# Kuwait Institute for Medical Specialization


# Membership of Specialty in Emergency Medicine

**Content:**

## Emergency Medicine.

## 1. Emergency Medicine is defined as:

Emergency Medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and emergent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioral disorders.

It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.

**(International Federation for Emergency Medicine 1991)**

The hour glass is an appropriate symbol, just because of the time element it represents. The waist of the hour glass can be seen as the Emergency Department itself with patients converging on from myriad origins and thereafter diverging according to functional destinations.

## 2. Job specification of a Specialist in Emergency Medicine:

The task of the specialist in Emergency Medicine is the following:

2.1. Distinguish the seriously ill patients from minor illness or injury.
2.2. Competently and efficiently manage conditions.
2.3. Support and stabilize the acutely ill and arrange appropriate management and referral.
2.4. Recognize, evaluate and initiate management for non-acute illness and injury.
2.5. Concurrently manage multiple patients with appropriate priorities.
2.6. Understand the natural history of an emergency situation, the social and family concept of continuity of care and community resources available for follow up care.
2.7. Develop, implement and support services in the community for pre-hospital ambulance service communication systems, poison control, public education, medical services and disaster planning.

2.8. Conduct and promote research.
2.9. Participation in training of under and post graduate students in the field of emergency medicine.

## 3. Objectives of The Training Program:

During the course of training, the candidate must acquire satisfactory knowledge and skills in the following areas:-

3.1. Primary care of the patient, a declared emergency including the recognition, evaluation and initial management of acute illness or injury.
3.2. Triage of patients with major illness or injury
3.3. The natural history of illness or injury commonly presenting as an emergency and principles of long term care and follow up essential for these conditions.
3.4. Supervisory and administrative aspects of emergency conditions, medical services, pre-hospital care of emergency paramedical emergency services, ambulance services communication systems and disaster planning.
3.5. Research areas of emergency medicine.
3.6. Social and family implications of or a serious illness or injury.

To achieve these goals there are general and terminal educational objectives.

### General Objectives:

The resident in emergency medicine is expected to demonstrate consultant level abilities in the recognition, understanding and treatment of illness and injuries presenting to the Emergency Department. During the course of the educational program, the resident must acquire and demonstrate satisfactory competence and knowledge of clinical skills, technical skills, administrative skills and attitudes consistent with the practice of the depth and breadth of Emergency Medicine, as out lined below.
The program of training leading to membership in Emergency Medicine is designed to provide practical training and experience under supervision.

## (1) Knowledge:

This encompasses an understanding of the entire body's anatomy, physiology of the major organ systems, thorough understanding of the pathophysiology of the significant illness and injury. Principles of pharmacology and toxicology as well as natural history of illness and injuries as presenting emergencies and the principles of the long term and follow up care for these conditions.

## (2) Clinical Skills:

This is demonstrated by the competent, independent and primary care of emergencies; including the recognition, evaluation, understanding and initial management of all acute illness and injury particularly of a life threatening nature. The resident will demonstrate the ability to choose the investigations and management appropriate to the clinical situation as well as the selection and timing of involvement of other members of a health care team in the immediate and continuing care of his/her patient.

## (3) Technical Skills:

Competence in all surgical and technical procedures commonly performed in Emergency Medicine is expected.

## (4) Administrative and Supervisory Skills:

The ability to concomitantly manage a number of ill and injured patients at any given time with a view to both providing these patients with excellence of care as well as ensuring the continuing smooth flow of patients through an Emergency Department must be demonstrated. Skills necessary for effective triage of patients within the Emergency Department are included. Competence in supervisory and administrative aspects of Emergency Medical Services Systems (i.e. the rationalization of emergency services, communication systems, pre-hospital care programs, ambulance services, paramedical emergency services and
D
isaster medicine is expected.

### (5) Attitudes:

The ability to communicate effectively with the patient, the demonstration of a compassionate interest in understanding the patient as a person, an appreciation of the psychosocial and family implications of serious illness or injury, the ability to function as a member of the health care team, an understanding of the obligation of continuing self education and teaching others. It is expected that the members should have an appreciation of the role of research and critical analysis of current developments related to the specialty.

## Terminal Educational Objectives in Emergency Medicine:

Terminal educational objectives are identified and presented for each of the nine categories in the core content of Emergency Medicine. Through each rotation directed reading of recommended bibliographies and formal teaching sessions, the Emergency Medicine resident will be expected to direct his/her learning towards a mastery of the core content material. The Emergency Medicine resident will demonstrate a thorough understanding and application of the necessary knowledge and skills in the following:

### I. Principles of Emergency care:

Recognition, intervention, resuscitation and stabilization of the patient's problems presented to the Emergency Department.

### II. Acute Disorders by Body Systems:

Relevant anatomy, presentation (symptoms and signs), pathophysiology, natural history, investigation modalities, management and disposition decisions of these acute disorders of body systems encountered in the Emergency Department.

### III. Trauma:

Evaluation, resuscitation, investigations and stabilization of patients with multiple and organ specific trauma with respect to mechanisms of injury,

pathophysiology, relevant anatomy, presentation, management decisions in the Emergency Department.

## IV. Acute Age Related Disorders:

Presentation, normal history of the disease, psychological factors, investigations, management, and disposition decisions of acute disorders in the pediatric and geriatric age groups encountered in the Emergency Department.

## V. Toxicology:

General principles of pharmacology with respect to absorption, kinetics and excretion; general approach to the poisoned/overdosed patient, the presentation, pathophysiology, history, investigations and management of patients suffering from toxic overdose and adverse reactions of specific and unknown pharmacological agents and poisons encountered in the Emergency Department.

## VI. Environmental Disorders:

The general approach to environmental disorders, recognition of specific presentations, their pathophysiology, natural history, investigations and the initiation of appropriate management in the Emergency Department.

## VII. Investigation Modalities in Emergency Department:

Selection, application and interpretation of available investigative modalities in the assessment of patient problems in the Emergency Department.

## VIII. Manipulative l Procedural Skills in Emergency Medicine:

Indications, contraindications, pre-requisite steps, priority setting in the application of technical skills in the Emergency Department. Preferred and alternate methods, recognition and assessment of manipulative procedural skills performed in the Emergency Department.

## IX. Emergency Medical Services:

Organizational and administrative aspects of Emergency Medical Services, pre hospital care, disaster planning, quality assurance programs in emergency medicine, medico legal aspects of emergency medical care, staff education and career development research.

## 4. Program Structure:

**4.1** To ensure that the candidate achieves the desired objectives of the training program, they are rotated amongst different mandatory specialties, electives, and assessed in an appropriate evaluation process.
During the five years of training:

- Candidates are based at a mother hospital where they will be assigned a local tutor for the duration of the whole program.
- Candidates will be sent to various specialties, which are relevant to the specialty of emergency medicine for different periods of time depending on the nature of the specialty.
- Minimum duration spent in the adult emergency medicine department is 23 months out of the five years.

## 4.2. Elective Component:

Electives taken in the following areas are acceptable:

4.2.1. Epidemiology.
4.2.2. Research.
4.2.3. Different specialties of Medicine.
4.2.4. Different specialties of Surgery.

The trainee should participate in the following during the program:

A) Post graduate lectures in Emergency Medicine.
B) Monthly interactive sessions.
C) Journal club.
D) Workshops.

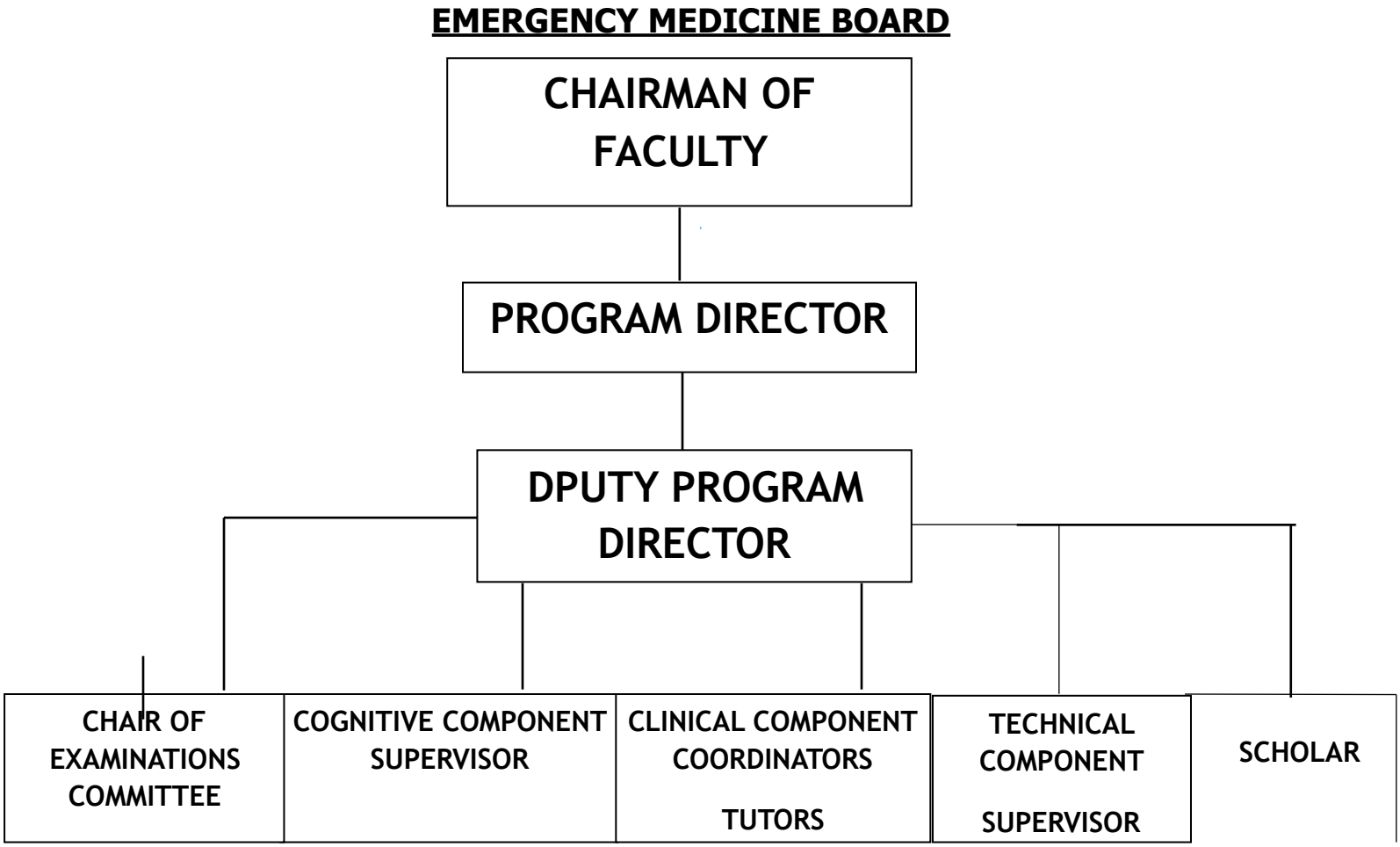
E) Case presentations and Grand rounds

## Required Rotations

| | |
|---|---|
| **Year I:**<br><br>**Adult Emergency Dept.:** 2 months | **One month each:** General surgery, radiology, anesthesia, internal medicine, ophthalmology, ENT, OBS/GYN, pediatric ED, orthopedics & plastic surgery. |
| **Year II:**<br><br>**Adult Emergency Dept.:** 5 months | • ICU: 3 months<br>• CCU: 2 months<br>• Pediatric anesthesia: 1 month<br>• Pediatric ED: 1 month |
| **Year III:**<br><br>**Adult Emergency Dept.:** 7 months (1 month for toxicology and US) | • Pediatric ED: 2 months<br>• PICU: 1 month<br>• CCU-EP: 1 month<br>• Psychiatry: 1 month |
| Year IV:<br><br>**Adult Emergency Dept.:** 7 months | • Neurology: 1 month<br>• Pediatric ED: 3<br>• EMS: 1 month |
| Year V:<br><br>**Adult Emergency Dept.:** 8 months | • Elective: 3 months<br>• Pediatric ED: 1 months |

