CURRICULUM OF THE FACULTY OF FAMILY MEDICINE

WEST AFRICAN COLLEGE OF PHYSICIANS

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CHAPTER ONE – INTRODUCTION

1.1 Introductory statement

Family medicine is the medical discipline also known as general practice, general medical practice, family practice, or primary care. It is a discipline which integrates several medical specialties into a new whole. It is concerned with the holistic approach to patient care in which the individual is seen in his totality and in the context of his family and community. The trainees in family medicine should be appropriately equipped to meet the contemporary and future health needs of individuals and families within their practice community. To meet this demand he needs to have a solid foundation in basic medical education, and acquire knowledge and skills in the major clinical disciplines with appropriate attitude essential to the practice of the specialty. This curriculum is therefore designed to guide the training of residents in Family Medicine.

Family Medicine Practice consists of three Core Areas: Primary Care, Health Facility Care and Family Care, Fig 1.

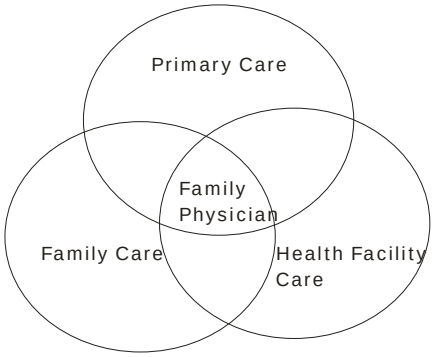

Figure 1: Domains of Family Medical Practice and position of Family Physician in the domain.

Primary Care consists of two areas of care, primary medical care and primary health care.

Primary Medical Care

The term primary medical care here refers to all care delivered at the point of first contact with the health care system which may be in small clinics, health centres or general practice sections of large district hospitals and tertiary centres.

Primary Health Care (PHC)

WHO defines Primary health care as essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Alma-Ata, 1978). It aims at delivering essential and comprehensive health services in an integrated manner to the people at the point of first contact. The practice of the Family Physician provides the patient and family access to integrated curative, preventive and health promotion services.

Hospital and Clinic Care (Facility-based Care)
In West Africa, the Family Physician functions as a general physician, with competences in surgery, obstetrics and gynaecology, especially in under-served and difficult-to-reach populations. In multi-specialty health institutions the Family Physician coordinates the care for the patient as he or she navigates the health system while receiving care from many linear specialists.

Family Care and Family Dynamics
Central to the practice of Family Medicine is the understanding of the concept of what the family is and the important interplay between family dynamics and the health of family members. Hence in Family care the family becomes the unit of care.

1.2 Needs analysis

Most countries in the West African sub-region parade poor health indices. The resources available for health in these countries are also very limited. Rural areas, where a large proportion of the people reside, tend to be particularly underserved.

It has long been recognized that primary health care is the key to attaining health for all. In the World Health Report of 2008 the WHO reviewed the implementation of the primary health care initiative after 30 years. It noted that in countries that had made significant progress, primary health care was centered around physicians with a specialization in family medicine or general practice.

In recognition of the unique role that family physicians can play in primary healthcare delivery, the Agenda item 12.4 of the Sixty Second World Health Assembly of 22 May 2009 (WHA62.12) asked member countries to 'train and retain adequate numbers of health workers, with appropriate skill mix, including primary health care nurses, midwives, allied health professionals and **Family Physicians, able to work in a multidisciplinary context,** in cooperation with non-professional community health workers in order to respond effectively to people's health needs'.

To bring quality health care closer to the people of West Africa there is the need to produce a critical mass of Family Physicians. Family Physicians will provide health maintenance/promotion, disease prevention, basic medical, surgical, paediatric, obstetric and gynaecological care within the community and provide coordination of care in multi-specialty health institutions. Such a physician will manage the total healthcare needs of the patient in collaboration with relevant specialists in the various clinical and allied disciplines. With the inadequate number of Family Physicians, the gap is poorly filled by general duty medical officers, subspecialists without postgraduate training in primary care, community health workers and a range of unorthodox practitioners.

1.3 Vision of the Faculty

Improved health and quality of life of the West African people through fostering and maintaining high standards in family medicine training, practice, and research.

1.4 Mission of the Faculty

To produce Family Physicians of international standards who are equipped with the knowledge, skills and attitudes needed to practice, teach, and conduct research competently in the sub-region and play key leadership roles in providing comprehensive health services that meet the needs of the individuals and families within the context of the communities they serve. It is hoped that in the foreseeable future all primary care providers in the West African sub-region are specialists in Family Medicine.

1.5 Aim and Goals of the Residency Training Programme

The Goal of the training programme is to produce Family Medicine Specialists of international standard who can meet the peculiar health needs of the West African People. At the end of the training the graduate of the programme will be able to:

A. Practice competently the field of Family medicine at the primary care, family care and institutional care levels.
B. Provide leadership for other health workers in his team for effective service delivery
C. Coordinate health care services and programmes

D. Manage health resources and institutions for efficient service delivery.
E. Manage training programmes to train Family Physicians and other relevant health workers
F. Initiate and conduct relevant research to improve practice and contribute knowledge to the specialty.
G. Play appropriate advocacy role for improved health and quality of life for people in his practice community in cooperation with other community health providers and stakeholders.

1.6 The Philosophy of the Training Programme.

Family medicine started at the very beginning of the evolution of medical practice. The first physicians were generalists and for thousands of years, generalists provided all of the medical care available. They diagnosed and treated illnesses, performed surgery, and delivered babies.

As medical knowledge expanded and technology advanced, many physicians chose to limit their practices to specific, defined areas of medicine. With time specialization began to flourish and

the number of specialists and subspecialists increased at a phenomenal rate, while the number of generalists declined dramatically.

In many countries the public became increasingly vocal about the fragmentation of their care and the shortage of personal physicians who could provide holistic, continuing and comprehensive care. Thus began the reorientation of medicine back to personal, primary care. The concept of the generalist was reborn with the establishment of family medicine as a specialty in many countries. The countries in Africa are at different stages of this evolutionary process.

Arising from this historical background, the philosophy of the residency training in Family Medicine is therefore to produce a well-grounded medical specialist of first contact that will provide high quality health care at the grassroots and serve as an efficient gate keeper to the health system.

The product of the programme will be a thorough bred clinician, a teacher, a counselor, a manager, a team leader, a researcher and a health advocate. He will have to recognize the common health problems in his practice community, manage most of them and refer the rest appropriately with a view to ensuring efficient utilization of health resources.

He will provide personalized, comprehensive, and continuing care to individuals and families in the community from cradle to grave. He will not only diagnose and treat diseases but will go further to explore the subjective aspects of the patient's unique illness experience in order to provide holistic care and enhance patient satisfaction. This requires commitment to a long lasting patient – physician relationship that will provide a thorough knowledge of the patient within the context of his family and the larger sociocultural environment.

Hence the breadth of this curriculum will be determined by ***"most of the health problems that most of the people have most of the time"*** rather than by age, gender or organ system. When referral is indicated, he will refer the patient to other specialists or caregivers but will remain the coordinator of the patient's health care in order to prevent fragmentation of that care. The family physician will serve as the patient's advocate in dealing with other medical professionals, third party payers, employers and others, and as such serve as a cost-effective coordinator of the patient's health service needs.

The knowledge, skills and attitudes prescribed in this curriculum will form the basis of his training and certification even though the content of his practice will vary with the needs of his practice community. The scope of the family physician's practice will also change over time, requiring maintenance of competency in current skills and the need to acquire new knowledge and skills through continuing medical education.

The continuous growth in medical knowledge confers on the family physician a responsibility

for life-long learning, as the scope of family medicine is dynamic, expanding, and evolutionary.

The training will be of international standard with appropriate consideration for the peculiar needs of the sub-region and will be conducted in accredited health institutions within the sub region while encouraging exposure outside the sub region where possible and appropriate. The trainee will be taken through basic medical sciences, rotations in major clinical disciplines, rotations in rural practice and practice management, engagement in research as well as training in medical ethics, education methodology and other relevant subjects.

Formative and summative assessments will be carried out to ensure that the certified trainee meets the standards envisaged by the training programme.

Structure of the Residency Program

Admission into Residency Program**:**
The program shall be open to candidates who:

1. possess an MBBS, MBCHB or equivalent from an approved University.
2. have completed a minimum of 12 months rotatory internship in an accredited hospital post university degree.
3. possess a valid Medical and Dental Council full Registration as a Medical Practitioner in the relevant constituent member country of West Africa.
4. Have passed the Entry Examination (Primary) of the West African College of Physicians or equivalent body in Family Medicine.

To be exempted from the entry examination candidate should possess MSc (FamMed), or M. FamMed, or equivalent degree acceptable by the College.

Membership training: The candidates must serve a minimum of two years in approved training posts covering a wide range of practical experience, including posts in internal medicine, surgery, obstetrics and gynaecology, paediatrics and community health. In addition, candidates will undergo course work, at accredited regional workshops on Principles of family Medicine and Health System Management and Organisation. After the minimum period of two years, and with satisfactory coverage of the curriculum, the candidate shall be eligible to sit the Membership examination.

Fellowship training: After passing the Membership examination, candidates will be required to work for a minimum of two years in a Family Medicine centre approved by the faculty board for training. During the two years the candidate will prepare a dissertation on a topic of his choice and a case book of 15 well-reviewed cases managed by him. These cases are intended to demonstrate the broad base of competencies expected of the trainee.
When entering for the fellowship examination, the candidate must:

1. have been registered with the faculty for a minimum of 4 years,
2. have passed the membership examination at least 2 years before applying for the fellowship examinations

3. show evidence of having satisfactorily served for at least two years in an approved part II training centre,
4. have submitted a dissertation and a case book,
5. Show evidence of attendance of at least one update course and one revision course; and in addition a course in Research methodology and Health System management and Organisation.
6. Show evidence of a 3 month tutelage in private practice management and a 3 month post-membership rotation in an accredited rural surgical practice. This is to acquire practical management skills and consolidate surgical skills in order to be able to meet the needs at the grassroots.

A period abroad in an area of subspecialisation in Family Medicine will be beneficial in enriching the quality of patient care and practice management in our environment. Therefore elective periods overseas, of up to one year duration, may be allowed by the Faculty in addition to the two years of Fellowship Training. On completion of two years, the Trainer will sign a Completion Certificate. The candidate will then forward his Dissertation and Casebook to the College Secretariat.

CHAPTER TWO – PRIMARY SYLLABUS

2.1 **Aim of the primary exam**

The Primary examination is a screening examination aimed at determining the suitability of the candidate in knowledge to pursue residency training in Family Medicine. The candidate is to demonstrate a good grounding in basic medical sciences and bio-psychosocial concepts relevant to the common conditions encountered in Family Medicine.

2.2 The Primary syllabus

Anatomy

Aim:

To demonstrate knowledge of applied gross and microscopic anatomy relevant to the practice of Family Medicine

Competencies and Course Contents:

Candidate should be able to describe, illustrate and discuss the clinical significance of the gross and microscopic anatomy of the following areas:

-Normal body structure, Surface anatomy, Skeletal system, Muscular system, Nervous system,
-Cardiovascular system, Respiratory system, Genitourinary system and Gastrointestinal system,
-Microscopic anatomy of the basic tissue elements, epithelium, connective tissue.

