in the care of patients. (See Appendix)

End of the appointment interview

The *viva voce* will be conducted for 20 minutes, by a panel of two teachers based mainly on medical emergencies.

The following will also be checked and included in the grading of the interview:

- Attendance: This will be graded on a scale of A, B, C: A = Those without a single day of absence from work, B=1 to 3 days absence with prior notice / supporting documents and

have handed over patients to a colleague. C= leave without notices or more than 3 days absents or patients have not been handed over.

- Assessment of Patient-Centered Learning: Grading by academics
- Assistant House-Officer scheme: Successful completion of shadow house officer
- Completed workbook and portfolio which includes medical emergencies, procedures and laboratory work
- Case Histories: Completed case histories (all endorsed by the consultant)

The OSCE

OSCE: includes clinical skills, communication skills and interpretation of clinical pictures, test results and data. OSCEs will be held in the last week of the appointment and consist of twenty, 5-minute stations.

CHAPTER 5

END OF COURSE EXAMINATION

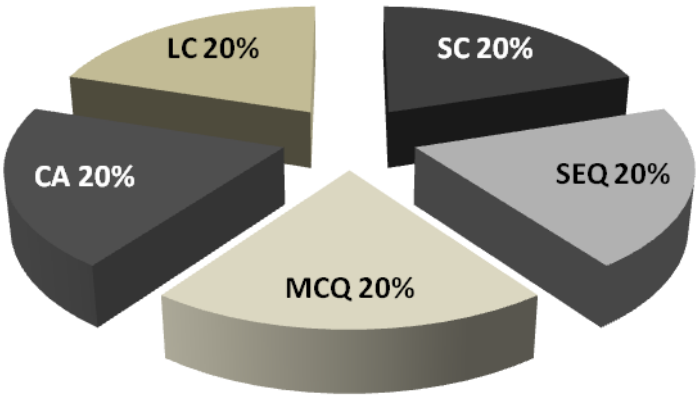
Given below are few aspects relevant to the End of Course Examination known as the 'Final MBBS'.

The mark in General Medicine consists of what you earn in 5 components. The Continuous Assessment (CA) assesses your performance during the Professorial Appointment. If your performance is unsatisfactory, your will be required to do an additional week or more of supervised ward work. You should pass the CA to be eligible to sit for the End of Course Examination in Medicine.

Components

1. CA - Continuous Assessment (marks obtained during the prof appointment)
2. SEQ - Structured Essay Questions (five questions, 3 hours)
3. MCQ - Multiple Choice Question papers

   Common Paper for ranking of Medical Graduates (50 questions: 20 true false type and 30 single best response type, 2 hours)
4. LC - Long Case 40 minutes with the patient and 20-minute interview with one pair of examiners
5. SC - Short Cases: 4 short cases in CVS, RS, NS and ABD, of 7.5 minutes each (i.e. a total of 30 min), four pairs of examiners



Note:
CA marks are taken only at the first attempt.

Only the "Common MCQ paper" and the Clinicals (LC & SC) are taken for ranking of medical undergraduates for internship appointments (Common Merit List)

This information is current at the time of printing of this book and is applicable only for the batch of students that it is being printed for.

Distribution of final marks

The objective of the long case examination is to test the candidate's ability to

- gather information relevant to the patient's problem through a comprehensive history and arrive at a tentative list of problems (including DD)
- perform a thorough physical examination
- interpret the information gathered logically, and derive a list of problems/ diagnoses, taking social-cultural aspects into consideration
- present the findings
- formulate a relevant and logical investigation and management plan for the patient, while demonstrating knowledge on limitation and interpretation of tests, preventive strategies and how to communicate information effectively
- demonstrate knowledge of the pathophysiological basis of symptoms, signs and the disease condition and the pharmacological basis of treatment proposed

The objective of the short case examination is to test the candidate's ability to

- perform a physical examination of a given system in a stepwise and technically correct manner
- elicit the physical signs present
- interpret them logically and arrive at a diagnosis or differential diagnosis
- demonstrate basic knowledge of the pathophysiological basis of the physical signs, the disease and treatment

DISTINCTIONS AND PRIZES

Distinction in Medicine

A student will be awarded a distinction in medicine if at the first sitting he/she obtains a minimum of 70% at the end of course assessment of the Clinical Sciences Stream in medicine and has a minimum of 65% at the continuous assessment in medicine.

CHAPTER 6
MEDICAL EMERGENCIES

We have listed below a few key medical emergencies and developed a section for you to complete. Please fill the blank areas on your own, based on a patient you see. We believe this will help you to learn and remember the important steps in managing the emergencies

1. Acute coronary syndromes
2. Acute left ventricular failure
3. Tachyarrhythmias
4. Bradycardias
5. Hypertensive emergencies
6. Acute pulmonary embolism
7. Acute severe asthma
8. Pneumothorax
9. Haematemesis
10. An unconscious patient
11. Stroke
12. Seizure
13. Syncope
14. Acute renal failure
15. Sepsis with multiorgan failure
16. Snakebite envenoming
17. Organophosphate poisoning
18. Paracetamol overdose
19. Oxalic acid ('Prinso') poisoning
20. Hypokalaemia and hyperkalaemia
21. Diabetic ketoacidosis
22. Diabetic hyperosmolar coma
23. Anaphylaxis
24. Dengue critical phase
25. Hepatic encephalopathy
26. Alcohol withdrawal syndrome
27. Delirium elderly

1. (a) ACUTE ST-ELEVATION MYOCARDIAL INFARCTION

Name:	Age:	Gender:

Ward:	BHT:	DOA:	Date seen:

Brief history:

Investigations (including ECG):

How the diagnosis was confirmed:

Immediate	Later

Plan of management:

Follow up and the outcome:

1. (b) OTHER ACUTE CORONARY SYNDROMES (INCLUDING NSTEMI)

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

Investigations done:

How the diagnosis was confirmed:

Plan of management:

Immediate	Later

Follow up and the outcome:

2. ACUTE LEFT VENTRICULAR FAILURE

		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

Results of investigations:

The underlying cause of LVF:

Plan of management:

Immediate	Later

Follow up and the outcome:

3. TACHYARRHYTHMIAS

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Presentation:

Type of the tachyarrhythmia:

The precipitating cause:

Draw typical ECG changes in this patient (or paste a picture of the ECG):

Plan of management:

Immediate	Later

Assignment: Read about ECG changes and treatment of other tachyarrhythmias

4. BRADYCARDIA

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Presentation:

Type of the bradycardia:

The precipitating cause:

Draw typical ECG changes in this patient (or paste a picture of the ECG):

Plan of management:

Immediate	Later

Assignment: Read about ECG changes and treatment of other causes of bradycardia

5. HYPERTENSIVE EMERGENCIES

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

The type of hypertensive emergency:

Precipitating cause:

Plan of management:

Immediate	Later

Long term management:

6. ACUTE PULMONARY EMBOLYSM

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

The type of hypertensive emergency:

Precipitating cause:

Plan of management:

Immediate	Later

Follow-up plan:

7. ACUTE SEVERE ASTHMA

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

Precipitating factors

Criteria for acute severe asthma in this patient:

PEFR:

Plan of management:

Immediate	Later

Advice on discharge from the ward:

8. PNEUMOTHORAX

Name:

Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

Write the steps when inserting an intercostal tube:

Management of the intercostal tube:

The outcome:

Draw an algorithm for management of pneumothorax:

9. HAEMATEMESIS

Name: Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

The cause of haematemesis in this patient:

Investigations done:

Plan of management in the ward

Immediate	Later

Drugs recommended on discharge

10. AN UNCONSCIOUS PATIENT

Name:

Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

GCS on admission

Investigations done:

Diagnosis:

Management:

Immediate	Later

The outcome:

Causes of coma without focal signs:

11. STROKE

Name: Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

Vascular territory involved: **Infarct or haemorrhage?**

Investigations done:

Risk factors:

Assessment of functional disability:

Plan of management:

Immediate	Later

The outcome and the prognosis:

12. SEIZURE

Name:

Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

Precipitating factors:

Investigations done:

Plan of management:

Immediate	Later

Advice on discharge from the ward:

Secondary causes of seizures:

13. SYNCOPE

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

The type of hypertensive emergency:

Precipitating cause:

Plan of management:

Immediate	Later

Long term management:

14. ACUTE KIDNEY INJURY

Name:

Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

Blood urea
S Creatinine
S Potassium
pH (ABG)

The underlying cause:

ECG changes (draw or paste a copy):

Plan of management:

The outcome:

Steps in the management of hyperkalaemia:

15. SEPSIS WITH MULTIORGAN FAILURE

Name: Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

The possible source of infection:

The responsible microbial agent:

Results of important investigations:

Management:

Antibiotic therapy

Cardiovascular support

Respiratory support

Renal support

Correction of haematological problems

Correction of metabolic abnormalities

Others (including nutrition, and physiotherapy)

What is the rationale for giving IV hydrocortisone to some patients with sepsis?

Complications in this patient (mark ✓)	
Hypotension	
Acute renal failure	
Acute respiratory distress syndrome	
DIC	
Liver failure	
Adrenal failure	
Neurological manifestations	
Other	

The outcome:

16. SNAKEBITE ENVENOMING

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

20 min WBCT

Identity of the snake:

Signs of envenoming:

Procedure for the administration of AVS	Steps in the management of anaphylaxis

Complications and the outcome:

17. ORGANOPHOSPHATE POISONING

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

Accidental or deliberate self-harm?

Features of organophosphate poisoning:

Plan of management:

Immediate	Late

Steps in monitoring of the patient:

18. PARACETAMOL OVERDOSE

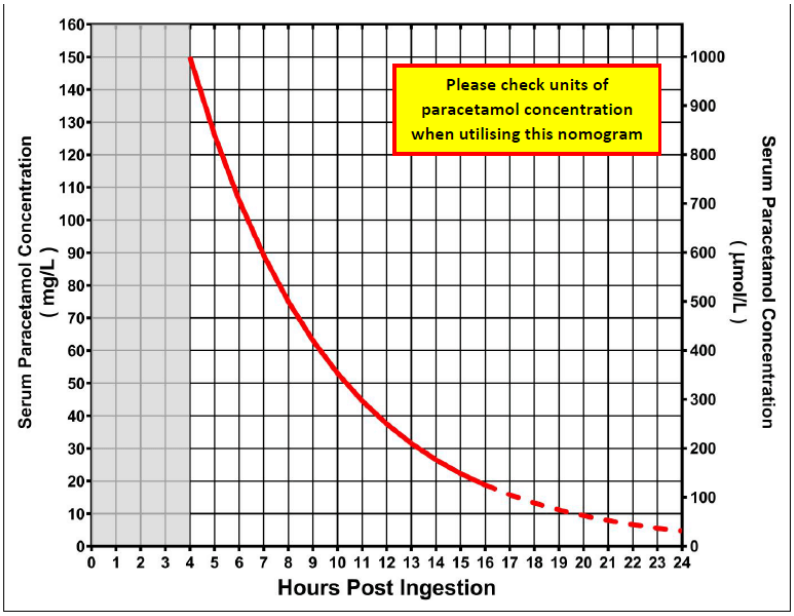
Name: Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

Investigations done:

If paracetamol levels are done, mark them on this nomogram (Given here is single line nomogram. You may refer double line nomogram too)



Plan of management

Reason for overdose:

19. OXALIC ACID ('PRINSO') POISIONING

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

Accidental or deliberate self-harm?