| | |
|---|---|
| • Adult ED: 29 months<br>• Pediatric ED: 8 months<br>• GS: 1 month<br>• IM: 1 month<br>• OBS/GYN: 1 month<br>• Anesthesia: 1 month<br>• P. Anesthesia: 1 month<br>• Plastic surgery: 1 month<br>• Orthopedic: 1 month | • Radiology: 1 month<br>• ICU: 3 month<br>• ICU: 3 month<br>• PICU: 1 month<br>• EMS: 1 month<br>• Neurology: 1 month<br>• ENT: 1 month<br>• Ophthalmology: 1 month<br>• Psychiatry: 1 month<br>• Elective: 3 months |

## 5. Organizational Framework of Emergency Medicine Specialist Training:



**SITE COORDINATORS**

- **COGNITIVE COMPONENT SUPERVISOR:** (LECTURES. MEETINGS, GRAND ROUNDS)
- **CLINICAL COMPONENT COORDINATORS/TUTORS:** (ROTATIONS AND CLINICAL ASPECT OF THE PROGRAM)
- **TECHNICAL COMPONENT SUPERVISOR:** (WORKSHOPS, LOG BOOKS)
- **SITE COORDINATORS:** (The site coordinator, under the direction and supervision of the program director is responsible for assisting in the administration of the residency program. Provides administrative support to the program director of the residency, chief residents, and faculty residents. Interacts with faculty, residents, and institutional and regulatory administrative offices as directed by the program director).

**5.1** The academic council (KIMS) has the final responsibility for the training program which is run by the faculty of Emergency Medicine (KIMS).

**5.2 <u>Training, Accreditation and Examination Board is responsible for:</u>**

5.2.1. Management of the training program.
5.2.2. Approval of the appointment of coordinators.
5.2.3. Recognition of training centers as well as regular evaluation of these centers.
5.2.4. Identification, nomination and appointment of supervisors.

5.2.5. Approval of nomination of trainers.
5.2.6. Acceptance of trainee.
5.2.7. Approving and reviewing the annual program for each trainee in conjunction with the supervisor, trainer and trainee.
5.2.8. Keeping progress records of trainees.

## 5.3 Examination Board:

It is responsible for the assessment of each trainee on completion of the program.

## 5.4 Program Director:

A recognized specialist in Emergency Medicine who coordinates the program in liaison with the training and accreditation boards.

## 5.5 Supervisor:

The supervisor is a designated, medically qualified person who has a direct supervisory responsibility for a designated trainee or more. He/ she is the person most directly responsible for the overall training program of the specified trainee and this would be expected to be expressed by regular meetings with him/her. The choice of the supervisor for each candidate should be made after consultation with the trainee and the coordinator. The responsibilities include

5.5.1. Preparation (in conjunction with trainee or trainers) of the training program for a specified candidate.
5.5.2. Regular tutorials and supervision of the trainees.
5.5.3. Nomination of trainers to be approved by the program coordinator or the country committee.
5.5.4. The Annual evaluation of trainees for the board of training and examination.

## 5.6 Tutor:

A designated medically qualified person fully acquainted with the work of the unit or program in which the training will be conducted. He/she is selected by the supervisor and coordinator. He/she will

provide on job supervision, assistance and advice on a particular topic or in connection with a specific problem or project. Responsibilities include:

5.6.1. Supervision and regular evaluation of the trainee.

5.6.2. Ensuring that the person of the organization (unit program) are adequately briefed and able to carry out their part of the program successfully.

## 5.7 Training Center:

It is a unit in the ministry of health. The training center is expected to have the following facilities:

5.7.1. The head of the center is an experienced person who is actively involved in the work of the center.

5.7.2. The organizational set up of the work is clearly defined centrally and peripherally.

5.7.3. There are clear objectives for the program of work and regular evaluation of its activities.

5.7.4 There is a clear flow system of information between the field and the center.

5.7.5 There is minimum man power and facilities to ensure the effective work of the health team.

5.7.6 An updated and accessible library.

5.7.7 Continuous educational activities.

5.7.8 A link with academic and scientific institutes in the country/ region or international health organizations.

## 6.0 KIMS Policies:

## 6.1 Postgraduate Education Admission Policies and Procedures for Residency and Fellowship Programs:

1.Introduction

1.1. Purpose

The purpose of the Postgraduate Education Admissions Policies and Procedures is to regulate the process of admissions for Residency and Fellowship Programs.

1.2. Acronyms:

1.2.1. KIMS - Kuwait Institute for Medical Specializations.

1.3. Definitions

1.3.1. Residency
Residency is a five years specialty training program that is completed after one year of internship following medical school. These programs offer supervised and specific training for the resident in their chosen specialty.
1.3.2. Fellowship
Fellowship is a three years sub-specialty training program that is completed after Residency. These programs offer supervised and specific training for the fellow in their chosen sub-specialty.

2. Timeframe

2.1. The Postgraduate Education Office must finalize all the timelines related to admissions every
academic year before the start of the admissions as per the annual admissions calendar.

2.2. The admission process shall be sequenced in phases based on the rules of KIMS.

3.Announcement of submission of applications

3.1. Mode of announcement – Shall be in main national newspapers, official KIMS website, formal letters from the KIMS to the Health Regions, internet social networks and announcement stands.

3.2. Reminders – Shall be as required.

4.Eligibility criteria for submission of application to Residency Programs

4.1. Academic qualification must be MBBS, MBBCh, BDS or equivalent.

4.2. Must be an employee of a governmental authority recognized by Ministry of Health (Applies to Kuwaitis).

4.3. Must be an employee of Ministry of Health in the applied specialty (Applies only to Non-Kuwaitis).

4.4. Must have completed the internship by 30th September of the corresponding Academic Year.

4.5. Must NOT be currently on a valid Scholarship. (Shall apply after official withdrawal – Applies only to Kuwaitis).

4.6. Must NOT be enrolled in other Residency Programs at the time of application (Shall apply after official withdrawal).

5.Eligibility criteria for submission of applications to Fellowship Programs

5.1. Academic qualification: Must have Residency Board

Certification.

5.2. Shall be an employee of a governmental authority recognized by Ministry of Health.

5.3. Shall not be currently on a valid Scholarship. (May apply after official withdrawal – Applies only to Kuwaitis).

5.4. Shall NOT be enrolled in other Fellowship Programs at the time of application (Shall apply after official withdrawal).

6.Screening of Applications

6.1. Documents required with the application shall be listed in the application form.

6.2. Candidates must attach all the required documents with the application form.

6.3. Any deficiency in documents shall make the application liable to non-acceptance.

6.4. All applications must be screened for completeness and eligibility at the time of submission by KIMS Postgraduate Education Office.

7.Processing of Applications:

7.1. Success in an admission test can be required by the Program Boards in order to be eligible for interviews.

7.2. A list of eligible candidates for interviews based on complete applications and success in admission test will be finalized by KIMS Postgraduate Education Office.

7.3. Program Committees shall call all the eligible candidates for interviews based on the schedule provided by Postgraduate Education Office.

8.Interview

8.1. Format – A standardized Interview scoring sheet must be provided to all the Residency and Fellowship Programs by KIMS Postgraduate Education Office.

8.2. Panel – The Interview Panel for each Residency and Fellowship Program shall comprise of a maximum of five members from the corresponding programs and a maximum of two external monitors.

8.3. External monitors shall not have a vote in the interview selection process.

8.4. External monitors shall ensure transparency and equal chances among the candidates.

8.5. Each applicant's interview shall be conducted in 15

minutes.

8.6. The Interview Panels must submit to KIMS Postgraduate Education Office a final list of accepted,
waiting and rejected candidates for its corresponding Residency and Fellowship Program.

9. Approval of the Final List of selected candidates. A Final List of selected candidates must be approved by KIMS Postgraduate Education Office.

10. Disclosure of Admissions Results

10.1. The Final List of selected candidates must be kept confidential.

10.2. Admissions results must be disclosed to the candidates privately by phone, email or KIMS official website.

11. Acceptance of Admissions

11.1. Candidates must sign their Residency or Fellowship Training Contracts within a month of the disclosure of admissions results.

11.2. Failure to sign the contract within the deadline shall result in a dismissal of the admission.

12. Appeals

12.1. Appeals challenging the Admissions Results shall be directed to the KIMS, Secretary General within one month of

the disclosure of results through an official letter.

12.2. The time period for submitting an Appeal on the admissions result shall be clearly indicated on the KIMS official website.

13. Withdrawals

Selected candidates deciding to withdraw their selection after signing the Residency or Fellowship training contract must submit an official request before the start of Program, i.e. October 1 of the corresponding year, otherwise they are not eligible for KIMS scholarships for one year.

14. Decisions on remaining vacancies

KIMS Postgraduate Education Office shall take decision on further availability of vacancies produced by non-signing of training contracts, withdrawals or non-occupancy and shall request the corresponding Residency and Fellowship Program Directors for subsequent action.

15. Equivalences and Exemptions

15.1. Requests concerning equivalence of candidate's prior achievements and resultant exemptions shall be forwarded to the corresponding Residency and Fellowship Programs for review and recommendations.

15.2. The recommendations from Residency and Fellowship Programs on equivalence and exemption requests must be approved by the KIMS Postgraduate Education Office.

## 6.2 KIMS Policy & Procedure on In-training Evaluation of Residents

The policy:

1. It is the program director's responsibility to ensure that all resident in

the program are evaluation no longer than 2 weeks (14 days) from the last day of the rotation.

2. The program director must ensure that all resident have the objective of each rotation prior to joining the rotation.

3. The program director must ensure that all clinical tutor and site supervisor have the objective of the rotation.

4. It is the clinical tutor's responsibility to discuss with the resident verbally at the mid-rotation using the provided form.

5. It is the resident's responsibility to ensure that he/she receives written evaluation at the end of the rotation using the provided form and no longer that 2 weeks (14 days) after finishing the rotation.

6. It is the clinical tutor responsibility to complete the provide form and discuss the evaluation with the resident.

7. Both the clinical tutor and the resident must signed and date the evaluation form.

8. It is the site supervisor responsibility to collect all completed evaluation forms and send them to the program director.

