Kuwait Institute for Medical Specialization
Faculty of Primary Healthcare

Family Medicine Residency Program
Trainers’ & Residents’ Guide to the curriculum
Preface

Our vision at The Kuwait Family Medicine Academic Program is to improve the health of the people of Kuwait through leadership in family medicine education, clinical practice, and research. To fulfill this vision, our mission is to develop and maintain exemplary family medicine educational programs for medical students, resident physicians, physician assistants, other faculty and practicing physicians who train healthcare providers for Kuwait. Furthermore, we thrive to provide comprehensive, high quality, cost effective and humanistic healthcare in our family medicine clinical education centers through interdisciplinary cooperation. In our mission we will promote the discovery and dissemination of knowledge that is important to teaching, clinical practice, and organization of healthcare. Finally, we will work in partnership with individuals, community organizations, and governmental institutions to address unmet primary care needs through education, community service, and contributions to help in improving health care delivery systems, while providing a nurturing educational and work environment where creativity is encouraged and diversity is respected.

This publication demonstrates the Family Medicine Curriculum in depth for the family medicine trainers, residents, medical students, and other faculty and practicing physicians who train in Family Medicine Centers.

Dr. Huda Alduwaisan
Chairman of the faculty of primary healthcare
Foreword

Family Medicine provides accessible, quality and cost-effective healthcare that is patient centered, evidence based, family focused, and problem oriented.

Family physicians are expert at managing common complaints, recognizing important diseases, uncovering hidden conditions, and managing most acute and chronic illnesses. They emphasize on health promotion and disease prevention. The scope of the discipline has been grounded in the core values of continuing, comprehensive, compassionate, and personal care provided within the context of family and community.

Kuwait’s primary health care system need for family physicians is enormous, were only 18 % of all current primary health care physicians (PHCP) are family physicians.

The Kuwait Institute for Medical specializations (KIMS) - in affiliation with the Royal College of General Practitioners (RCGP) - established family medicine residency program (FMRP) almost 35 years ago, as a three-year residency program. Since 2010, the program duration evolved into five years from a four-year duration commenced since the years of 2001. MRCGP (INT) accreditation was awarded in 2005.

Family medicine residents need to learn and demonstrate skills across a spectrum of clinical domains in order to provide initial, continuing, comprehensive and coordinated medical care for all individuals, families and communities and which integrates current biomedical, psychological and social understandings of health. Therefore, there is a need to develop a comprehensive curriculum for family physicians so that they can offer a full range of care to meet the needs of the community and to provide a varied range of clinical competencies and adequate training as essential requirements for family physicians.

Over the last 20 years the number of family medicine program graduates has reached 410 by October 2017. The Curriculum Scientific Group sincerely thanks the Curriculum Working Group of the previous curriculum (2008) led by Dr Samia Almusallam (ex. director of FMRP) for their effort and excellent work. Large Part of the current update of the curriculum work was based on the previous curriculum.

The group is deeply indebted for all who contributed to the development of this current update of the curriculum, for their hard work and commitment.

Dr. Deena Aldhubaib
Director of the Family Medicine Residency Program
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WPBA Committee Members in the FMRP (Kuwait):
Work Place Based Assessment Tools
WPBA Requirements for Each Residency Year

**Examination entrance Eligibility Requirements**

WPBA Blue print
Life support certification policy
Work place based assessment for in-clinic training
Work place based assessment for in-hospital training

**Suggested FMRP References**

[A]- Helpful Reference Books (use the Latest edition):
[B]- Online Resources: (To ease, complement & facilitate your original Readings)
[C]- For Evidence based guidelines:

**Contacts**

Family Medicine Residency Program
Vision

The family practice residency program aims to be a premier training program in the region, by providing an extensive and innovative high standard training for the family medicine residents. It also aims to be the primary destination of medical school graduates in order to increase the number of family physicians that can cover the community.

Mission

The mission of the Family Medicine Residency Program in Kuwait is to improve the primary health care system by ensuring the provision of highly qualified family physicians who are capable of providing a high standard comprehensive health care. In addition, the program works to prepare family physicians who are equipped to deal with the growing challenges in the community.
Introduction

Residents will find family medicine specialty challenging yet exciting. It is unique and differs from other medical specialties by being the point of first contact within the organized healthcare system, dealing with all health problems regardless of the age, sex or any other characteristic of the person concerned. It is a specialty that is committed to the person first rather than to a particular body of knowledge, group of diseases or interventions. What makes it distinctive is that it relies, largely, on the subjectivity of patient’s personal health beliefs and cultural influences in the different aspects of intervention. In addition, the doctor-patient relationship that is established over time, through effective communication between doctor and patient, plays an essential role of the discipline (2-3). Residents will learn how to make efficient use of limited healthcare resources through coordinating care and working with other professionals, how to manage illnesses presenting in an undifferentiated way at an early stage and how to master consultation skills (4-5).

This curriculum is intended as a guide to both residents and trainers. It went through progressive stages of evolution (6-9). It is designed to address the wide ranging knowledge, competencies, clinical and professional attitudes considered appropriate for a doctor intending to commence a profession of family medicine. This curriculum is a dynamic and complex document that will change and develop as medicine changes and develops (10-11).

Dr. Deena Aldhubaib
Director of the Family Medicine Residency Program
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The curriculum is last reviewed and updated on January/2021; by scientific committee members.
Goals

By the end of the five years residency training we aim to develop family physicians who (4-5):-

1. Are safe, competent & confident in managing a variety of health problems ranging from minor self-limiting illnesses to those more serious or life threatening, irrespective of age and gender. As well as being skilled at dealing with ambiguity and uncertainty.

2. Embrace a holistic and a comprehensive approach to the management of disease and illness in patients and their families.

3. Have a unique consultation process that establishes a working relationship, through effective communication between doctor and patient on the long term, thus maintaining continuity of care.

4. Provide high-quality, cost-effective care in collaboration with other healthcare providers.

5. Adopt a systematic preventive care approach for the practice population as a whole.

6. Are responsive and adaptive to the community’s changing needs and circumstances. Moreover, have the ability to advocate a public policy that promotes their patients’ health in society.

7. Take responsibility for continuously monitoring, maintaining and if necessary improving clinical aspects, services and organization, patient safety and patient satisfaction of the care they provide.

8. Apply evidence-based medicine in their daily work to improve patients’ care with validated, up to-date and high quality literature.

9. Have the required knowledge and skills to conduct researches and audits that contribute to raise the standard and professionalism in the health care system.
10. Have effective strategies for a self-directed, lifelong learning process and be able to demonstrate the highest standard of professional conduct and ethical practice.

Learning/Teaching & Rotations during the residency program

Most of the resident’s knowledge, attitudes and skills will be attained through caring for patients in the family medicine centers (Family Practice Based Training FPBT) were residents are expected to spend a total period of 40 months. The moment the resident is accepted in the residency program, he/she is allocated to a trainer. From there, the journey of teaching and learning begins. The teaching and learning process during FPBT period is unique, in which the primary relationship is between the trainer (educator) and the resident (learner), a relationship that is embedded in active and professional practice. During the years of training, each resident will be exposed to different trainers in different health regions, to ensure adequate exposure to a variety of cultural and ethnic groups in the society.

Residents will spend a total of 20 months in different hospital attachments (Hospital Based Training HBT) with different specialties to reinforce and refine their knowledge, skills and attitudes in the different medical specialties and subspecialties. It is considered as a fundamental part of the training experience in our residency program. We provide our residents with diverse training prospects by experienced hospital consultants. We offer them the chance to practice as an integrated part of the hospital team under full supervision.
Mandatory & Elective rotations in the family medicine residency program:

<table>
<thead>
<tr>
<th>PGR1</th>
<th>Fam Med Foundation 4 Months</th>
<th>Emergency Medicine 2 Months</th>
<th>Pediatrics 3 Months</th>
<th>Fam Med 2 Months</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Genetic Medicine 1wk</td>
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<tr>
<td>PGR2</td>
<td>Internal Medicine 3 Months</td>
<td>Fam Med 1 m.</td>
<td>Obs/Gyn 1 Month</td>
<td>Fam Med 1 m.</td>
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<td>Ortho 1 m.</td>
<td>Minor Theater</td>
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<td></td>
<td>Surgery/urology 1 Month</td>
<td>Fam Med 4 Monts</td>
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<tr>
<td>PGR3</td>
<td>Psych 2 Months</td>
<td>Ophth 1 Month</td>
<td>Derma 1 Month</td>
<td>Palliative care 2 weeks</td>
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<td></td>
<td></td>
<td></td>
<td>ENT 1 Month</td>
<td>Pediatric surgery 2 weeks</td>
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<td></td>
<td>Fam Med 6 Months</td>
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<tr>
<td>PGR4</td>
<td>Fam Med Months / Geriatric Care</td>
<td>Infectious disease 2 weeks</td>
<td>Audit Project</td>
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<td>PGR5</td>
<td>Fam Med Months</td>
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A variety of elective opportunities are offered during PGR4.

Residents are offered the following specialties to be spent as elective rotations in PGR4 (maximum 2 months):

- Allergy & Immunology
- Preventive medicine
- Infectious disease
- Genetics
KFMRP Spiral Curriculum

R5: Organization management. Community health in FM.
R4: Medical complexity. Patient-centered approach. QIP. Leadership.
R3: Holistic approach, ethical & medico-legal principles.
R2: Applying knowledge. EBM. Scholar role. Audit.
The Kuwait Family Medicine Competency framework

The Kuwait family medicine competency framework for the residents describes the different competencies; skills and professional attitudes that residents in the family medicine residency program need to acquire and develop during their five residency years. It is a result of extensive review of internationally well-acclaimed curricula \(^{(4,12-13)}\)

Upon completion of the five years residency, the resident should be able to demonstrate that he/she has gained the Kuwait Family Medicine Competencies acquired through their residency which are essential to them as family physicians.