Features of poisoning at presentation:

What are the complications:

Plan of management:

Immediate	Late

20. HYPOKALAEMIA AND HYPERKALAEMIA

Name: Age: Gender:

Ward: BHT: DOA: Date seen:

Causes of K^+ ↓	Causes of K^+ ↑
List the clinical features of K^+ ↓	List the clinical features of K^+ ↑
Draw the ECG features of K^+ ↓	Draw the ECG features of K^+ ↑
Options of Treatment K^+ ↓	Modalities of Treatment - K^+ ■

21. DIABETIC KETOACIDOSIS (DKA)

Name: Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

DOA:
Age:
Type of DM:
Main cause:

Precipitating causes:
(Insulin Rx, hydration, acidosis, K^+)

On admission
RBS:
ABG pH:
ABG HCO_3
Anion Gap
FBC
Cardiac Enzyme
ECG
Blood Urea

Criteria for diagnosing DKA in the patient:

Immediate management:

Continuation of management:

Plan on discharge:

22. HYPERGLYCAEMIC HYPEROSMOLAR STATE (HHS)

Name: Age: Gender:

Ward: BHT: DOA: Date seen:

Brief history:

DOA:
Age:
Type of DM:
Main cause:

Precipitating causes:
(Insulin Rx, hydration, acidosis, K^+)

On admission
RBS:
ABG pH:
ABG HCO_3
Anion Gap
FBC
Cardiac Enzyme
ECG
Blood Urea

Criteria for diagnosing HHS in the patient:

Immediate management:

Continuation of management:

Plan on discharge:

23. ANAPHYLAXIS

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief History:

Precipitating factor:

Investigations done:

Immediate management:

Further management in the ward:

Advice to the patient on discharge:

24. DENGUE CRITICAL PHASE

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief History:

Relevant examination findings:

Investigations: Attach a copy of a critical phase chart

Attach graph giving values of Hb, PCV, Platelets, WBC, and absolute N and L counts

Plan of management:

Guidelines issued by the Ministry of Health applicable to this patient:

25. HEPATIC ENCEPHALOPATHY

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

what are the physical findings that support the hepatic encephalopathy?

How do you grade the HE in this patient?

What is the precipitant of HE in you patient?

Outline the management of your patient

26. ALCOHOL WITHDRAWAL SYNDROME

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

How do you establish the diagnosis in your patient?

What is the sequelae of untreated or inadequately treated alcohol withdrawal syndrome?

Outline the management of your patient

27. DELIRIUM IN ELDERLY

Name:		Age:	Gender:
Ward:	BHT:	DOA:	Date seen:

Brief history:

Outline the investigations performed in your patient with their results

What is/are the cause(s) for delirium in your patient?

Outline the management of your patient

REFLECTIVE LEARNING

Type of emergency:

Date of learning event: Site:

Event

Specify the type of event in your own words (case history or procedure or relating to patient encounter etc):

Myself

What I used to do previously when faced with a similar situation /event:

Experience of event

A description of the event as it happened: .

Feelings

Aspects of the event that I think went well:
Aspects that I think were not too good:
My feelings about what happened:

Learning

What did I learn from the event?
How did I learn it?
What would I do if I face a similar event in future?
Comments by a colleague and signature:

In future...

Did you face such an event again?
If yes, what did you do?

CHAPTER 7

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

1. Cardio-pulmonary resuscitation (CPR)
2. Cardioversion
3. Oxygen therapy, Non-invasive ventilation and Mechanical ventilation
4. Arterial blood gas analysis
5. Organ biopsy (Liver or Renal)
6. Bone marrow aspiration and biopsy
7. Pleural fluid aspiration
8. Ascitic fluid aspiration
9. Lumbar puncture
10. Transfusion of blood or blood products
11. 20-minute whole blood clotting test
12. Peritoneal dialysis
13. Haemodialysis
14. Urine analysis
15. Blood pictures