9. The program director must provide face-to-face feedback to the resident based on the completed evaluation form at least twice yearly.

10. Unsatisfactory completion of two rotations or more in one year requires activation of the remediation policy by the program director within 4 weeks (28 days) of receiving the evaluations.

11. A rotation where the summative assessment of resident performance is unsatisfactory will be deemed an unsatisfactory rotation. In addition, a resident may be deemed to have failed to meet the criteria for a rotation with any of the following:

    - An unsatisfactory evaluation in any domain of the rotational In-Training Evaluation report (ITER).
    - Documentation that a resident, regardless of clinical performance during the rotation, has not satisfied accepted standards of ethical and professional behavior

The Procedure:

1. Provide the resident, site supervisor, clinical tutors of the objective of rotation and the evaluation form at the beginning of the rotation.
2. At mid-rotation (e.g. 2 weeks of 4 week-rotation), the clinical tutor will provide a verbal feedback on resident performance based on the objective of the rotation and evaluation form.
3. At the end of the rotation and no longer than 2 weeks (14 days), the clinical tutor will provide a written evaluation based of the objective of the rotation and evaluation form.
4. Both the clinical tutor and the resident will sign and date the evaluation form.
5. The clinical tutor will hand the evaluation form to the site coordinator.
6. The site coordinator will hand the evaluation for to the program director no longer than 2 weeks (14 days) to the program director.
7. The program director will keep all resident evaluation in secure place.
8. If the resident had two unsatisfactory rotations, follow the

remediation policy.

9. The program director will provide the resident with a verbal feedback to the resident twice per year.

10. The program director will prepare In-Training Evaluation Report based on evaluations of the rotation with/without In-Training Examination annually.

11. When a resident has fully met the expectations for the level

of training for all rotations during the year and has successfully met the program-specific criteria for that year, he/she will be promoted to the next academic level in the same program.

12. An overall score of 3 (meet expectation) and higher (4 above expectation, 5 exceed expectation) is considered a successful completion of rotation.

13. An overall score of 1 (unsatisfactory) or 2 (below expectation) is considered unsuccessful completion of rotation. A specific reason(s) has to be documented by the clinical tutor if such score is noted.

14. If more than 2 areas competencies are scored 1 or 2 in respective of the overall score, remediation needs to be implemented.

**KIMS policy & procedure on remediation:**

Remediation will be implemented for any of the following reasons:

1. If a resident receives two unsatisfactory or borderline evaluations in two rotations in one academic year.

2. Upon recommendation of the Postgraduate Training Committee and/or the Program Director for any of the following reasons:

- Academic progress which is borderline or unsatisfactory

- Any serious issue in relation to lack of professionalism

- Substantial absence from the program. Once a resident receives an unsatisfactory evaluation, the process for dealing with an unsatisfactory evaluation will be put into effect.

3. Appropriate documentation regarding the evaluation review will be placed in the confidential resident file.

4. When remediation is required, the remedial program will be developed by the Program Director, and the resident in consultation with other individuals as required.

5. The remedial program outline must be provided to the resident in writing and must include:

- Identified areas to be remediated including specific problems or areas of weakness

- Detailed outline of the remedial program

- Expected action needed to successfully complete a remediation program

- Expected outcomes of remediation

- Time frame for the remedial program

- Criteria and evaluation process used for determining that the deficiency has
  been corrected consequences of an unsatisfactory remedial

program.

- The remedial program must be approved by the Postgraduate Medical Training Committee.
- The remedial program may include repeating rotations or program-specific requirements.
- Remediation MUST be instituted when a resident is on probation, but MAY also occur at other times during training.
- The resident must comply with the remedial plan. Failure to comply will result in an unsuccessful remediation period and implementation of probation.
- In the event of unsuccessful remediation, the resident will be required to undergo a period of probation.

6. Two remediation periods in a twelve-month time frame, regardless of whether the first has been successful, will result in a period of probation.
7. Notification must be provided Training Office when a remedial program is implemented for a resident. Prior approval must be obtained from the Secretary General for any proposed extension of training.
8. Elective rotation block(s) may only be used for remediation with the approval of the Program Director.
9. During a remedial rotation, any leaves of absence and all holiday requests must be approved by the Program Director.
10. The remedial program may or may not count towards the duration of training required for certification by the Postgraduate Medical Training Committee.
11. Postgraduate Medical Training Committee will review the evaluations

from the remedial program and make a recommendation to the Program Director regarding the need for extension of training. Prior approval must be obtained from the Secretary General for any proposed extension of training.

## Appendix A: CanMEDS Competencies Framework

## Medical Expert

## Definition

As Medical Experts, physicians integrate all of the CanMEDS roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centred care. Medical Expert is the central physician role in the CanMEDS framework.

## Description

Physicians possess a defined body of knowledge, clinical skills, procedural skills and professional attitudes, which are directed to effective patient-centred care. They apply these competencies to collect and interpret information, make appropriate clinical decisions, and carry out diagnostic and therapeutic interventions. They do so within the boundaries of their discipline, personal expertise, the healthcare setting and the patient's preferences and context. Their care is characterized by up-to- date, ethical, and resource efficient clinical practice as well as with effective communication in partnership with patients, other health care providers and the community. The Role of Medical Expert is central to the function of physicians and draws on the competencies included in the Roles of Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional.

## Key Competencies

Physicians are able to...

1. Function effectively as consultants, integrating all of the CanMEDS Roles to provide optimal, ethical and patient-centred medical care.

2. Establish and maintain clinical knowledge, skills and attitudes appropriate to their practice.

3. Perform a complete and appropriate assessment of a patient.

4. Use preventive and therapeutic interventions effectively.

5. Demonstrate proficient and appropriate use of procedural skills, both diagnostic and
therapeutic.

6. Seek appropriate consultation from other health professionals, recognizing the limits of their expertise.

**Enabling Competencies**

Physicians are able to...

1. Function effectively as consultants, integrating all of the CanMEDS roles to provide optimal, ethical and patient-centred medical care:

1.1. Effectively perform a consultation, including the presentation of well- documented assessments and recommendations in written and/ or verbal form in response to a request from another health care professional

1.2. Demonstrate effective use of all CanMEDS competencies relevant to their practice

1.3. Identify and appropriately respond to relevant ethical issues arising in patient care CanMEDS 2005 Framework

1.4. Effectively and appropriately prioritize professional duties when faced with multiple patients and problems

1.5. Demonstrate compassionate and patient-centred care

1.6. Recognize and respond to the ethical dimensions in medical decision- making

1.7. Demonstrate medical expertise in situations other than patient care, such as providing expert legal testimony or advising governments, as needed

2. Establish and maintain clinical knowledge, skills and attitudes appropriate to their practice:

2.1. Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to the physician's specialty

2.2. Describe the Royal College framework of competencies relevant to the physician's specialty

2.3. Apply lifelong learning skills of the Scholar Role to implement a personal program to keep up-to-date, and enhance areas of professional competence

2.4. Contribute to the enhancement of quality care and patient safety in their practice, integrating the available best evidence and best practices

3.Perform a complete and appropriate assessment of a patient

3.1. Effectively identify and explore issues to be addressed in a

patient
encounter, including the patient's context and preferences

3.2. For the purposes of prevention and health promotion, diagnosis and or management, elicit a history that is relevant, concise and accurate to context and preferences

3.3. For the purposes of prevention and health promotion, diagnosis and/or management, perform a focused physical examination that is relevant and accurate

3.4. Select medically appropriate investigative methods in a resource- effective and ethical manner

3.5. Demonstrate effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating information to generate differential diagnoses and management plans

4. Use preventive and therapeutic interventions effectively:

4.1. Implement an effective management plan in collaboration with a patient
and their family

4.2. Demonstrate effective, appropriate, and timely application of preventive and therapeutic interventions relevant to the physician's practice

4.3. Ensure appropriate informed consent is obtained for therapies

4.4 Ensure patients receive appropriate end-of-life care

5. Demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic

    5.1. Demonstrate effective, appropriate, and timely performance of diagnostic procedures relevant to their practice

    5.2. Demonstrate effective, appropriate, and timely performance of therapeutic procedures relevant to their practice

    5.3. Ensure appropriate informed consent is obtained for procedures

    5.4. Appropriately document and disseminate information related to procedures performed and their outcomes

    5.5. Ensure adequate follow-up is arranged for procedures performed

6. Seek appropriate consultation from other health professionals, recognizing the limits of their expertise

    6.1. Demonstrate insight into their own limitations of expertise via self- assessment

    6.2. Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care

    6.3. Arrange appropriate follow-up care services for a patient and their family

**Communicator**

## Definition

As Communicators, physicians effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.

## Description

Physicians enable patient-centered therapeutic communication through shared decision-making and effective dynamic interactions with patients, families, caregivers, other professionals, and important other individuals. The competencies of this Role are essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care. Poor communication can lead to undesired outcomes, and effective communication is critical for optimal patient outcomes. The application of these communication competencies and the nature of the doctor-patient relationship vary for different specialties and forms of medical practice.

## Key Competencies:

Physicians are able to:

1. Develop rapport, trust and ethical therapeutic relationships with patients and families.

2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals.

3. Accurately convey relevant information and explanations to patients and families, colleagues and other professionals.

4. Develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care.

5. Convey effective oral and written information about a medical

encounter.

## Enabling Competencies

Physicians are able to:

1. Develop rapport, trust, and ethical therapeutic relationships with patients and families:

    1.1. Recognize that being a good communicator is a core clinical skill for physicians, and that effective physician-patient communication can foster patient satisfaction, physician satisfaction, adherence and improved clinical outcomes

    1.2. Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy

    1.3. Respect patient confidentiality, privacy and autonomy

    1.4. Listen effectively

    1.5. Be aware and responsive to nonverbal cues

    1.6. Effectively facilitate a structured clinical encounter

2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals:

    2.1. Gather information about a disease, but also about a patient's beliefs, concerns, expectations and illness experience

2.2. Seek out and synthesize relevant information from other sources, such as a patient's family, caregivers and other professionals

3. Accurately convey relevant information and explanations to patients and families, colleagues and other professionals:

3.1. Deliver information to a patient and family, colleagues and other professionals in a humane manner and in such a way that it is understandable, encourages discussion and participation in decision- making

4. Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care:

4.1. Effectively identify and explore problems to be addressed from a patient encounter, including the patient's context, responses, concerns, and preferences

4.2. Respect diversity and difference, including but not limited to the impact of gender, religion and cultural beliefs on decision-making

4.3. Encourage discussion, questions, and interaction in the encounter

4.4. Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care

4.5. Effectively address challenging communication issues such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

5. Convey effective oral and written information about a medical encounter:

5.1. Maintain clear, accurate, and appropriate records (e.g., written or electronic) of clinical encounters and plans

5.2. Effectively present verbal reports of clinical encounters and plans

5.3. When appropriate, effectively present medical information to the public or media about a medical issue

## Collaborator

## Definition

As Collaborators, physicians effectively work within a healthcare team to achieve optimal patient care

## Description

Physicians work in partnership with others who are appropriately involved in the care of individuals or specific groups of patients. This is increasingly important in a modern multi-professional environment, where the goal of patient-centered care is widely shared. Modern healthcare teams not only include a group of professionals working closely together at one site, such as a ward team, but also extended teams with a variety of perspectives and skills, in multiple locations. It is therefore essential for physicians to be able to collaborate effectively with patients, families, and an inter-professional team of expert health professionals for the provision of optimal care, education and scholarship.