The curriculum is according to the Triple C Competency which is a Family Medicine residency curriculum that provides the relevant learning contexts and strategies to enable residents to integrate competencies, while acquiring evidence to determine that a resident is ready to begin to practice in the specialty of Family Medicine."\(^{(CANMED)}\)

The triple C.s

1. Comprehensive Care and Education: across Life cycles, clinical settings, clinical responsibilities, including special populations and core procedures through a comprehensive curriculum and modeling comprehensive care
2. Continuity of Education and Patient Care: through continuity of care and continuity of education. Continuity of care includes follow patients over time, follow patients in different settings, experience relationship and responsibility of care. The continuity of education encompasses continuity of supervision and assessment, continuity of learning environment, continuity of curriculum and continuous integration.
3. Centered in Family Medicine: which includes control of goals and curricular elements, primarily Family Medicine contexts and teachers (Augmented as required with other experiences), content relevant to the needs of Family Medicine trainees and opportunities to develop professional identity as a Family Physician
Kuwait Family Medicine Competency Framework

Fig 1 Kuwait Family Medicine Competency Framework

These aspects ensure that the Family Medicine Resident excels in the KIMS adopted Can Meds roles framework (Professional, Communicator, Collaborator, Manager, Health advocate, Scholar)
<table>
<thead>
<tr>
<th>Kuwait Family Medicine Competencies</th>
<th>Description</th>
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</table>
| **1. Clinical proficiency**        | 1.1 Cover a full range of knowledge in health conditions  
|                                    | 1.2 Master the skills of history taking and physical examination  
|                                    | 1.3 Selectively gather and interpret information from history taking, physical examination and investigations and apply it to an appropriate management plan in collaboration with the patient  
|                                    | 1.4 Build diagnostic hypotheses based on prevalence, community incidence and consideration of urgent treatable problems  
|                                    | 1.5 Develop analytical and clinical reasoning skills to identify patients' problems with consideration of ethical principles and professional responsibilities.  
|                                    | 1.6 Manage patients with random and unfiltered problems which include common, serious and undifferentiated conditions.  
|                                    | 1.7 Manage simultaneously multiple clinical issues and complexities, both acute and chronic, often in a context of uncertainty  
|                                    | 1.8 Recognize personal limits in knowledge, skills and attitudes  
|                                    | 1.9 Adopt appropriate working principles (e.g. incremental investigation, using time as a tool) within the available resources in collaboration with patient.  
|                                    | 1.10 Prioritize the management plan, based on the patient’s perspective, medical urgency and context  
|                                    | 1.11 Able to provide long term continuity of care as determined by the individual need of the patient.  
|                                    | 1.12 Able to apply the principles of safe prescription in everyday practice with particular attention to those with poly pharmacy.  
|                                    | 1.13 Recognize occasions when referral to hospital specialist is indicated and act accordingly.  
|                                    | 1.14 Use time effectively in assessment and management  
|                                    | 1.15 Appropriately document procedures performed and their outcomes, and ensure adequate follow-up.  
|                                    | 1.16 Reach clinical decisions according to best available evidence, patient’s perspective and past experience.  |
2. Communication

2.1 Develop rapport, and ethical therapeutic relationships with patients and families that are characterized by understanding, trust, respect, honesty and empathy.

2.2 Apply appropriate communication techniques to resolve conflict and balance physician’s performance and patient’s expectations.

2.3 Adopt a patient-centered approach in the consultation with sensitivity to each patient’s expectations, needs and health beliefs.

2.4 Communicates management options clearly to the patient and provides appropriate support and information to patients and their caregivers.

2.5 Bring about an effective doctor–patient relationship, with respect for patient’s autonomy.

2.6 Use bio-psycho-social models, taking into account cultural dimensions (holistic approach).

2.7 Demonstrates an ability to break bad news clearly and empathically including the communication of a terminal prognosis.

These competencies prepare the resident to be a good Communicator.
<table>
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<th>3. Health Promotion</th>
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<tr>
<td>3.1 Relate the health needs of individual patients with the health needs of the community in which they live, balancing these against available resources.</td>
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<tr>
<td>3.2 Improve health and quality of life by applying health promotion and disease prevention strategies appropriately.</td>
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<tr>
<td>3.3 Provide preventive care through application of current standards for the practice population.</td>
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<tr>
<td>3.4 Identify the determinants of health within their communities, including barriers to accessing care and resources.</td>
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<td>3.5 Able to optimize health prevention and promotion as well as the traditional concept of diagnosis and treatment of disease.</td>
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<tr>
<td>3.6 Aware of the importance of a physician’s own health behavior in fostering quality in his or her personal life to function as a positive role model.</td>
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<td>3.7 Encourage the patient’s awareness of self-responsibility in obtaining optimal health and readiness to change.</td>
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<td>3.8 Recognize the importance of family structure and support systems in health behavior.</td>
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<tr>
<td>3.9 Able to assess risks for preventable disease in each patient.</td>
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<tr>
<td>3.10 Assess, monitor and communicate chronic disease care plans to patients as a means of secondary prevention.</td>
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<tr>
<td>3.11 Recognize the importance of health care maintenance and disease prevention with regard to age- and gender appropriate screening guidelines and immunizations.</td>
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</table>
3.12 Able to address a diverse range of patient behaviors that adversely affect health, such as tobacco, alcohol and drug misuse, overeating, and sedentary lifestyle, with compassion and empathy.
3.13 Show basic understanding of current public health issues and concerns on global and local levels.
3.14 Demonstrate ability to apply the three categories of prevention: primary, secondary and tertiary at consultation and practice levels:

| 3.14.1 | Aware about age-specific dietary recommendations for nutrition, weight management and exercise guidelines for fitness |
| 3.14.2 | Recognize the influences on psychosocial wellbeing, including internal perceptions, external stressors and significant life events |
| 3.14.3 | Injury prevention at home and while driving |
| 3.14.4 | Safe sexual practices regarding sexually transmitted infections and pregnancy planning |
| 3.14.5 | Periodic health screening |
| 3.14.6 | Cancer screening (e.g. mammography, Pap tests, colorectal cancer screening) |
| 3.14.7 | Physical assessment of BMI and blood pressure…. etc. |
| 3.14.8 | Recognize community resources for health promotion |

3.15 Community health responsibilities in family medicine

*These competencies prepare the resident to be a Health Advocate*
| **4. Evidence-based Practice** | 4.1 Have a firm grasp of the principles of epidemiology and statistics  
4.2 Able to formulate a well-built clinical question in order to search for the EBM resources and choose the best evidence.  
4.3 Able to search for the best evidence to manage patients’ problems.  
4.4 Able to critically appraise articles and studies-as needed-and apply this information to practice decisions using relevant tools  
4.5 Able to apply the principles of evidence base medicine in the management of patients  
4.6 Demonstrate ability to monitor and improve the quality of care by performing clinical audits and researches  
4.7 Demonstrate ability to understand and interpret the following critical appraisal measures e.g.:  
4.7.1 P value  
4.7.2 Confidence interval  
4.7.3 Publication bias  
4.7.4 Funnel & Forest plot graphs, Test for heterogeneity  
4.7.5 Specificity and sensitivity  
4.7.6 Positive predictive value & Negative predictive value  
4.7.7 Likelihood ratios  
4.7.8 Odds Ratio (OR)  
4.7.9 Relative Risk (RR)  
4.7.10 Absolute Risk Reduction (ARR)  
4.7.11 Relative Risk Reduction (RRR)  
4.7.12 Number Needed to Treat (NNT)  
4.7.13 Number Needed to Harm (NNH)  

**These competencies prepare the resident to be a Scholar** |
| **5. Working as a team** | 5.1 Appreciate the importance of team work and to act in collaboration with colleagues both as a leader and as part of the team.  
5.2 Coordinate and facilitate care with other professionals within primary care and with other specialties.  
5.3 Ensure respect to colleagues in the practice.  
5.4 Act appropriately when aware of unethical conduct by a colleague.  
5.5 Work proficiently with other colleagues to ensure patient care, including sharing of information with colleagues.  
5.6 Community health responsibilities in family medicine |
<table>
<thead>
<tr>
<th><strong>These competencies prepare the resident to become a Collaborator</strong></th>
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<tr>
<td><strong>6.Organisation Management and leadership</strong></td>
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<tr>
<td>6.1 Understand the nature of primary health care system in Kuwait with respect to medico-legal, ethical and organizational aspects</td>
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</table>
| 6.2 Implement processes to ensure continuous quality improvement within the practice:  
  6.2.1 Ability to select the aspect of care to be audited, monitored and improved.  
  6.2.2 Ability to implement the necessary changes to achieve the required standards. |
| 6.3 Employ information technology and acquire the necessary skills to deal with the electronic medical records to provide a better patient care and follow up. |
| 6.4 Recognize the importance of appropriate allocation of healthcare resources, including referral to other health care professionals and community resources.  
  1. Resources-and cost-effective practice  
    - Definition: all material, personal, facilities, funds and anything else that can be used for providing health care services.  
    - Inappropriate Referrals, investigations, prescriptions, sick leaves  
    - Inappropriate use of instruments, papers  
    - Resources and cost effectiveness part in (COT/CBD if applicable)/DOPES/ Multi-source feedback/prescribing assessment) (WPBA) |
| 6.5 Show effective leadership skills |
| 6.6 Demonstrate an awareness of the role of the family physician in situations other than patient care, such as participation in health care management, policy development and planning |
| 6.7 Consider issues of patient safety in the provision of care and other professional responsibilities |
| 6.8 Ability to apply ethical principles to other parties' e.g. pharmaceutical companies, staff and colleagues, health system resource allocators and researchers. |
| 6.9 Resources and cost effective practice  
  Prescription, investigation, referrals, workforce (human resources) |
| 6.10 Community health responsibilities in family medicine  
  *These competencies prepare the resident to be a good leader* |
| 7. Personal and Professional Growth | 7.1 Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life.  
7.2 Aware of the effects of stress on perception, integration and decision-making by physicians and other health care team members and deal with it appropriately.  
7.3 Maintain and enhance professional activities through ongoing self-directed learning based on reflective practice.  
7.4 Awareness that continuous development process is a successful tool to improve the patient’s care.  
7.5 Show commitment to continuous professional development through CME, audit…etc.  
7.6 Facilitate the education of trainees, colleagues and other health professionals as appropriate.  
7.7 Able to maintain the quality of care to the level of national and international standards.  
7.8 A self-awareness regarding personal ethical strengths and vulnerabilities as they affect one’s own professional practice.  
7.9 Apply appropriate ethical dimensions in clinical decision making; taking into account patient’s dignity, age, mental capability, social, cultural and religious diversities.  
7.10 Ability to deal with different ethical dilemmas appropriately:  
7.10.1 Physician error (identification and coping with own and others errors)  
7.10.2 Act appropriately if a patient is only partially competent, or is incompetent  
7.10.3 Decide when it is ethically justified to breach confidentiality  
7.10.4 Self-monitor one’s own professional behavior  
7.10.5 Autonomy—patients’ rights and physicians’ rights  
7.10.6 Equity and justice  
7.10.7 Beneficence—acting in the best interest of patients. Non-maleficence—to do no harm (or the least harm possible)  
7.10.8 Honesty as an absolute vs. situational good—when withholding information is appropriate in the context of culture, patient emotional and cognitive status, etc.  
7.11 Resident wellbeing  

*These competencies prepare the resident to be professional.*
Kuwait Family medicine Residency Program Curriculum – The six area Capabilities