Physiology

Aim:

To demonstrate knowledge of normal physiology

Competencies and Course Contents:

Candidate should be able to discuss the normal functioning of the following body systems and describe the clinical consequences of derangement in their normal physiology:

-Blood, Heart, and Circulation; Fluid and electrolyte physiology; Respiratory Physiology
-Digestive System; Regulation of Metabolism; Physiology of the Kidneys; Reproduction;
-Immune System; Nervous system

Nutrition

Aim:

To demonstrate knowledge of nutrition

Competencies and Course Contents:

Candidate should be able to describe, illustrate and discuss

-Normal nutritional requirements; causes, prevention and management of malnutrition
-Nutritional value of common foods including human breast milk;
-Nutritional and immunological properties of human breast milk;
-Comparison of the composition of human breast milk and that of cow's milk;
-Infant feeding;- Complementary diet.

Biochemistry

Aim: To demonstrate knowledge of basic biochemistry

Competencies and Course Contents: Candidates should be able to

-Discuss the structure and functions of proteins and enzymes
-Discuss the structure, function and replication of nucleic acids
-Discuss and illustrate the metabolism of proteins, and amino acids
-Discuss the metabolism of carbohydrate, fat, and
haemoglobin.
-Discuss the functions and clinical significance of vitamins and minerals
-Discuss the clinical significance of deranged metabolism

Foetal development (Embryology)

Aim: To demonstrate knowledge of normal foetal development and its clinical relevance

Competencies and Course Contents: Candidates should be able to

-Describe the process of development, including gametogenesis, fertilization; foetal development and growth.
-Enumerate and discuss factors that affect normal embryogenesis e.g. nutritional, endocrine, pharmacologic, infections, occupational, clinical and intrinsic factors (e.g. twinning, anaemia, etc.).

Genetics and Genomics

Aim: To demonstrate basic knowledge of Genetics and its clinical application.

Competencies and Course Contents

Candidates should be able to discuss the following:

Mendelian genetics, molecular, physical and biochemical basis of inheritance, chromosomal aberrations. Common genetic problems and syndromes (e.g. haemoglobinopathies, Down's and Turner's syndrome etc.). Basic genetic counselling (e.g. premarital counselling on sickle cell disease, counselling on risks of other genetic diseases etc.).

Human Development

Aim:

To demonstrate knowledge of Human physical and psychological development

Competencies and Course Contents:

Candidates should be able to describe and discuss the following:

Development at the various stages of infancy, childhood, adolescence, maturity and adulthood including Physical, Intellectual and psychological development
Personality formation, personality types and personality disorders; Normal sleep and sleep disorders; Grief reaction; Ageing and senility; Human sexuality and related disorders

Pharmacology
Aim: To demonstrate knowledge of pharmacology relevant to drugs commonly used in Primary care.
Competencies and Course Contents
Candidates should be able to discuss the following:
Basic pharmacokinetics- absorption, distribution, metabolism, and excretion of drugs. Basic mechanisms of drug action. Indications for common classes of drugs, including dosages, side effects, and drug interactions. Principles of Essential Medicines list. Drug use in liver and kidney diseases, pregnancy, breast feeding, elderly. Rational use of Medicines.

Pathology - Morbid, Chemical Pathology, Microbiology, Immunology, Parasitology, Haematology
Aim: To demonstrate knowledge of the pathological basis of common problems seen in Family Medicine.
Competencies and Course Contents:
Candidates should be able to
-discuss the pathophysiology and pathological changes in common conditions seen in Family Medicine including infections and infestations, endocrine and metabolic disorders, degenerative conditions; Principles of neoplastic transformation, genetic-metabolic transformation concept of carcinogenesis.
-discuss how to carry out common point of care tests
-interpret common tests of body function
-discuss blood group physiology and its clinical application

Forensic Medicine
Aim:
To demonstrate awareness of the Ethical and Legal issues in Medical Practice
Competencies and Course Contents:
Candidates should be able to outline ethical considerations in day to day practice, cases of assault and sexual offences, consent and confidentiality; concept of vulnerable groups

Introduction to Family Medicine
Aim:
To demonstrate awareness of family medicine as a specialty and family as a health resource and unit of care
Competencies and Course Contents:
Candidates should be able to briefly discuss the following:

Scope of family medicine, Basic principles of family medicine, Family structure, basic family tasks and functions, Influence of the family in health and disease

Medical Informatics

Aim: To demonstrate awareness of analytic tools in the production, control, analysis and decision making with medical data

Competencies and Course Contents:

Candidates should be able to briefly define or explain the following:

-basic descriptive statistics i.e. rates, ratios, mean median, mode etc.

-vital and health statistics and their importance

- Use of ICT tools in medical information and clinical decision support

2.3 The Primary revision course

The Faculty will organize revision course from time to time on the primary syllabus. This will cover major aspects of the syllabus as much as possible and showcase the format of the examination questions for candidates to be familiar with. This will be through on site or distance learning programmes.

2.4 **The Primary examination** shall consist of multiple choice questions with single best answer.

The pass mark shall be 50%.

2.5 **Recommended textbooks and reference materials**

Clinical Anatomy by Harold Ellis
Ganong's review of Medical Physiology
Langman's Medical Embryology
Guyton and Hall Textbook of Medical Physiology
Harper's Biochemistry
Clinical Pharmacology made ridiculously simple
Handbook of family medicine by Bob Marsh
Handbook of training in Family Medicine – WACP publication
WACP prospectus

CHAPTER THREE: MEMBERSHIP SYLLABUS

3.1 Goal for the membership training

To produce a physician that is well equipped with basic knowledge, skills and attitude to practice as a specialist in Family Medicine as well as have a solid foundation for the fellowship training in Family Medicine.

3.2 Introduction/General structure

The membership training builds on the basic medical training of the first degree and the internship training. It takes place in accredited health institutions and lasts a minimum of two years. During the period the trainee shall go through rotations and be certified in the major clinical specialties including Family Medicine. He shall also complete prescribed course work organized by the College and Faculty at Workshops, Update courses and Revision courses.

3.3 Rotations with duration

The following rotations and durations are to be considered the minimum acceptable requirements. The stated durations are for the structured posting. It is expected that the trainee will have continuous exposure to clinical activities in these areas throughout the membership training period. In recognition of the fact that some practice settings do not offer such integrated service opportunities, the following minimal durations of postings are recommended. The duration may be increased by the Family medicine trainer to achieve the recommended competencies.

Family Medicine	3 months
Surgery	3 months
Maternal Health	3 months
Internal Medicine	2 months
Mental Health	2 months
Child Health	2 months
Accident and Emergency	2 months
Ophthalmology	4 weeks
Anaesthesia	4 weeks
Radiology	4 weeks
Community Medicine and PHC	4 weeks
ENT	4 weeks
Haematology and blood transfusion	2 weeks
Chemical Pathology	2 weeks

Histopathology	2 weeks
Microbiology and Parasitology	2 weeks
Oral health	2 weeks

3.4 Syllabus for core knowledge

Family medicine

Aim: To demonstrate knowledge of the core principles of Family Medicine which should guide the approach to all patients irrespective of the disease the patient presents with.

Objectives and learning outcomes:

Introduction to Family Medicine
The resident should be able to:

Define Family medicine, list the essential attributes of the family physician and discuss the role of the Family physician in health care delivery.
Define the family, describe family types, list the attributes of families and describe basic family tasks.
Discuss the influence of the family on the health of its members and vice versa
Discuss General system theory and Family systems theory.
Describe Family lifecycle, Family circle, Family genogram and Family developmental stages
Discuss Family dynamics in health and disease.
Describe Family-centred care –including the young family, the middle years, the aging family, abuse and domestic violence, and the elderly,
Discuss Communication in family medicine.
Discuss the role of Spirituality in health and disease and describe Spiritual assessment.
Discuss referral in Family practice.

Lifestyle medicine
The resident should be able to discuss the following and their application in family practice:

- Fitness and wellness concept.
- Life style factors and their effects on health.
- Counselling for lifestyle modification.
- Prescription of physical activity and exercise.
- Factors that promote adoption and practice of health promoting lifestyles.
- Lifestyle changes in common disease condition
- Digital lifestyle and its effect on health.

Palliative care
The trainee should be able to define and discuss the following:

- Palliative care and its objectives
- Palliative care package – clinical, spiritual, and end of life care as well as bereavement management. Care of the terminally ill.

- Palliative care delivery sites, multidisciplinary approach to palliative care and tools for palliative care

Generational Medicine
The trainee should be able to define and describe the components of the following:

- Adolescent Health
- Men's Health
- Women's Health
- Care of the Elderly.

Recreational/Sports Medicine
The trainee should be able to discuss the following:

- Fitness for sport and other physical activities.
- Prohibited substances and medications in sports.
- Common sports injuries – bruises, lacerations, fractures.

Travel Medicine
The trainee should be able to describe how to conduct the following:

- pre-travel assessment of the traveller
- assessment of travel itinerary
- travel care plan including education, vaccine prescription and chemoprophylaxis, health insurance.
- post-travel assessment including illness identification, management and referral.

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee weekly record form, trainee portfolio, mock examinations.

Terminal assessment: End of posting examination

Recommended books and reference materials:
Bratton's Family Medicine Board Review
Textbook of Family medicine – Rakel
Manual of Family Practice – Robert B Taylor
Current diagnosis and treatment in Family Medicine

Swanson family practice review: a problem oriented approach
Emdex
The Merck manual
South Africa manual of family medicine

Internal medicine

Aim: To demonstrate a thorough grounding in the principles and practice of adult internal medicine.

Objectives and learning outcomes:

Respiratory Medicine

The resident should be able to

-discuss common symptoms, signs, and investigative modalities in respiratory diseases.

-Define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common respiratory conditions in primary care such as:*

Pneumonia, Chronic obstructive pulmonary disease, lung-abscess and asthma, upper respiratory tract infections.

Cardiovascular disease medicine

The resident should be able to

-discuss common symptoms, signs, and investigative modalities in cardiovascular diseases.

-Define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common cardiovascular conditions in primary care such as:*

hypertension, left ventricular failure and acute pulmonary oedema, Congestive cardiac failure, cardiomyopathy, ischaemic heart diseases, Venous thrombosis, Arterial peripheral vascular disease, valvular heart disease

Gastroenterology

The resident should be able to

-discuss common symptoms, signs, and investigative modalities in gastrointestinal diseases.

-Define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common GIT conditions in primary care such as:*

Acute gastro-enteritis, cholera, chronic diarrhea, dysentery, irritable bowel disease, infective hepatitis, liver cirrhosis, amoebic liver abscess, Acid related diseases (GERD, PUD), inflammatory bowel diseases

Endocrinology and Metabolism

The resident should be able to

-discuss common symptoms, signs, and investigative modalities in endocrine diseases.

-define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common endocrine and metabolic conditions in primary care such as:*

Diabetes mellitus, thyroid diseases, metabolic syndrome, overweight and obesity, disorders of calcium metabolism, Cushing's disease

Neurology

The resident should be able to

-discuss common symptoms, signs, and investigative modalities in neurological diseases.

-define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common neurological conditions in primary care such as:*

Headaches, stroke, seizure disorders, neuralgia and peripheral neuritis, head injury, nerve palsies, Parkinson's disease, dementia.

Nephrology

The resident should be able to

-discuss common symptoms, signs, and investigative modalities in renal diseases.