## Key Competencies

Physicians are able to:

1. Participate effectively and appropriately in an inter-professional healthcare team.

2. Effectively work with other health professionals to prevent, negotiate, and resolve inter-professional conflict.

**Enabling Competencies**

Physicians are able to:

1.Participate effectively and appropriately in an inter-professional healthcare team

1.1. Clearly describe their roles and responsibilities to other professionals

1.2. Describe the roles and responsibilities of other professionals within the health care team

1.3. Recognize and respect the diversity of roles, responsibilities and competences of other professionals in relation to their own

1.4. Work with others to assess, plan, provide and integrate care for individual patients (or groups of patients)

1.5. Where appropriate, work with others to assess, plan, provide and review other tasks, such as research problems, educational work, program review or administrative responsibilities

1.6. Participate effectively in inter-professional team meetings

1.7. Enter into interdependent relationships with other professions

for the provision of quality care

1.8. Describe the principles of team dynamics

1.9. Respect team ethics, including confidentiality, resource allocation and professionalism

1.10. Where appropriate, demonstrate leadership in a healthcare team

2.Effectively work with other health professionals to prevent, negotiate, and resolve
inter-professional conflict

2.1. Demonstrate a respectful attitude towards other colleagues and members of an inter-professional team

2.2. Work with other professionals to prevent conflicts

2.3. Employ collaborative negotiation to resolve conflicts

2.4. Respect differences, misunderstandings and limitations in other professionals

2.5. Recognize one's own differences, misunderstanding and limitations that may contribute to interprofessional tension

2.6. Reflect on inter professional team function

## Manager Definition

As Managers, physicians are integral participants in healthcare organizations, organizing sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the healthcare system.

## Description

Physicians interact with their work environment as individuals, as members of teams or groups, and as participants in the health system locally, regionally or nationally. The balance in the emphasis among these three levels varies depending on the nature of the specialty, but all specialties have explicitly identified management responsibilities as a core requirement for the practice of medicine in their discipline. Physicians function as Managers in their everyday practice activities involving co- workers, resources and organizational tasks, such as care processes, and policies as well as balancing their personal lives. Thus, physicians require the ability to prioritize, effectively execute tasks collaboratively with colleagues, and make systematic choices when allocating scarce healthcare resources. The CanMEDS Manager Role describes the active engagement of all physicians as integral participants in decision-making in the operation of the healthcare system.

## Key Competencies

Physicians are able to...

1. Participate in activities that contribute to the effectiveness of their healthcare organizations and systems.

2. Manage their practice and career effectively.

3. Allocate finite healthcare resources appropriately.

4. Serve in administration and leadership roles, as appropriate.

## Enabling Competencies

Physicians are able to...

1.Participate in activities that contribute to the effectiveness of their healthcare
organizations and systems

1.1. Work collaboratively with others in their organizations

1.2. Participate in systemic quality process evaluation and improvement, such as patient safety initiatives

1.3. Describe the structure and function of the healthcare system as it relates to their specialty, including the roles of physicians

1.4. Describe principles of healthcare financing, including physician remuneration, budgeting and organizational funding

2.Manage their practice and career effectively

2.1. Set priorities and manage time to balance patient care, practice
requirements, outside activities and personal life

2.2. Manage a practice including finances and human resources

2.3. Implement processes to ensure personal practice improvement

2.4. Employ information technology appropriately for patient

care

3.Allocate finite healthcare resources appropriately

3.1. Recognize the importance of just allocation of healthcare resources, balancing effectiveness, efficiency and access with optimal patient care

3.2. Apply evidence and management processes for cost-appropriate care

4.Serve in administration and leadership roles, as appropriate

4.1. Chair or participate effectively in committees and meetings

4.2. Lead or implement a change in health care

4.3. Plan relevant elements of health care delivery (e.g., work schedules)

## Health Advocate

### Definition

As Health Advocates, physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.

### Description

Physicians recognize their duty and ability to improve the overall health of their patients and the society they serve. Doctors identify advocacy activities as important for the individual patient, for populations of patients and for communities. Individual patients need physicians to assist them in

navigating the healthcare system and accessing the appropriate health resources in a timely manner. Communities and societies need physicians' special expertise to identify and collaboratively address broad health issues and the determinants of health. At this level, health advocacy involves efforts to change specific practices or policies on behalf of those served. Framed in this multi-level way, health advocacy is an essential and fundamental component of health promotion. Health advocacy is appropriately expressed both by individual and collective actions of physicians in influencing public health and policy.

## Definition

Describe an approach to implementing a change in a determinant of health of the populations they serve

Describe how public policy impacts on the health of the populations served Identify points of influence in the healthcare system and its structure

Describe the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism

Appreciate the possibility of conflict inherent in their role as a health advocate for a patient or community with that of manager or gatekeeper

Describe the role of the medical profession in advocating collectively for health and patient safety

## Key Competencies

Physicians are able to...

1. Respond to individual patient health needs and issues as part of patient care.

2. Respond to the health needs of the communities that they serve.

3. Identify the determinants of health of the populations that they serve.

4. Promote the health of individual patients, communities and populations.

## Enabling Competencies

Physicians are able to...

1. Respond to individual patient health needs and issues as part of patient care

    1.1. Identify the health needs of an individual patient

    1.2. Identify opportunities for advocacy, health promotion and disease prevention with individuals to whom they provide care

2.Respond to the health needs of the communities that they serve

    2.1. Describe the practice communities that they serve

    2.2. Identify opportunities for advocacy, health promotion and disease prevention in the communities that they serve, and respond appropriately

    2.3. Appreciate the possibility of competing interests between the communities served and other populations

3.Identify the determinants of health for the populations that they serve

    3.1. Identify the determinants of health of the populations, including barriers
    to access to care and resources

    3.2. Identify vulnerable or marginalized populations within those served and respond appropriately

4.Promote the health of individual patients, communities, and populations

## Scholar

## Description

physicians demonstrate a lifelong commitment to reflective learning, as well as as Scholars,
creation, dissemination, application and translation of medical knowledge.

Physicians engage in a lifelong pursuit of mastering their domain of expertise. As learners, they recognize the need to be continually learning and model this for others. Through their scholarly activities, they contribute to the creation, dissemination, application and translation of medical knowledge. As teachers, they facilitate the education of their students, patients, colleagues, and others.

## Key Competencies

Physicians are able to:

1. Maintain and enhance professional activities through ongoing learning.

2. Critically evaluate information and its sources, and apply this appropriately to practice decisions.

3. Facilitate the learning of patients, families, students, residents, other health professionals, the
   public, and others, as appropriate.

4. Contribute to the creation, dissemination, application, and translation of new medical
   knowledge and practices.

## Enabling Competencies

Physicians are able to:

1.Maintain and enhance professional activities through ongoing learning

1.1. Describe the principles of maintenance of competence

1.2. Describe the principles and strategies for implementing a personal knowledge management system

1.3. Recognize and reflect learning issues in practice

1.4. Conduct a personal practice audit

1.5. Pose an appropriate learning question

1.6. Access and interpret the relevant evidence

1.7. Integrate new learning into practice

1.8. Evaluate the impact of any change in practice

1.9. Document the learning process

2.Critically evaluate medical information and its sources, and apply this appropriately to practice decisions

2.1. Describe the principles of critical appraisal

2.2. Critically appraise retrieved evidence in order to address a clinical question

2.3. Integrate critical appraisal conclusions into clinical care

3.Facilitate the learning of patients, families, students, residents, other health professionals, the public and others, as appropriate

3.1. Describe principles of learning relevant to medical education

3.2. Collaboratively identify the learning needs and desired learning outcomes of others

3.3. Select effective teaching strategies and content to facilitate others' learning

3.4. Demonstrate an effective lecture or presentation

3.5. Assess and reflect on a teaching encounter

3.6. Provide effective feedback

3.7. Describe the principles of ethics with respect to teaching

4. Contribute to the development, dissemination, and translation of new knowledge and practices

4.1. Describe the principles of research and scholarly inquiry

4.2. Describe the principles of research ethics

4.3. Pose a scholarly question

4.4. Conduct a systematic search for evidence

4.5. Select and apply appropriate methods to address the question

4.6. Appropriately disseminate the findings of a study

## Professional

### Definition

As Professionals, physicians are committed to the health and well being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior.

### Description

Physicians have a unique societal role as professionals who are dedicated to the health and caring of others. Their work requires the mastery of a complex body of knowledge and skills, as well as the art of medicine. As such, the Professional Role is guided by codes of ethics and a commitment to clinical competence, the embracing of appropriate attitudes and behaviors, integrity, altruism, personal well- being, and to the promotion of the public good within their domain. These commitments form the basis of a social contract between a physician and society. Society, in return, grants physicians the privilege of profession-led regulation with the understanding that they are accountable to those served.[1]

### Key Competencies

Physicians are able to...

1. Demonstrate a commitment to their patients, profession, and society through ethical practice.

2. Demonstrate a commitment to their patients, profession, and society through participation in
profession-led regulation.

3. Demonstrate a commitment to physician health and sustainable practice.

## Enabling Competencies

Physicians are able to...

1.Demonstrate a commitment to their patients, profession, and society through ethical
practice

1.1. Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect and altruism

1.2. Demonstrate a commitment to delivering the highest quality care and maintenance of competence

1.3. Recognize and appropriately respond to ethical issues encountered in practice

1.4. Appropriately manage conflicts of interest

1.5. Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law

1.6. Maintain appropriate relations with patients.

2.Demonstrate a commitment to their patients, profession and society through
participation in profession-led regulation

2.1. Appreciate the professional, legal and ethical codes of practice

2.2. Fulfill the regulatory and legal obligations required of current practice

2.3. Demonstrate accountability to professional regulatory bodies

2.4. Recognize and respond to others' unprofessional behaviors in practice

2.5. Participate in peer review

3.Demonstrate a commitment to physician health and sustainable practice

3.1. Balance personal and professional priorities to ensure personal health and a sustainable
practice

3.2. Strive to heighten personal and professional awareness and insight

3.3. Recognize other professionals in need and respond appropriately

## Appendix B: In-Training Evaluation Form

## Appendix C: (To Be Filled Before "Remediation Letter" Form)

Request for Mediation

Date:

FOR: Resident name, name of the training program

Year of training

A. Request of PGTC To

___ Remediation for period of time ___ Probation for period of time ___ Remediation and Probation ___ Dismissal

___ OTHER:

B. Background
Trainee Information

Dr. Resident name is a currently a Resident in the year of training year of the name of the training program

The name of the training program is a duration training program.

Based on current level of performance, we request that during this period of remediation, Dr. Resident name will be evaluated at the PG year of training level.