- Scholar role
- Critical appraisal & EBM
- Family Medicine Doctor
- Medical complexity
- Ethical & medicolegal
- Cultural & community health
- Leadership & teamwork
<table>
<thead>
<tr>
<th><strong>Kuwait Family Medicine capability</strong></th>
<th><strong>Description</strong></th>
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<tr>
<td><strong>1. Scholar role</strong></td>
<td>1.1 The residents expressed a desire for a more structured learning environment and focused training on “evidence-informed guidelines.” 1.2 When teaching guidelines throughout all aspects of residency, they felt that a structured approach—from didactic sessions to direct application of knowledge in clinical settings with trainer supervision—would increase their sense of confidence around competencies related to the clinical application of the Scholar role.</td>
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<tr>
<td><strong>2. Critical appraisal &amp; EBM</strong></td>
<td>2.1 Evidence based approach to medical care for reaching health care decisions on the best available valid and relevant evidence. 2.2 Learning critical appraisal of the medical literature with a focus on evaluating research design and statistical methods. 2.3 Integration of information EBM knowledge and skills as well as critically appraising medical literature and using evidence to inform clinical decisions. 2.4 To consider the “information mastery” approach which emphasize on evaluating and using information resources ranging from pre-digested information in the form of research synopses and systematic reviews to guidelines and expert opinion in day-to-day practice. 2.5 Implementation of EBM are integrated into all educational activities.</td>
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<tr>
<td><strong>3. Medical complexity</strong></td>
<td>3.1 Manage multiple chronic problems in a safe practice and cost effective way. 3.2 Patient complexity that involved four categories:  - <strong>Medical complexity</strong>, including discordant conditions, chronic pain, medication intolerance, unexplained symptoms and cognitive issues;  - <strong>Socioeconomic factors</strong>, such as the unaffordability of medication, family stressors and low levels of health</td>
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| 24 | literacy;  
|    | • **Mental illness**, such as depression resulting in poor medication adherence, addiction, and anxiety that confused the clinical picture; and  
|    | • **Behaviors and traits** described as demanding, argumentative and anxious.  
| 3.3 | Addressing the needs to achieve high-value health care and optimizing care within the medical home.  
| 3.4 | Opportunities for health care providers and policy implementation to develop strategies to enhance care delivery and to decrease costs.  
| 3.5 | Important outcomes include decreasing unplanned hospital admissions, decreasing emergency department use, ensuring access to health services, and improving patient and family experiences, quality of life, and satisfaction with care.  

| 4. Ethical & medico legal issues | 4.1 To practice medical ethics in acute, episodic, problem-focused, and institution-centered.  
|  | 4.2 Family medicine doctor who is applying relationship-based model of care that is accessible, comprehensive, continuous, contextual, community-focused and patient-centered reconciling ethical concepts and emphasizing different values.  
|  | 4.3 To assert that family medicine doctor incorporate family medicine ethics in medical education and invite others to explore its use in teaching and practice.  

| 5. Cultural & community health | 1. Understand the difference between “health” and “the health care system:  
|    | • Gain the understanding the most important determinants in health.  
|    | • Support public health professionals & community partners in educating policy makers & public on the most important determinants of health  
|    | • Encouraging individuals and communities to |
demand & to create the conditions necessary for health
  • Advocate for individual & communities in their pursuit for the conditions necessary for health

2. Lead the way to an equitable, effective, affordable health care system:
  • Explore the different experience of diverse populations interacting with the health care system
  • Create clinical systems that assure equitable health care to all patients regardless of their backgrounds
  • Create clinical system that assure equitable health care to all patients regardless of their backgrounds
  • Develop & support models of care that maximize patient engagement & empowerment
  • Recruit & retain a diverse health care work force
  • Support patient & community adversary boards representative of the clinical populations served
  • Conduct and/or support research that patient and community engaged

3. Be a partner
  • Collaborate and/or support collaboration with public health professionals and community partners to address the upstream determinants of health
  • Gain & maintain skills in community collaboration
  • Offer your clinical and other content expertise
  • Gain and maintain awareness of the benefits of your professionalism and position of privilege
  • When parenting know your role, including when to lead and when to step back and follow the leadership of others
  • Share the stories you have been interested with

Community Health Competencies

1. Assess and evaluate the role of cultural, social, and behavioral determinants of health and health disparities.

2. Distinguish and prioritize individual, organizational, and community concerns, assets, resources and deficits relevant to theory-driven and theory-informed CHS interventions and research.

4. Formulate policy changes needed to support and sustain evidence-based CHS interventions.

5. Synthesize and evaluate research results for the purpose of oral and written communication, instruction, and dissemination for scientific and lay audiences.

6. Teach basic and advanced CHS methods and theory to students.

7. Formulate CHS research using current knowledge of causes of disease.

8. Develop community partnerships to support CHS interventions.

9. Prepare grant proposals for extramural peer-reviewed funding.

10. Demonstrate responsible and ethical conduct in the practice of community health policies.

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<thead>
<tr>
<th>Leadership &amp; teamwork</th>
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<tr>
<td>• Able to apply leadership skills to improve quality, safety and efficiency of care in work environments.</td>
</tr>
<tr>
<td>• To create new &amp; innovative services and adopt transformative change.</td>
</tr>
<tr>
<td>• To consider future development that reflect needs of busy primary care professionals and the reality of team working to deliver integrated services at local level.</td>
</tr>
<tr>
<td>• Demonstrate understanding of primary care center systems, including the appropriate use of administration systems, MOH policies rules &amp;</td>
</tr>
</tbody>
</table>
regulations.
• Emphasis on the importance of effective record keeping and the use of IT for the benefit of patient care.
• Demonstrate the financial management skill e.g. foreigners fees or budget availability for a campaign...
• Able to identify the job description & responsibilities of each doctor, nurse, pharmacist, administrative staff & laboratory staff with supporting teamwork.
• Accountability for justice, acting as patient’s advocate for children, young people and geriatric, with sharing information & keep recording especially safety aspects e.g. criminal issues, neglects…
• Demonstrate ability to document incident report, communicating respectfully with health care workers and affected patient considering dealing with complain procedure.
• Contribute with sharing experience with other PHC & as well secondary care setting as regards plans, strategies, quality & accreditation in health care system

Assessment of Learners

Samples observable competencies: Within all seven Kuwait Family Medicine competency Framework, across the Domains of Clinical Care guided by the work place-based assessment evaluation objectives (which are WPBA evaluation objectives and reports e.g. COT-CBD-DOEPs-Time sheet- Mid-verbal feedback, reflection, prescribing assessment, leadership, ITER and FITER) resulting in consistent and continuous demonstration of competence

The skill dimension assessed are: clinical reasoning, selectivity, communication Skills, patient-centered approach, professionalism, procedure Skills, feedback given and judgment of the performance (Mid-verbal feedback, ITER and FITER). Processes and methods of assessment are integrated into the curriculum, assessment is an ongoing, formative process, progress is monitored, educational planning, including remediation, is individualized, promotion criteria and summative decisions are competency-based
Specific learning objectives per year of training

Residency Year-1

<table>
<thead>
<tr>
<th>Kuwait Family Medicine Competencies</th>
<th>Details</th>
</tr>
</thead>
</table>
| 1.Clinical proficiency              | 1.1 Being able to differentiate between the primary care setting and the hospital setting  
1.2 Developing problem solving skills: history taking & Clinical examination skills, discriminative of the wide range of interventions available (including investigations) and Interpretation and analysis of data  
1.3 Show ability to make initial management decisions about common acute and chronic problems encountered in family medicine.  
1.4 Recognize occasions when referral to hospital specialist is indicated and act accordingly.  
1.5 Adequate knowledge and skills for dealing with common pediatrics problems with particular awareness of the unique vulnerabilities of infants and children that may require special attention, consultation and/or referral.  
1.6 Show ability to manage appropriately emergency cases before transferring patients (e.g. resuscitation and stabilization)  
1.7 Show ability to prioritize tasks to manage acute illness and trauma effectively |

| 2.Communication                     | 2.1 Able to understand the importance of patient-centered approach in the consultation with sensitivity to each patient’s expectations, needs and health beliefs  
2.2 Initial integration of the holistic approach when dealing with patients |

| 3.Health Promotion                  | 3.1 Able to understand the principle of disease prevention and the importance of partnership between doctors and patients to promote optimal health. |

| 4.Evidence based practice            | 4.1 Able to apply the principles of evidence base medicine in the management of patients. |

| 5.Working as a team (collaboration)  | 5.1 Involve in team work and to act in collaboration with colleagues both as a leader and as part of the team  
5.2 Able to understand the importance of collaboration with specialists in secondary care for best patients’ outcome  
5.3 Able to write comprehensive referral letter |
6. Organization management and leadership

6.1 Able to understands principles of organization management, medical ethics, administrative regulations and teamwork.
6.2 Able to understands comprehensive record-keeping

7. Personal and professional growth

7.1 Commitment to educational activities and recognition of continuing educational needs
7.2 Show capabilities and limitations, then work on meeting those needs and inadequacies.
7.3 Able to apply medico-legal & ethical issues encountered in the primary care setting.

Residency Year-2

In addition to the previously mentioned competencies, at the completion of PGR2, the residents should demonstrate ability to:

<table>
<thead>
<tr>
<th>Kuwait Family Medicine Competencies</th>
<th>Details</th>
</tr>
</thead>
</table>
| 1.Clinical proficiency             | 1.1 Show understanding and clinical knowledge of the causes, pathophysiology, clinical manifestations and management of common and important medical diseases (refer to particular specialty).
|                                    | 1.2 Demonstrate competency in acquiring appropriate and adequate history from patients, performing appropriate and sensitive physical examination and performing appropriate and discriminative investigations.
|                                    | 1.3 Competently manage conditions encountered during the different hospital rotations.
|                                    | 1.4 Competently perform the required practical procedural skills that are pertinent to the primary care setting.
|                                    | 1.5 Able to identify the red flags of serious and potentially serious presentations in the corresponding specialties.
<p>|                                    | 1.6 Provide appropriate care in emergencies related to the different specialties. |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
</table>
| 2. Communication                            | 2.1 Develop rapport and ethical therapeutic relationships with patients and families.  
2.2 Apply appropriate communication techniques during consultation.  
2.3 Adopt a patient-centered approach in the consultation with sensitivity to each patient’s expectations, needs and health beliefs.  
2.4 Use whole person approach (holistic approach) |
| 3. Health Promotion                          | 3.1 Applies principles of health promotion and disease prevention strategies relevant to the corresponding hospital discipline. |
| 4. Evidence based practice                   | 4.1 Develop an understanding of the principles of evidence based medicine and critical appraisal  
4.2 Applies up-to-date clinical guidelines to common problems encountered in the corresponding discipline. |
| 5. Working as a team                         | 5.1 Be able to recognize his/her own practice limitations and seek consultation with other health care providers to provide optimal care by embracing a multi-disciplinary approach.  
5.2 Collaborate with specialists in secondary care, using the diagnostic and treatment resources available in hospitals.  
5.3 Able to refer to hospital specialist when indicated and provide appropriate follow up for the cases  
5.4 Hand over the care of a patient to another health care professional to facilitate continuity of safe patient care |
| 6. Organization management and leadership    | 6.1 Understand the nature of secondary and tertiary health care system in Kuwait with respect to medico-legal, ethical and organizational aspects.  
6.2 Recognize the importance of appropriate allocation of healthcare resources, including referral to other health care professionals and community resources.  
6.3 Plays an active role in situations other than patient care, such as participation in health care management, policy development and planning.  
6.4 Consider issues of patient safety in the provision of care |
### 7. Personal and professional growth