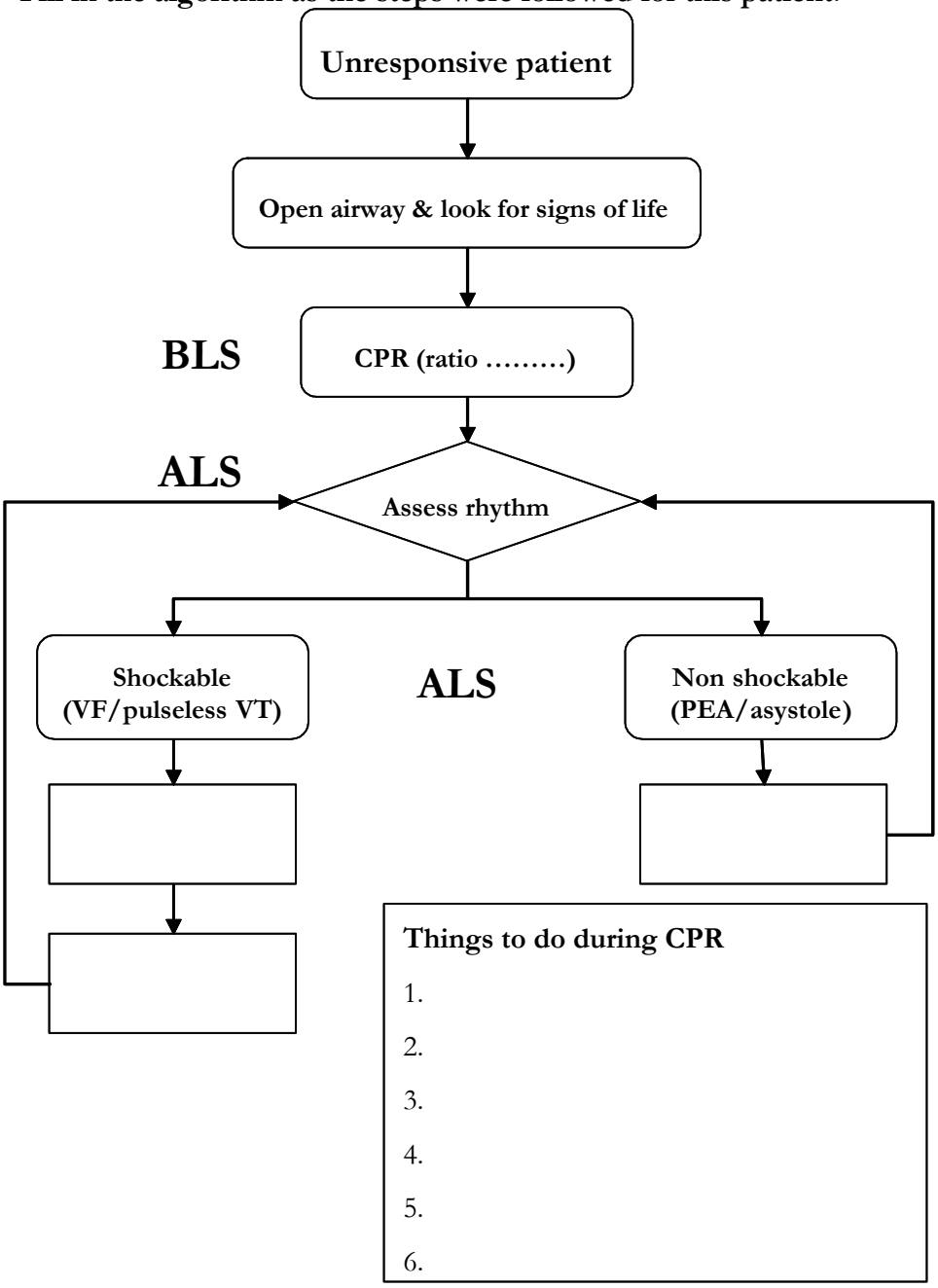
1. CARDIOPULMONARY RESUSCITATION

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Cause of the cardiac arrest:

Fill in the algorithm as the steps were followed for this patient:



What are the reversible causes of cardiac arrest?

The 4 'H's	The 4 'T's

What are the causes of pulseless electrical activity PEA?

Was the patient resuscitated?

Management following resuscitation

What was the outcome?

If the patient died, what was the cause of death?

How was death confirmed?

What was the cause of death given in the 'Death Certificate'?

_____

Signature & name of the supervising registrar/ senior registrar

2. CARDIOVERSION

Name:	Age:	Gender:	Ward:	BHT:
Done by:	Date:		Place:	

Reason for cardioversion:

Pre-procedure preparation

Consent

Drugs (sedation, anticoagulation)

Procedure

Machine settings

How was it synchronized?

Paddle placement

Precautions

Energy delivered

Outcome

After care

_____

Signature & name of the supervising registrar/ senior registrar

3. MECHANICAL VENTILATION

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Clinical problem leading to respiratory failure:

ABG results

Type I	
Type II	

The mode of ventilation used:

Ventilator settings

Other modes of ventilation available:

What are the complications of ventilation?

Early	Late

What is CPAP?

What is PEEP?

What is non-invasive ventilation?

4. ARTERIAL BLOOD GAS ANALYSIS

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Paste the report here

Clinical problem:

Preparation:

Steps of the procedure:

Interpretation of ABG:

What are the other sites that can be used for ABG?

What is the importance of Allan's test?

How was the specimen transported?

Interpret these ABG values:

pH	**P_aCO_2**	**Standard HCO^3**	**Base Excess**	**Interpretation**	**Example**
Low	Normal	Low	Deficit		
Normal	Low	Low	Deficit		
Low	High	High	Excess		
Normal	High	High	Excess		
High	Normal	High	Excess		
High	Low	Low	Deficit		

Signature & name of the supervising registrar/ senior registrar

5. ORGAN BIOPSY (LIVER OR KIDNEY)

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Indication

Preparation:

Precautions taken:

Procedure:

Site:

Instrument:

Post-procedure care:

Transport of the specimen:

Histology report:

Explain how this helped in the management

6. BONE MARROW ASPIRATION AND BIOPSY

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Indication

Preparation:

Procedure:

Site:

Instrument:

Post-procedure care:

The report (summary):

Explain how this helped in the management:

Other indications for aspiration biopsy
Other indications for trephine biopsy
Complications

Signature & name of the supervising registrar/ senior registrar

7. PLEURAL FLUID ASPIRATION AND BIOPSY

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Indication:

Preparation:

Procedure:

Site:

Instrument:

The cause of effusion in this patient:

Fluid analysis report

- ☐ Appearance _____
- ☐ Glucose _____
- ☐ Proteins _____
- ☐ Cells _____
- ☐ Other _____

☐ Exudate ☐ Transudate

Other diagnostic tests that can be performed on pleural fluid:

Other changes that you expect in the fluid analyses to confirm the diagnosis:

_____

Signature & name of the supervising registrar/ senior registrar

8. ASCITIC FLUID ASPIRATION

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Indication: **Therapeutic or diagnostic?**

Preparation:

Procedure: **Site:** **Instrument:**

Fluid analysis report

- ☐ Appearance _____
- ☐ Glucose _____
- ☐ Proteins _____
- ☐ Cells _____
- ☐ Other _____
- ☐ SAAG _____

☐ Exudate ☐ Transudate

The cause of ascites in this patient:

What is the importance of serum ascites albumin gradient (SAAG)?

What are the side effects of ascites fluid aspiration?

What are the criteria for diagnosing spontaneous bacterial peritonitis (SBP)?

_____

Signature & name of the supervising registrar/ senior registrar

9. LUMBAR PUNCTURE

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Indication:

Preparation and precautions:

Procedure:

Instruments used:

Aseptic precautions:

Selection of the site:

Specimens collected:

Post-procedure care:

The diagnosis:

Contraindications

X

Fluid analysis report

Appearance _____

Pressure _____

Proteins _____

Cells _____

Glucose _____ (RBS _____)

Gram stain _____

Culture _____

Other tests _____

Signature & name of the supervising registrar/ senior registrar

10. TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

Name	Age:	Gender:	Ward:	BHT:

Done by:	Date:	Place:

Indication:

Blood product used: **Volume transfused:**

Pre-transfusion checklist:

Have you cross-checked the 'blue chit' with the 'pink chit'?