-define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common nephrology conditions in primary care such as:*

Glomerulonephritis, urinary tract infections, acute kidney injury, chronic kidney disease, nephrotic syndrome, nephropathies from drugs, hypertension, diabetes, etc.

Dermatology

The resident should be able to

- discuss common symptoms, sign, and investigative modalities in skin diseases.
- define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common skin conditions in primary care such as:* - Superficial fungal infections, infestations, bites, chronic dermatitis, bacterial skin infectons, vitiligo, acne, leprosy, chicken pox, herpes zoster, herpes simplex, urticaria, atopic dermatitis,
  psoriasis, warts, drug eruptions, skin tumours etc.
- cutaneous manifestations of systemic diseases

Rheumatology

In the region, the paucity of subspecialists in this area implies that these conditions will be managed in a variety of settings from GOP clinics, Medical outpatient clinics to Surgical clinics and departments.

The resident should be able to
- Discuss common symptoms, signs, and investigative modalities in rheumatology.
- Define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common rheumatologic conditions in primary care such as*

- Rheumatoid arthritis
- Other connective tissue disorders

Oncology
The resident should be able to
- Discuss common symptoms, signs, and investigative modalities in oncology.
- Define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common cancers in primary care including:*

- Hepatoma, lymphoma, leukaemia
- HIV related tumours e.g. Kaposis sarcoma
- Breast cancer, cervical cancer,
- Prostate cancer

- Discuss cancer prevention.

Clinical haematology
The resident should be able to
- discuss common symptoms, signs, and investigative modalities in haematology.
- define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common haematological conditions in primary care such as:*Anaemias, haemoglobinopathies, bleeding disorders, haematologic malignancies – leukaemia, lymphoma, multiple myeloma,
-describe how to manage blood transfusion, transfusion reactions and other complications.

Infectious diseases
The resident should be able to
- discuss common symptoms, signs, and investigative modalities in infectious diseases

- define the condition and describe the *aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of the common infectious diseases in primary care such as:* Malaria, typhoid fever, meningitis, encephalitis, amoebiasis, giardiasis,

tuberculosis, pyrexia of unknown origin, helminthiasis – ascariasis, hookworm, taeniasis, strongyloidiasis, schistosomiasis, dracunculus, filariasis, STIs, HIV/AIDS, viral haemorrhagic fevers

Toxicology and others
The resident should be able to:

- discuss the general principles of management in toxicology
- describe the causative factors, *pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common toxicology conditions in primary care such as:*
Poisoning and drug overdose, snake bite, dog bite, other bites and stings, industrial poisoning

- Common poisons in the region and appropriate antidotes e.g. rat poison, organophosphates etc.

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee portfolio, mock examinations.

Terminal assessment: End of posting assessment

Recommended books and reference materials:
Harrison's Principles of internal medicine
Davidson's Principles and Practice of Medicine
Hutchinson clinical method
Current Medical Diagnosis and Treatment
Emergency Medicine
The clinical practice of emergency medicine
ECG Made Easy
Rapid interpretation of EKGs

Surgery
Aim: To demonstrate knowledge of the principles and practice of surgery.

Objectives and learning outcomes:

General Surgery
The resident should be able to *discuss the definition, aetiology, pathophysiology, clinical features, diagnosis, investigations, treatment, surgical procedures and prevention of the following conditions:*
Hernias – inguinal, femoral, epigastric, umbilical, incisional, obstructed, strangulated.

Acute abdomen. Intestinal obstruction including gut resection. Acute peritonitis. Appendicitis. Hydrocele. Lipoma. Ganglion, Sebaceous cyst. Breast lumps. Other benign swellings. Abscess. Foreign body in tissues. Pleural effusion. Burns and wounds. Head injury. Ingrown toenail.

Urology

The resident should be able to *discuss the definition, aetiology, pathophysiology, clinical features, diagnosis, investigations, treatment, surgical procedures(where appropriate) and prevention of the following conditions:*

Acute urinary retention. Urethral stricture. Circumcision. Phimosis and paraphimosis. Priapism Testicular torsion. Epididymo-orchitis.

Prostatic diseases. Scrotal trauma. Urolithiasis. Haematuria. Calculi, Fournier's gangrene

Orthopaedics and Trauma

The resident should be able to *discuss the definition, aetiology, pathophysiology, clinical features, diagnosis, investigations, treatment, surgical procedures(where appropriate) and prevention of the following conditions:*

Dislocation of jaw, shoulder, hip joints. Common fractures of the clavicle, humerus, radius and ulnar, tibia and fibula and femur. The head injured unconscious patient. Haemathrosis. Joint effusions. Osteoarthritis. Maxillo-facial injuries

- describe how to perform common office procedures in orthopaedics and trauma

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee portfolio, mock examinations.

Terminal assessment: End of posting assessment

Recommended books and reference materials:

Primary Surgery vol. 1
Primary Surgery vol. 2
Short practice of surgery by Bailey & Love
Principles and practice of surgery

Maternal Health

Aim: To demonstrate knowledge of the principles and practice of obstetrics and gynaecology relevant to Family Medicine practice.

Pre-requisite: Certified posting in Family Medicine department

Objectives and learning outcomes:

Gynaecology

The resident should be able to *discuss the definition, aetiology, pathophysiology, clinical features, diagnosis, investigations, treatment, surgical procedures and prevention(as appropriate) of the following*

Abortion. Infertility, Pelvic inflammatory disease, Ectopic pregnancy. Menopause. Family planning- contraception, infertility assessment, assisted reproduction. Uterine fibroids, Benign gynaecological tumors. Menstrual disorders, Recognition of gynaecological malignancies, Gestational trophoblastic diseases

Obstetrics

The resident should be able to discuss the following:

Antenatal care. Hypertensive disorders in pregnancy. Common medical conditions in pregnancy – malaria, UTI, anaemia, diabetic mellitus, sickle cell anaemia, HIV. Antepartum complications of pregnancy – antepartum haemorrhage, premature rupture of membranes, premature labour, rhesus isoimmunization. Labour and delivery – including operative deliveries. Intrapartum complications – cord prolapse, hand prolapse, foetal distress, prolonged labour, obstructed labour, retained second twin. Post-partum complications – retained placenta, postpartum haemorrhage, cervical and perineal lacerations, puerperal psychosis. Post-natal care. Multiple pregnancy.

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee portfolio, mock examinations.

Terminal assessment: End of posting assessment

Recommended books and reference materials:

Current diagnosis and treatment in O&G

Williams obstetrics with images

Child Health

Aim: To demonstrate knowledge of the principles and practice of paediatrics and child health relevant to Family Medicine.

Pre-requisite: Certified posting in Family Medicine department

Objectives and learning outcomes:

Neonatology

The resident should be able to *define and discuss the aetiology, pathophysiology, clinical and*

laboratory features, diagnosis, treatment and prevention of the following:
Newborn resuscitation, Birth asphyxia, Small for date babies, Prematurity and twins, Common congenital abnormalities, Neonatal sepsis, Neonatal tetanus, Neonatal jaundice, Feeding problems.

Infectious diseases
The resident should be able to *define and discuss the aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of the following:*
Acute respiratory infections, malaria and its complications, gastroenteritis, measles and its complications, chickenpox, viral haemorrhagic fevers, pneumonia, pertussis, diphtheria, tetanus, tuberculosis, poliomyelitis and acute flaccid paralysis, mumps, meningitis, encephalitis, febrile convulsion. skin sepsis, paediatric HIV and PMTCT, viral hepatitis

Non communicable diseases and Well child care
The resident should be able to *define and discuss the aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of the following:*
Failure to thrive and malnutrition, anaemia, bronchial asthma, seizure disorder, haemoglobinopathies, Immunization, Growth monitoring

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee portfolio, mock examinations.

Terminal assessment: End of posting assessment

Recommended books and reference materials:
Current Paediatric diagnosis and treatment
Nelson textbook of paediatrics
Standard operating procedures for paediatric patients

Mental Health
Aim: To demonstrate adequate knowledge for the recognition and management of common psychiatric diseases including appropriate referral.

Objectives and learning outcomes:
The resident should be able to *define and discuss the aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of the following:*
Anxiety disorders – acute stress disorder, post-traumatic stress disorder, generalized anxiety disorder, phobias, panic disorders.
Somatoform disorders – somatization, pain disorder, hypochondriasis, conversion disorder.

Mood disorders – Depression, bipolar disorder.
Schizophrenia and other psychotic disorders
Substance abuse – alcohol, cannabis, other drugs of abuse.
Paediatric and adolescent mental health.
Psychotherapy
Cognitive behavioural therapy

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee weekly record form, trainee portfolio, mock examinations.

Terminal assessment: End of posting assessment

Recommended books and reference materials:
Oxford textbook of psychiatry
Kaplan Textbook of psychiatry

Accident & Emergency
Aim: To demonstrate knowledge of the principles and practice of emergency care.

Objectives and learning outcomes:
The resident should be able to *discuss the following:*
Basic life support including cardio-pulmonary resuscitation
Advanced cardiac life support including use of defibrillator
Advanced Trauma Life Support
Clinical reasoning and differential diagnosis in emergency medicine
Management of shock
Initial management and stabilization of the patient with medical, surgical, paediatric and O&G emergencies
Management of mass casualty including Triage

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee portfolio, mock examinations.

Terminal assessment: End of posting assessment

Recommended books and reference materials:
Emergency Medicine
The clinical practice of emergency medicine

Ophthalmology
Aim: To demonstrate knowledge of the diagnosis and management of common eye diseases.

Objectives and learning outcomes:
The resident should be able to
-discuss the symptoms, signs, and investigation of eye diseases
-define and describe the aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of common ophthalmological conditions in primary care such as:
Visual impairment, visual assessment and basic optometry
Common inflammatory, infective and allergic eye conditions – infective conjunctivitis, allergic conjunctivitis, trachoma, keratitis, iritis, uveitis, pan-ophthalmitis, pterygium, chalazion, orbital cellulitis, parasitic eye disease
Traumatic eye conditions – corneal abrasion, corneal ulcer, eye contusion, foreign body in the eye.
Cataract, Glaucoma, Entropion, Ectropion, congenital glaucoma and retinoblastoma
Common causes of blindness, corneal ulcers, allergies, the red eye, Eye infections.

Teaching methods: Bedside teaching during clinical rotations, Lectures, tutorials, seminars, Case presentation, Problem based learning

Formative assessment: Log book assessments, Mini clinical examination (MiniCEX), presentation feedback assessment, trainee portfolio, mock examinations.

Terminal assessment: End of posting assessment

Recommended books and reference materials:
Comprehensive ophthalmology new age
The Wills Eye manual

ENT
Aim: To demonstrate knowledge of the diagnosis and management of common ENT diseases

Objectives and learning outcomes:
The resident should be able to
-discuss the symptoms, signs and investigation of common ENT diseases

-discuss the aetiology, pathophysiology, clinical and laboratory features, diagnosis, treatment and prevention of the following:

- Otitis externa, acute otitis media, chronic otitis media, wax impaction, foreign body in the ear, hearing impairment, evaluation of dizziness and vertigo.
- Foreign body in the nose, epistaxis, acute sinusitis, chronic sinusitis, oral health
- acute tonsillitis, acute and chronic laryngitis, evaluation of hoarseness,

Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars Journal Review, problem based learning, mentorship

Formative assessment: Log book assessments, seminar and case presentations, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
An illustrated colour text of ENT – Dhillon and East

Oral Health

The resident should be able to describe how to recognize and provide initial management of the following conditions

- Common oral conditions: dental caries (tooth decay), periodontal diseases (gingivitis and periodontitis), dental abscess; tooth sensitivity, discoloured teeth

- Other oral diseases and conditions: necrotizing ulcerative gingivitis and cancrum oris; temporomandibular diseases; oral HIV/AIDS conditions; sialolithiasis, halitosis (bad breath) sores and ulcers in the oral cavity.