<table>
<thead>
<tr>
<th>Competency</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Understand their capabilities and limitations, then work on meeting those needs and inadequacies.</td>
<td></td>
</tr>
<tr>
<td>7.2 Ability to apply ethical principles to patients and other parties' e.g. pharmaceutical companies, staff and colleagues, health system resource allocators and researchers.</td>
<td></td>
</tr>
</tbody>
</table>

#### Residency Year-3

*In addition to the previously mentioned competencies, at the completion of PGR3, the residents should demonstrate ability to:*

<table>
<thead>
<tr>
<th>Kuwait Family Medicine Competencies</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Clinical proficiency</strong></td>
<td>1.1 Selectively gather, prioritize and interpret information and apply it to an appropriate, justified management plan in collaboration with the patient</td>
</tr>
<tr>
<td></td>
<td>1.3 Confidently provide appropriate management of emergencies encountered in their daily work in the clinic</td>
</tr>
<tr>
<td><strong>2. Communication</strong></td>
<td>2.1 Adopt a person-centered approach, paying attention to communication and effective doctor–patient relationship</td>
</tr>
<tr>
<td></td>
<td>2.3 Extends applying his/her communication skills to include other parties e.g. patients relatives</td>
</tr>
<tr>
<td><strong>3. Health Promotion</strong></td>
<td>3.1 Promote life style modification and disease prevention in their practice</td>
</tr>
</tbody>
</table>
| 4. Evidence based practice | 4.1 Understand and analyze epidemiological and statistical data.  
4.2 Critically appraise medical literature  
4.3 Apply evidence based medicine in the management of patients  
4.4 Acquire the required knowledge and skills to conduct researches and audits that contribute to professionalism, accountability and quality assurance in the health care system. |
|---|---|
| 5. Working as a team | 5.1 Appreciate the importance of team work and to act in collaboration with colleagues both as a leader and as part of the team.  
5.2 Coordinate and facilitate care with other professionals within primary care and with other specialties.  
5.3 Ensure respect to colleagues in the practice.  
5.4 Cooperates with other colleagues to ensure better patient care, including sharing of information with colleagues. |
| 6. Organization management and leadership | 6.1 Use the required administrative skills to deal with the medico-legal, ethical and organizational aspects of general practice in Kuwait.  
6.2 Knows how to fill death certificates and related documents. |
| 7. Personal and professional growth | 7.1 Maintain and enhance professional activities through ongoing self-directed learning based on reflective practice.  
7.2 Awareness that continuous development process is a successful tool to improve the patient’s care  
7.3 Show commitment to continuous professional development through CME, audit…etc.  
7.4 Able to understand and apply the full range of ethical framework during work, whether during consultation or during contact with primary health care team members |
**Residency Year-4**

*By the end of the end of PGR4, residents should expand their consultation competencies, from the level of ability and adequacy to the level of high competency in the following areas:*

<table>
<thead>
<tr>
<th>Kuwait Family Medicine Competencies</th>
<th>Details</th>
</tr>
</thead>
</table>
| **1. Clinical proficiency**        | 1.1 Demonstrate competent problem solving skills (Information gathering, clinical examination, investigations, analysis and decision making)  
1.2 Able to practice safely and independently.  
1.3 Able to manage patient at home during home visit |
| **2. Communication**               | 2.1 Adopt a person-centered approach (i.e. sharing patient in the whole consultation)  
2.2 Able to establish effective doctor–patient relationship.  
2.3 Embrace a holistic approach, taking into account cultural dimensions |
| **3. Health Promotion**            | 3.1 Formulate and individualize appropriate prevention plans.  
3.2 Able to apply health promotion and disease prevention strategies appropriately and effectively |
| **4. Evidence based practice**     | 4.1 Understand the rationale for an evidence-based approach to clinical practice.  
4.2 Justify their practice by applying evidence base medicine principles. |
| **5. Working as a team**           | 5.1 Coordinate patient care with other professionals in other areas of the health system in Kuwait.  
5.2 Able to communicate effectively with, staff and other health professionals in providing quality health care and work as part of a team in providing a professional service.  
5.3 Work collaboratively with colleagues to maintain and improve patient care. |
| **6. Organization management and leadership** | 6.1 Apply and follow rules and regulations to deal with the medico-legal, ethical and organizational aspects.  
6.2 Able to audit different aspects of care provided to the patients.  
6.3 Able to appropriately fill death certificates and related documents.  
6.4 Obtain and document informed consent explaining the |
risks and benefits of a proposed procedure or therapy.
6.5 Effectively report patient safety related incidents in the practice by filling MOH incident reports.
6.6 Knows and applies principles of quality and safety and risk management in primary care.
6.7 Able to recognize & managing sever-life-threatening emergencies, provide CPR, use AED in timely & effective manner.

| 7. Personal and professional growth | 7.1 Able to disseminate the information learnt to other colleagues.
7.2 Recognize personal educational needs and create an individual developmental plan accordingly.
7.3 Demonstrate an explicit commitment to high ethical standards (autonomy, beneficence, non-maleficence, confidentiality, equity and doctors’ probity).
7.4 Maintain and develop his skills in applying ethical framework during consultation and during contact with the primary health care team members. |

_Residency Year-5_

By the end of PGR5, residents should expand the previously mentioned competencies, from the level of ability and adequacy to the level of high competency and/or mastery.

<table>
<thead>
<tr>
<th>Kuwait Family Medicine Competencies</th>
<th>Details</th>
</tr>
</thead>
</table>
| **1. Clinical proficiency** | 1.1 Demonstrate competency in all aspects of consultation including diagnosis and management. 
1.2 Recognize and deal with complexities like ambiguity, uncertainty, multiple complaints and comorbidities. 
1.3 Record work clearly, accurate and legibly. 
1.4 Show competency in managing patient at home during home visit. |
| **2. Communication** | 2.1 Demonstrate competent communication skills. 
2.2 Provide appropriate counseling skills in dealing with patients. |
## 3. Health Promotion

3.1 Provide the appropriate health promotion care considering the needs, potentials and limitations of the community in terms of its’ socio-economic characteristics and health features, balancing these issues against available resources.

3.2 Offer continuous, coordinated and comprehensive care on the level of the patients, their families and the community.

3.3 Work as a catalyst for health promotion and prevention by recommending and supporting positive lifestyle changes and appropriate screening programs.

## 4. Evidence based practice

4.1 Able to appraise trials and guidelines.
   (refer to main framework table)

4.2 Develop and maintain the professional performance by applying evidence base medicine principles.

## 5. Working as a team

5.1 Maintain and lead collaboration as part of a team to provide a professional and high quality health care

5.2 Actively participate in teaching and education of others (junior residents, general practitioners …etc.)

## 6. Organization management and leadership

6.1 Maintain safe practice and apply risk avoidance strategies

6.2 Outline and apply the general principles of administrative management and quality assessment with regard to the latest evidence based guidelines

6.3 Actively contribute, as an individual and as a member of a team providing care, to the continuous improvement of health care quality and patient safety

## 7. Personal and professional growth

7.1 Able to set a personal development plan in order to maintain his ongoing learning process so to meet his educational needs

7.2 Preserve high ethical standards within the practice

7.3 Demonstrate competency in applying ethical principles during consultation and during contact with the primary health care team members
<table>
<thead>
<tr>
<th>Year of training</th>
<th>Teaching/learning methods</th>
<th>Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PGR1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Observing trainers and other experienced family practitioners.</td>
<td>1. Diagnosis and Management course (5 days)</td>
</tr>
<tr>
<td></td>
<td>• Joined consultations followed by independent supervised consultations</td>
<td>2. Cardiovascular problems in GP (2 days)</td>
</tr>
<tr>
<td></td>
<td>• Direct observed consultations with feedback (COT)</td>
<td>3. Presentation skills for residents workshop (1day)</td>
</tr>
<tr>
<td></td>
<td>• Reflection on learning (reflective diaries).</td>
<td>4. Emergencies in General Practice (3 days)</td>
</tr>
<tr>
<td></td>
<td>• Learning through case analysis (CBD)</td>
<td>5. Respiratory problems in GP (2 days)</td>
</tr>
<tr>
<td></td>
<td>• Learning through random case selection from the candidate work time sheet</td>
<td>6. Pediatrics Problems in GP (5 days)</td>
</tr>
<tr>
<td></td>
<td>• Formal tutorials.</td>
<td>7. Understand the theory of reflection &amp; reflective diary (2 days)*</td>
</tr>
<tr>
<td></td>
<td>• Opportunity to work as assistant registrars in pediatrics department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Opportunity to work as assistant registrars in emergency department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clinic and hospital direct observation of procedural skills (DOPES)</td>
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<tr>
<td></td>
<td>• Prescribing assessment</td>
<td></td>
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<tr>
<td></td>
<td>• Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community Health activities</td>
<td></td>
</tr>
<tr>
<td><strong>PGR2</strong></td>
<td>• Opportunity to be exposed to different hospital attachments by</td>
<td>1. Evidence Based Medicine foundation course (5 days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Dermatology in GP (2 days)</td>
</tr>
</tbody>
</table>
| | working as assistant registrar in medicine, surgery, Ob&gyn and orthopedics.  
| | • Clinical Skill enhancements (Clinical skill lab - Dasman Diabetes institute)  
| | • Independent supervised consultations  
| | • Independent self-directed learning.  
| | • Direct observed consultations with feedback (COT)  
| | • Reflection on learning (reflective diaries).  
| | • Learning through case analysis (CBD)  
| | • Learning through random case selection from the candidate work time sheet  
| | • Formal tutorials  
| | • Clinic and hospital direct observation of procedural skills (DOPES)  
| | • Prescribing assessment  
| | • Leadership  
| | • Community Health activities  
| | 4. Dilemmas in DM diagnosis and management (2 days)  
| | 5. Orthopedic problems in GP (2 days)  
| | 6. ENT problems (1 day)  
| | 7. Eye problems in GP (1 day)  
| | 8. Life support (BLS & ACLS) certifications.  