Information given on the pack:

Measures taken when blood products are stored

- **Screening:**
- **Preparation:**
- **Temperature:**
- **Additives**

Complications expected from a transfusion:

Treatment in case of a reaction:

_____

Signature & name of the supervising registrar/ senior registrar

11. 20-MINUTE WHOLE BLOOD CLOTTING TEST

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Clinical situation:

Equipment:

Steps of the procedure:

Result: clotted / not clotted

Results of subsequent tests:

Explain how this test helped in the management:

]

Signature & name of the supervising registrar/senior registrar

12. PERITONEAL DIALYSIS (IF AVAILABLE)

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Indication:

Results of relevant tests prior to dialysis:

Preparation:

Procedure:

Why PD was selected over HD for this patient:

What are the contraindications for the procedure?

What is the potassium concentration in the fluid used for PD?

Investigation	**Serum creatinine**	**Blood urea**	**S. potassium**
Pre - dialysis			
Post - dialysis			

Complications of peritoneal dialysis:

How did the procedure help in the management?

Signature & name of the supervising registrar/ senior registrar

13. HAEMODIALYSIS

Name: Age: Gender: Ward: BHT:

Done by: Date: Place:

Indication:

Preparation:

Paste label from dialysate solution

Method and site of vascular access:

Procedure and medications used:

Why was HD selected over PD for this patient?

What are the contraindications for the procedure?

What is the potassium concentration in the fluid used for HD?

Investigation	**Serum creatinine**	**Blood urea**	**S. potassium**
Pre - dialysis			
Post - dialysis			

Complications of haemodialysis:

How did the procedure help in the management?

Signature & name of the supervising registrar/ senior registrar

14. URINE ANALYSIS

During the professorial medicine appointment, the student has to do the following tests in the laboratory of the Department of Clinical Medicine and obtain a certification from the technical officer.

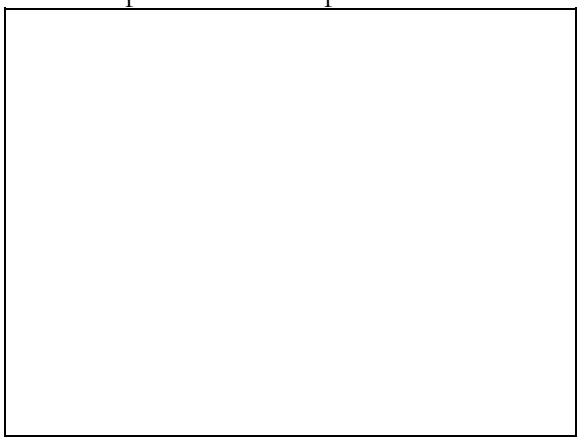
Write down the procedure in this log book.

Using dipsticks to test urine and interpretation

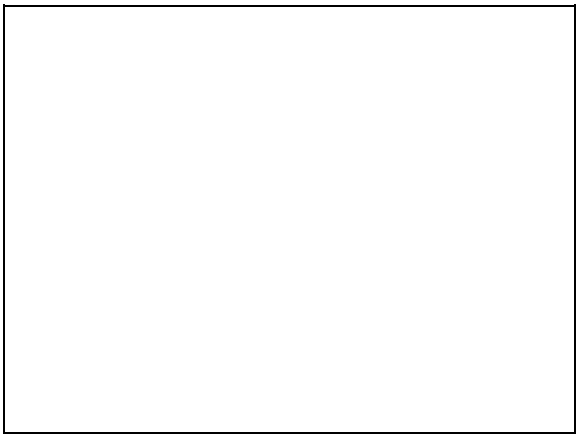
Procedure for proteins

14. BLOOD PICTURES

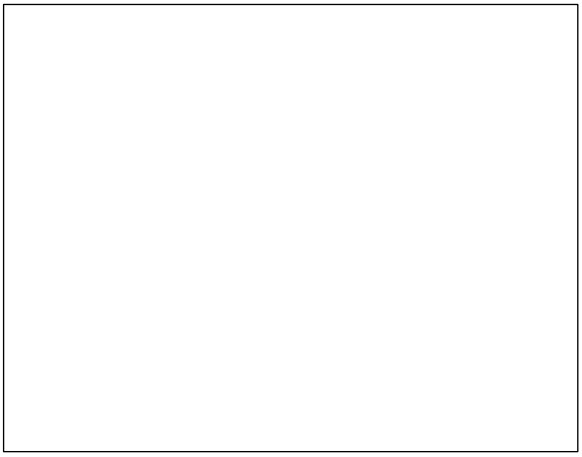
Draw or paste the blood pictures of the following disease conditions.