Remediation Committee Profile

Outline previous Remediation Committee actions for this trainee: ___ Not Applicable

___ Dr. Resident's name was previously considered by the Remediation Committee with the following outcome:

_____

Training Profile

The overview of the training profile is outlined below:

§ DATES (e.g. Oct. 20XX-Sept. 20XX)
Year One: OUTCOMES of training and evaluations

§ DATES (e.g. Oct. 20XX-Sept. 20XX)
Year Two: OUTCOMES of training and evaluations

§ DATES (e.g. Oct.20XX-Sept. 20XX)
Year Three: OUTCOMES of training and evaluations

In the Name of the Training Program, a "pass" is 3/5.

NOTES:

§ Append ITERs, other relevant evaluations, documents

C. Plan

Rationale

§ Identify the aspects of the trainee's performance or behavior that require remedial attention (i.e. provide a brief summary in narrative form that outlines the rationale for request).

Purpose of Remediation/Probation

___ To provide a period of focused education to enable the resident to meet the Program Goals & Objectives for PGY __

___ To provide a period of focused education to detail ___ to undertake a focused assessment detail
___. Other: detail

Specifically, the PLAN will focus on meeting the goals and objectives related to:

| | | | |
|---|---|---|---|
| | Medical Expert | | Communicator |
| | Collaborator | | Advocate |

| | | | |
|---|---|---|---|
| | Scholar | | Manager |
| | Professional | | |

Details of Remedial Plan

- State the specific duration of remediation period
- List the assigned rotation (s), training location(s), and length of time/ dates spent at each rotation/location, during remediation per

**Specific remedial plan goals, strategies, evaluation and outcome measures are listed in the following table:**

| Period of Remedial Plan | CanMEDS ROLE | Goals and Objectives | Learning or Teaching Strategy | Evaluation of Achievement |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

NOTES:

- Comment on who is the supervisor for the remedial plan
- Comment on who is/are the mentor(s) during the remediation period (i.e. mentors with non-evaluative role)

- Other evaluation of remedial progress
- Outline typical week during remediation period, e.g. noting academic half-day, clinical sessions, coaching sessions, protected reading time, etc.

| Sunday | Monday | Tuesday | Wednesday | Thursday |
|---|---|---|---|---|
| | | | | |

**Outcome of Remediation**

Upon **successful completion** of the remedial plan:

Dr. Resident name would begin residency training for PGY___

**OR**

Dr. Resident Name would have completed the PGY___ residency training

Upon **unsuccessful completion** of the remedial plan

- Outcome

**Development of The Plan**

2.Plan was reviewed by the Resident on __ __ /__ __ /__ __ __ __

3.The Resident was offered the opportunity to meet about the Plan with the PGTC and accepted or declined.

4.This Plan was reviewed and approved by PGTC on __ __ /__ __ /__ __ __ __.

Signed & Dated

_____ _____

Program Director, Date

**Appendix D: (To be filled after remediation)**

**Report of Remediation**

**Date**:

**FOR**:

- Resident Name

- Name of the Training Program
- Year of Training

**A. Report to PGTC**
**UPDATE** period of time report for current remedial plan.

**B. Background**
**Trainee Information**

Dr. Resident name is a currently a Resident in the Year of training year of the Name of the training program

The Name of the training program is a duration training program.

Based on current level of performance, we request that during this period of remediation, Dr. Resident name will be evaluated at the PG Year of training level.

**Remediation Committee Profile**

Outline previous Remediation Committee actions for this trainee: ___ Not Applicable

___ Dr. Resident's Name was previously considered by the Remediation Committee on

_____

With the following outcome:

## Training Profile

The overview of the training profile is outlined below:

DATES (e.g. Oct. 20XX-Sept. 20XX)
Year One: OUTCOMES of training and evaluations

DATES (e.g. Oct. 20XX-Sept. 20XX)
Year Two: OUTCOMES of training and evaluations

DATES (e.g. Oct.20XX-Sept. 20XX)
Year Three: OUTCOMES of training and evaluations

§ DATES (e.g. Oct.20XX-Sept. 20XX)
Year Three: OUTCOMES of training and evaluations

## Progress During Remediation

Dr. Resident's name ITERs pertaining to duration on remediation are as follows:

| Date | Rotation Block | ITER Grading | Comments |
|---|---|---|---|
| | | | |
| | | | |

NOTES:
Append ITERs, other relevant evaluations, documents

Updates regarding Dr. Resident's name progress against each area (CanMEDS role) identified in the approved remedial plan are outlined below:

INSERT details from approved remedial plan (table) into the table below. ADD comments on progress & outcomes of completed evaluations

| Period of Remedial Plan | CanMEDS ROLE | Goals and Objectives | Learning or Teaching Strategies | Evaluation of achievement | Progress | Outcome |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

NOTES:

- INSERT name of supervisor for the remedial plan (as noted in approved remedial plan)

- INSERT name of mentor(s) during the remediation period (as noted in approved remedial plan)
- INSERT other evaluation of remedial progress (as noted in approved remedial plan)

**KIMS - Policies and Procedures for In-Training Evaluation of Resident**

Outline typical week during remediation period, e.g. noting academic half-day, clinical sessions, coaching sessions, protected reading time, etc.

| Sunday | Monday | Tuesday | Wednesday | Thursday |
|---|---|---|---|---|
| | | | | |

Summary of Current Status:

Provide a brief narrative summary of this resident's progress with respect to program expectations

Comment on projected outcome at the end of this remediation period.

Outcome of Remediation:

INSERT outcomes of a successful or unsuccessful remediation (i.e. from approved remedial plan)

Development of the REPORT:

This interim remediation report was forwarded to Dr. Resident's name for review on __ __ /__ __/ __ __ __ __.

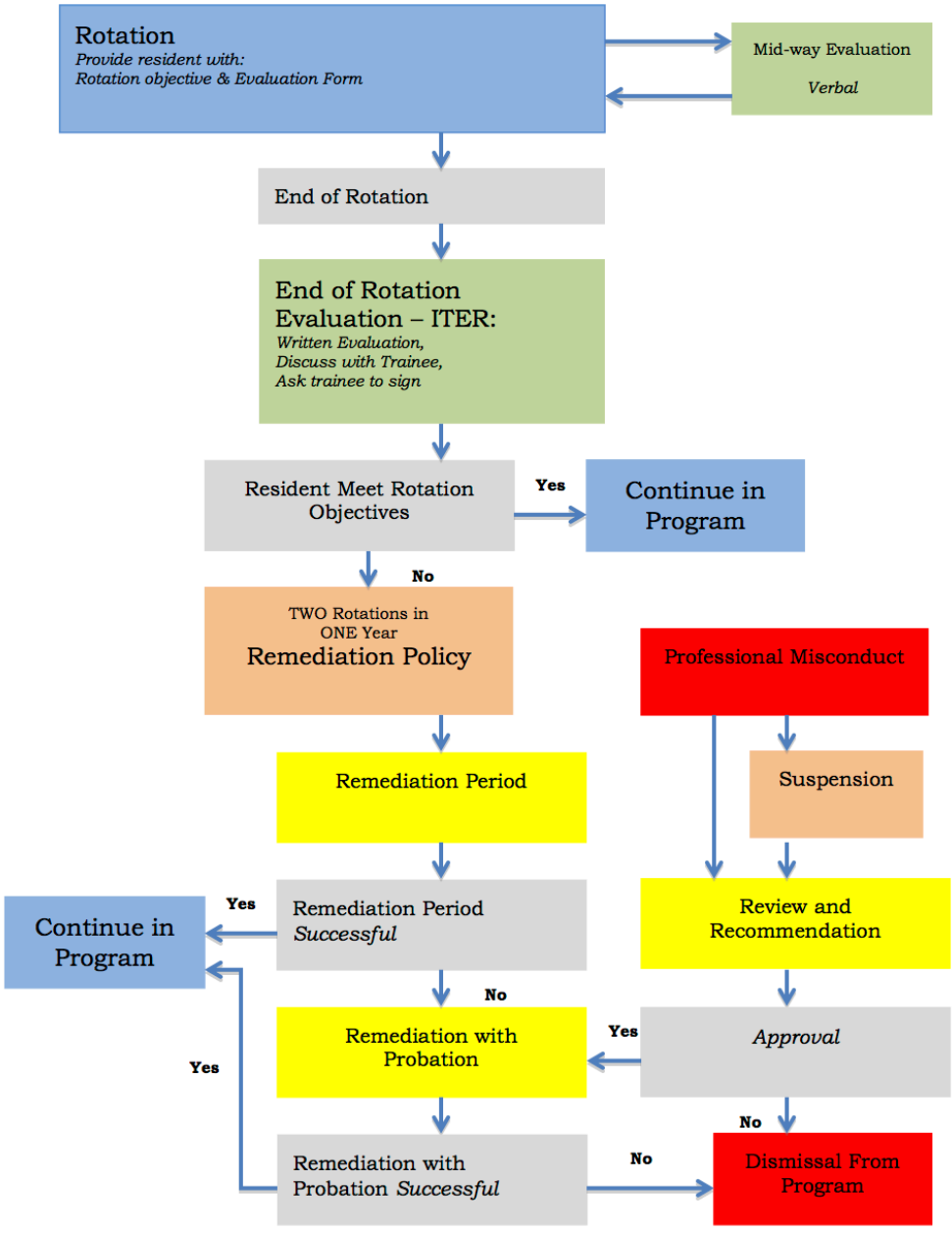
The resident met with Program Director, to review progress under remediation __ __ /__ __/ __ __ __ __.

Signed & Dated:

_____

Program Director, Date

## Appendix E: Evaluation Flow Chart



## 6.3 KIMS Examinations Policies and Procedures for Residency and Fellowship Programs

1.1. Purpose

The purpose of the KIMS Examinations Policies and Procedures is to:

1.1.1. Describe the examinations process in place for all Residency and Fellowship Programs conducted by KIMS.

1.1.2. Ensure that examinations are consistent with program goals and objectives of postgraduate medical education as defined by KIMS.

1.2. Acronyms:

1.2.1. KIMS - Kuwait Institute for Medical Specializations. 1.1.1. ITER - In-training Evaluation Report.

1.2.2. FITER - Final In-Training Evaluation Report.

1.3. Definitions

1.3.1. Residency: a five years specialty training program that is completed after one year of internship following medical school. These programs offer supervised and specific training for the resident in their chosen specialty.

1.3.2. Fellowship:
a three years sub-specialty training program that is completed after Residency. These programs offer supervised and specific training for the fellow in their chosen sub-specialty.

1.3.3. Program Examinations Committee: a specific examinations committee for a Residency or a Fellowship Program.

1.3.4. Certification: in a residency or fellowship will be granted upon the satisfactory completion of all credentials, training, and examination requirements. KIMS Certification confirms that specialist physicians and surgeons have met KIMS standards and training requirements.

## Draft KIMS Examinations Policies and Procedures for Residency and Fellowship Programs – Nov 2014

1. Introduction

2. Program Examinations Committee

2.1. Program Committees must constitute Program Examinations Committee for their Programs and designate a Chair of the Program Examinations Committee.