Community medicine and Primary Health Care

Aim: To demonstrate knowledge of the concepts and practice of primary health care

Objectives and learning outcomes:
The resident should be able to *discuss the following:*
Community diagnosis, participation and mobilization; health education and counseling for target groups; Biostatistics; basic research methods; Epidemiology; principles and components of PHC. Community obstetrics and family planning; Notifiable infectious diseases; Occupational health; School health, Under five clinics – use of growth chart; Nutrition – breast feeding, weaning and diet supplementation; Immunization – preschool child, school age boosters, anti-tetanus for all,

international travel requirements, immunization for adults, control programmes for communicable and non-communicable diseases.

Teaching methods: Hands-on training during clinical rotations, Lectures/ tutorial/seminars Journal Review, problem based learning, mentorship

Formative assessment: Log book assessments, seminar and case presentations, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Short textbook of Public Health – Adetokunbo Lucas
World Health Report 2008

Laboratory medicine
Aim: To demonstrate knowledge of appropriate indications and use of laboratory investigations.

Objectives and learning outcomes:
The resident should be able to *discuss the indications, use, procedure and interpretation of the following laboratory tests:*
Haematology - common heamatological tests including blood group, blood screening and cross-matching for blood transfusion, collection and preservation of specimens.
Microbiology and Parasitology – blood film and staining for malaria parasite, urine microscopy and culture, stool analysis, microscopy and culture, Gram and Ziehl-Neelsen stain, collection and preservation of specimens.
Chemical Pathology - Urinalysis, blood chemistry, hormone profile and other common laboratory tests, point of care testing
Histopathology - Care and disposal of corpses, specimen collection and preservation, fine needle aspiration biopsies. Forensic medicine; common staining techniques.

Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars Journal Review, problem based learning, mentorship

Formative assessment: Log book assessments, seminar and case presentations, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Manual of laboratory and diagnostic tests
District laboratory practice in tropical countries part I & II

Anaesthesia

Aim: To demonstrate knowledge of appropriate use and safety of anaesthetic agents and procedures.

Objectives and learning outcomes:

The resident should be able to

discuss the properties, use, dosage, side effects, contra-indications and complications of commonly used anaesthetic drugs- diazepam, pentazocine, pethidine, morphine, tramadol, lignocaine, marcaine, bupivacaine, ketamine, halothane, ether, suxamethonium etc.

-discuss the indications, contra-indications, side effects, complications and how to carry out the procedures below:

Pre-anaesthetic assessment of patients for emergency and elective surgical procedures;
intra and post-operative monitoring of the anaesthetised patient;
Local anaesthesia – ring block, infiltration, field blocks, local spray
Regional anaesthesia – Bier's block, epidural, spinal subarachnoid anaesthesia,
Conscious sedation and analgesia
General anaesthesia – Total Intravenous anaesthesia using ketamine etc., Inhalational anaesthesia
Airway management – oro-pharyngeal airway, endotracheal intubation
Oxygen therapy, intensive care, pain management

Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars Journal Review, problem based learning, mentorship

Formative assessment: Log book assessments, seminar and case presentations, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Primary Anaesthesia
Textbook of Anaesthesia – Aitkenhead

Radiology

Aim: To demonstrate basic knowledge of the indication, use, preparation, procedure and interpretation of common radiological investigations

Objectives and learning outcomes:

The resident should be able to

-discuss the indication, patient preparation, appropriate request and safety concerns for radiological investigations including plain radiographs, contrast studies, ultrasound scan, CT scan and MRI.

-describe the procedure for plain radiographs, IVU, HSG, Barium studies, pelvic ultrasound,

obstetric ultrasound, abdominal ultrasound
-discuss basic interpretation of radiographs of the chest, abdomen, pelvis, limbs, spine. IVU and HSG
-discuss the basic principles and the value of ultrasound in clinical medicine

Teaching methods: Lectures/ tutorial/seminars, problem based learning, mentorship

Formative assessment: Log book assessments, seminar and case presentations, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Manual of Radiologic interpretation for general practitioners

3.5 Syllabus for skills acquisition

Family medicine
Aim: To demonstrate competencies in offering holistic and continuing care to patients in the context of their family and social background.

Objectives
Ability to conduct a patient centered consultation and use appropriate interviewing skills
Ability to take a detailed history including the use of appropriate family medicine tools
Ability to conduct a detailed clinical examination in a conducive environment with adequate attention to consent, privacy, confidentiality and respect.
Ability to apply bio-psychosocial care to patient management
Ability to function effectively under pressure
Ability to respond to, and address the concerns of patients, their relatives and carers
Ability to impart knowledge to junior colleagues, including medical students
Ability to relate with other health workers with courtesy, professionalism and respect hierarchy.

Learning outcomes
The resident should be able to:

- Demonstrate the use of family practice tools for holistic management of patients including: family genogram, family circle, family conference, eco-map, timelines, assessment of patient's spirituality etc.
- Demonstrate counseling skills in the following areas while ensuring respect, compassion, empathy, trust, patient's comfort, modesty, and confidentiality of information: Motivation for behavior change, managing bereavement and grief reactions, adolescent

and couple counseling, counseling for healthy lifestyle and counseling in special situations like HIV, abortion etc.

- Conduct care of travellers including: pre-travel assessment, travel care plan and post-travel care.
- Identify the needs and plan the care of the young family, the middle age family and the aging family while ensuring effective communication
- Conduct health promotion care including: pre-school, pre-employment, and periodic examinations, and appropriate screening of healthy adolescents, men, women and the elderly with due consideration to judicious use of resources.
- Manage sportsmen and women including: assessment of fitness for exercise and sports, treatment of common sports injuries and counseling on prohibited substances.
- Write appropriate medical documents including: sick leave and maternity leave certificates, death certificate, discharge summaries, medical reports, referral letters etc. with due regard to honesty, professionalism and ethical conduct.
- Carry out home based care
- Develop essential medicine lists for units or hospital
- Apply ethical principles in clinical practice and research
- Code clinical encounters using International Classification in Primary Care (ICPC)

Training location: General outpatient clinic, Staff clinic and Managed care unit

The trainers and supervisors: Consultants in Family Medicine, Medical record officers, Psychologists, Medical social workers

Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars

Problem based learning, Mentorship with appropriate emphasis on affective domains.

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Direct observation of procedural skills, resident's weekly record form, resident's portfolio.
Terminal assessment: End of posting examination

Recommended books and reference materials:
Bratton's Family Medicine Board Review
Textbook of Family medicine – Rakel
Manual of Family Practice – Robert B Taylor
Current diagnosis and treatment in Family Medicine
Swanson family practice review: a problem oriented approach
Emdex Africa
The Merck manual
South African manual of family medicine

Internal medicine

Aim: To demonstrate competence in the diagnosis and management of common medical diseases presenting in primary and secondary care.

Learning outcomes I: Clinical skills

The resident should demonstrate the following competencies in patient care in all the areas listed in section 3.4 under internal medicine:

- history taking under a conducive setting, in a focused and logical sequence with building of rapport and trust while also paying attention to non-verbal cues and ensuring confidentiality
- physical examination with appropriate attention to good communication, consent, patient's comfort, privacy, respect and courtesy
- investigation with consideration for judicious use of resources
- diagnosis
- management including communication of findings, management plan and patient's role
- prevention including necessary lifestyle changes
- patient centred clinical methods

Learning outcomes II: Procedures

The resident should be able to identify indications, carry out the following procedures, recognize and manage complications where such occur and recognize when there is need for referral.

Diagnostic procedures:

ECG – Set up, record and interpret 12 lead ECG
Measure Peak Expiratory Flow rate
Perform Lumbar puncture
Perform Pleural tap
Perform emergency life-saving pericardial tap

Therapeutic procedures:

Nebulize patient
Teach the use of inhaler and spacer
Perform CPR
Use defibrillator
Perform Heimlich maneuver
Insert Nasogastric tube, urethral catheter, intravenous cannula etc.

Training location: Medical wards, ECG room. Medical clinics

Trainers and supervisors: Consultant physicians, Medical Technologists, Emergency care physicians

Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars Journal Review, problem based learning, mentorship, Direct Observation of Procedural Skills

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill sessions, resident's weekly record form, resident's' portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Harrison's Principles of internal medicine
Davidson's Principles and Practice of Medicine
Hutchinson clinical method
Current Medical Diagnosis and Treatment
Emergency Medicine
The clinical practice of emergency medicine
ECG Made Easy
Rapid interpretation of EKGs
Dermatology in black skin and Africans
A colour handbook of dermatology

Surgery

Aim: To demonstrate competence in the diagnosis and management (including surgical procedures) of common surgical conditions presenting in primary and secondary care.

Pre-requisite: Expertise in the core competences of history taking, physical examination, investigation, and diagnosis of surgical conditions listed in the cognitive section of the membership curriculum under surgery (Section 3.4)

Objectives/Learning outcomes:

General Surgery

The resident should be able to:
- Conduct appropriate pre-operative and post-operative management of surgical patients
- Carry out the following procedures:

Herniorrhaphy for – inguinal, femoral, epigastric, umbilical, incisional, obstructed and strangulated hernias.
Laparotomy for acute abdomen, intestinal obstruction, Acute peritonitis.
Closure of perforated bowel, Bowel resection and anastomosis, Reduction of intussusception
Appendicectomy. Hydrocelectomy.
Removal of Lipoma. Ganglion, Sebaceous cyst. Breast lumps and other benign swellings.
Removal of foreign body in tissues. Lymph node biopsy.
Management of burns and wounds.
Evaluation and initial management of head injury

Chest tube insertion for drainage of pleural effusion
Drainage of abscess including intra-peritoneal abscesses.
Removal of in-grown toenail
Management of complications arising from above procedures
Prompt and appropriate referrals when necessary

Urology
The resident should be able to carry out the following procedures:
Appropriate pre-operative and post-operative management of the urological patient
Urethral catheterization, Suprapubic catheterization, catheterization with guide, urethral dilatation.
Circumcision.
Orchidopexy for testicular torsion.
Management of epididymo-orchitis.
Scrotal exploration for trauma.
Investigation and management of haematuria.
Management of Urolithiasis.
Medical management of erectile dysfunction
Medical management of BPH

Orthopaedics and Trauma
The resident should be able to carry out the following procedures:
Reduction of jaw dislocation, shoulder dislocation and hip dislocation.
Closed reduction of common fractures
Application of cast
Skin traction and Skeletal traction.
Joint aspirations, Intra-articular injections
Suturing of lacerations. Wound management
application of external fixators

Training location: Accident and emergency unit, outpatient theatre, main theatre, surgical outpatient clinic, wards.
Trainers and supervisors: Consultant surgeons, Perioperative nurses, Anaesthesiologists, Anaesthetists
Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars, Mentorship

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill sessions, resident's weekly record form, resident's portfolio
Terminal assessment: End of posting examination

Recommended books and reference materials:
Primary Surgery vol. 1
Primary Surgery vol. 2
Short practice of surgery by Bailey & Love
Principles and practice of surgery

Maternal Health

Aim: To demonstrate competence in the diagnosis and management of common maternal health problems presenting at the primary and secondary care level.