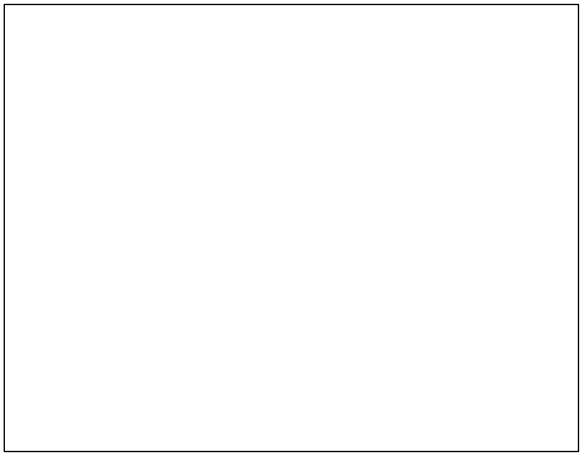
Normal



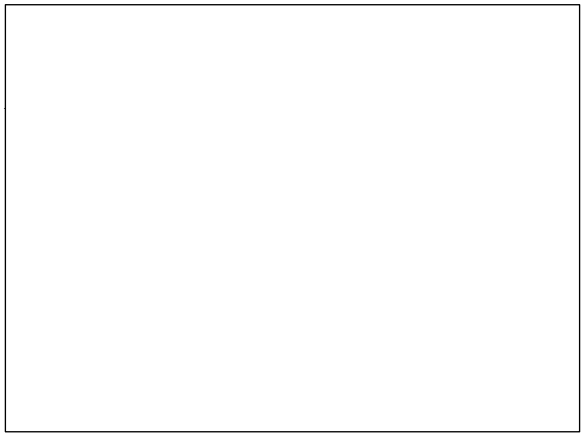
Iron deficiency anemia



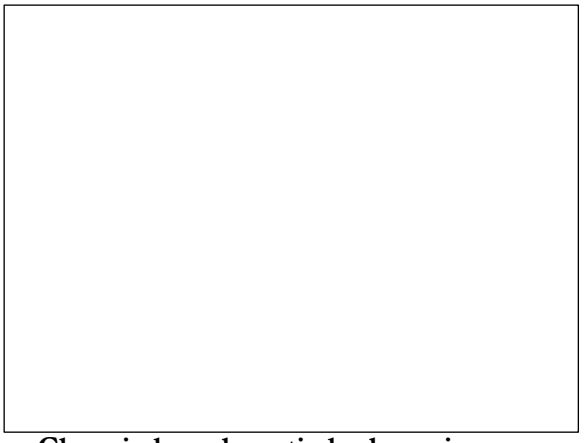
Thalassaemia



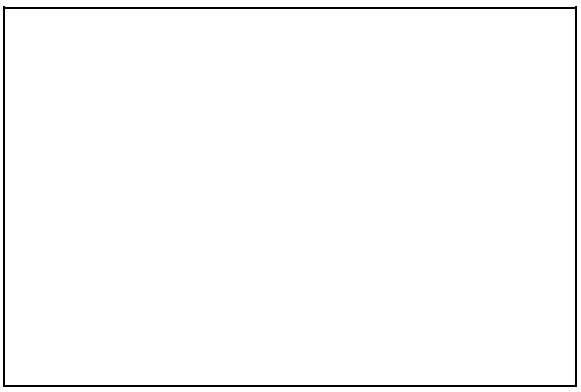
DIC



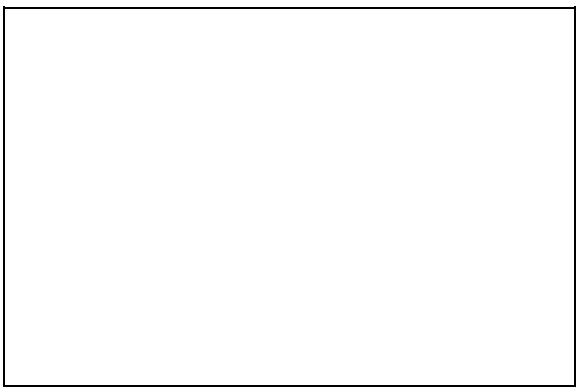
Acute leukaemia



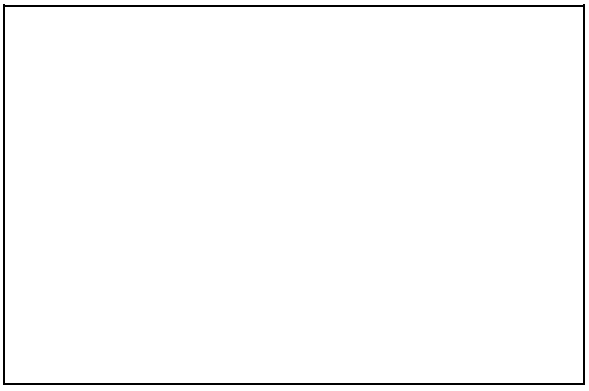
Chronic lymphocytic leukaemia



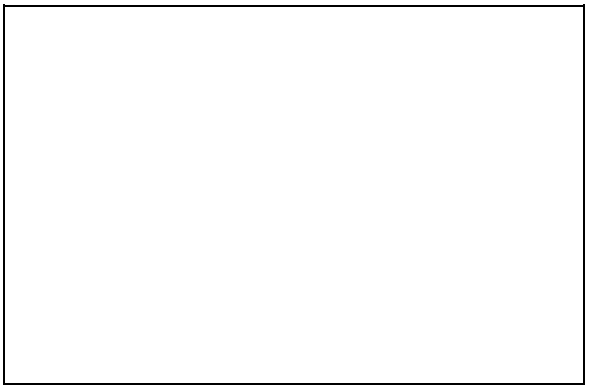
Chronic myeloid leukaemia



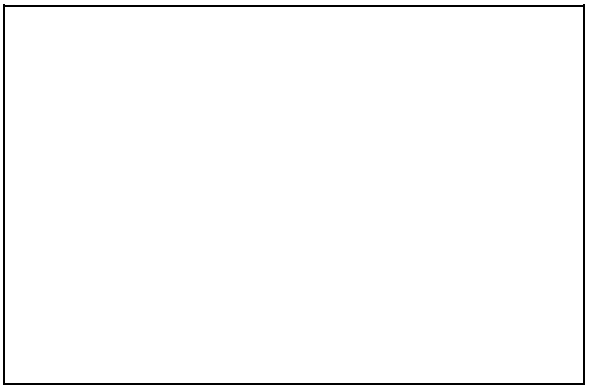
Multiple myeloma



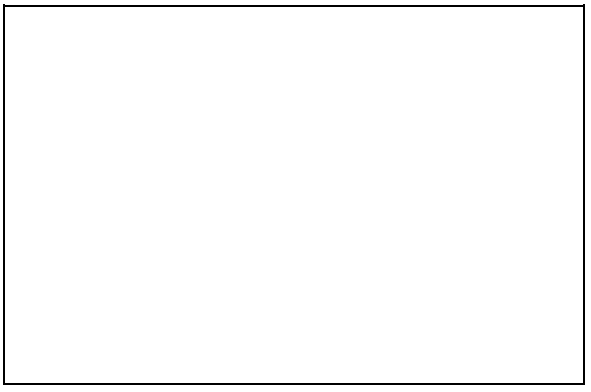
Megaloblastic anaemia



Non-megaloblastic macrocytosis

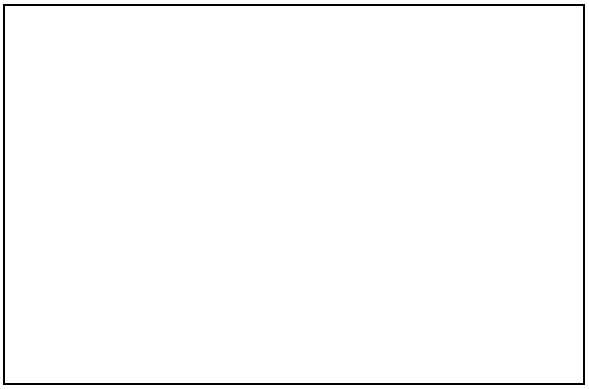


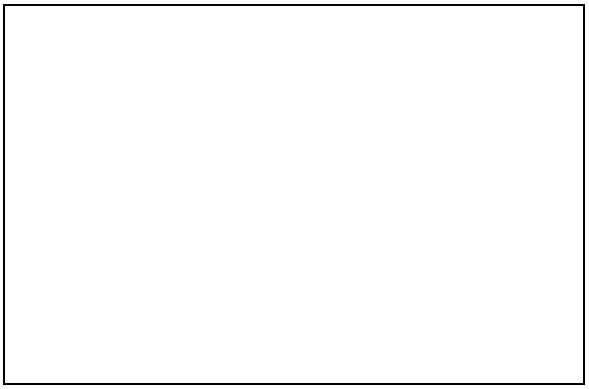
AIHA

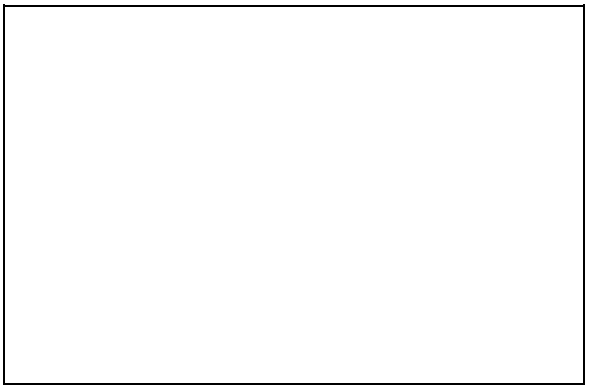


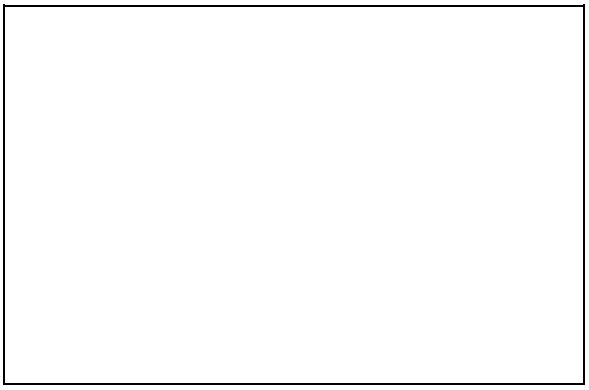
Leucoerythroblastic blood picture

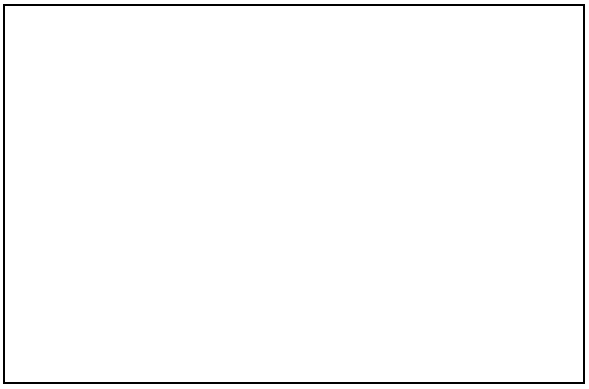
Other blood pictures of interest

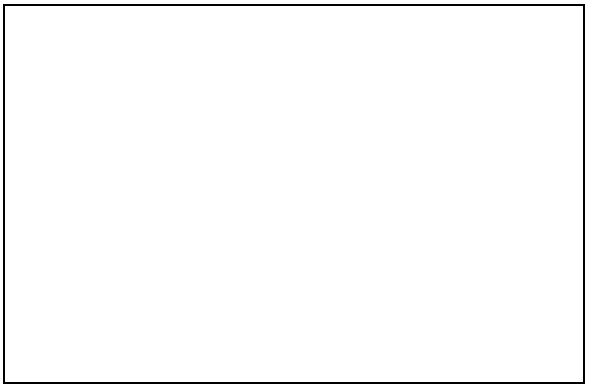












REFLECTIVE LEARNING

Procedure:

Date of procedure: Site:

Event

Specify the type of event in your own words (case history or procedure or relating to patient encounter etc.):

Myself

What I used to do previously when faced with a similar situation/event:

Experience of event

A description of the event as it happened:
.

Feelings

Aspects of the event that I think went well:
Aspects that I think were not too good:
My feelings about what happened:

Learning

What did I learn from the event?
How did I learn it?
What would I do if I face a similar event in future?
Comments by a colleague and signature:

In future...

Did you face such an event again?
If yes, what did you do?

CHAPTER 8
LIST OF CBDS – BY THE DEPARTMENT OF MEDICINE

(This list is subject to modifications)

In addition to the above lectures there will be following Case-Based Discussions (CBD) conducted during the final year. Sessions will be conducted for the whole batch.