2.2. Chief of Program Examinations Committee shall have a term for three years which
can be renewed once.

2.3. Chief of Program Examinations Committee must not be a member of the Post
graduate Training Committee.

2.4. The eligibility criteria for Chief of Program Examinations Committee shall be:

2.4.1. Minimum two years of experience as an examiner,

2.4.2. Active contributor of assessment items,

2.4.3. Excellent clinician involved in clinical teaching,

2.4.4. Participation in basic and advanced level workshops on Assessment,

2.4.5. Good skills in MS Word and Excel.

2.5. The eligibility criteria for a member of Program Examinations Committee shall be:

2.5.1. Minimum one year of experience as an examiner,

2.5.2. Active contributor of assessment items,

2.5.3. Excellent clinician involved in clinical teaching,

2.5.4. Participation in basic and advanced level workshops on Assessment,

2.5.5. Good skills in MS Word and Excel.

2.6. Program Examinations Committee shall have minimum 3 to maximum 9 members.

2.7. Program Examinations Committee of each Program is responsible for:

2.7.1. conduct of examinations in coordination with the KIMS Examinations Office,

2.7.2. development of table of specifications and all components of exams,

2.7.3. banking of questions and cases in coordination with KIMS Examinations Office,

2.7.4. formation and supervision of Program Examinations sub-committees,

2.7.5. security and confidentiality of all components of exams,

2.7.6. compilation of results and psychometric analysis in coordination with KIMS Examinations Office,

2.7.7. selection and supervision of exam authors, examiners and invigilators,

2.7.8. orientation of authors, examiners and invigilators to the relevant policies and procedures,

2.7.9. assurance of fairness in all components and processes of examinations,

2.7.10. any other specifics stated in KIMS Examinations Policies and Procedures.

3. Examinations Appeals Committee

3.1. Examinations Appeals Committee must be constituted by the Secretary General of KIMS.

3.2. Examinations Appeals Committee shall respond to requests regarding eligibility,
examinations process and results.

3.3. Examinations Appeals Committee must be allowed access to information regarding
eligibility, examinations process and results during a review process.

4.Role of Examinations

4.1. Part 1 Exam is one of the prerequisite for Final Exam for Residency Programs.

4.2. Final Exam is a certifying exam and it leads to Certification.

5.Eligibility for Examinations

5.1. Eligibility criteria for Part I Residency Exam include:

5.1.1. Two successful ITERs of initial two years of residency training,

5.1.2. Completion of minimum 21 months of residency training.

5.2. Eligibility criteria for Final Residency Exam include:

5.2.1. Success in part I exam within past three years,

5.2.2. Successful FITER,

5.2.3. Minimum 52 months of residency training.

5.3. Eligibility criteria for Final Fellowship Exam include:

5.3.1. Successful FITER,

5.3.2. Minimum 30 months of fellowship training.

6. Examinations Timelines

6.1. Timelines for examinations must be developed by KIMS Examinations Office for each
academic year and must be communicated to all Chairs of Program Examinations Committees.

6.2. Chairs of Program Examinations Committee shall meet the timelines for Examinations
announced by KIMS.

6.3. Programs in collaboration with international bodies shall run in compliance to their
international agreements and shall submit their calendars to KIMS Examinations Office one year in advance.

7.Examinations Registration

7.1. Chairs of Program Examinations Committees must send a list of candidates eligible to challenge KIMS examinations every academic year before the deadline provided by KIMS Examinations Office.

7.2. Examination registrations must be only available to candidates who have been ruled eligible for examinations.

7.3. Candidates who intend to register for examinations must bring the following documents to the KIMS Examinations Office:

7.3.1. Original Civil ID

7.3.2. Two recent photographs on specifications stipulated by the KIMS Examinations Office.

7.4. Once registered in the KIMS Examinations Office, the candidates must receive a KIMS Examinations Registration Letter for the respective year.

7.5. A candidate can opt not to register for an exam, only once in the entire period of training.

7.6. A candidate opting not to register for an exam must submit an approved request from the Chair of Program Examinations Committee to KIMS Examinations Office.

7.7. Any further requests on exemption from registration can only be approved by the KIMS Examinations Appeals Committee.

8.Timeline for Examinations Registration

8.1. A timeline for examinations registration must be announced by the KIMS
Examinations Office and it must be communicated to all eligible candidates by Chairs of Program Examinations Committee.

8.2. Late registrations must have a formal approval from the Chair of Program Examinations Committee and must be submitted to KIMS Examinations Office.

9.Examinations Dates and Time

9.1. Part 1 and Final exams shall be administered once per year.

9.2. All exams shall be conducted at the end of the academic calendar.

9.3. Examination dates and reporting time for all components of their respective exams
must be provided in the Examinations Registration Letter issued to candidates.

9.4. Examination dates and time can change without prior notice.

9.5. A change in dates and time for the written exams must be communicated to
candidates by KIMS Examinations Office.

9.6. A change in dates and time for the Oral, Viva, OSCE, OSPE

or Clinical Examinations
must be communicated to the candidates by the corresponding Chairs of Program Examinations Committees and the KIMS Examinations Office must be notified.

10. Examinations Venue

10.1. Examinations may be held in various venues across Kuwait.

10.2. Examination venues for all the components of their respective exams must be provided in the Examinations Registration Letter issued to candidates.

10.3. A change in venue for the written exams must be communicated to the candidates by the KIMS Examinations Office.

10.4. A change in venue for the Oral, Viva, OSCE, OSPE or Clinical Examinations must be communicated to the candidates by the corresponding Chair of the Program Examinations Committee.

11. Examinations Format

11.1. A Table of Specifications (Blueprint) shall be developed for each exam by the Program Examinations Committee and shall be submitted to the KIMS Examinations Office.

11.2. KIMS examinations incorporate written and clinical components that may include MCQs, SAQs, Oral, OSCEs, Practical or other examination methods.

11.3. Information about the examination format of each Residency and Fellowship Training Program must be communicated one year in advance to the candidates every academic year by the corresponding Chair of the Program Examinations Committee.

12. Exam author, clinical examiner and invigilator

12.1. Criteria for exam author includes:

12.1.1. Shall be a clinical tutor,

12.1.2. Shall be a competent clinician with Evidence Based Medical Practice,

12.1.3. Must be approved by the Program Examinations Committee,

12.1.4. Shall have completed basic workshops on Assessment,

12.1.5. Shall be efficient in MSWord.

12.2. Criteria for clinical examiner includes:

12.2.1. Shall be a clinical tutor,

12.2.2. Must be an exam author,

12.2.3. Shall be a competent clinician with Evidence Based Medical Practice,

12.2.4. Must be approved by the Program Examinations

Committee,

12.2.5. Shall have completed basic workshops on Assessment,

12.2.6. Shall be efficient in MSWord.

12.3. Criteria for invigilator includes:
12.3.1. Must be approved by the Program Examinations Committee or Head of KIMS Examinations Office.

13. Candidates with Special Needs, Conditions or Disabilities

13.1. KIMS shall accommodate candidates with special needs, conditions or disabilities, except where such accommodation would not impose undue hardship on KIMS Examinations Office. Applicants with special needs, conditions or disabilities that require particular consideration must notify in writing to the KIMS Examinations Office at the time of registration for exams.

13.2. Candidates with special needs, conditions or disabilities, must ensure that the KIMS Examinations Office receives appropriate documentation supporting the request for accommodation in sufficient detail to allow KIMS to assess request for accommodation and make suitable arrangements.

14. Examinations Language

14.1. KIMS examinations are offered in English. Some competencies, as identified by the Program Examinations Committees, might require an assessment in Arabic.

14.2. Candidates must ensure that they have reasonable fluency, written and oral, in English.

15. Examinations Decisions

15.1. A candidate must sit all components of an exam together and must pass all components in order to pass the Exam.

15.2. All aspects of and decisions on Examinations shall be based on Best Evidence Medical Education.

15.3. Residency and Fellowship Programs shall have a marking system based on their psychometric approaches.

15.4. Residency and Fellowship Programs shall have standard setting based on their psychometric approaches.

15.5. All Exam results must be approved by the Secretary General of KIMS.

16. Question Bank

16.1. All questions (for e.g., MCQs, OSCEs, SAQs and Structured Oral Questions) shall be secured in a centralized Question Bank.

16.2. Questions stored in Question Bank must have been reviewed by the discipline experts in Residency and Fellowship Programs and accepted for use in examinations.

16.3. Program Examinations Committee shall extract questions from the Question Bank for an exam based on Table of Specifications.

16.4. Chairs of Program Examinations Committee shall arrange exam paper review meeting before submission of the final

paper to the KIMS Examinations Office.

16.5. No changes shall be allowed in the Examination Paper (content and sequence) after the paper has been submitted to the KIMS Examinations Office.

16.6. Questions in the Question Bank must not leave the KIMS Examinations Office in any form except as a part of an exam paper.

16.7. Personal Computer hosting the Question Bank must not be connected to any network.

16.8. Personal Computer hosting the Question Bank must have a restricted access and it should be located in a room with restricted access.

16.9. A back-up of Question Bank must be kept in a restricted hard disk locked in a fire resistant safe inside the restricted access KIMS Examinations Office.

16.10. Programs that use OSCE as an assessment tool shall develop Standardized Patient Bank.

17. Exam Papers

17.1. Written Exam Papers shall be submitted by Chairs of Program Examinations Committees to KIMS Examinations Office in line with the Examinations Timelines.

17.2. Printing of Exam Papers must be done under the supervision of the Chair of Program Examinations Committee in KIMS Examinations Office in line with the Examinations

timelines announced by KIMS Examinations Office.

17.3. Exam Papers must be stored in sealed envelope/s signed by corresponding Chair of Program Examinations Committee.

17.4. Sealed envelope/s carrying Exam Papers must be stored in restricted locker inside the restricted room in KIMS Examinations Office.

17.5. Sealed envelope/s carrying Exam Papers must not leave KIMS Examinations Office before the scheduled time of the corresponding exam.

18. Examinations Logistics

18.1. The KIMS Examinations Office staff must prepare the final list for student attendance of the examination and get it reviewed by the Chair of Program Examination Committees.

18.2. The Chair of Program Examination Committees shall design seating arrangements, and assign invigilation duties.

18.3. In order to avoid errors, the Chair of the Program Examination Committee shall communicate with the KIMS Examinations Office to check details of the exams.

18.4. On the day of examination the Invigilation staff shall reach the venue at least 15 minutes before the reporting time announced to candidates.

18.5. The Chair of Program Examinations Committee or designee receiving the exam papers in sealed envelope/s must count the papers after opening the seal at the venue and must sign a receipt letter for the KIMS Examinations Office.

18.6. After the exam is finished the KIMS Examinations Office staff must count all the exam papers and answer sheets and must seal them in envelope/s and take the signature of the Chair of Program Examinations Committee or designee on a corresponding receipt at the venue.

19. Candidate's Conduct

19.1. An absence from an exam or its component after registration for examinations in KIMS Examinations Office shall be considered as a 'Failed' attempt.