Objectives/Learning outcomes:
The resident should be able to:
-demonstrate expertise in history taking, physical examination, investigation, diagnosis and - treatment of conditions listed in the cognitive section of the membership curriculum under maternal health (Section 3.4)
-carry out the following procedures:
Appropriate pre-operative and post-operative management of the gynaecological and obstetric patient
Manual Vacuum aspiration, Dilatation and curettage.
Family Planning counseling, IUCD insertion, implants insertion, tubal ligation
Sample collection for pap smear
Cervical cancer screening using Visual Inspection with Acetoacetic acid (VIA)
Medical management of ectopic pregnancy.
Laparotomy for ectopic pregnancy
Myomectomy for fibroids
Antenatal care: identification of high risk pregnancies, prevention of Rhesus isoimmunization,
Development of delivery plan for high risk pregnancies at term.
Diagnosis and monitoring of labour using partogram
Conducting deliveries for singleton and multi-foetal pregnancies including breech delivery
Assisted vaginal delivery using vacuum and obstetric forceps
Repair of episiotomy and perineal injuries
Caesarean delivery, caesarean hysterectomy as a live saving procedure
Manual removal of placenta
Post-delivery counseling, conducting post-natal visit

Training location: Labour ward, gynae, antenatal and postnatal wards. Theatre

Trainers and supervisors: Consultant obstetrician/gynaecologist

Teaching methods: Ward rounds, Hands on assistance in labour ward, gynae emergency wards and theatre

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Current diagnosis and treatment in O&G
Williams Obstetrics with images

Child Health

Aim: To demonstrate competence in the diagnosis and management of common paediatric conditions.

Objectives/Learning outcomes:
The resident should
-demonstrate competency in history taking, physical examination, investigation, and prevention in areas listed in the child health section of the cognitive syllabus.
-be able to carry out the following procedures:
Incubator care for small for date and premature babies
Newborn resuscitation. Cardio-pulmonary resuscitation in children
Growth monitoring and Immunization for under-fives
capillary blood sampling, lumbar puncture, venipuncture
umbilical vein cannulation, securing intravenous and intra-osseous access
exchange blood transfusion,

Training location: Neonatal ward, children's ward, children emergency ward, well-child clinic

Trainers and supervisors: Consultant paediatricians

Teaching methods. Hands on training during clinical rotations, Lectures/ tutorial/seminars, Journal Review, Problem based learning, Mentorship

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Current Paediatric diagnosis and treatment
Nelson textbook of paediatrics
Standard operating procedures for paediatric patients

Mental Health

Aim: To demonstrate competence in the recognition and management of common psychiatric problems presenting in primary care.

Learning outcomes

To demonstrate competence in psychiatry history taking
Ability to conduct detailed mental state examination
Recognition of mood disorders and substance abuse; commencement of initial management and appropriate referral.
Point of care testing for substance abuse
Co-management of mentally ill patients with psychiatrists through liaising psychiatry
Recognition and management of somatoform disorders and anxiety disorders.
Conducting supportive psychotherapy, brief dynamic psychotherapy and cognitive behavioural therapy

Training location: psychiatric ward and clinics

Trainers and supervisors: Consultant psychiatrists, Clinical psychologists

Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars, Problem based learning

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Oxford textbook of psychiatry
Kaplan Textbook of psychiatry

Accident &Emergency

Aim: To demonstrate competence in resuscitation, stabilization and prevention of further deterioration of patients presenting with emergencies.

Objectives/Learning outcomes:
The resident should be able to
-organize the A&E for emergency preparedness and coordinate the emergency care team
-rapidly assess A&E patients and initiate appropriate life-saving procedures
-conduct airway management including endotracheal intubation
-provide cervical spine immobilization
-conduct CPR

-provide rapid iv access including cut down
-carry out basic and advanced life support procedures.
-work effectively under pressure
-triage and coordinate management of mass casualty

Training location: Accident and emergency department

Trainers and supervisors: A&E physicians, Family Physicians, Surgeons

Teaching methods: hands on experience and drills in A&E

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Emergency Medicine
The clinical practice of emergency medicine

Ophthalmology

Aim: To demonstrate competence in recognition and appropriate management of eye disease in primary care.

Learning outcomes:
The resident should be able to
conduct history taking and appropriate physical examination for eye diseases.
assess patients for visual impairment
carry out fundoscopy using an ophthalmoscope
conduct visual acuity test and basic optometry
diagnose and manage common inflammatory eye conditions listed in the cognitive section
recognize and refer corneal ulcers, cataract, glaucoma and other serious eye diseases.

Training location: ophthalmology department

Trainers and supervisors: Consultant ophthalmologist, Optometrists, Opticians

Teaching methods: Hands on training during clinical rotations, Lectures/ tutorial/seminars, Mentorship

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Comprehensive Ophthalmology

ENT

Aim: To demonstrate competence in recognition and appropriate management of simple ENT diseases in primary care.

Learning outcomes

The resident should be able to
conduct history taking and examination in ENT diseases
diagnose and manage conditions listed under ENT in the cognitive section
remove foreign body in the ear and nose.
carry out anterior and posterior nasal packing for epistaxis
conduct assessment of hearing using Rinne's and Weber tests
remove impacted wax
assess dizziness and vertigo
make appropriate radiological request to evaluate the sinuses

Training location: General outpatient clinics, ENT clinic and ward, theatre

Trainers and supervisors: Consultant ENT surgeons, Consultant Family physicians, Audiologists, Speech therapists

Teaching methods: Hands on assistance during procedures

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
An illustrated colour text of ENT – Dhillon and East

Community Medicine and Primary Health Care

Aim: To demonstrate competence in the deployment of strategies for disease prevention and health promotion

Learning outcomes:

The resident should be able to
conduct health education sessions
carry out community entry, community diagnosis, and encourage community participation
participate in training community health workers

carry out contact tracing for notifiable diseases
carry out workplace visit and safety assessment
participate in school health programme
linkage between family physician and public health authorities

Training location: Community health department and primary care outposts

Trainers and supervisors: Community health physicians, Medical officers of health, Public health nurses

Teaching methods: Hands on experience and participation in community outreaches

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Short textbook of Public Health – Adetokunbo Lucas
World Health Report 2008

Laboratory medicine
Aim: To demonstrate competence in appropriate use of laboratory services
Learning outcomes:
The resident should be able to
- collect and preserve laboratory specimens
-perform simple point of care tests e.g. Urinalysis, blood glucose estimation, rapid diagnostic tests
-perform complete blood count, blood group and cross matching, Gram staining, urine microscopy, skin snip for microfilaria, skin scrapping for fungi studies, fine needle aspiration
-interpret laboratory results

Training location: Medical laboratories. Hospital clinical laboratories

Trainers and supervisors: Consultant laboratory physicians and Medical laboratory technologists

Teaching methods: Hands on experience in the laboratory and clinics

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, resident's weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Manual of laboratory and diagnostic tests

Anaesthesia

Aim: To demonstrate competence in making surgery safe and pain free through adequate patient assessment and appropriate choice of anaesthesia.

Learning outcomes:

The resident should be able to

-carry out pre-operative assessment for emergency and elective surgical procedures
-perform local anaesthesia including anaesthetic spray, ring block, infiltration, and field blocks.
-perform regional anaesthesia including Bier's block and spinal anaesthesia.
-perform conscious sedation for short procedures.
-perform total intravenous anaesthesia e.g. ketamine
-assist in inhalational anaesthesia
-monitor patient during anaesthesia and in the recovery room.
-secure airway through appropriate maneuvers, oro-pharyngeal airway, and endotracheal intubation
-carry out post-operative care
-recognize and monitor patient requiring intensive care

Training location: theatre, intensive care unit, accident and emergency unit, wards.

Trainers and supervisors: Consultant anaesthesiologists, Anaesthetists

Teaching methods: Hands on training, assistance during anaesthetic procedures

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, residents' weekly record form, resident's portfolio

Terminal assessment: End of posting examination

Recommended books and reference materials:
Primary Anaesthesia
Textbook of Anaesthesia – Aitkenhead

Radiology

Aim: To demonstrate competence in appropriate use and interpretation of imaging investigations.

Learning outcomes:

The resident should be able to

-make correct request and prepare patient for radiological investigations

-carry out basic gynaecological, obstetric and abdominal ultrasound as a point of care investigation in primary care.

-interpret plain radiographs
-carry out contrast injection during contrast studies

- Recognize common pathologies on CT Scan of brain

Training location: radiological department

Trainers and supervisors: Consultant radiologist, Radiographers, Sonographers

Teaching methods: Hands on training, assistance during procedures

Mode of formative assessment: Log book assessments, Mini clinical examination exercises, Directly observed practical skill, residents' weekly record form, resident's portfolio

Terminal assessment: End of posting assessment

Recommended books and reference materials:
Manual of Radiologic interpretation for general practitioners

CHAPTER FOUR: FELLOWSHIP SYLLABUS

4.1 Goal of the fellowship training

The goal of the fellowship training is to produce a specialist that is equipped with knowledge, skills and attitudes needed to function independently as a consultant in the field of Family Medicine in the areas of practice, teaching, research and leadership

4.2 Introduction/General structure

The trainee in Family Medicine who has passed the membership examination needs to consolidate the knowledge and skills acquired during the membership training and gradually assume greater responsibility and independence. The training at this level therefore requires exposure in a centre where the broad range of family medicine services is rendered. Such a centre will provide continuous and integrated exposure in family care, internal medicine, surgical care, maternal health care, mental health, child health, dermatology, oral health and managed care. Some of these services will be provided through a structured co-management with appropriate specialists. The training will last a minimum of two years.

4.3 Rotations with durations

- Integrated, comprehensive, Family medicine Practice: 18 months (may involve rotation in different units)
- Rural Surgical Posting: 3 months
- Private practice tutelage: 3 months

4.4 Syllabus for knowledge and skills

Knowledge

In-depth cognitive knowledge for practice, teaching, research and leadership in all the areas contained in the membership curriculum. In addition, cognitive domain for special areas reflected in integrated, comprehensive family medicine practice outlined below

Skills

- **Integrated, comprehensive Family Medicine Practice**
  Aim: To demonstrate competence in the day to day running and management of the various units of the Family medicine department, including training and supervision of junior residents, clinical audit/research with minimal supervision by the Consultant.

Objectives and learning outcomes:

The trainee should be able to show leadership in service delivery, teaching and resource management in the following areas of Integrated Family Medicine practice:

- Child health unit
- General adult medicine
- Maternal health unit
- Surgical Unit
- Consolidation of office procedural skills
- Other special clinics e.g. Geriatrics, Mental health, Skin, HIV, Lifestyle etc.

Training location: Approved integrated Family Practice Centre

Trainers and supervisors: Consultant Family Physicians

Teaching methods: Supervised operative sessions, Supervised teaching assignments, Lectures/ tutorial/seminars, Journal Review, Mentorship, Doctors as educators (teaching skills) programme, Workshop on Management, dissertation and case book writing in Family Medicine

Formative assessment: Periodic assessments of presentations, operative sessions and teaching assignments.