| PGR3 | • Independent supervised consultations  
| | • Opportunity to be exposed to different hospital attachments by working as assistant registrar in psychiatry, ophthalmology, dermatology, ENT, pediatric surgery and palliative care.  
| | • Independent self-directed learning.  
| | • Direct observed consultations with feedback (COT)  
| | • Reflection on learning (reflective diaries).  
| | • Learning through case analysis (CBD)  
| | • Learning through random case selection from the candidate work  
| | 1. Clinical Audit in GP (3 days)  
| | 2. Women’s problems (2 days)  
| | 3. Men’s problems (1 day)  
| | 4. Ethical and medico-legal issues (2 days)  
| | 5. Nutrition course (3 days)  

37
<table>
<thead>
<tr>
<th></th>
<th>time sheet</th>
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<tbody>
<tr>
<td></td>
<td>• Formal tutorials</td>
</tr>
<tr>
<td></td>
<td>• Clinic and hospital direct observation of procedural skills (DOPES)</td>
</tr>
<tr>
<td></td>
<td>• Prescribing assessment</td>
</tr>
<tr>
<td></td>
<td>• Leadership</td>
</tr>
<tr>
<td></td>
<td>• Community Health activities</td>
</tr>
</tbody>
</table>

| PGR4 | • Independent supervised consultations                                  |
|      | • Independent self-directed learning.                                   |
|      | • Direct observed consultations with feedback (COT)                    |
|      | • Reflection on learning (reflective diaries)                          |
|      | • Learning through case analysis (CBD)                                 |
|      | • Formal tutorials                                                      |
|      | • Clinic and hospital direct observation of procedural skills (DOPES)   |
|      | • Video case analysis                                                   |
|      | • Small group teaching                                                  |
|      | • Prescribing assessment                                                |
|      | • Leadership                                                             |
|      | • Community Health activities                                            |

|    | 1. Psychiatry problems (2 days)                                          |
|    | 2. Health promotion and disease prevention (2 days)                      |
|    | 3. Principles of quality and safety in primary care and risk management (3 days) |
|    | 4. Life support (BLS & ACLS) certifications. (Re-validation of the certificate) |
|    | 5. Infectious diseases in PC (2 weeks).                                  |
|    | 6. SG teaching: video case analysis & critical appraisal workshop.       |

| PGR5 | • Independent supervised consultations                                  |
|      | • Independent self-directed learning.                                   |
|      | • Direct observed consultations with feedback (COT)                    |
|      | • Reflection on learning (reflective diaries)                          |
|      | • Learning through case analysis (CBD)                                 |
|      | • Formal tutorials                                                      |
|      | • Clinic and hospital direct observation of procedural skills (DOPES)   |
|      | • Video case analysis                                                   |

|    | 1. Geriatric problems (2 Days)                                          |
|    | 2. SG teaching: video case analysis                                      |
|    | 3. Written exam preparation workshop (3 Days)                            |
Self-directed learning based on reflective practice

Self-Directed Learning: A Key Component of Adult Learning Theory. The best reduction tool to empower it and incorporated in the program is by developing reflection skills of the residents.

There strong suggestion to be introduced early in the program and to be monthly report requirement (initially not to be formally assessed).

R 1
Methods: to be included in ODSC, 2 days course (introduction to reflection skills)
Tools:
- Tutors for the course
- guided writing template,
- preferably initially to be supervised by his site trainer.
- Schedule for submission (once monthly)
- To be considered as eligibility requirement for WAPA
- Not to be considered as formal assessment but as a requirement

R2,R3
- Schedule for submission (once monthly)
- To be evaluated by the site trainers
- An evaluation sheet to be used

R4,R5
- Schedule for submission (once monthly)
- To be evaluated by the site trainers
- To be included in ITER (annual in- training evaluation report) – R4
- To be included in FTER (final in-training evaluation report) – R5
* Understand the theory of reflection

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection to Experience</td>
<td>Makes clear the connection(s) between the experience and the dimension being discussed.</td>
</tr>
<tr>
<td>Accuracy</td>
<td>Makes statements of fact that are accurate and supported with evidence; for academic articulated learning statements, accurately identifies, describes, and applies appropriate academic principle(s).</td>
</tr>
<tr>
<td>Clarity</td>
<td>Consistently expands on and expresses ideas in alternative ways, provides examples/illustrations.</td>
</tr>
<tr>
<td>Relevance</td>
<td>Describes learning that is relevant to the articulated learning statement category and keeps the discussion specific to the learning being articulated.</td>
</tr>
<tr>
<td>Depth</td>
<td>Addresses the complexity of the problem; answers important question(s) that are raised; avoids over-simplifying when making connections.</td>
</tr>
<tr>
<td>Breadth</td>
<td>Gives meaningful consideration to alternative points of view and interpretations.</td>
</tr>
<tr>
<td>Logic</td>
<td>Demonstrates a line of reasoning that is logical, with conclusions or goals that follow clearly from it.</td>
</tr>
<tr>
<td>Significance</td>
<td>Draws conclusions, sets goals that address a (the) major issue(s) raised by the experience.</td>
</tr>
</tbody>
</table>
E-learning

Definition of E-learning:
E-learning is an educational process (learning and teaching process) in which information and communication technology is used, contributing thus to quality improvement of the process and quality of its result.

2. Vision:
All learners, in KIMS residency programs, can thrive in digital classrooms that are engaging, learning-focused and inclusive.

3. Mission:
• We, the E-learning Committee of the KFMRP, are leading the development and delivery of innovative digital learning experiences through building the Elearning platform.
• We are building the capacity of trainers and system leaders, training the trainers, for the purposeful integration of teaching and learning with technology.

4. Aim of Integrating E-learning into KFMRP’s Curriculum:
To provide a supportive online learning experience to the KFMRP that is efficient and convenient in terms of time and place

Objectives:
• Providing easy access to updated evidence-based online sources of educational materials
• Creating and communicating new training materials and policies in a more efficient way
• Enhancing the ability to implement learnt knowledge at the workplace (hospital and/or primary healthcare centres)
• Encouraging continuous clinical learning through an effective and efficient learning system
• Monitoring the progress of each trainee through efficient utilization of the elearning site (quizzes, assignments, forums)
Introduction to Workplace Based Assessment (WPBA)

Definition

The evaluation of resident’s performance in the workplace throughout their vocational training period based on specified areas of competence. It is a process through which evidence of competence in independent practice is gathered in a structured and systematic framework. WPBA ensures that what residents do in controlled assessment situations correlates positively with their actual performance in real life, on a day-to-day basis. It also helps to reveal areas of deficiency early in training and prompt learning.

End of year training report is issued for each resident to indicate the fulfillment of training requirement and eligibility to move to the next level of training.

The aims of WPBA

1. Connects assessment tools from both the hospitals and primary care centers to create a complete reflection of the true performance.
2. Enables residents to know what is expected of them and demonstrates attainment overtime.
3. Facilitates a safe teaching environment in practice.
4. Ensures that the training is as close as possible to the real situations in which doctor’s work.
5. Monitors resident’s performance in order to pass or fail the training year based on multiple assessments.
6. Provides feedback to the resident on areas of strengths and weaknesses.
7. Effectively assesses some competences that are not well assessed in any other way, e.g. physical examination skills, procedural skills, ethical principles, teamwork and practice organization management.
8. Opens communication with residents regarding any arising issues or difficulties.
9. Allocation of residents in different rotations.
10. Follow up of residents rotations, leaves and completion of training requirements.
11. Identification and follow up for residents with issues by remediation and probation in collaboration with post graduate training committee.

**Vision**

To gain accreditation and enhance the quality of WPBA to be included in the summative assessment process for residents in family medicine.

The application of electronic portfolios and improving communication between different site coordinators in hospital and primary care centers.

**Process of the WPBA**

The main responsibility of WPBA Committee is follow up of residents throughout the residency program. Multisource feedback is gathered for evidence indicating areas of strengths and development needs thus deciding those who are eligible to proceed to the next level of assessment.

WPBA evaluation is based on the Kuwait Family Medicine Competency Framework against which evidence is gathered through validated tools. These tools ensure that evaluation is robust and fair for each resident and promote consistency among trainers and hospital tutors. The committee uses the tools (reports) to document evidence about the performance of the resident. All assessment reports are collected within 2 weeks of completing the training through WPBA e-mail
A copy of the reports is kept in the resident's file and in the personal WPBA portfolio. Residents' signature is required to indicate that the resident has read the report.

**WPBA Committee Members in the FMRP (Kuwait):**

- Dr. Deena ALDhubaib (Program Director)
- Dr. Sawsan Al Bannai (WPBA convener)
- Dr. Walaa Alkandari
- Dr. Alya Husain
- Dr. Ameena Alatwan
- Dr. Rawan Alturki
- Dr. Esraa Hasan
- Dr. Maram Jarkhi (Potential Trainer)
**Work Place Based Assessment Tools**

The Tools for WPBA includes the following:

1. Case Based Discussion (**CBD**) (General Practice)
2. Consultation Observation Tool (**COT**) (General Practice)
3. KIMS evaluation Forms (General practice and Hospital)
4. Audit project (General Practice)
5. Direct observation of procedural & examination skills (**DOPES**) (General practice and Hospital)
6. Consultation Time Sheet (**CTS**) (General Practice)
7. Tutorials (General Practice)
8. Missed teaching session report. (general practice)
9. Monthly workplace feedback. (general practice)
10. Small Group teaching sessions (**SGT**) (General Practice)
11. Completion of Courses Report (**CCR**) (General Practice)
12. Mid-rotation trainee verbal feedback. (General practice and Hospital)
13. Annual in-training evaluation report (**ITER**) final in-training evaluation report (**FITER**)
15. Prescribing assessment
16. Leadership
17. Community health activities

1) **Case Based Discussion (CBD)** Tool

The Case-based Discussion (CBD) is a structured interview designed to assess the resident’s professional judgment in clinical cases. CBD is one of the tools used to collect evidence for Trainee Portfolio, as part of the Workplace Based Assessment component. The cases are selected by the resident and presented for evaluation on a weekly basis. The trainer should ensure that a diversity of cases are...
represented including those involving children, older adults, chronic diseases, emergencies, psychosocial cases etc., across varying contexts i.e. clinic and home visits. The CBD report includes the following:

1. Professional Competencies:
   a) Data gathering and interpretation
   b) Practicing Holistically
   c) Making diagnosis / Making decisions and Prioritizes options and Justifies decision
   d) Clinical management and Managing Medical complexity

2. Fitness to practice

3. Overall assessment

4. Agreed action

2) The Consultation Observation Tool (COT)

Trainers use the Consultation Observation Tool (COT) to support holistic judgments about the resident’s practice on primary care placements. COT is one of the tools used to collect evidence for Trainee Portfolio. It should be performed on weekly basis, and provide the resident with a structured feedback to improve performance. Each session should consist of at least five cases or video case or simulated case discussion.