CBDs done in final Year
1. An approach to a febrile patient
2. Patient presenting with bilateral ankle swelling
3. Anaemia
4. Patient presenting with reduced urine output
5. Haematuria
6. Patient presenting with faintness and low blood pressure
7. Patient presenting with shortness of breath on excretion
8. CKD – management
9. Irregular pulse
10. Acute vertigo
11. Back pain
12. The complicated diabetic
13. Chest pain
14. Hypertensive urgency and emergency
15. A breathless patient
16. Patient having swollen painful joints, back ache
17. A patient with history of rheumatic fever, presenting with breathlessness
18. A patient with jaundice
19. A patient with chronic cough
20. Dengue
21. Haemoptysis
22. Haematemesis and ankle edema
23. Hemiparesis
24. Limb weakness
25. Altered level of consciousness
26. Bleeding from gums and bleeding into joint
27. Leptospirosis
28. Headache

CHAPTER 9
A CHECKLIST OF KEY TOPICS

Have you clerked patients with these problems during the professorial medicine appointment?

- ☐ ACS
- ☐ Hypertension
- ☐ Chronic heart failure
- ☐ Valvular heart diseases
- ☐ Infective endocarditis
- ☐ Rhythm abnormalities
- ☐ Diarrhoea
- ☐ Peptic ulcer disease
- ☐ Inflamm. bowel disease
- ☐ Haematemesis
- ☐ Diabetes
- ☐ DKA
- ☐ HONK
- ☐ Hypoglycaemia
- ☐ Thyrotoxicosis
- ☐ Hypothyroidism
- ☐ Addison's disease
- ☐ Hyponatraemia
- ☐ Hypokalaemia
- ☐ Hyperkalaemia
- ☐ Snakebite envenoming
- ☐ Organophosphate & other poisonings
- ☐ Paracetamol & drug overdoses
- ☐ Plant poisoning
- ☐ Others
- ☐ Asthma & COPD
- ☐ Pulmonary tuberculosis
- ☐ Pneumonia
- ☐ Pleural effusion
- ☐ Bronchiectasis & lung abscess
- ☐ Viral Hepatitis
- ☐ Chronic liver disease & portal hypertension
- ☐ Portal hypertension
- ☐ Urinary tract infections
- ☐ Nephritic syndrome
- ☐ Nephrotic syndrome
- ☐ Acute renal failure
- ☐ Chronic renal failure
- ☐ Renal transplant
- ☐ Rheumatoid arthritis
- ☐ SLE
- ☐ Backache and other spondyloses
- ☐ Acute septic arthritis
- ☐ Stroke and TIA
- ☐ Meningitis
- ☐ Epilepsy
- ☐ Spinal cord compression
- ☐ Neuropathies
- ☐ Malaria
- ☐ Leptospirosis
- ☐ Dengue fever
- ☐ Sepsis
- ☐ PUO
- ☐ Haemolytic anaemia
- ☐ Leukaemia & lymphoma
- ☐ Bleeding disorders
- ☐ Multiple myeloma
- ☐ Bone marrow failure

CHAPTER 10
CHECKLIST OF SKILL LEVELS YOU SHOULD HAVE ACHIEVED

		Date performed/Observed	Signature of supervisor
Perform independently	Venipuncture		
	Maintaining a Glasgow Coma Scale		
	Maintaining a fluid balance chart		
	Measuring and charting the temperature		
	Measuring the Peak Flow Rate (PFR)		
	Collection and transport of specimens		
	Using a glucometer		
	Connecting to an ECG monitor		
Perform under supervision	Inserting an NG tube		
	Giving IV, IM and SC injections		
	Inserting an IV cannula		
	Setting up an intravenous infusion		
	Nebulization		
	Doing a 12-lead ECG		
	Biochemical analysis of urine		
	Setting up a blood transfusion		
Perform on a model	Cardiopulmonary resuscitation		
	Lumbar puncture		
	Pleural aspiration		
Observe	Arterial puncture		
	Peritoneal dialysis		
	Pituitary and adrenal function tests		
	Basic physiotherapy		
	Aspiration and intra-articular injection		
	Insertion of a central venous line		
	Haemodialysis		

	Liver biopsy		
	Renal Biopsy		
	Artificial Ventilation		
	Endoscopy		
	Fast scan for dengue		
	Ultrasound, CT and MRI scanning		
	Contrast studies of the GI and GU tracts		
	EEG		
	EMG and Nerve Conduction Studies		
	Echocardiogram		
	Coronary Angiogram		
	Holter Monitoring		
	Exercise Stress ECG		
	Spirometry		

CHAPTER 11

LIST OF CASE HISTORIES

To be ready for submission at the final interview

	Date	Name	BHT	Diagnoses
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				

	Date	Name	BHT	Diagnoses
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				
31.				
32.				
33.				
34.				
35.				

CHAPTER 12

APPENDIX

ASSESSMENT OF ETHICS

The discussion on ethics will include the reflective practice of a scenario you encountered in the ward that highlights a potential ethical issue. The discussion will focus on the underlying values and the four principles of ethics (i.e. autonomy, beneficence, non-maleficence and justice) and other moral principles (e.g. truth-telling). You should also discuss how the ethical issues could be resolved in the ward setting.

REFLECTIVE LEARNING: ETHICS

Case number:

Ward:

Specify the event in your own words

Identify the ethical issues:

How were the ethical issues resolved or ethical conflicts prevented?
.

Communication Skills

Communication skills is being introduced as part of the formative assessment. The objective is to assess the skills at explaining or communicating with a Sri Lankan patient.
The skills will be assessed in either Sinhalese or Tamil and the student will choose the medium of language to do the assessment.
On completion of the interview, you may obtain feedback from the patient. They often give an interesting perspective of the interview.

Component	**Very poor**	**Fail**	**Pass**	**Good pass**
Introduction, consent and explains the process to patient	0	0.25	0.5	1
Builds rapport with open ended questions and appropriate non-verbal cues	0	0.25	0.5	1
Evaluation of the patient's knowledge, concerns and ideas	0	0.5	1	2
Explanation of the procedure/process without using jargon	0	1	2	4
Confirmation of understanding	0	0.25	0.5	1
Conclusion of interview (Thanks patient)	0	0.25	0.5	1

TOTAL (from 10)

Comments

Examiner's Name…… Signature……

---------- **Hope you enjoy your learning!** --------