Terminal assessment: End of posting examination

Recommended books and reference materials:
Textbook on Management
Text on Research and Statistics
Handbook of training in Family Medicine

Integrated/Rural Surgical Posting

Aim: To acquire skills in providing surgical care in resource limited settings where there may be need to improvise and be innovative.

Objectives and learning outcomes:
The resident should demonstrate ability to:
- assess patients needing emergency surgical intervention
- institute resuscitative measures to save life and organs
- recognize cases needing immediate referrals and refer and follow up appropriately
- carry out life-saving emergency surgical procedures where the skills and facilities are available
- provide integrated surgical care to populations in underserved areas with unmet surgical needs.
- perform common surgical procedures like simple herniorrhaphy, appendicectomy, simple

fracture management etc.
- work effectively in resource limited health care settings

Pre-requisites: Surgery and O&G postings during the membership training

Training location: Approved integrated Family Practice Centre

Trainers and supervisors: Consultant Family Physicians

Teaching methods: Supervised operative sessions, Supervised teaching of surgical skills to junior residents, Lectures/ tutorial/seminars, Mentorship,

Formative assessment: Periodic assessments of presentations, operative sessions and teaching assignments.

Terminal assessment: End of posting examination

Recommended books and reference materials:
Primary Surgery
Primary Anaesthesia

Private practice Tutelage

Aim: To acquire knowledge and skills in the management of Private general medical practice

Objectives and learning outcomes:
-The trainee should be able to:

- describe the requirements and process of setting up a private medical practice
- Apply knowledge of sustainable services to manage a private medical practice
- apply a conceptual model of Human resource management to a private practice
- illustrate how to manage capital and other resources to achieve organizational goals
- provide effective leadership to other members of staff.

Training location: Approved Private Practice Centres

Trainers and supervisors: Medical Directors, Hospital Administrators, Consultant Family Physicians

Teaching methods: Lectures on management principles, involvement in management meetings, organization of services, preparation of management accounts, purchase of goods and services, mentorship etc.

Formative assessment: Monthly assessment of progress

Terminal assessment: End of posting assessment, Trainee tutelage report

Recommended books and reference materials:

4.6 Proposal writing

The Family medicine fellowship trainee is required to prepare and submit for college approval, a dissertation proposal within three months of commencing the fellowship training. This is towards producing a dissertation on a family medicine relevant issue to be presented for the fellowship examination

4.7 Dissertation writing

A dissertation should be carried out in accordance with an approved dissertation proposal (synopsis). The size of the dissertation should be between 80 and 120 pages. (Preliminary pages and appendices are not included). There should be a minimum of 60 references. Referencing of text should be in Vancouver style. Referenced publication dates should preferably be within 10 years and not more than 10% of such published work should be more than 10 years old by the date of examination when appearing for the examination for the first time. Local publications should constitute at least 25% of these references except in very rare conditions in which locally published work are not available. Locally published work in this context refers to published work in the country of study and the West Africa region (10% country of residence and 15% rest of West Africa).

The book should be compiled using the following format:

(1) Preliminary pages (numbered in small Roman numerals) should include: Title page; Declaration, Certification-by supervisors and HOD, Dedication, Acknowledgement; Table of Content; List of Tables; List of Figures; Appendices.

(2). Summary: Put a summary that includes the background, objectives, methods-(design, sample size and how subjects were handled or manipulated), results and conclusion. This should not be more than one and half pages or more than 500 words. Start the numbering of the book here with 1 and continue to the list of references and beyond making up the book size of 80-120 pages. Note that appendices are not included in the book size of 80-120 pages.

(3). Chapter 1: **Introduction**- this chapter introduces the topic or the research issue. Research should always seek to provide solutions to identified problems. This chapter should define the research problems as follows: what is the size or magnitude of problem? Who does it affect and how? when does the problem commonly occur, how was the problem addressed in the past and what were the outcome? how will your proposed work benefit or further improve how the

problem should be handled in future? This chapter should end with the study objectives and justification for the study.

(4). Chapter 2: **Review of the Literature**-Candidate should demonstrate his understanding of the research problem (topic) from published work on the research problem. Emphasis here should be on both global and sub-regional work on the problem. It should be critical reading of the published work emphasizing the nature of studies and their relevance to the research problem. Discussion of literature should be logical often starting with the global picture and narrowing down to the local context where such information exists. The literature review should address all aspects of the study methods and objectives.

(5). Chapter 3: **Material and Methods**-Candidate should give a brief description of study site and state how the study was carried out including the type of patients used. Bear in mind that only study patients that meet the inclusion criteria could be excluded. State how the sample size was estimated and how ethical issues were handled with reference to the ethical standards of the responsible committee on Human Experimentations or with Helsinki Declarations 1975 (revised 1983).

(6). Chapter 4: **Results**- Give the result of the study starting with Socio-demographic information. Result should be presented in text, tables, figures, charts and any other appropriate illustrations. Use the appropriate statistical test for every given variable. Bear in mind that the choice of a statistical test depends on the scale of measurement of the variable. The use of charts should match the nature of data for example a pie chart is only meaningful for a variable with a maximum of three values. Candidates should demonstrate their understanding of statistic by selecting the appropriate chart for a given variable. Drawing of inferences from the results should be reserved for the chapter on discussion. Results should address all aspects of the objectives.

(7). Chapter 5: **Discussion**- this section should address interpretation of study results. Study results are interpreted here, and compared with similar previous studies. Identified similarities or differences between the findings of the current study and previous studies should be explained. New but important findings from the study should be reported and commented on.

(9). Limitation of the study should be clearly identified and itemized. Limitation often refers to those aspects of the study objectives which were not properly assessed due to the imperfection of the methods or study instruments used.

(10). Conclusion and recommendations -candidates are expected to draw inferences from the study results that are vital to Family Medicine practice in the sub-region. Also recommendations for incorporation of research finding into clinical practice are stated here. Comments on limitations of the work and suggestions for further studies are stated.

Presentation of the book for Examination

i. The dissertation should be typed on one side of A4 paper, double line spacing of the main text using font size 12 Times New Roman with approximately 250 words per page.

Heading should be in upper case and in font size 12 and not bold. Subheading should also be in font size 12 not bold but each word capitalized. Sentences should not start with figures. Illustrative photographs should be black and white or colour prints and not photocopies.

ii. Margins of each page should be set at 1½ inches (3.75 cm) at the left border, ½ an inch (1.25cm) at the right border, and 1 inch (2.5cm) at both upper and lower borders.

iii. Five loose bound copies should be prepared and four submitted to the College when applying for the examination while the candidate presents at the examination with the fifth copy to defend what was sent.

iv. The books should be spiral bound. The front of the book should be transparent showing the title page while the back cover should be opaque.

4.8 Casebook writing

The Fellowship trainee is required to prepare a case book consisting of well selected patients managed during the fellowship training period. Cases should be selected in line with the distribution shown below:

Maternal Health- 2 cases (1 obstetric, 1 Gynaecology); Internal Medicine-2 cases; Child Health - 2 cases; Surgery - 2 cases; Mental Health - 2 cases; Trauma/orthopedics - 2 cases; Ophthalmology - 1 case; ENT - 1 cases; Family case study - 1 case.

Case management should reflect Family Medicine principles which should include among others the following:

i. Patient Centred Clinical Methods (PCCM)-addressing disease/illness/sick role, whole person care and mutual decision making.

ii. Biopsychosocial assessment and management of patients

iii. Family oriented care demonstrating the use of such family medicine tools as, APGAR, Genogram, Ecomap, Family Circle, Family interview and conferencing; etc.

iv. Application of chronic disease model and disability management.

v. Communication skills including the use of motivational interviewing and breaking of bad news.

vi. Home visit and home based care

vii. Resolution of ethical dilemma in Family Practice

C. Case book documentation should be in accordance with this format: Title page; Declaration, Certification, Dedication, Acknowledgement and Table of Content. Individual cases should be presented in the following format: Biodata; History; Physical Examination; Diagnosis/Differential Diagnoses; Management; Discussion which should include Lessons learnt; Conclusion; References. Each case, except for the family case study should have a minimum of 10 references and a range of 8-9 pages per case. The family case study should be a maximum of 14 pages, giving a book size of 120-140 pages. (Preliminary pages and appendices are not included). Publication year of a cited reference should not be more than 10 years from the date of submission of a book to the College for the examination.

CHAPTER FIVE: TRAINING INSTITUTIONS AND REQUIREMENTS FOR ACCREDITATION

5.1 Training institutions

Institutions seeking accreditation for the residency training in Family Medicine must have adequate facilities, personnel, services and patient load to meet training needs within the stipulated duration of the training programme. Application for accreditation is open to tertiary and secondary health facilities. Such institution may be government owned, private not for profit (missionary, NGO) or private for profit.

5.2 Accreditation procedure

An institution is said to have a training program only when such a program has been accredited. Institutions establish training program and request the College to go and accredit them. An institution with a training program seeking for accreditation is expected to apply and pay the necessary fees through the office of the Secretary-General. A form is sent to the institution and once it is filled and submitted, the Faculty is usually notified to raise a team for the accreditation visit.

Accreditation in Family Medicine is usually an institutional rather than a departmental assessment because residents in training in Family Medicine usually rotate through many departments and accreditation team must assess the adequacy of those departments to train Family Medicine residents. For cost considerations, a team visiting a public sector or organized private sector institutions is often made of three members while that for a mission institution is often made up of two members.

A key aspect of the accreditation exercise is determining the quota of residents to be trained once an institution meets all other requirements. A certified trainer is expected to supervise four (4) residents at membership level and two (2) residents at fellowship level. A part time certified trainer is expected to supervise two (2) residents at membership level and one (1) resident at fellowship level. A coordinator of training must be a certified trainer of not less than 5 years post fellowship experience.

At the end of an accreditation exercise the team must brief the management of the institution on how the institution has fared in the exercise. The management team must endorse the accreditation report before it is submitted to the College. The team makes recommendation to the Faculty Board on whether the institution should be granted accreditation and the type of accreditation to be granted. Accreditation could be denied and in such a case the institution could re-apply after twelve (12) months. Where accreditation is recommended, it could be full (five years), temporary (2 years) or partial where the institution could only carry out certain parts of the training for example membership or fellowship. An institution in which accreditation has lapsed cannot present candidates for examination and their trainers may not be eligible for invitation as examiners. It is the responsibility of an institution to seek for re- accreditation. An

institution that pays for accreditation but is not willing to receive an accreditation team within six months usually forfeits the money paid and will have to pay again before it is visited for accreditation. In institutions seeking for fresh accreditation, the effective period of training for a trainee starts from the day the institution is granted accreditation.

5.3 Accreditation requirements – Services, Personnel, Facilities

General: The institution should be well equipped with good catchments population and easy accessibility

Departments:
Family Medicine:
- General Outpatient Clinic
- NHIS Clinic
- Staff Clinic
- Outpatient Theatre
- Outreach/Rural outpost for integrated family practice - mandatory for teaching hospitals, tertiary centres and hospitals where services are organized strictly along specialty lines
- Admission facility for Family Medicine

Accident and Emergency
Internal Medicine
General Surgery
Paediatrics
Obstetrics and Gynaecology
Community Health
Psychiatry
Inpatient facility for all departments

Supporting Departments - manned by qualified personnel
Laboratory for Routine Tests
Access to Radiology Services
Blood Transfusion Facilities
Well-equipped Pharmacy with well stocked and preserved drugs
Medical Records Department
Library and Journal Services
Accessible Referral Centre
Provision for care and removal of corpses
Facilities for continuing medical education lectures, clinical meetings, etc.