The components of the COT are:

2. Data Gathering
3. Examination
4. Defines the clinical Problem
5. Management and health promotion
6. Interpersonal-communication skills
7. Overall assessment
8. Feedback and recommendations for further development
3) KIMS evaluation Forms

This evaluation form was prepared and distributed by KIMS to support holistic judgments about the trainee practice in the workplace setting. It is one of the tools used to collect evidence for Trainee’s Portfolio, as part of the Workplace Based Assessment component. It was modifies by WPBA team to suit the primary care setting as well as family medicine based training in hospital rotations according to family medicine curriculum.

Includes 3 forms:

1. The trainee evaluation form: the trainers assess the trainee’s competencies (medical expert, communicator, collaborator, manager, scholar, and professional)
2. Tutor evaluation form: the trainees assess their tutor’s competencies (scholar, medical expert, communicator, collaborator, manager, advocate, professional).
3. Evaluation of clinical rotation: the trainees assess the clinic/hospital according to the clinical exposure, education, supervision, feedback, system based practice and overall rating of rotation.

4) Audit Project

Clinical audit is a way to measure and improve the quality of clinical care. The aim of the Audit project is to introduce the residents to the future responsibilities towards improving the health services in the primary healthcare setting. It is considered as a prerequisite to the final assessment. It must be completed, submitted, and passed during R4. All residents need to sign a document that validates the authenticity of their Audit project and attach a cover page indicating (name, email, batch, audit title, PHC center, health area, dates of data collection, criteria, standard, results, percentage of change).

The following headings should be used in undertaking an audit:

- Title
- Reason for the audit
- Criterion or criteria to be measured
- Standard(s) set
• Preparation and planning
• Results and date of data collection one
• Description of change(s) implemented
• Results and date of data collection two
• Conclusions

5) Direct observation of procedural & examination skills (DOPES)

The assessment of procedural & examination skills is an important part of training. Competence in these skills is integral to the provision of good clinical practice and it is one of the tools used to collect evidence for trainee Portfolio, as part of the Workplace Based Assessment component. The procedures have been selected as sufficiently important and/or technically demanding to warrant specific assessment. In addition to that, residents attend Clinical skills enhancement workshops to provide them with the opportunity to master certain procedural skills under professional supervision.

Clinical DOPES include:

• IV line
• Suturing
• Removal of suture
• Application of dressing
• Direct ophthalmoscope
• Foreign body removal
• Performance and interpretation of ECG
• Spirometer
• Injections
• Death certificate
• Incident report
• Home visit
• Police report
• Others
• Examination includes joint, back, CNS, cardiovascular, respiratory, special examination for vertigo, hearing loss & other conditions.

Hospital DOPS include:

• IV line
- Airway management
- Direct ophthalmoscope
- Performance and interpretation of ECG
- Blood collection
- Excision of skin lesions
- Suturing
- Application of dressing
- Foreign body removal
- CPR
- Injections
- Incision and drainage of abscess
- Foley’s catheter
- Cervical cytology
- Fluorescein staining of cornea
- Joint and peri-articular injections
- Episiotomy
- Ear wash
- NG tube insertion
- Vaginal swab
- Spirometer
- Proctoscopy
- Conduct labor
- Tympanogram / audiogram

6) Consultation Time Sheet (CTS)

Consultation Time Sheet (CTS) is a tool to support holistic judgments about the resident’s practice in primary care placements. It is one of the tools used to collect evidence for Trainee Portfolio. It should be performed on weekly basis. The tutor prints out the time sheet for the resident at the end of the day and chooses 1-2 cases randomly for discussion.

7) Tutorial

Mini lectures are held by the trainer according to knowledge needs of the trainee. It should be done once per week.

8) Missed teaching session report.

This report is to document a missed teaching session when the resident is not able to attend for different reasons to ensure commitment & continuity of training as required.
9) Monthly workplace feedback.

This is to monitor punctuality of the resident in terms of attendance as well as number of afternoon shifts, chronic disease attendance and complaints if any.

10) Small Group Teaching Session (SGT)

The aim is to enhance consultation skills of residents and to expose residents to different style of teaching by different trainers for the PGR4 and PGR5 residents. All residents are required to prepare a video case for analysis & discussion. The group teaching sessions are part of the WPBA. Therefore, attendance & punctuality are mandatory.

11) Completion of course report (CCR)

Reports about residents' performance (participation & punctuality) during any course, which lasts 3 – 5 days, should be fulfilled and submitted at the end of each course by the course tutors to the WPBA coordinator.

12) Mid-rotation trainee verbal feedback.

The trainer gives verbal feedback on the trainee's competencies (medical expert, communicator, collaborator, manager, scholar, and professional) to reflect the trainee's performance at this point of the rotation based on strength, weakness and areas for improvement. A form is filled and signed by both the trainer and trainee. A meeting is held with the board director and each resident to discuss the mid rotation feedback reflection.

13) Annual in training evaluation of residents

Annual in-training evaluation reports (FITER/ITER) are prepared by WPBA committee members for each resident in the program, which is then sent to KIMS.
1) These reports are based on multi-source feedback:
   a. Exam results if applicable.
   b. KIMS trainee evaluation from hospital and clinic trainers.
   c. Verbal feedback from trainer.
   d. Attendance reports of all teaching activities (ODSC, small group teachings sessions)
   e. Leaves and absent days.

2) FITER (final in-training evaluation report) is done for all R5, R6 residents by mid of March of each year.

3) ITER (in-training evaluation report) for all residents from R1 to R4 is prepared and sent mid of March each year.

Both ITER's and FITER's are discussed and signed in a formal meeting between each trainee and the program director in the presence of WPBA member allocated for each batch.


This is used for residents with issues related to Professionalism in terms of patient care, ethical/legal aspects and behavioral misconduct.
**WPBA Requirements for Each Residency Year**

Residents should achieve adequate performance in WPBA assessment in order to ensure readiness of the resident to proceed to the next level of training.

<table>
<thead>
<tr>
<th>Residency year</th>
<th>Rotations and Courses</th>
<th>Time off training</th>
<th>Duties</th>
<th>Repots</th>
</tr>
</thead>
</table>
| PGR1           | Attendance of all/passing 75% of the Rotations and Courses of R1 | 45 days/ year | Minimum 220 Hours / year | Clinic:  
- Each month:  
  - 4 COT/month, 2 CBDs, 1 time sheet & 1 tutorial & 1 reflection/month.  
  - DOPES (2 procedures/month)  
  - CCR for each course  
  - Mid rotation verbal feedback  
  - KIMS forms (trainee + tutor+ clinic) evaluation form at the end of rotation  
  - ITER  
Hospital:  
- DOPES (2-4 /month)  
- mid rotation verbal feedback  
- KIMS forms (trainee + tutor+ clinic) evaluation form at the end of rotation |
<table>
<thead>
<tr>
<th>PGR2</th>
<th>Attendance of all/passing 75% of the Rotations and Courses of R2</th>
<th>45 days / year</th>
<th>Minimum 220 Hours / year</th>
</tr>
</thead>
</table>

**Clinic:**
- 4 COT/month, 2 CBDs, 1 time sheet & 1 tutorial & 1 reflection/month (effective from 2020/2021)
- DOPES (2 procedures/month)
- CCR for each course
- mid rotation verbal feedback
- KIMS forms (trainee + tutor + clinic) evaluation form at the end of rotation
- Life support (BLS & ACLS) certifications
- ITER
- Prescribing assessment
- Leadership
  - Community Health activities

**Hospital:**
- DOPES (2-4/month)
- mid rotation verbal feedback
<table>
<thead>
<tr>
<th>PGR3</th>
<th>Attendance of all/passing 75% of the Rotations and Courses of R3</th>
<th>45 day / year</th>
<th>Minimum 220 Hours / year</th>
<th>Clinic:</th>
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</thead>
<tbody>
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<td></td>
<td></td>
<td>- 4COT/month</td>
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<td>- 4CBD/month</td>
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<td>The following is effective from 2021/2022):</td>
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<td>Each month: 4 COTs, 2 CBD.s, 2 tutorials &amp; 1 reflection/month.</td>
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<td>- DOPES (2/month)</td>
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<td>- mid rotation verbal feedback</td>
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<td></td>
<td>- KIMS forms (trainee + tutor+ clinic) evaluation form at the end of rotation</td>
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<td>- ITER</td>
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<td>- Prescribing assessment</td>
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<td>- Leadership</td>
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<td></td>
<td>- Community Health activities</td>
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<td></td>
<td>Hospital:</td>
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<tr>
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<td>- 12 DOPES (2/ month)</td>
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<td></td>
<td>- CCR for the course</td>
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<td>- mid rotation verbal feedback</td>
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<td></td>
<td>- KIMS forms (trainee + tutor+ clinic) evaluation</td>
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</tbody>
</table>
| PGR4 | Attendance of all / passing 75% of the Rotations and Courses of 4 | 45 day / year | Minimum 220 hours / year | **Clinic:**  
- 4 COT/month  
- 4 CBD/month  
The following is effective from 2022/2023):  
Each month: 3 COTs, 2 CBD.s, 2 tutorials & 1 reflection/month.  
-DOPES (2/month)  
-5 SGT  
-Audit Project Report (Pass)  
-mid rotation verbal feedback  
- KIMS forms (trainee + tutor+ clinic) evaluation form at the end of rotation  
-Life support (BLS & ACLS) revalidation of certifications  
-ITER  
-Prescribing assessment  
-Leadership  
- Community Health activities |
| PGR5 | Attendance of all / passing 75% of the Rotations and Courses of 4 | 45 day / year | Minimum 220 hours / year | **Clinic:**  
-4 COT/month |
Courses of R5

-4 CBD/month

The following is effective from 2023/2024):

Each month: 3 COTs, 2 CBD.s, 2 tutorials & 1 reflection/month.

- DOPES (2 /month)
- 5 SGT
- mid rotation verbal feedback
- KIMS forms (trainee + tutor+ clinic) evaluation form at the end of rotation
- FITER
- Prescribing assessment
- Leadership
- Community Health activities

Residents should achieve adequate performance in the WPBA in order to ensure readiness of the resident to proceed to next level of training.
<table>
<thead>
<tr>
<th>Clinical proficiency</th>
<th>Communication</th>
<th>Health Promotion</th>
<th>Working as a team</th>
<th>Organization management</th>
<th>Professional development/ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation observation tool</td>
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<tr>
<td>Case based discussion</td>
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<tr>
<td>Mid rotation verbal evaluation</td>
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<tr>
<td>KIMS evaluation report</td>
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<tr>
<td>DOPES</td>
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<tr>
<td>Monthly WPBA feedback</td>
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<tr>
<td>ITER/FITER</td>
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<tr>
<td>Prescribing assessment</td>
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<tr>
<td>Leadership</td>
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<tr>
<td>Community health activities</td>
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Family Medicine Residency Program
Training Guide

Aim
To ensure that the quality and quantity of training and supervision are sufficient, addressing the curriculum, and preparing the residents adequately for Kuwait MRCGP (Int). This is clearly important for patient’s safety, to be able to deliver a family medicine workforce from the recruits to the program, and to ensure a high quality-training program for attracting high quality residents to the profession. Failure to prepare the residents sufficiently for the exams will result in a higher failure rate with consequent implications for the already stretched resources.