19.2. Candidates must present their Civil ID and KIMS Examinations Registration Letter to the staff at the Registration Desk at the venue of the exam.

19.3. Impersonation or false identity will be subject to applicable government rules.

19.4. Candidates arriving at the exam venue Registration Desk half an hour after the start of examinations shall NOT be allowed to attempt the exam.

19.5. Specific instructions shall be provided on the day of the exam which will require a strict compliance.

19.6. Candidates shall not bring electronic devices, books or notes to the examination premises.

19.7. Smoking is not allowed in the examination premises.

19.8. Candidates must not give or obtain unauthorized

information or aid during an exam.

19.9. Candidates must not look at the examination materials of others.

19.10. Candidates must not take any component of an exam outside the examination premises in any form.

19.11. Candidates must not talk to each other inside the examination premises.

19.12. Candidates must not engage in any disruptive behavior.

19.13. Candidates shall be allowed to leave the examination premises half an hour after the start of examinations.

19.14. Non-compliance with any of the above shall be considered a misconduct subject to disciplinary action by the invigilator varying from verbal warning to a written report with required implications to the Head of KIMS Examinations Office.

19.15. If the candidate is requested to leave the examination premises by the invigilator with an approval from the Head of KIMS Examinations Office, then it must be complied.

20. Preparation of Results

20.1. KIMS Examinations Office shall scan OMR response sheets and shall verify the output by manual checking of random samples of OMR response sheets.

20.2. Compiled marks of OSCEs, SAQs, Oral examinations shall be submitted in a USB drive with a signed hard copy from the Chair of Program Examinations Committee.

20.3. Results must be printed and signed by Chair of Program Examinations Committee and the KIMS Head of Examinations

Office in the results meeting.

21. Results Meeting

21.1. Results meeting must be conducted at the completion of all components of Residency and Fellowship Examinations.

21.2. Results meeting must be attended by the Chair of Program Examinations Committee and the KIMS Head of Examinations Office.

21.3. Results meeting shall be attended by the external examiners and members of the Program Examinations Committee.

21.4. The Chair of Program and Program Director shall not be a part of the Results meeting.

22. Declaration of Results

22.1. KIMS Examinations Office will upload the results on its Examinations website.

22.2. Results will be disclosed to the candidates, individually, confidentially, through a password restricted access, ONLY through KIMS Examinations website.

23. Exam Attempts

23.1. Residents shall be allowed two attempts to Part 1 Exam.

23.2. Residents must get an approval from the Program Examinations Committee in order to get a third attempt to Part

1 Exam.

23.3. Residents and Fellows shall be allowed two attempts to Final Exam.

23.4. Residents and Fellows must get an approval from the Program Examinations Committee in order to get a third attempt to Final Exam.

23.5. Candidates failing an exam in the maximum of three attempts will be expelled from the Program.

24. Scrutiny of results

24.1. Any request for scrutiny of results shall be submitted to the KIMS Examinations Office within four weeks of declaration of the results.

24.2. Candidates must not be allowed access to scores or scored component of an exam.

25. Notification of Errors

25.1. Chair of Program Examinations Committee must notify in writing to the Head of KIMS Examinations Office about any errors detected in the scores after the declaration of results.

26. Storage

26.1. Printed exam questions papers will be destroyed, shredded or incinerated, after the respective exam.

26.2. Response sheets (MCQs and Essays of certifying exams) must be retained in KIMS Examinations Office for three years.

26.3. Soft copies of exam scores shall be stored for six years.

## 6.4 KIMS – Policies and Procedures for leaves during Postgraduate Education

### Introduction

The policies and procedures for leaves during Postgraduate Education is a detailed manual outlining the position of Kuwait Institute for Medical Specialization regarding resident's/fellow's leaves during postgraduate education.

The purpose of this policy and procedure manual is to:

1. Provide a guidance to the process of leaves throughout the postgraduate education programs at KIMS

2. Ensure consistent practices among postgraduate education programs at KIMS

### The following outline the summary of the policy:

· Each resident/fellow registered in residency/ fellowship program must follow the leave policy at the KIMS.

· The resident/fellow must ensure that he/ she meets the minimal training requirement of the training and the eligibility for the examination.

· The resident/fellow and the Program Director must ensure that resident's/ fellow's leaves do not affect goals and objectives of the rotation.

· The resident/ fellow must submit his/her leave request to the Site Coordinator/ Program Director in timely fashion in the designated form.

· The Site Coordinator must ensure that resident's/fellow's leaves do not interfere with clinical duties.

· The Program Director must approve all resident's/fellow's leaves prior to final processing.

· The Program Director must capture all resident's/fellow's leaves and monitor days of leaves.

ALL LEAVES THAT ARE NOT APPROVED BY THE PROGRAM DIRECTOR AND THE POSTGRADUATE EDUCATION OFFICE MUST BE CONSIDERED VOID.

For further information regarding this policy and procedures please contact:

Kuwait Institute for Medical Specializations Postgraduate Education Office 9th Floor, Behbehani Building:

Tel:

E-mail:

## 1. Section One: General Information

Postgraduate education of the resident/fellow at KIMS is an observed process to ensure that he/she achieves targeted objectives of the rotation and overall goals in an allocated timeframe.

The goals and objectives of postgraduate education are achieved by structured rotations designed in sequence and duration in addition to other components such as academic days, workshops, etc.

KIMS has established a minimal required period of postgraduate education for its exam eligibility as delineated in the examinations policies.

### 1.1. Definitions

1.1.1. Resident: A physician enrolled in a postgraduate education residency program recognized by KIMS and registered at the Postgraduate Education Office of KIMS for the academic year.

1.1.2. Fellow: A physician enrolled in a postgraduate education fellowship program recognized by KIMS and registered at the Postgraduate Education Office of KIMS for the academic year.

1.1.3. Academic Year: An year of education that starts on Oct. 1 of each year and ends on the Sept. 30 of the following year

1.1.4. Effective Training: The time actually spent in clinical and/or structured rotations excluding all leaves (annual leaves, sick leaves, study leaves, maternity leaves of absence, haj leaves, conference leave, etc.). It is counted as months of training

1.1.5. Rotation: A period of time spent in a clinical and/or other health-related services. The rotations vary according to the discipline and the program (e.g., a 3months rotation starts on Oct. 1 and ends on Dec. 31)

## 2. Section Two: Policy and procedures on Leaves During Postgraduate Education

2.1. General rules: General rules must be applied to all clauses in the Leave Policies and Procedures

2.1.1. The resident/ fellow's leave must not affect the goals and objectives of the rotations and hence the following must apply:

> 2.1.1.1. In two-months or lesser rotation, leaves must not exceed 5 working days
>
> 2.1.1.2. In two-months to four-months rotation, leaves must not exceed 10 working days
>
> 2.1.1.3. In four months or more rotation, leaves must not exceed 30 days including weekends

2.1.2. The maximum allowed time for completion of all requirements of five-years Residency is eight years and the maximum allowed time for completion of all requirements of three-years Fellowship is five years inclusive of the approved leaves

2.1.3. 75% attendance is must for the success of a rotation

2.1.4. Leaves must not be transferred to the next academic year

2.1.5. All leaves must be approved by the Program Director / designee

2.1.6. If the total requested leaves exceed 60 days of leaves then "Leave of Absence" rules and regulations shall apply

2.1.7. On Call Duties shall not be waived during rotations

**Leaves Categories**

The following are categories of leaves within the maximum time allowed for the residency and fellowship postgraduate education programs:

**2.2. Annual Leaves: 30 days of annual leaves** shall be granted each academic year **including the public holidays.**

2.2.1. Annual leave is effective from Oct. 1st to Sept 30 of the following year

2.2.2. Annual leave must not be transferred

2.2.3. General Rules in section 2.1 apply

**2.3. Medical (Sick) Leave:** Residents/fellows are allowed a total of 15 days of authorized sick leave each academic year

2.3.1. Medical leaves exceeding 15 days per year must be approved by the General Medical Council, MOH, Kuwait.

2.3.2. For resident/ fellow granted 30 days continuous medical leaves twice (total of 60 days duration) by the General Medical Council, "leave of absence" rule and regulations shall apply.

2.3.3. General Rules in section 2.1 apply.

**2.4. Professional Leaves**

2.4.1 Study Leaves: A total of 14 days of study leaves shall be granted during residency/ fellowship program

2.4.1.1. The last day of the leave shall be the last day of the exam

2.4.1.2. The study leave shall only be granted for Kuwait Board Examinations and not other examinations

2.4.1.3. Study leaves shall be taken as:

2.4.1.3.1. (7 days) for Part 1 examination

2.4.1.3.2. (7 days) for Final examination

2.4.1.3.3. (14 days) for Part 1 examination

2.4.1.3.4. (14 days) for Final examination

**2.5. Conference Leaves:** Each resident/ fellow is granted a 5 working days conference leaves each academic year.

2.5.1. Evidence of registration to the conference and certificate of attendance is must

2.5.2. This shall not grant a financial support or working days

**2.6. Special Leaves for residents/fellows**

2.6.1. Emergency leaves: Each resident/ fellow shall be granted emergency leaves in line with MOH regulations and these must be processed as annual leaves.

2.6.2. Grieving Leaves: A resident/fellow shall be granted 4 days of grieving leave upon death of husband/wife or first degree relatives.

2.6.3. Maternity Leaves: A female resident/ fellow shall be granted 30 days of maternity leaves twice during residency and once during fellowship.

2.6.4. Companion Leaves: Each resident/ fellow shall be allowed a total of 15 days of companion to first degree relative.

2.6.4.1. An authorized letter from the treating physician and head of department indicating a day of admission and discharge must be provided.

2.6.4.2. In case of travel abroad, companion approved letters from treatment abroad office must be provided.

## 2.7. Special Leaves for Muslim residents/fellows

2.7.1. Hajj Leaves: A muslim resident/fellow can be granted a 30 days of Hajj Leaves once during residency/ fellowship.

2.7.1.1. This leave must not have been granted prior to joining the program

2.7.1.2. The resident/ fellow must be officially registered by pilgrim group, licensed by the Ministry of Awqaf and Islamic Affairs

2.7.1.3. Evidence of presence in Kingdom of Saudi Arabia during the period of Hajj as shown in resident/ fellow's passport

2.7.1.4. Hajj Official Mission is only allowed once to a resident /fellow and shall not consume the Hajj Leaves

2.7.2. Female widow Grieving Leave: A married muslim female resident is entitled a grieving leave upon her husband death for 4 months and 10 days.

2.7.2.1. Official Governmental letter is required.

**2.8. Leave of Absence:** Resident/ fellow may need to interrupt his/her training due to various reasons. "Leave of Absence" (LOA) is a voluntary leave for a specific period of time that resident/fellow may choose to take during residency/ fellowship due to legitimate reasons.

2.8.1. The leave must be discussed and approved by the Program Director

2.8.2. The leave must be a minimum of 2 months and maximum of 12 months

2.8.3. A resident/fellow is allowed a cumulative of maximum of 12 months of LOA during residency

2.8.4. It shall be taken as a block of rotation/s and not mid-rotation

2.8.5. If under special circumstances, LOA is approved during the rotation, criteria for maximum allowed leaves during the rotation is applied to credit the successful completion of rotation

2.8.6. The Program Director must notify the KIMS Office of Postgraduate Education of the details including the first day and last day of the planned LOA.

2.8.7. The period of leave must not be considered as effective period of postgraduate education.

## 6.5 Safety Policy:

The policy allows resident discretion and judgment regarding their personal safety and ensure that all residents are adequately supervised during all clinical situations they experience.

Residents have the right to work in a safe environment during their residency training. The responsibility for such an environment is shared between KIMS, the faculty of emergency medicine, the hospitals/clinical departments, residency training programs and the residents themselves.

**Key Obligations:**

- Residents - To provide information and communicate safety concerns to the program director and to strictly follow safety policies.
- Residency Training Programs
  - To act immediately to address identified safety concerns and incidents and to be decisive in providing a safe learning environment.

**Physical Safety:**

These guidelines apply during residents' activities that are related to the carrying out of residency duties:

## Travel Safety:

- ➢ When residents are traveling for clinical or other academic assignments by private car, it is expected that they maintain their vehicle in proper working order and travel with proper supplies and contact information. The law in the State of Kuwait prohibits non-hands free cell phone use and text messaging, with heavy fines, while driving.
- ➢ For long distance travel for clinical or other academic activities, residents should ensure that a colleague or the residency office is aware of their schedule.
- ➢ Residents should not be on call the day before long distance travel for clinical or other academic activities by car. When long distance travel is needed before beginning a new rotation, the resident should request that she/he not be on call on the last day of the preceding rotation. If this cannot be arranged then there should be a day of travel on the first day of the new rotation before the start of any clinical activities.
- ➢ Residents are not to be expected to travel long distances during adverse weather for clinical or other academic assignments. If such weather prevents travel, the resident is expected to contact the program office immediately. Assignment of an alternate activity is at the discretion of the Program Director.

## Hospital Safety:

- ➢ Residents should not be expected to walk alone for any long or unsafe distances at night. This includes walking on the hospital

ground and parking areas. The residents are expected to request security assistance if such circumstances occur. Residents should not drive home after a call if they have not had enough rest.

➢Residents should not assess violent or psychotic patients without being backed up by security and an knowledge of the nearest exits. When interacting with patients with potential for violence, residents should be aware that there is backup from security staff and that the patients are seen in an area, which allows for safe and easy exit. The space required for management of violent patients must be provided where applicable.

➢Site orientations should include a review of local safety procedures.

**Personal Safety:**

➢Residents should only telephone patients using caller blocking.

➢Residents should be familiar with the location and services offered by the Safety/Occupational Health Office of the Ministry of Health. This includes familiarity with policies and actions to be taken for infection control and protocols following exposure to contaminated fluids, needle stick injuries, and reportable infectious diseases.

➢Residents must observe universal precautions and isolation procedures when required.

➢Residents should keep their immunizations up to date. Overseas travel immunizations and advice should be requested

well in advance when traveling overseas for electives or conferences.

➢Pregnant residents should be aware of specific risks to themselves and their fetus in the training environment and request accommodations where appropriate.

**Psychological Safety:**

1. The learning environments must be free from intimidation, harassment, and discrimination. Where there are situations where there are concerns regarding intimidation, harassment or discrimination residents are strongly encouraged to discuss this with the Program Director, Assistant Program Director or Site Coordinator. Residents may also contact KIMS directly.

2. When a resident's performance is affected or threatened by poor health or psychological conditions, (physical or mental) the resident should be allowed to have a leave of absence and receive the required support. Such residents should not return to work until a thorough assessment has declared them ready.

3. Residents should be aware of and have easy access to the available sources of immediate and long-term help for psychological problems, substance abuse problems, harassment, and injustice issues asise.

**Professional Safety:**

7. A residents may experience conflicts between their ethical or religious beliefs and the training requirements and professional duties of physicians. Resources should be made available to residents to deal with such issues. Examples

include the Program Director, KIMS and Ministry of Health.

8. Residents must be properly supervised recognizing that part of the residency training program is graded responsibility. Details regarding specific standards of supervision will be explained.

9. Where there is a disagreement between a resident and a faculty member with respect to the management of a patient. The process of resolution includes:

   1. The resident consults with the site coordinator about the issue.

   2. The site coordinator will speak with the attending physician/supervisor and attempt to resolve the issue.

   3. If the resident does not feel that the issue had been resolved, she/he may approach the program director.

   4. If the issue still remains unresolved, the resident may approach the Postgraduate Office at KIMS.

10. Where possible the Program will accommodate for religious holidays taking in regard professional and patient care responsibilities.

11. Residents should have adequate support from the program following an adverse event or critical incident

12. Programs should promote a culture of safety in which residents are able to report and discuss adverse events, critical incidents, 'near misses', and patient safety concerns without fear of punishment.

13. Residency program committee members must not divulge information regarding residents. It is the responsibility of the residency Program Directors to make the decision and to disclose information regarding residents (e.g. personal information and evaluations) outside of the residency program committee and to do so only when there is reasonable cause. The resident file is confidential.

14. Resident feedback and complaints must be handled in a manner that ensures resident anonymity, unless the resident consents otherwise.

1. **The Role of Residents in Ambulance Transports:**

10. In many programs, participation in patient transport is a valuable learning
experience for residents.

11. There must be clear educational objectives underlying the resident's participation in patient transport.

12. Residents must have adequate training with demonstrated abilities in the circumstances relevant to the transport experience.

13. Communication and supervision between the resident and her/his designated supervising physician must be available at all times.

14. Resident well-being should be considered in all transports.

## 7.0 Program Curriculum in detail

### 7.1. Principles of Emergency Care

7.1.1. Recognition / intervention of acute Illness and Injury.
7.1.2. Resuscitation / Stabilization of the seriously Ill and Injured patient.

### 7.2. Acute Disorders by Body Systems

7.2.1. Head and Neck.
7.2.2. Eye.
7.2.3. Cardiovascular.
7.2.4. Thoracic / Respiratory.
7.2.5. Abdominal / Gastrointestinal.
7.2.6. Renal / Urinary Tract.
7.2.7. Genital tract.
7.2.8. Dermatological.
7.2.9. Musculoskeletal / Rheumatologic.
7.2.10. Nervous System.
7.2.11. Psychological / Behavioral.
7.2.12. Hematological.
7.2.13. Endocrine / Metabolic / Nutritional.
7.2.14. Acid Base.
7.2.15. Fluid and Electrolyte.
7.2.16. Allergic / Immunological.

### 7.3. Trauma

7.3.1. Multiple Trauma.
7.3.2. Trauma to the Head, Neck (Including CNS and Spinal Tract).
7.3.3. Trauma to the Face (Including Eyes/Ears/Nose/Tongue/ Mouth/ Teeth).
7.3.4. Trauma to the Chest.
7.3.5. Trauma to the Heart and cardiovascular System.
7.3.6. Trauma to the Abdomen.
7.3.7. Trauma to the Urogenital System.
7.3.8. Trauma to the Musculoskeletal System.
7.3.9. Trauma to the Hand / wrist.
7.3.10. Trauma to Skin / Soft Compartments.

## 7.4. Acute Age-Related Disorders: Pediatric Disorders

7.4.1. Clinical Assessment on Infant / child.
7.4.2. Resuscitation.
7.4.3. Neonatal Conditions.
7.4.4. Specific clinical Presentations / Considerations.
7.4.5. Acute Pediatric Disorders by Body Systems.
7.4.6. Congenital / Development Syndromes.
7.4.7. Toxicological Disorders in Childhood.
7.4.8. Infectious Disorders in childhood.
7.4.9. Pediatric Hematology / Oncology.
7.4.10. Child Abuse / Deprivation / Family Dysfunction.

## 7.5. Acute Age-Related Disorders: Geriatric Disorders

7.5.1. Physiology of Aging.
7.5.2. History and Physical Examination of the Elderly.
7.5.3. Specific Clinical Presentations / Consideration.
7.5.4. Evaluation of Functional Ability.
7.5.5. Effect of Aging on Diagnostic Test.
7.5.6. Pharmacokinetics in the Elderly.
7.5.7. Common Psychosocial Disorders in the Elderly.
7.5.8. Geriatric Disorders presenting with Variable Manifestations.

## 7.6. Toxicology

7.6.1. General Principal of Drug Absorption / Kinetics / Excretion.
7.6.2. General Approach to Poisoned / Overdosed Patient.
7.6.3. Specific Clinical Presentations / Considerations.
7.6.4. Drug Interactions / Adverse Reactions.
7.6.5. Drug Acting at Synaptic and Neuroaffector Sites.
7.6.6. Medicinal Agent.
7.6.7. Specific Toxic Agents / Poisons (Toxidromes).
7.6.8. Plant poisons.
7.6.9. Toxins Produced by Biological Agents.
7.6.10. Neurotoxins /cellular Toxins.
7.6.11. Local Acting Drugs.

7.6.12. Food poisons.

## 7.7. Environmental Disorders

7.7.1. Pathophysiology in Environmental Disorders.
7.7.2. Clinical Syndromes – heat Induced.
7.7.3. Clinical Syndromes – Cold Induced.
7.7.4. Clinical Syndromes – Water Immersion.
7.7.5. Hyperbaric Syndromes.
7.7.6. Hypobaric Syndromes.
7.7.7. Contamination of Air.
7.7.8. Radiation Exposure / Syndromes.
7.7.9. Microwave / Laser Exposure.
7.7.10. Electrical Injuries.
7.7.11. Chemical Injuries.
7.7.12. Animal Bites.
7.7.13. Insect / Arthropod Bites / stings.
7.7.14. Transport of Hazardous products.

## 7.8. Investigative Modalities in Emergency Medicine

7.8.1. Hospital Laboratory Determinations.
7.8.2. Emergency Department Laboratory Assessments.
7.8.3. Physiological Measurements – Static.
7.8.4. Physiological Measurements – Invasive.
7.8.5. Imaging.

## 7.9. Manipulative / Procedural Skills Emergency Medicine

7.9.1. Resuscitation.
7.9.2. Airway Management.
7.9.3. Ventilation.
7.9.4. Venous Access.
7.9.5. Arterial Access.
7.9.6. Stabilization / Immobilization.
7.9.7. Emergency Department Anesthesia / Analgesia.
7.9.8. Wound Management (Skin and Soft Tissue).
7.9.9. Assessment of Infectious Processes.

7.9.10. Management of Superficial Infection.
7.9.11. Plastic Surgery Procedures.
7.9.12. Musculoskeletal Procedures.
7.9.13. Neurological / Neurosurgical Procedures.
7.9.14. Specific Procedural Skills Common to All Specialties.
7.9.15. Toxicological.

## 7.10. Emergency Medicine Services (EMS)

7.10.1. Pre-hospital Emergency Medicine Service.
7.10.2. Emergency Department Administration.
7.10.3. Disaster Medicine.
7.10.4. Medico-legal Aspects of Emergency Medicine.
7.10.5. History Education Research in Emergency Medicine.
7.10.6. Emergency Medicine Organization and Liaisons.