Organized Teaching
Lectures, Seminars, Journal Reviews, Clinical Meetings, Teaching Rounds
Formative Assessment Sessions

Learning Resources
Well-equipped Library with relevant Books and Journals
Access to online resources for service and research e.g. Hinari, etc.
Seminar Room, Multimedia Projector, Public Address System, Projecting Screen, Computer, White Board

Staff
Medical Doctors
Co-coordinator of Training - Family Physician FWACP of at least 5 years in the Specialty
Other FWACP (FM) Consultants, Other Family Medicine Consultants
Other Consultants working Full time or Part time
Nursing
SRN or BSc Nursing - Head of Institution Nursing Services
One Registered Nurse per 5-10 Beds

Beds
Family Medicine Beds - Minimum of Five (5)
Others Adult Beds - Minimum of Twenty (20)
Other Paediatric Beds and/or Cots - Minimum of Ten (10)

Accommodation
Office for Head of Department
Office for Training Coordinator
Offices for other Consultant Family Physicians
Office for departmental secretary
Good Common Room for Residents
Living quarters for Trainees
Sleeping-in Facilities for Resident-on-Call
Provision of Consulting Room for the Trainees

Theatre
Reasonably well-equipped for common surgical and obstetric & gynaecological operations

Transportation

- Ambulances
- Duty vehicles

General Infrastructure

- Electricity
- Running water
- Satisfactory waste disposal facility

Health and Safety

- Procedures for health and safety of staff and patients e.g. PEP protocol, fire extinguishers, muster point, emergency exits, emergency driills
- Infection prevention and control protocols
- documentation of health and safety activities

Quality Assurance

- Hospital quality assurance mechanisms
- Presence of quality manual
- Evidence that quality assurance procedures are being followed and documented

CHAPTER SIX – ASSESSMENT

6.1 Introduction

The assessment of candidates to enter into the residency programme in family medicine and the subsequent certification of quality of training achieved until the candidate is a fellow of the WACP is the paramount function of the College. These assessments will not only ascertain that the core competencies to commence and complete training in family medicine have been achieved but will also seek to document the process and provide an opportunity for learning and immediate constructive feedback to the trainees from the trainers. The latter assessments are the formative assessments, which have taken more prominence in the current curriculum, as a window into the attainment of knowledge required at each level of training, clinical skill base and attitudes over the years in the programme.

The formative assessments would occur with different category of health staff, and not necessarily with a fellow of the faculty of family medicine. However, the most extensive formative assessment will occur between the trainee and his/her trainer/mentor, who will be a fellow of the faculty. These interactions will form the basis for a reflective learning process by using questioning and effective feedback to achieve a subjective assessment of knowledge and skills acquired in each posting.

Assessment of Trainees**:**
The Faculty uses two forms of assessment. (a) Summative and (b) Formative

6.2 Summative assessment:

These occur at three levels:

The Primary Examination: the purpose of this summative assessment is to ascertain that candidates for training have the required foundational knowledge on which to build the competencies expected of the faculty of family medicine.

It comprises Multiple Choice Questions with a one best answer format in areas of basic sciences and clinical medicine as delineated in the curriculum. The examination has been decentralised for the convenience of the candidates but is marked centrally. The communication of the results is also done centrally through the Secretary General's Office.

The Membership examination: This examination is for candidates who have received training in family medicine in a WACP accredited centre of training in family medicine for a period of at least two years. The period of two years is counted from the notification to the College of commencement of training **through the submission and payment of necessary fees for the resident-in-training form.** This examination awards a Membership of the WACP in FM, which is both an exit examination certification and eligibility to proceed for the fellowship training in family medicine.

Eligibility to sit for this examination further comprises submission and payment of the examination form, which will be accepted only with the attachment of the following documents:

1. Certification of training signed by the Head of Department and the Director of Training of the accredited hospital.

2. A completed logbook comprising patients managed and certified by the trainer as **adequately done** at the time of managing the patient (please note that certification done of patients managed over a two year period, must be filled real time).

   IMPORTANT NOTICE

   *Please note that the Logbook/Portfolio must be **completely** filled, as the Logbook contains the **minimum** number of cases in the different areas in the training that must be managed by the candidate to be certified as a member of the College in family medicine.*

3. Evidence of attendance of a WACP Revision course during the period of membership training.

4. Evidence of attendance of an Update course organised by the WACP during the period of training.

5. Evidence of attendance of a Medical Ethics course organised by the WACP during the period of training.

6. Evidence of registration as physician-in-training.

7. Evidence of formative assessments across the spectrum of clinical postings during the membership training in a portfolio which may be either attached to the logbook in the first instance or submitted independently.

8. For candidates in Nigeria, evidence of having served the country in the National Youth Service Corps, or evidence of exemption

The theory examination is run in two stages.

The first is a screening to assess the extent of acquisition of required knowledge and application of this to clinical settings necessary for the practice of Family Medicine. This is done through two written examinations:

The first comprises of two hundred Multiple Choice Questions with a single best answer format assessing knowledge acquired in the different areas of medicine expected at this level of training as stated in the curriculum.

The second comprises of 100 Problem Solving Questions with one best answer out of five possible options that tests the candidates' ability in application of knowledge acquired to clinical scenarios.

The candidate must pass this theory examination to be eligible to proceed to the clinical part of the Membership examination.

The clinical exam is subdivided into two sections that must be passed independently.

The first section is the Objective Structured Clinical Examination (OSCE). This comprises of multiple stations that test the spectrum of skills expected of a Member of the WACP in Family Medicine. Examiners will attend each of these stations with a marking schedule for the stations provided by the Chief Examiner. These are collated and entered real time.

Oral examinations are subsequently held to defend the Logbook and Portfolio submitted by the candidate. This is to test the candidate's recall of management principles applicable to the patients managed. Further an oral examination of topics relevant to family medicine, by at least two other examiners, tests the breadth and proficiency of the candidate on these subjects. The oral questions are delineated by the Chief Examiner and available at each examination interaction station to ensure all candidates are tested on the same topics.

To be awarded the Membership of the WACP-FM, the candidate must satisfy the examiners in the Written, OSCE and Oral examinations independently.

The Fellowship examinations: This examination is for candidates who have spent a further minimum of two years in a WACP accredited training centre. The period is counted from the pass date of the Membership examination. When this certification is awarded to a candidate it attests that the candidate is a specialist in Family Medicine and a Fellow of the WACP.

The candidate is required to carry out a research in a clinical topic pertinent to Family Medicine. The topic of research will be submitted as a proposal that will be vetted by examiners of the faculty, appointed by the Chief Examiner, after ethical approval has been sought from the training Institutions' ethical Review Board (IRB).

The candidate is to submit a compilation of fifteen cases managed during the fellowship training years. One of these cases must be a family case study while the fourteen other cases must follow the spectrum and number of cases expected in the different areas of medicine such that would be seen and managed in a family medicine practice. The casebook must be presented in the approved format as contained in this curriculum.

Dissertations and casebooks must be signed and dated by the candidates, certified by the supervisors and Heads of Department.

Eligibility to sit for this examination further comprises submission and payment of the examination form, which will be accepted only with the attachment of the following documents:

1. Certification of training signed by the Head of Department and the Director of Training of the accredited hospital for the fellowship-training period encompassing the eighteen (18) months rotation as listed in the Chapter 4 of the curriculum).

2. Evidence of attendance of a WACP Research Methodology Course during the period of Fellowship training.

3. Evidence of attendance of an Update course organised by the WACP during the period of Fellowship training.

4. Evidence of payment of Membership fee.

5. Evidence of up-to-date payment of annual dues as a Member of WACP.

6. Evidence of formative assessments across the spectrum of clinical postings during the Fellowship training.

7. Evidence of Tutelage in Private Practice.

8. Evidence of completion of the Integrated Rural Surgical posting.

The Fellowship examination is run in three stages:

Stage 1: The defence of the dissertation: the dissertation is defended for one hour with two examiners of the College, one of whom usually would have read the proposal of the candidate.

The examiners are to decide if the dissertation is satisfactory as is or needs only administrative correction in which case a **full pass** is awarded.

If the candidate has shown competence in the research process and topic, and the book is considered acceptable with corrections that need to be vetted by an examiner, a **provisional pass** is awarded and an examiner is appointed to certify the corrections before a pass result is issued.

The candidate is awarded a **fail** assessment if the candidate was not able to defend the dissertation submitted or has major flaws in the dissertation. This would entail the candidate

representing the dissertation at the next examinations reflecting the modifications communicated to the candidate. One of the examiners at the previous examination would usually be one of the examiners for that candidate at the next examination.

The candidate may have his dissertation **rejected** in the occasion when the candidate carries out a dissertation at variance with the approved proposal or with major faults in methodology at the level of data collection that can no longer be amended.

Stage 2: The defence of the Casebook: This entails a one-hour defence of a compilation of fifteen cases successfully managed by the candidate. The examiners are to decide if the casebook is acceptable as it is or needs only administrative corrections in which case a **full pass** is awarded.

The candidate is given a Provisional Pass if the book has been successfully defended and is considered acceptable with corrections that require vetting by an examiner. An examiner will be appointed to certify the corrections before a pass result is issued.

The candidate is awarded a **fail** assessment if even one of the cases presented is judged to be inappropriately chosen or managed. A fail may also be awarded if in the defence of a case, the candidate's direct involvement in the management of the patient becomes questionable, with a consequent rejection of the case. This would entail the candidate representing the casebook at the next examinations reflecting the modifications communicated to the candidate and a new case successfully managed. One of the examiners at the previous examination would usually be one of the examiners for that candidate at the next examination.

The Casebook may be **rejected** if the candidate carries out a casebook compilation at variance with the approved format for casebook presentation in the faculty. This situation will also be upheld when a reported act of medical neglect/wrong management, questionable professional integrity of the candidate occurs in case management, rejection of 50% (>7) of the cases or plagiarism discovered.

Stage 3: The general orals: this entails a one-hour defence of topics pertinent to family medicine principles, management and practice. The questions will be compiled by the Chief

Examiner and made available for the examinations in such a way that all examination stations have the same questions.

A joint assessment form for the orals will be used to assess depth of knowledge of the topic, internalisation of the concept for practice, ability to show adaptation to social and economic considerations that may become prevalent over time and consideration of ethical and professional choices.

Criteria for passing the fellowship examination

The candidate is to pass each part of the examination independently to obtain a full pass in this Fellowship examination. If any one part of the examination is awarded a fail or rejection, only that part of the examination needs to be represented at the next examinations.

6.3 Formative assessment

This form of assessment is an opportunity to carry out a clinical task under the un-interruptive observation of an assessor/trainer with the goal of receiving constructive feedback on competencies achieved and identifying areas of need for improvement. This is particularly useful for an effective preparation for the membership and fellowship examinations as it offers the candidate concrete assessment of skill sets and acquaints the trainees with the examination processes.