R1 and R2 training schedule

- Residents start with an induction period for every new clinic they attend (approximately one week) followed by 2-3 weeks of joint surgeries.
- Following the induction period, residents are aware that they would be closely supervised to establish the ongoing supervision necessary to ensure patient safety. With increasing experience of the resident, a reduced level of supervision is expected.
- The resident should be aware of supervision arrangements so that they are supervised in a particular way at all times (this includes periods when the trainer is on leave or away from the clinic). A named deputy should be informed to the resident during trainer’s absence.
- Minimum afternoon duty should be twice per week.
- Two teaching sessions per week should be scheduled for each resident in the clinic.
- Each month trainees should get minimally 4 COT’s, 2 CBD’s, 1 time sheet, 1 tutorial & 1 reflection teaching sessions.
- Prescribing assessment
- Leadership
- Community Health activities

<table>
<thead>
<tr>
<th>1st week</th>
<th>2nd - 4th week</th>
<th>3rd week-end of rotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction period</td>
<td>Joined consultation</td>
<td>4 hrs teaching/week</td>
</tr>
</tbody>
</table>
R3 Schedule

- Each month trainees should get minimally 3 COT’s, 2 CBD’s, 1 time sheet & 1 tutorial teaching sessions.
- **Prescribing assessment**
- **Leadership**
- Community Health activities
- Minimum afternoon duty should be twice per week.
- Teaching may be delivered by trainer, or another doctor or healthcare professional within the practice and may include:
  - Tutorials on specific topics agreed by both trainer and resident.
  - Joint consultation with direct observation of resident by trainer or vice versa.
  - Regular review time after surgeries for problem consultations to be discussed.
  - Random case analysis, where the trainer will chooses few cases in a random way from the consultation time sheet of the resident for discussion.
  - Video review for consultation skills training.
  - Role play of important scenarios that the residents is unlikely to come across in every day practice.

R4 and R5 Schedule

- Each month trainees should get minimally 3 COT’s, 2 CBD’s, 1 time sheet & 1 tutorial teaching sessions.
- **Prescribing assessment**
- **Leadership**
- Community Health activities
- Residents should practice different clinic procedures at least twice per month (specifically death reports, police reports, and home visits which must be done at least twice per rotation) and signed in the DOPES form.
- Minimum afternoon duty should be twice per week.
- Residents should be exposed once weekly to the available specialized clinics as joint consultations for R4 and as independent doctor for R5.
- R5 residents can be involved in teaching of other residents by doing tutorials, joint consultation with R1 and R2 candidates.

**General training points for all residents:**
- The trainer or his/her deputy should be notified at all times in the following situations:
  1-Emergency patient attending the clinic.
2- Diagnosis/management in doubt.
3- Significant event reporting.
4- Patient condition is deteriorating.
5- Medico-legal situation.
6- Prior to home visits.
7- Writing death certificates.

- Teaching may be delivered by trainer, or another senior doctor or healthcare professional within the practice and may include:
  ✓ Tutorials on specific topics agreed by both trainer and resident
  ✓ Joint clinics with direct observation of resident by trainer or vice versa.
  ✓ Regular review time after clinics for problem consultations to be discussed.
  ✓ Video review for consultation skills training.
  ✓ Role play of important scenarios that the residents is unlikely to come across in every day practice.

  - To be familiar with FMRP curriculum available on the KFMRP website.
  - Reading of recommended references and materials.
  - To be familiar with rules and regulations of KIMS (eg leaves).
  - To be familiar with administrative rules and regulations (eg working hours, weekend duties, referral policy..etc.) in different training sites.
  - To monitor own leaves and prompt submission of leave forms to FMRP secretaries.
  - To be aware that recurrent absence in weekend duties will have consequences.
  - Verbal mid rotation feedback and written end of rotation feedback will be given.
  - To be aware that regular checkup visits as well as printed time sheet consultation will be held by WPBA committee members.
Life Support Certification Policy

Aims

- To prepare a safe and competent future family physician.
- To continually improve the quality of healthcare service provided to patients.
- To update and refresh the knowledge and skills of family medicine residents regarding life support measures.

Basic Life Support (BLS)

1. Perform high quality CPR for adults / pediatrics/ infants
2. Demonstrate the appropriate use of an AED
3. Provide effective ventilation by using barrier device
4. Describe the technique for relief of foreign body airway obstruction for an adult or child

Advanced Cardiac Life Support (ACLS)

1. Integrate BLS survey and primary survey in patient assessment and care
2. Demonstrate high quality cardiopulmonary resuscitation with AED for adults
3. Use the ACLS algorithms effectively
4. Observe effective resuscitation team dynamics
5. Demonstrate immediate post cardiac arrest care
6. How to treat Stroke and ACS patients

The Policy

- All R2 and R4 candidates are required to acquire the BLS and ACLS certification in order to advance to the following year.
- It will be part of the FITER (R2) and ITER (R4).
- It will be implemented starting from academic year 2019/2020.
- Deadline to complete the course and get the certification is the end of December of respective training year i.e. December at the beginning of R2 and R4 residency year.
- The candidate can take the course on his/her own, or contact the following organizers/providers of life support courses:
  a. Emergency Medical Services - الصحة - وزارة الطوارئ الطبية www.moh.gov.kw Tel 24792000
  b. Kuwait society of family physicians and general practice
  c. Kuwait medical association - gulf CPR training institute www.cprgulf.com Tel 99280663-97747123
  d. Life support academy www.lsc.ae
  e. Prime advanced learning (PALI) www.pali.edu
  f. Dar alshifa training center - www.daralshifa.com Tel 1802555
  g. Dasman diabetes institute – clinical skills center (CSC) www.dasmaninstitute.org
  h. Hadi clinic – education and training center: the life support training center www.hadiclinic.com.kw Tel 1828282 – 25363000

- Please note that the life support courses:
  o Should be in compliance with the American Heart Association guidelines
  o Should be conducted Face-to-Face and NOT online
Kuwait Family Medicine Residency Program

Work place based assessment for in-clinic training

- Clinic Rotation schedules are prepared by the WPBA committee, so as trainees from R1 to R3 remain in the same clinic based on their predominant hospital training.

- R4 and R5 trainees have rotations among different clinics yearly.

- The clinic trainers will receive letters of the trainees allocated in their clinic in advance.

- The trainee will receive the letter of clinic commencement from WPBA committee.

- The trainer will supervise the trainee in the clinic by preparing weekly training schedule according to his training level and needs.

- Another supervision tool is the monthly workplace feedback form which includes days of absence/excuse, afternoon shifts, complaints, chronic disease clinics.

- Different teaching activities are scheduled in the clinic including consultation observation, case based discussions, video case analysis, joint consultations, DOPES, consultation time sheet (log diary) and tutorials.

- To ensure continuity of teaching the trainee is reallocated to another trainer in case of prolonged leave (>2 weeks), and a missed teaching session form is completed and signed if the trainee missed his scheduled teaching for any reason (excuse, shift exchange, sick leave)

- Mid rotation verbal feedback is given to the trainee by the trainer.

- At the end of each rotation Trainee’s evaluation forms (KIMS trainee evaluation forms) is completed and discussed, and a copy is sent to WPBA by email.
<table>
<thead>
<tr>
<th></th>
<th>Healthcare center</th>
<th>Consultant FM</th>
<th>Specialist FM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Shwaikh Healthcare center</td>
<td>Sameera Alkanderi</td>
<td>Rawan Al Turki,</td>
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<td></td>
<td></td>
<td>Consultant FM</td>
<td>Specialist FM</td>
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<td>2</td>
<td>Khalid Algunaim Healthcare center</td>
<td>Maleka Serour</td>
<td>Nusaiba alkandary</td>
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<td></td>
<td>(Al Qadsiya)</td>
<td>Consultant FM</td>
<td>(potential trainer)</td>
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<tr>
<td>3</td>
<td>Al Mansouria Healthcare Center</td>
<td>Aliaa Sadeq, Senior</td>
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<td></td>
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<td>Specialist FM</td>
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<td>4</td>
<td>Abdulla AlAbdulhadi healthcare center</td>
<td>Huda Aliduwaisan,</td>
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<td>(Yarmouk)</td>
<td>Consultant FM</td>
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<td>Tasneem Al Jariki,</td>
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<td>Senior Specialist FM</td>
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<td>Mahdi Al Mousawi</td>
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<td>5</td>
<td>Futooh Alsabah Healthcare center</td>
<td>Huda Al Abduljalil,</td>
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<td>(shamiya)</td>
<td>Consultant FM</td>
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<td>Ghaidaa Al Mutairi,</td>
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<td>Consultant FM</td>
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<td>Fajer Al Barak,</td>
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<td>Specialist FM</td>
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<td>6</td>
<td>Qortuba Healthcare center</td>
<td>Sawsan Al Bannai,</td>
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<td>Consultant FM</td>
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<td>Fatema Bushihri (senior registrar)</td>
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<td>7</td>
<td>Ali Thunayan Alghanim Healthcare Center</td>
<td>Deena Al Dhubaib,</td>
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<td>Consultant FM</td>
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<td>Shaimaa Al Fouderi,</td>
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<td>Specialist FM</td>
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<td>Ahmed Alarouj</td>
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<td>(potential trainer)</td>
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<td>8. Alnafeesy Healthcare center (Abdullah Al Salem)</td>
<td>Sana Al Mansour, Consultant FM</td>
<td></td>
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<tr>
<td>10. AlNuzha Healthcare center</td>
<td>Amel Al Juhaidli, Consultant FM, Aliaa Husain, Senior Specialist FM</td>
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<td>11. Alsurra healthcare center</td>
<td>Dalia Al Sane, Consultant FM, Shaimaa AL Faris, Specialist FM</td>
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<tr>
<td>12. Alihqaki healthcare center (Daiya)</td>
<td>Esraa Hassan, Senior Specialist FM</td>
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<tr>
<td>13. Abdulmugni healthcare center (Faiha)</td>
<td>Anwar Buhamra, Consultant FM, Lujain Al Edan, Specialist FM, Hessa AL Ansari (potential trainer)</td>
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<td>14. AlKhaldiya healthcare center</td>
<td>Abbas Maarafi, Senior FM</td>
<td></td>
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<tr>
<td>15. Alayyar healthcare center (Kaifan)</td>
<td>Dalal Al Hajeri, Consultant FM, Hamad Al Hamad, Consultant FM</td>
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<tr>
<td>16. Alsager healthcare center (Adaliya)</td>
<td>Anood Al Juwaihil, Specialist FM</td>
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<tr>
<td>17. Al Qairawan Health Center</td>
<td>Amina AL Atwan, Consultant FM</td>
<td></td>
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<td>18. AlShaab Health Center</td>
<td>Yasmin Yahya, Senior</td>
<td></td>
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<tr>
<td>No.</td>
<td>Location</td>
<td>Center Name</td>
<td>Consultant/FM Details</td>
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<td>Hawally</td>
<td>AL Salam Health Center</td>
<td>Bassam AL Bathi, Senior Specialist FM</td>
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<td>20</td>
<td>Hawally</td>
<td>Sabah Alsalem health clinic</td>
<td>Eman Sarkhouh, Consultant FM</td>
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<td>21</td>
<td>Ahmadi</td>
<td>Hadiya health center</td>
<td>Amel Almehzaa, Consultant FM</td>
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<td>Ahmadi</td>
<td>Mubarak Alkabeer Health center</td>
<td>Khalid AlZaid, consultant FM</td>
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<td>23</td>
<td>Farwaniya</td>
<td>Al Masayel Healthcare center</td>
<td>Abeer Al Kandiri, Specialist FM</td>
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<td>Farwaniya</td>
<td>Alomariah health center</td>
<td>Tahani Alansari, Senior Specialist FM</td>
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<td>Farwaniya</td>
<td>Al Nahda Healthcare Center</td>
<td>Walaa Al Kandari, Senior Specialist FM</td>
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<td>Farwaniya</td>
<td>Ishbelia Healthcare center</td>
<td>Najlaa Al Jassim, Specialist FM</td>
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<td>Farwaniya</td>
<td>Al andalous Health Center</td>
<td>Ibrahim AL Mousa, Consultant FM</td>
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<td>Farwaniya</td>
<td>Al Osaimi Clinic (Khaitan)</td>
<td>Shaikha Al Kandiri, Specialist FM</td>
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<td>29</td>
<td>Farwaniya</td>
<td>Abdulla Almubarak health center</td>
<td>Mona Almutairi</td>
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</tbody>
</table>
Kuwait Family Medicine Residency Program

Work place based assessment for in-hospital training

• Hospital training schedules for all batches are prepared and sent to KIMS in March of each year.

• Each WPBA team member is allocated for certain hospital departments and will be in charge for informing the trainees and clinical site coordinators about the training schedules as well as providing follow up and support.

• Scheduled meetings held between WPBA member and the site coordinator to explain the assessment process and handling of assessment reports with distribution of electronic and hard copies of the assessment reports.

• Formal meetings with each batch by the board director, WPBA convener and the team member in charge of the batch to update them about the rules and regulations as well as next year rotation details.

• Aims, objectives and skills that the candidates need to fulfill in each rotation is included in the trainees’ evaluation form which is completed by the hospital site coordinator at the end of the rotation.

• Hospital rotation commencement letter for each candidate is available at the family medicine board office one week ahead of each rotation.

• A letter is sent to WPBA confirming the trainee’s commencement at the hospital.

• Mid rotation verbal feedback should be given to the trainee by the site coordinator.

• At the end of each rotation Trainee’s evaluation forms are completed and discussed verbally between the site coordinator and the trainee then sent electronically to WPBA email or by a messenger.

• Trainee’s evaluation forms done by the coordinator include:
  1. Mid rotation verbal feedback.
  2. KIMS trainee evaluation form.

• Trainee should fill the following forms by the end of each rotation:
1. KIMS tutor evaluation form.
2. Direct observation of procedural & examination skills (DOPES).
3. KIMS evaluation of clinical rotation form.

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Specialty</th>
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<tbody>
<tr>
<td>Mubarak</td>
<td>Internal Medicine, Casualty, General surgery</td>
</tr>
<tr>
<td>Adan</td>
<td>Internal Medicine, Casualty, General surgery, Obs/ Gynea, Pediatrics, Orthopedics, Dermatology</td>
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<tr>
<td>Amiri</td>
<td>Internal Medicine, Casualty, General surgery, Pediatrics, E.N.T</td>
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<td>Al Jahra</td>
<td>Internal Medicine, Casualty, Obs/ Gynea, Pediatrics, Orthopedics, General surgery</td>
</tr>
<tr>
<td>Farwaniya</td>
<td>Internal Medicine, Casualty, General surgery, Obs/ Gynea, Pediatrics, E.N.T</td>
</tr>
<tr>
<td>Sabah</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Maternity hospital</td>
<td>Obs/ Gynea</td>
</tr>
<tr>
<td>Al Razi Hospital</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Al Bahar</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Asaad Al Hamad</td>
<td>Dermatology</td>
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</tbody>
</table>
Family medicine infectious diseases hospital rotation (Infectious disease hospital) will be as follows:

1. A 2 weeks rotation
2. Week 1: adult  Week 2: pediatrics

<table>
<thead>
<tr>
<th>Day</th>
<th>Week 1</th>
<th>Week 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ward</td>
<td>Ward</td>
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<tr>
<td>2</td>
<td>Casualty</td>
<td>Casualty</td>
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<tr>
<td>3</td>
<td>OPD</td>
<td>OPD</td>
</tr>
<tr>
<td>4</td>
<td>Tutorial</td>
<td>Tutorial</td>
</tr>
<tr>
<td>5</td>
<td>Case presentation and discussion</td>
<td>Case presentation and discussion</td>
</tr>
</tbody>
</table>
3. Objectives:

- Familiarize the residents with the facilities and services available in infectious diseases hospital.
- Diagnosing and managing the most common infectious diseases that can be encountered in family medicine practice (e.g. Chicken pox, Shingles, Measles, Mumps, Rubella, Hand foot mouth disease, slapped cheek diseases, animal bites, Brucellosis)
- Immunization (schedule, indications, side effects)
- Notifiable diseases and the policy for notification
- Indications for direct referral (emergency/OPD)
- Actions and management taken before referral
- Infection control in primary care settings
- Overview of the protocols available in dealing with HIV/Hepatitis cases

Number of groups:

1. 9 groups
2. Each group contain 4 residents (from November – end of March)
3. 2 weeks off in new year vacation, and 2 weeks off in national days celebration 

Family medicine policies during hospital rotations:

- Hospital training schedules for all batches are prepared and sent to KIMS in March of each year.
- Aims, objectives and skills that the candidates need to fulfill in each rotation is included in the trainees’ evaluation form which is completed by the hospital site coordinator at the end of the rotation.
- Hospital rotation commencement letter for each candidate will be attached with the evaluation forms (KIMS trainee evaluation form, KIMS tutor evaluation form, KIMS evaluation of clinical rotation, DOPS) and handed to the site coordinator at the beginning of the rotation.
- A letter is sent to work place based assessment (WPBA) confirming the trainee’s commencement at the hospital.
- At the end of each rotation Trainee’s evaluation forms are completed and discussed verbally between the site coordinator and the trainee then sent electronically to WPBA email.
- Maximum days of leaves (annual + sick leaves) from the rotation is 2 days only.
Exceeding this number will result in rotation repetition.

- Any urgent matter regarding the residents has to be discussed immediately with the site coordinator (Dr. Sara Al-Hammouri 97956799)
- The site coordinator should be informed about any sick leave.
- Annual leaves will be signed and approved by the program director 2 months in advance and the hospital coordinator will be informed.
- The schedule for the ODSCs are set ahead of the academic year and sent to the residents and to each site coordinator.
  1- Residents should be exempted from morning hospital duties (8 a.m.- 2p.m) to attend the family medicine study course which will be for one or more days according to the attached schedule.
  2- One day study courses (ODSCs) are not included in the number of missed days.
  3- Residents can attend the on-call duties on the same days of the courses but from 4 p.m.
  4- Any changes or updates will be sent from the assigned work place site coordinators.
Suggested FMRP References

[A]- Helpful Reference Books (use the Latest edition):


2. Primary care medicine: office evaluation and management of the adult patient by: Allan H Goroll; Albert G Mulley.

2. Textbook of family medicine. by: Robert E Rakel; David Rakel.

4. Practical General Practice: Guidelines for Effective Clinical Management, by : Alex Khot; Andrew Polmear

5. Taylor's manual of family medicine. By: Paul M Paulman; Audrey A Paulman; Kimberly Jarzynka; Nathan P Falk.


7. Current diagnosis & treatment: family medicine, by: Jeannette E South-Paul; Samuel C Matheny; Evelyn L Lewis.

8. Oxford handbook of general practice. By: Chantal Simon; Hazel Everitt; Francoise van Dorp; Matt Burkes. (Only use it as a vade mecum in the consultation BUT NOT as the only resource for main readings)

9. Symptom Sorter .By: Keith Hopcroft; Vinvent Forte (helpful for generating Hypotheses)

10. The 10 minutes consultation assessment. By: Knut Schroeder

11. CSA Symptom Solver, clinical frameworks for the MRCGP CSA exam. By : Muhammed Akunjee; Nazmul Akunjee
12. Cases and concepts for the MRCGP. By: Naidoo

13. The Inner Consultation: How to Develop an Effective and Intuitive Consulting Style. By: Roger Neighbour

14. Macleod’s clinical Examination. By J. Alastair Innes Anna Dover Karen Fairhurst

[B]- Online Resources: (To ease, complement & facilitate your original Readings)


3. American Family Physician: (https://www.aafp.org/journals/afp.html) [Latest articles]


5. GP Notebook: https://www.gpnotebook.co.uk/

[C]- For Evidence based guidelines:

1. https://guideline.gov/


<table>
<thead>
<tr>
<th>Topic</th>
<th>Suggested guideline</th>
</tr>
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<tbody>
<tr>
<td>Asthma</td>
<td>Ginathma</td>
</tr>
<tr>
<td>COPD</td>
<td>Goldcopd</td>
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<tr>
<td>Diabetes</td>
<td>ADA</td>
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<td>Hypertension</td>
<td>Nice / ACC</td>
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<tr>
<td>Hyperlipidemia</td>
<td>ACC</td>
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<tr>
<td>Osteoporosis</td>
<td>Kuwait Guidelines for the Management of osteoporosis.</td>
</tr>
</tbody>
</table>
Contacts

**KIMS:**

- [ ] [www.kims.org.kw](http://www.kims.org.kw)
- [ ] Tel: 22418782
- [ ] Fax: 22410028
- [ ] [@kims_news](https://twitter.com/kims_news)

**Family Medicine Residency Program:**

- [ ] [www.kfmrp.com](http://www.kfmrp.com)
- [ ] Tel: 24860100
- [ ] Fax: 24870017
- [ ] [@kfmrp83](https://twitter.com/kfmrp83)

The curriculum is last reviewed and updated on January/2021; by scientific committee members.