Further, formative assessments are a routine for the training programme in Family Medicine and constitute a significant part of the portfolio, giving the examiner a view of the resident's improvement in clinical competency and application of self to the training programme for maximal benefit.

In summary, formative assessment offers the following:

1. Opportunity to receive formative feedback
2. Routine output to inform WACP FM
3. Contribute to summative assessment
4. Motivation - positive feedback and suggestions for development can be very motivating and encourage aspiration to mastery

5. Inform further learning objectives by identifying areas that need improvement.
6. Demonstrate progress

The most frequently used formative assessment tools in the WACP –FM are:

1. **Logbook –** This contains the lists of the type and number of cases that the trainee is expected to see and manage during the membership rotations. The trainee is to carry this with him as he sees patients every day. Cases adjudged to have been adequately managed by the posting supervisor are to be entered into the logbook and signed real time by the supervisor. The Family Medicine trainer should also countersign the case after certifying the competence of the trainee in managing the case.
2. **Directly Observed Procedures (DOPs).** This formative assessment is designed to give feedback on procedural skills. Please see an example of the form in appendix.
3. **Minimal Clinical Examination (Mini-CEX).** This is a 15 minutes snap shot of doctor/patient interaction. Assesses clinical skills, attitudes and behaviours of trainees. Please see an example of the form in the appendix
4. **Multisource feedback/360° feedback (MSF):** The purpose of the MSF is to assess behaviour; team working and communication skills of trainees **NOT** assess knowledge or practical skills. It is designed to collate views from a range of co-workers which may include: Allied health professionals, Radiographers, Physiotherapists, Nurses, Other doctors, Secretarial and clerical staff. Please see an example of the form in appendix.

Effective feedback is the key to the success of these assessment methods.

6.4 Mentorship

Apart from the formative assessments, which could initiate an interaction between the trainer and trainee, the trainee would have regular interactions with his/her appointed mentor whose responsibility is to ensure that the trainee obtains the skills and competence expected by assisting in the navigation of the institutions' system already well understood by this trainer. Furthermore the mentor is to assess the competencies acquired from each posting be it at the membership or fellowship training, document and certify this training in the logbook and an assessment form – the Mentor-Mentee Interaction form (see appendix) and give the go-ahead to the institutions' Residency Training Coordinator (RTC) to proceed on the next posting. The mentor should also

develop a Personal Development Plan (see appendix) to span variable periods from quarterly to yearly depending on the needs of the trainee.

The Personal Development Plan includes the following objectives:

- Identification of prior learning
- Identification of current learning needs (objectives)
- Planning of activities to meet these needs
- Timelines and support required to enable these activities to take place
- How learning will be evaluated (with the suggested tools)

You need to keep in mind:

1. The international training outcomes for Family Medicine in West Africa.
2. Your personal learning needs.
3. The relation of your planned rotations with the health service platform.

Patient Centred Clinical Method: it is expected that the family medicine trainee will use this method of clinical interview. This skill set should be assessed through video recording of a consultation process with the expressed consent of the patient and submitted to the mentor for assessment on patient centeredness. The trainee should carry out this procedure once a year to ascertain progress and proficiency in this skill set.

Appendices:

Useful references and resources

1. Instruments for Workplace-based Assessment (WBA): Follow link from: www.fdg.unimaas.nl/educ/cees/sa
2. Govaerts MJB, Van der Vleuten CPM, et at. Broadening Perspectives on Clinical Performance Assessment: Rethinking the nature of In-training Assessment. Advances in Health Sciences Education 2007; 12:239-260
3. Couper I, Mash B. Obtaining consensus on core clinical skills for training in family medicine SA Fam Pract 2008;50(6):69-73
4. Mash R, Goedhuys J, D'Argent F. Enhancing the educational interaction in family medicine registrar training in the clinical context SA Fam Pract 2010;52(1):51-54

Mentor Mentee Interaction Form

Department of Family Medicine, _____(insert institutional name)

Name of Resident Doctor: _____

Name of Mentor: _____

Date of Interaction: _____

Purpose of Interaction:

1. Interaction to assess eligibility to proceed on posting ☐
2. Mid posting interaction (optional) ☐
3. End of posting interaction (review of logbook) ☐
4. Interaction on multisource/360^0 feedback ☐
5. Interaction on DOPS and Mini CEX ☐
6. Research ideas ☐
7. Professional Development ☐
8. Psychological issues influencing development ☐

Main issues discussed

1. _____
2. _____
3. _____

Resolutions	Timeline
1. _____	_____
2. _____	_____
3. _____	_____

Signature of Mentee: _____

As true representation of the proceedings

Signature of Mentor: _____

As true representation of the proceedings

Mini-Clinical Evaluation Exercise (mini-CEX)

Date of Assessment (DD/MM/YY) ☐☐/☐☐/☐☐

Trainee's Surname

Trainee's Forename

Trainee's Year

Trainee's MDCN Number

Assessor's Registration Number (MDCN)

Assessor's Name

Assessor's Email

Assessor's Position:

Consultant ☐ SR ☐ R ☐ SHO ☐ FP ☐ Nurse ☐ Other ☐

Brief Summary of Case:

Setting for Assessment (e.g. A&E, OPD):

Please score the trainee on the scale shown. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training	*Below expectation for stage of training*	*Borderline for stage of training*	*Meets expectation for stage of training*	*Above expectation for stage of training*	*Well above expectation for stage of training*	*Unable to Comment*
Medical Interview Skills						
☐	☐	☐	☐	☐	☐	☐
Physical Examination Skills						
☐	☐	☐	☐	☐	☐	☐
Counselling and Communication Skills						
☐	☐	☐	☐	☐	☐	☐
Clinical Judgement						
☐	☐	☐	☐	☐	☐	☐
Consideration for Patient/Professionalism						
☐	☐	☐	☐	☐	☐	☐
Organisation/Efficiency						
☐	☐	☐	☐	☐	☐	☐
Overall Clinical Competence						
☐	☐	☐	☐	☐	☐	☐

Based on this observation please rate the level of overall competence the trainee has shown:

Overall Clinical Judgement		
Rating	**Description**	
Below Level expected during Foundation Programme	Demonstrates basic consultation skills resulting in incomplete history and/ or examination findings. Shows limited clinical judgement following encounter	☐
Performed at the level expected at completion of Foundation Programme / early Core Training	Demonstrates sound consultation skills resulting in adequate history and/ or examination findings. Shows basic clinical judgement following encounter	☐
Performed at the level expected on completion of Core Training/ early Higher Training	Demonstrates good consultation skills resulting in a sound history, and/or examination findings. Shows solid clinical judgement following encounter consistent with early Higher Training	☐
Performed at level expected during Higher Training	Demonstrates excellent and timely consultation skills resulting in a comprehensive history and/or examination findings in a complex or difficult situation. Shows good clinical judgement following encounter	☐
Performed at level expected for completion of Higher Training	Demonstrates exemplary consultation skills resulting in a comprehensive history and/or examination findings in a complex or difficult situation. Shows excellent clinical judgement following encounter consistent with completion of Higher Training.	☐

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Trainee's Signature.....

Assessor's Signature.....

Direct Observation of Procedural Skills (DOPS) – Family Medicine

Please complete the questions using a cross: × Please use black ink and CAPITAL LETTERS

Trainee's	Surname	
	Forename	
MDCN number:		MDCN NUMBER MUST BE COMPLETED

Clinical setting: Theatre ☐ ICU ☐ A&E ☐ Delivery Suite ☐ OPD ☐ Other ☐

Procedure:

Case Category: Elective ☐ Scheduled ☐ Urgent ☐ Emergency ☐

ASA Class: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Assessor's position: Consultant ☐ SR ☐ R ☐ Nurse ☐ Other ☐

Number of times previous DOPS observed by assessor with any trainee: 0 ☐ 1 ☐ 2-5 ☐ 5-9 ☐ >9 ☐

Number of times procedure Performed by trainee: 0 ☐ 1-4 ☐ 5-9 ☐ >10 ☐

Please grade the following areas using the scale below:	Below expectations		Borderline	Meets expectations	Above expectations		U/C*
	1	2	3	4	5	6	
1. Demonstrates understanding of indications, relevant anatomy, technique of procedure							
2. Obtains informed consent							
3. Demonstrates appropriate pre-procedure preparation							
4. Demonstrates situation awareness							
5. Aseptic technique							
6. Technical ability							
7. Seeks help where appropriate							
8. Post procedure management							
9. Communication skills							
10. Consideration for patient							
11. Overall performance							

*U/C Please mark this if you have not observed the behaviour and therefore feel unable to comment

Please use this space to record areas of strength or any suggestions for development

	Not at all									Highly
Trainee satisfaction with DOPS	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
Assessor satisfaction with DOPS	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

What training have you had in the use of this assessment tool? Face-to-face ☐ Have read guidelines ☐ Web/CD ROM ☐

Assessor's signature: .....

Date: ☐☐☐☐☐☐

Time taken for observation: (in minutes) ☐☐

Time taken for feedback: (in minutes) ☐☐

Assessor's name:

Assessor's GMC number		Acknowledgements: Adapted with permission from American Board of Internal Medicine

Direct Observation of Procedural Skills (DOPS)

DOPS assessment takes the form of the trainee performing a specific practical procedure that is directly observed and scored by a consultant observer in each of the eleven domains, using the standard form.

Performing a DOPS assessment will slow down the procedure but the principal burden is providing an assessor at the time that a skilled trainee will be performing a practical task.

Being a practical specialty there are numerous examples of procedures that require assessment as detailed in each unit of training. The assessment of each procedure should focus on the *whole event*, not simply, for example, the successful insertion of cannula, the location of epidural space or central venous access such that, in the assessors' judgment the trainee is competent to perform the individual procedure without direct supervision.

Feedback and discussion at the end of the session is mandatory.

Multisource Feedback (MSF) also known as 360° feedback

Date of Assessment:	
Trainee's Surname:	
Trainee's Forename:	
Trainee's GMC Number:	
Trainee's Year:	
Assessor's Name:	
Assessor's Registration Number:	

Assessor Position

Please grade the following areas using the scale below:

Well below expectations for stage of training	Below expectations for stage of training	Borderline for stage of training	Meets expectations for stage of training	Above expectations for stage of training	Well above expectations for stage of training	Unable to comment*
Attitude to staff: Respects and values contributions of other members of the team						
❍	❍	❍	❍	❍	❍	❍
Comments						
Attitude to patients: Respects the rights, choices, beliefs and confidentiality of patients						
❍	❍	❍	❍	❍	❍	❍
Comments						
Reliability and punctuality						
❍	❍	❍	❍	❍	❍	❍
Comments						
Communication skills: Communicates effectively with healthcare professionals						
❍	❍	❍	❍	❍	❍	❍
Comments						
Team player skills: Supportive and accepts appropriate responsibility; Approachable						
❍	❍	❍	❍	❍	❍	❍
Comments						

Leadership skills: Takes responsibility for own actions and actions of the team						
❍	❍	❍	❍	❍	❍	❍
Comments						
Overall professional competence						
❍	❍	❍	❍	❍	❍	❍
Comments						

**U/C Please mark this if you have not observed the behaviour and feel unable to comment.*

Comments

Do you have any concerns about this doctor's honesty and integrity?

❍ No	❍ Yes

If yes please state your concerns

Anything especially good?

Please describe any behaviour that has raised concerns or should be a particular focus for development:
