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 years 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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   1.3 Cardiovascular system
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   1.5 Respiratory System
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2. Children’s health
3. Adolescent’s health
4. Women’s problems
5. Men’s health
6. Geriatric problems
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8. Care of surgical patient
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10. Dermatology
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Introduction to Workplace Based Assessment (WPBA)
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Process of the WPBA
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WPBA Blue print
Kuwait Family Medicine Residency Program
Work place based assessment for in-clinic training
Kuwait Family Medicine Residency Program
Work place based assessment for in-hospital training

Maternity hospital
Jaber Al Ahmad Al Sabah hospital

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

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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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This curriculum will be updated and reviewed every 2 years (On April/2020).
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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<tbody>
<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>Fam Med 1 m.</td>
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<td>Obs/Gyn 1 Month</td>
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<td>Surgery /urology</td>
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<td>1 Month Minor</td>
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<td>Fam Med 4 Months</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 2 weeks</td>
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<td>EN T 1 Month</td>
<td>Pediatric surgery</td>
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<td>2 weeks</td>
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<td>Fam Med 6 Monts</td>
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<td>PGR4</td>
<td>Fam Med Months / Audit Project</td>
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<td>PGR5</td>
<td>Fam Med Months</td>
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<td>Audit Project</td>
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</table>

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
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

These aspects ensure that the Family Medicine Resident excels in the KIMS adopted Can Meds roles framework (Professional, Communicator, Collaborator, Manager, Health advocate, Scholar)

Fig 1 Kuwait Family Medicine Competency Framework
<table>
<thead>
<tr>
<th>Kuwait Family Medicine Competencies</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>1. Clinical proficiency</strong></td>
<td>1.1 Cover a full range of knowledge in health conditions</td>
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<tr>
<td></td>
<td>1.2 Master the skills of history taking and physical examination</td>
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<td>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</td>
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<td>1.4 Build diagnostic hypotheses based on prevalence, community incidence and consideration of urgent treatable problems</td>
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<td>1.5 Develop analytical and clinical reasoning skills to identify patients' problems with consideration of ethical principles and professional responsibilities.</td>
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<td>1.6 Manage patients with random and unfiltered problems which include common, serious and undifferentiated conditions.</td>
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<td>1.7 Manage simultaneously multiple clinical issues and complexities, both acute and chronic, often in a context of uncertainty</td>
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<td>1.8 Recognize personal limits in knowledge, skills and attitudes</td>
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<td>1.9 Adopt appropriate working principles (e.g. incremental investigation, using time as a tool) within the available resources in collaboration with patient.</td>
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<td>1.10 Prioritize the management plan, based on the patient’s perspective, medical urgency and context</td>
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<td>1.11 Able to provide long term continuity of care as determined by the individual need of the patient.</td>
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<td>1.12 Able to apply the principles of safe prescription in everyday practice with particular attention to those with poly pharmacy.</td>
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<td>1.13 Recognize occasions when referral to hospital specialist is indicated and act accordingly.</td>
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<td></td>
<td>1.14 Use time effectively in assessment and management</td>
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<td>1.15 Appropriately document procedures performed and their outcomes, and ensure adequate follow-up.</td>
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<td></td>
<td>1.16 Reach clinical decisions according to best available evidence, patient’s perspective and past experience.</td>
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<tr>
<td>2. Communication</td>
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<td>------------------</td>
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<tr>
<td>2.1 Develop rapport, and ethical therapeutic relationships with patients and families that are characterized by understanding, trust, respect, honesty and empathy</td>
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<td>2.2 Apply appropriate communication techniques to resolve conflict and balance physician’s performance and patient’s expectations.</td>
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<td>2.3 Adopt a patient-centered approach in the consultation with sensitivity to each patient’s expectations, needs and health beliefs.</td>
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<td>2.4 Communicates management options clearly to the patient and provides appropriate support and information to patients and their care givers.</td>
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<td>2.5 Bring about an effective doctor–patient relationship, with respect for patient’s autonomy</td>
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<td>2.6 Use bio-psycho-social models, taking into account cultural dimensions (holistic approach)</td>
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<td>2.7 Demonstrates an ability to break bad news clearly and empathically including the communication of a terminal prognosis.</td>
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</table>

These competencies prepare the resident to be a good Communicator.
| **Health Promotion** | 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.  
3.2 Improve health and quality of life by applying health promotion and disease prevention strategies appropriately.  
3.3 Provide preventive care through application of current standards for the practice population.  
3.4 Identify the determinants of health within their communities, including barriers to accessing care and resources.  
3.5 Able to optimize health prevention and promotion as well as the traditional concept of diagnosis and treatment of disease.  
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.  
3.7 Encourage the patient’s awareness of self-responsibility in obtaining optimal health and readiness to change.  
3.8 Recognize the importance of family structure and support systems in health behavior.  
3.9 Able to assess risks for preventable disease in each patient.  
3.10 Assess, monitor and communicate chronic disease care plans to patients as a means of secondary prevention.  
3.11 Recognize the importance of health care maintenance and disease prevention with regard to age- and gender appropriate screening guidelines and immunizations. |
|---|---|
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

These competencies prepare the resident to be a Health Advocate
### 4. Evidence-based Practice

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

### 5. Working as a team

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<tbody>
<tr>
<td>5.1</td>
<td>Appreciate the importance of teamwork and to act in collaboration with colleagues both as a leader and as part of the team.</td>
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<tr>
<td>5.2</td>
<td>Coordinate and facilitate care with other professionals within primary care and with other specialties.</td>
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<td>5.3</td>
<td>Ensure respect to colleagues in the practice.</td>
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<td>5.4</td>
<td>Act appropriately when aware of unethical conduct by a colleague.</td>
</tr>
<tr>
<td>5.5</td>
<td>Work proficiently with other colleagues to ensure patient care, including sharing of information with colleagues.</td>
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*These competencies prepare the resident to become a Collaborator*
<table>
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<tr>
<th><strong>6. Organization Management and leadership</strong></th>
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<tbody>
<tr>
<td>6.1 Understand the nature of primary health care system in Kuwait with respect to medico-legal, ethical and organizational aspects</td>
</tr>
</tbody>
</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. |
| 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. |
| **These competencies prepare the resident to be a good leader** |

| **7.1** Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life |
| 7. Personal and Professional Growth | 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.  

These competencies prepare the resident to be professional |
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, 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>
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</table>
| 1. Clinical proficiency            | 1.1 Awareness of the difference 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 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 Ability to manage appropriately emergency cases before transferring patients (e.g. resuscitation and stabilization)  
1.7 Ability to prioritize tasks to manage acute illness and trauma effectively |
| 2. Communication                   | 2.1 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 Awareness of the principle of disease prevention and the importance of partnership between doctors and patients to promote optimal health. |
| 4. Evidence based practice         | 4.1 Understands the importance of applying the principles of evidence base medicine in the management of patients. |
| 5. Working as a team (collaboration) | 5.1 To 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 Understand the importance of collaboration with specialists in secondary care for best patients’ outcome  
5.3 Ability to write comprehensive referral letter |
6. Organization management and leadership

<table>
<thead>
<tr>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Awareness of principles of organization management, medical ethics, administrative regulations and teamwork.</td>
</tr>
<tr>
<td>6.2 Awareness of comprehensive record-keeping</td>
</tr>
</tbody>
</table>

7. Personal and professional growth

<table>
<thead>
<tr>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>7.1 Commitment to educational activities and recognition of continuing educational needs</td>
</tr>
<tr>
<td>7.2 Aware of their capabilities and limitations, then work on meeting those needs and inadequacies.</td>
</tr>
<tr>
<td>7.3 Awareness of medico-legal &amp; ethical issues encountered in the primary care setting.</td>
</tr>
</tbody>
</table>

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>
<tbody>
<tr>
<td>1.Clinical proficiency</td>
<td>1.1 Have a good understanding and clinical knowledge of the causes, pathophysiology, clinical manifestations and management of common and important medical diseases (refer to particular specialty).</td>
</tr>
<tr>
<td></td>
<td>1.2 Demonstrate competency in acquiring appropriate and adequate history from patients, performing appropriate and sensitive physical examination and performing appropriate and discriminative investigations</td>
</tr>
<tr>
<td></td>
<td>1.3 Competently manage conditions encountered during the different hospital rotations.</td>
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<tr>
<td></td>
<td>1.4 Competently perform the required practical procedural skills that are pertinent to the primary care setting</td>
</tr>
<tr>
<td></td>
<td>1.5 Recognizes the red flags of serious and potentially serious presentations in the corresponding specialties</td>
</tr>
<tr>
<td></td>
<td>1.6 Provide appropriate care in emergencies related to the different specialties</td>
</tr>
</tbody>
</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 Recognize occasions when referral to hospital specialist is indicated and act accordingly  
|                                         | 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 |
### Personal and professional growth

7.1 Understand their capabilities and limitations, then work on meeting those needs and inadequacies.  
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.

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**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>
</table>
| **1.Clinical proficiency** | **1.1** Selectively gather, prioritize and interpret information and apply it to an appropriate, justified management plan in collaboration with the patient  
**1.2** Deal with unselected problems and cover a full range of health conditions. In addition to providing long-term continuity of care according to the patients’ needs  
**1.3** Confidently provide appropriate management of emergencies encountered in their daily work in the clinic  
**1.4** Able to provide initial management to patients at home during home visits. |
| **2.Communication** | **2.1** Adopt a person-centered approach, paying attention to communication and effective doctor–patient relationship  
**2.2** Use a bio-psycho-social model (holistic approach), taking into account cultural dimensions  
**2.3** Extends applying his/her communication skills to include other parties e.g. patients relatives |
| **3.Health Promotion** | **3.1** Promote life style modification and disease prevention in their practice |
| 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 | 8.1 Use the required administrative skills to deal with the medico-legal, ethical and organizational aspects of general practice in Kuwait.  
| | 8.2 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>
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</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. |
| 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. |
|---|---|
| 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 based medicine principles. |
| 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.) |
| 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 |
| 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 |
## Learning /Teaching Opportunities in FMRP

<table>
<thead>
<tr>
<th>Year of training</th>
<th>Teaching/ learning methods</th>
<th>Courses</th>
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</thead>
</table>
| **PGR1**         | • Observing trainers and other experienced family practitioners.  
• Joined consultations followed by independent supervised consultations  
• 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.  
• Opportunity to work as assistant registrars in pediatrics department  
• Opportunity to work as assistant registrars in emergency department  
• Clinic and hospital direct observation of procedural skills (DOPES) | 1. Diagnosis and Management course (5 days)  
2. Cardiovascular problems in GP (2 days)  
3. Presentation skills for residents workshop (1day)  
4. Emergencies in General Practice (3 Days)  
5. Respiratory problems in GP (2 days)  
6. Pediatrics Problems in GP (5Days)  
7. Understand the theory of reflection & reflective diary (2 days)* |
| **PGR2**         | • Opportunity to be exposed to different hospital attachments by | 1. Evidence Based Medicine foundation course (5 Days)  
2. Dermatology in GP (2 days) |
| PGR3 | 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) |
|---|---|
| | 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. |
| | 1. Clinical Audit in GP (3 Days)  
2. Women’s problems (2 Day)  
3. Men’s problems (1 Day)  
4. Ethical and medico-legal issues (2 Days)  
5. Nutrition course (3 days) |
<table>
<thead>
<tr>
<th></th>
<th>• Clinic and hospital direct observation of procedural skills (DOPES)</th>
</tr>
</thead>
</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 |

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)

|     | • 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 |

1. Geriatric problems (2 Days)  
2. Written exam preparation workshop (3 Days)
*Understand the theory of reflection*

## 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 - علاج الطوارئ
  b. Kuwait society of family physicians and general practice
  c. Kuwait medical association - gulf CPR training institute
  d. Life support academy
  e. Prime advanced learning (PALI)
  f. Dar alshifa training center - دار الصفا
  g. Dasman diabetes institute – clinical skills center (CSC)
  h. Hadi clinic – education and training center: the life support training center

- 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

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*البَعِيدَةُ بَعدُ"*
Detailed Residents and Trainers Guide to Training in Different Specialties

The Domains of clinical care are arranged by: Life cycle, clinical settings, spectrum of clinical responsibilities, care of underserved patients, procedural skills which are covered during hospital rotation and primary care setting as will be described below.

- Care of Patients Across the Life Cycle includes: Children and adolescents, adults, women’s health, including maternity care, men’s health care, care of the elderly, end of life and palliative care
- Care of Patients Across Clinical Settings: Across different settings in different districts as office practice, hospital, long term care, emergency settings, care in the home, other community-based settings.
- Spectrum of Clinical Responsibilities: Prevention and health promotion, diagnosis and management of presenting problems: acute, Subacute, Chronic, chronic disease management, rehabilitation, supportive care and palliation
- Care of Underserved Patients: including, but not limited to: citizens in far-areas and patients with mental illness or addiction, disabled person, individual with language barrier or with limited literacy.

In addition to the previously mentioned domains and competencies, residents need to gain specific knowledge, attitudes and skills in the following areas:

1. Internal medicine including subspecialties

   1.1 Competencies:

   At the completion of residency training in internal medicine, the resident should:

   1.1.1 Have good understanding and clinical knowledge of the causes, pathophysiology, clinical manifestations and management of common and important medical diseases.
1.1.2 Be able to perform proper history and perform appropriate clinical examination and develop an appropriate working diagnosis.

1.1.3 Develop appropriate management plan for patients with medical conditions based on knowledge of best available evidence & local resources.

1.1.4 Be able to recognize his/her own practice limitations and seek consultation with other health care providers to provide optimal care by embracing a multidisciplinary approach.

1.1.5 Be aware of the ethical & medico-legal issues related to patients with medical conditions and their families.

1.1.6 Recognize the red flags for patients with medical conditions

1.2 Attitudes:

The resident should demonstrate attitudes that encompass:

1.2.1 A considerate and comprehensive approach to the care of patients with medical disease especially those with chronic problems, including the support of their families

1.2.2 Empathy, compassion and respect in discussing diagnosis and treatment (communication within a consultation).

1.2.3 Ability to break bad news clearly and empathically including the communication of a terminal prognosis.

1.2.4 Communication of management options clearly to the patient and provides appropriate support and information to patients and their corers.

1.2.5 Respect of the patient’s autonomy when negotiating management particularly when dealing with chronic diseases (e.g. diabetes)

1.2.6 A multidisciplinary approach to the care of individuals with chronic disease(s) or multiple co-morbidities.

1.2.7 The recognition of the importance of social support in the overall life of patients who have chronic disease(s).

1.2.8 The consideration of the polypharmacy issue in patients with multiple comorbidities.

1.2.9 Patient’s education about the risk of complications from chronic conditions
1.2.10 Emphasis on the importance of health promotion conducted among different age groups.
1.2.11 Patient-centered approach for life style modification especially among patients with non-communicable diseases

By the end of training in internal medicine, residents should achieve specific knowledge and skills in the following areas:

1.3 Cardiovascular system

1.3.1 Knowledge:

By the end of training the resident should demonstrate the ability to apply knowledge of:

1.3.1.1 Normal cardiovascular anatomy and physiology.
1.3.1.2 Cardiovascular disease Risk factors.
1.3.1.3 Specific diseases/conditions:
   1.3.1.3.1 Coronary artery disease / acute coronary syndromes
   1.3.1.3.2 Syncope, cardiogenic and non-cardiogenic.
   1.3.1.3.3 Dysrhythmias
   1.3.1.3.4 Hypertension
   1.3.1.3.5 Pulmonary heart disease
   1.3.1.3.6 Heart failure
   1.3.1.3.7 Thromboembolic disease
   1.3.1.3.8 Valvular heart disease
1.3.1.3.9 Congenital heart disease
   1.3.1.3.10 Dissecting aneurysm.
   1.3.1.3.11 Heart murmurs.
   1.3.1.3.12 Peripheral vascular disease
   1.3.1.3.13 Cardiomyopathies.
   1.3.1.3.14 Pericardial disease.
   1.3.1.3.16 Infective endocarditis.
   1.3.1.3.16 Dyslipidemia
   1.3.1.3.17 Cardiovascular pharmacology
1.3.2 Skills:

In the appropriate setting, the resident should demonstrate the ability to perform / observe / refer appropriately:

1.3.2.1 Diagnostic procedures:
1.3.2.1.1 Performance of history taking and physical examination.
Calculating atherosclerotic cardiovascular disease (ASCVD) risk using ASCVD risk calculator.
1.3.2.1.2 Performance and interpretation of ECG
1.3.2.1.3 Interpretation of chest X-ray
1.3.2.1.4 Awareness of:
  - Stress testing.
  - Echocardiography.
  - Ambulatory BP monitoring
  - Holter monitoring
  - CT coronary angiogram
  - Coronary calcium score
  - Radioisotope imaging.
  - Vascular Doppler examination.
  - Invasive investigations: e.g. diagnostic cardiac catheterization
  - Therapeutic Cardiovascular interventions: e.g. coronary artery bypass, implantable cardioverter-defibrillator…. etc.
1.3.2.1.5 Relevant laboratory interpretation, including serum enzymes, isoenzymes and lipids.

1.3.2.1.6 Therapeutic procedures:
  1.3.2.1.6.1 Detection & management of cardiovascular risk factors.
  1.3.2.1.6.2 Cardiopulmonary resuscitation (CPR)
  1.3.2.1.6.3 Treating dysrhythmias / conduction disturbances.
  1.3.2.1.6.4 Management of acute coronary syndrome, post infarction care, and complications.
  1.3.2.1.6.5 Congestive heart failure.
  1.3.2.1.6.6 Hypertensive urgencies /emergencies.
  1.3.2.1.6.7 Supervision and management of cardiovascular rehabilitation
  1.3.2.1.6.8 Management of patients after an intervention (e.g. coronary artery bypass surgery, valve surgery,
congenital heart disease surgery): e.g. Lifestyle adjustments.

1.4 Neurology

1.4.1 Knowledge:

The resident should demonstrate the ability to apply knowledge of pathological neurological disorders among all age groups, including:

1.4.1.1 Headache (types, differential diagnoses & management)
1.4.1.2 Multiple sclerosis
1.4.1.3 Disorders of motor function: Upper and lower motor neuron disorders, coordination & movement disorders.
1.4.1.4 Cerebrovascular diseases: e.g. Ischemic stroke, hemorrhagic stroke, vasculitis, transient ischemic attacks.
1.4.1.5 Infections (e.g., meningitis, encephalitis)
1.4.1.6 Epilepsy: Types & treatment
1.4.1.7 Dementia (e.g. Alzheimer’s, vascular, Parkinson’s disease .... etc.)
1.4.1.8 Brain tumors
1.4.1.9 Disorders of consciousness: Syncope, stupor and coma: E.g. Toxic, metabolic...etc.
1.4.1.10 Head and spinal cord trauma: Evaluation, management & prevention.
1.4.1.11 Encephalopathy (acute, chronic): Toxic & Metabolic.
1.4.1.12 Aphasia & apraxia.
1.4.1.13 Recognition of increased intracranial pressure.
1.4.1.14 Spinal cord disorders
1.4.1.15 Disorders of peripheral nerve, neuromuscular junction and muscle: E.g. Muscular dystrophy, Peripheral neuropathy, Myopathy, Guillain-Barre syndrome...etc.
1.4.1.16 Congenital disorders
1.4.1.17 Cranial nerves disorders
1.4.2 Skills:

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:

1.4.2.1 Evaluation skills:
   1.4.2.1.1 Early detection and defining the neurological problem.
   1.4.2.1.2 To be able to take an appropriate focused and comprehensive history for patients presenting with neurological complains.
   1.4.2.1.3 To be able to perform thorough neurological examination including mental and physical e.g. mental status examination…etc.
   1.4.2.1.4 Localization of neurologic lesions based on clinical examination data and differential diagnosis.
   1.4.2.1.5 Assessing the severity and prognosis of clinical problems, determining for urgent care and specialist referral.
   1.4.2.1.6 Formulating a rational plan for further investigation and management.
   1.4.2.1.7 Awareness regarding indications and significance of additional tests:
      1.4.2.1.7.1 Lumbar puncture.
      1.4.2.1.7.2 Electroencephalogram (EEG).
      1.4.2.1.7.3 Muscle and nerve biopsy
      1.4.2.1.7.4 Carotid ultrasound
      1.4.2.1.7.5 MRI, CT-scan…. etc.
      1.4.2.1.7.6 Nerve conduction studies and EMG

1.4.2.2 Management skills:
   1.4.2.2.1 Formulating a diagnostic and management plan of common neurological problems and assessing the need for expert advice with an awareness of the risks, benefits and costs of evaluation.
   1.4.2.2.2 Understanding the role of a neurology specialist and the implications of special testing in
patients who have neurologic disease and the implications of the test results for the patient.

1.4.2.2.3 Managing emergent neurology problems and obtaining urgent consultation when appropriate, e.g. Stroke, coma, Meningitis…. etc.

1.5  Respiratory System

1.5.1 Knowledge

By the end of training the resident should demonstrate the ability to apply knowledge of the followings among all age groups:

1.5.1.1 Normal respiratory system anatomy and physiology.
1.5.1.2 Prevention of respiratory disease (e.g. Bronchial asthma, COPD)

1.5.1.3 Specific diseases/conditions:
   1.5.1.3.1 Asthma
   1.5.1.3.2 Chronic obstructive airway disease
   1.5.1.3.3 Pulmonary embolism
   1.5.1.3.4 Upper respiratory tract infections
   1.5.1.3.5 Lower respiratory tract Infections (Acute bronchitis, Pneumonia, lung abscess, TB)
   1.5.1.3.6 Bronchiectasis
   1.5.1.3.7 Interstitial lung diseases
   1.5.1.3.8 Sarcoidosis
   1.5.1.3.9 Environmental pulmonary diseases (e.g. occupational asthma)
   1.5.1.3.10 Pulmonary hypertension
   1.5.1.3.11 Mediastinal and pleural disorders (e.g. pleural effusion, pleural fibrosis)
   1.5.1.3.12 Pneumothorax
   1.5.1.3.13 Aspiration of a foreign body
   1.5.1.3.14 Sleep apnea
   1.5.1.3.15 Lung cancer
1.5.1.4 Respiratory pharmacology

1.5.2 Skills:

1.5.2.1 Diagnostic procedures:
   1.5.2.1.1 Performance of history taking and physical examination.
1.5.2.1.2 Interpretation of chest X-ray
1.5.2.1.3 Performance and interpretation of peak flow meter (PFM) and spirometry
1.5.2.1.4 Interpretation of pulmonary function test (flow rates, lung volume…. etc.)
1.5.2.1.5 Interpretation of blood gas analysis
1.5.2.1.6 Indications and interpretations of lab investigations (CBC, gram stain, culture and sensitivity…etc.)
1.5.2.1.7 Performance and understanding of the indications of thoracocentesis

1.5.2.2 Awareness of the indications/interpretation of:
1.5.2.2.1 CT scan
1.5.2.2.2 Ventilation perfusion scanning
1.5.2.2.3 MRI and other imaging studies
1.5.2.2.4 Bronchoscopy
1.5.2.2.5 Sleep studies

1.5.3 Management skills:
1.5.3.1 Formulating a diagnostic and management plan for common respiratory diseases e.g. asthma and COPD, and assessing the need for expert advice with an awareness of the risks, benefits and costs of evaluation.
1.5.3.2 Understanding the role of a pulmonologist and the implications of special testing in patients who have respiratory disease and the implications of the test results for the patient.
1.5.3.3 Managing emergent respiratory problems and obtaining urgent consultation when appropriate, e.g. pneumonia, acute attacks of asthma and COPD, pneumothorax, pulmonary embolism …etc.
1.6 **Gastro Intestinal and hepatobiliary System**

1.6.1 **Knowledge**

By the end of training the resident should demonstrate the ability to apply knowledge of the followings among all age groups:

1.6.1.1 Normal Gastro Intestinal and hepatobiliary system anatomy and physiology.
1.6.1.2 Prevention of gastrointestinal and hepatobiliary disease (e.g. Gastroenteritis, hepatitis…)
1.6.1.3 The effects of liver disease on drug metabolism and liver damage caused by drugs
1.6.1.4 Specific diseases/conditions:
   1.6.1.4.1 Esophageal disorders: Gastroesophageal reflux, hiatus hernia, motility disorders…etc.
   1.6.1.4.2 Gastritis and peptic ulcer disease
   1.6.1.4.3 Gastroenteritis: e.g. traveller’s diarrhea
   1.6.1.4.4 Functional gastrointestinal disorders: e.g. Irritable bowel disease
   1.6.1.4.5 Mal-absorption syndromes e.g. Celiac disease
   1.6.1.4.6 Inflammatory bowel disease: Crohn’s, ulcerative colitis
   1.6.1.4.7 Diverticular diseases
   1.6.1.4.8 Ano-rectal disorders: e.g. Anal fissure, hemorrhoids, abscess
   1.6.1.4.9 Gall bladder and bile duct disorders: e.g. gall stone, acute cholecystitis
   Pancreatitis
   1.6.1.4.10 Hepatitis: viral, chronic
   1.6.1.4.11 Liver fibrosis & cirrhosis
   Colorectal cancer
   1.6.1.4.12 Other tumors of the GI: pancreas and hepato-biliary systems…etc.
   1.6.1.4.13 Fatty liver disease: Non-alcoholic and alcoholic steatohepatitis (NAFLD- AFLD)

1.6.2 **Skills:**

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:
1.6.2.1 **Diagnostic procedures:**

1.6.2.1.1 Performance of history taking and physical examination.

1.6.2.1.2 Performance and understanding the indications/ contraindications of diagnostic procedures: e.g. nasogastric intubation, abdominal paracentesis

1.6.2.1.3 Understanding the indications/ contraindications and Interpretation of abdominal X- rays (with/ without contrast)

1.6.2.1.4 Understanding the indications/ contraindications and interpretation: Abdominal ultrasound, endoscopy, sigmoidoscopy, colonoscopy, ambulatory PH monitoring……..

1.6.2.1.5 Indications and interpretations of lab investigations (CBC, LFT, blood biochemistry, culture and sensitivity, H-pylori test, fecal occult blood…..etc.)

1.6.2.1.6 Awareness of the indications of:

1.6.2.1.6.1 CT scan, PET scan

1.6.2.1.6.2 MRI

1.6.2.1.6.3 ERCP, PTC

1.6.2.2 **Management skills:**

1.6.2.2.1 Formulating a diagnostic and management plan for common gastrointestinal diseases e.g. gastroesophageal reflux, Peptic ulcer disease, functional gastrointestinal diseases….etc. and assessing the need for expert advice with an awareness of the risks, benefits and costs of evaluation.

1.6.2.2.2 Understanding the role of a gastroenterologist and the implications of special testing in patients who have gastrointestinal disease and the implications of the test results for the patient.

1.6.2.2.3 Managing emergent gastrointestinal problems and obtaining urgent
consultation when appropriate, eg acute GI bleeding, acute hepatitis …etc.

1.7 Rheumatology

1.7.1.1 Knowledge

By the end of training the resident should demonstrate the ability to apply knowledge of the followings among all ages:

1.7.1.1 Normal musculoskeletal system anatomy and physiology.
1.7.1.2 The appropriate focused history for joint and soft tissue symptoms, screening, a complete musculoskeletal examination, functional assessment and use of laboratory and imaging modalities
1.7.1.3 The clinical presentation, diagnostic criteria and initial treatment for the common rheumatologic conditions
1.7.1.4 Prevention of rheumatological disease (e.g. osteoarthritis, osteoporosis…)
1.7.1.5 Specific diseases/conditions:
   1.7.1.5.1 Osteoarthritis
   1.7.1.5.2 Rheumatoid arthritis (RA)
   1.7.1.5.3 Spondyloarthropathy (Ankylosing spondylitis, Reiter’s disease, Psoriatic arthritis, inflammatory bowel disease)
   1.7.1.5.5 Infections that cause direct and indirect forms of arthritis (Acute rheumatic fever, Subacute bacterial endocarditis, Post-dysenteric)

Hyperuricemia
1.7.1.5.6 Crystal-induced arthropathies (Gout & others)
1.7.1.5.7 Connective tissue disorders: (e.g. SLE, polymyalgia rheumatica etc.)
1.7.1.5.8 Vasculitis.
1.7.1.5.9 Osteoporosis and Osteopenia
1.7.1.5.10 Fibromyalgia and chronic fatigue syndrome
1.7.2 Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:

1.7.2.1 Diagnostic procedures:

1.7.2.1.1 The basic elements of a rheumatic assessment (including a targeted history, musculoskeletal examination and functional assessment).

1.7.2.1.2 Development of a differential diagnosis based on the pattern of joint and soft tissue involvement such as symmetrical small joints, non-symmetrical large joints and axial skeleton.

1.7.2.1.3 Evaluation of limitations in activities of daily living and affect on social and psychological status of the patient.

1.7.2.1.4 A focused history, musculoskeletal exam and laboratory evaluation to evaluate disease progression.

1.7.2.2 Management skills:

1.7.2.2.1 The ordering of appropriate laboratory tests and radiographic images based on initial evaluation and interpretation of the results.

1.7.2.2.2 Recognition of urgent joint conditions such as “the red hot joint” and performing appropriate management.

1.7.2.2.3 Treatment of rheumatologic conditions and the monitoring of the laboratory, physical exam and potential side effects in consultation with a rheumatologist.
1.8 Endocrine and metabolic problems

1.8.1 Knowledge

By the end of training the resident should demonstrate the ability to apply knowledge of:

1.8.1.1 Prevention of common endocrine disease (e.g. Diabetes mellitus, dyslipidemias)

1.8.1.2 The family medicine resident is required to demonstrate the knowledge of the followings:

1.8.1.2.1 Diabetes mellitus:
   1.8.1.2.1.1 Pathophysiology, Epidemiology, Type 1 diabetes mellitus (diagnosis, presentation, principles of care and management, nutrition)
   1.8.1.2.1.2 Type 2 diabetes mellitus (pathophysiology, epidemiology, diagnosis, presentation, principles of care and management, nutrition)
   1.8.1.2.1.3 Diabetes across the age spectrum (children, adolescents, adults, elderly, pre-pregnancy/pregnancy)
   1.8.1.2.1.4 Diabetes emergencies (hypoglycemia, diabetic ketoacidosis, hyperosmolar hyperglycemic syndrome)
   1.8.1.2.1.5 Prevention, early detection and management of the complication of diabetes
   1.8.1.2.1.6 Drugs & life style measurements relevant to patients with diabetes across their age & disease stage spectrum
   1.8.1.2.1.7 Psychosocial impact of diabetes.

1.8.1.2.2 Thyroid disorders:
   1.8.1.2.2.1 Hypothyroidism, Hyperthyroidism, Approach to the patient with a thyroid nodule, Thyroid cancers
   1.8.1.2.2.2 Thyroid emergencies (myxoedema, hyperthyroid crisis),
   1.8.1.2.2.3 Medications prescribed in primary care setting.

1.8.1.2.3 Dyslipidemia (prevention, screening, detection & medications.

1.8.1.2.4 Obesity (prevention, screening, Diagnosis & management)
1.8.1.2.5 Metabolic syndrome (screening, diagnosis & management)
1.8.1.2.6 Osteoporosis (screening, diagnosis & management)
1.8.1.2.7 Adrenal disorders (Cushing’s syndrome, hyperaldosteronism, Addison’s disease, phaeochromocytoma)
1.8.1.2.8 Pituitary disorders (prolactinoma, acromegaly, diabetes insipidus)
1.8.1.2.9 Fluid and electrolyte metabolism e.g. Hypo and hypernatremia, Hypo and hyperkalemia, Hypo and hypercalcemia…….

1.8.2 Skills:
1.8.2.1 Diagnostic procedures:

1.8.2.1.1 Clinical history, data gathering, and following the current literature in diagnosis common metabolic disorders, specifically, diagnostic criteria for diabetes mellitus, hypo & hyperthyroidism.
1.8.2.1.2 Physical examination assessment especially for the following areas:
1.8.2.1.2.1 Body mass index calculation, and weight circumference
1.8.2.1.2.2 Diabetic foot examination.
1.8.2.1.2.3 Thyroid examination.
1.8.2.1.2.4 Visual acuity and retinal photography (diabetic retinopathy).
1.8.2.1.2.5 Diabetic neuropathy
1.8.2.1.2.6 The use of blood glucose measuring devices
1.8.2.1.2.7 The technique of using different insulins and injectable anti-diabetic medication.
1.8.2.1.3 The ability to interpret the following laboratory results:
1.8.2.1.3.1 Fasting, Random & postprandial blood sugar.
1.8.2.1.3.2 Hemoglobin A1c
1.8.2.1.3.3 Albumin: creatinine ratio, dipstick for microalbuminuria.
1.8.2.1.3.4 Estimated glomerular filtration rate
1.8.2.1.3.5 Serum electrolyte and urate results.
1.8.2.1.3.6 Thyroid function tests and understand their limitations – TSH, T4, free T4, T3, auto-antibodies.
1.8.2.1.3.7 Lipid profile tests – total cholesterol, HDL, LDL, triglycerides.
1.8.2.1.3.8 Awareness of the investigations in the secondary care e.g. thyroid and abdominal ultrasound, fine needle aspiration, and other endocrine procedures.

1.8.3 Therapeutic procedures:

At the completion of residency training, the resident should be able to:
1.8.3.1 Recognize that patients with metabolic problems are frequently asymptomatic or have nonspecific symptoms and that diagnosis is often made by screening or recognizing symptom complexes.
1.8.3.2 Decide a management plan for patients with a metabolic problem at initial stage.
1.8.3.3 Demonstrate a logical, incremental approach to investigate and diagnose metabolic problems.
1.8.3.4 Understand principles of treatment of common metabolic conditions managed commonly in primary care (obesity, diabetes mellitus, hypothyroidism, hyperlipidemia)
1.8.3.5 Develop strategies to simplify medication regimens in case of polypharmacy and encourage concordance with treatment.
1.8.3.6 Work in a multidisciplinary team with other health care providers for managing metabolic diseases encountered in primary health care setting.
1.8.3.7 Understand the indications for referral to an endocrinologist for management or investigation of complex metabolic problems.
1.8.3.8 Understand the systems of care for metabolic conditions, including the roles of primary and secondary care, shared-care arrangements, multidisciplinary teams and patient involvement.
1.8.3.9 Show competence in the management of the common endocrine disorders like: diabetes, hypothyroidism, dyslipidemia…. etc.
1.9 Hematology

1.9.1 Knowledge:
By the end of training the resident should demonstrate the ability to apply knowledge of the followings among all age groups:

1.9.1.1 Normal hematological laboratory values
1.9.1.2 Prevention of hematological diseases like iron deficiency anemia and other types of anemia
1.9.1.3 Specific diseases/conditions:
   1.9.1.3.1 Iron deficiency anemia (etiology, diagnosis, treatment)
   1.9.1.3.2 Sideroblastic anemia
   1.9.1.3.3 Anemia of chronic disease
   1.9.1.3.4 Megaloblastic macrocytic anemia: Vitamin B12 deficiency, Folate deficiency
   1.9.1.3.5 Anemias caused by hemolysis: Sickle cell anemia, Glucose-6 Phosphate Dehydrogenase Deficiency, Thalassemia
   1.9.1.3.6 Neutropenia, Lymphocytopenia
   1.9.1.3.7 Thrombocytopenia, Thrombocytosis
   1.9.1.3.8 Polycythemia
   1.9.1.3.9 Eosinophilia
   1.9.1.3.10 Leukemias (AML, ALL, CLL, CML)
   1.9.1.3.11 Lymphomas (Hodgkin, non-Hodgkin)
   1.9.1.3.12 Multiple myeloma.

1.9.1.4 Common Drugs with hematological effect.

1.9.2 Skills:

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:

1.9.2.1 Ensures appropriate history taking and relevant physical examination.
1.9.2.2 Ensures rational requesting of hematology tests, considering yield, cost & resources.
1.9.2.3 Interprets results of common hematological laboratory tests (e.g. CBC, ESR, Hemoglobin
electrophoresis, coagulation profile, Blood grouping and rhesus factors).

1.9.2.4 Recognizes uncommon but serious diseases e.g. acute and chronic leukemia, myeloma and lymphomas.

1.9.3 Management skills:
1.9.3.1 Formulates a diagnostic and management plan for common hematological diseases e.g. iron deficiency anemia, G6PD deficiency etc.....and assessing the need for expert advice.
1.9.3.2 Understands the role of a hematologist and the implications of special testing in patients who have hematological disease and the implications of the test results for the patient.
1.9.3.3 Manages emergent hematological problems and obtaining urgent consultation when appropriate, e.g. acute hemolysis, acute complications of sickle cell diseases.... etc.
1.9.3.4 Recognizes the risk & benefits of blood transfusion.
1.9.3.5 Appropriately counselling patients on the benefits and risks of screening for hematological diseases.
1.9.3.6 Awareness of referral criteria to hematologist.
1.9.3.7 Participates in liaison between laboratory and clinical staff e.g. Team Working.
1.9.3.8 Consults where necessary to obtain appropriate advice in reporting findings.
1.9.3.9 Understands the sensitivities around the diagnosis of a familial disorder, for example, premarital counseling.
1.9.3.10 Exhibits understanding of the impact of hemoglobin disorders on the patient and their family.
2. **Children’s health**

2.1 *Competencies:*

At the completion of residency training, a family medicine resident should:

2.1.1 Demonstrate the ability to take proper history and perform appropriate clinical examination for pediatric patients at different age groups.

2.1.2 Formulate an appropriate diagnosis and treatment plan for common pediatric conditions.

2.1.3 Communicate effectively with the patient / family /caregiver(s).

2.1.4 Be aware of his / her own practice limitations and seek consultation with other health care providers & resources when necessary to optimize patient care.

2.1.5 Be aware of the ethical & medico-legal issues related to pediatric patients and their caregivers.

2.1.6 Recognize the red flags for children’s health conditions

2.2 *Attitudes:*

The resident should demonstrate attitudes that encompass:

2.2.1 Empathic concern for the health of the child in the context of the family.

2.2.2 Promotion of healthy lifestyles in children and families.

2.2.3 An awareness of the unique vulnerabilities of infants and children that may require special attention, consultation and/or referral.

2.2.4 Emphasis of the awareness of social, cultural and environmental factors that impact children’s health and welfare.

2.2.5 Emphasis of the importance of educating children, family and society on environmental factors that impact children’s health and welfare.

2.2.6 The importance of obtaining information about school performance and learning disabilities.
2.3 Knowledge:

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

2.3.1 Fetal and neonatal period: Pathophysiology of the neonatal period; including infections and non-infectious conditions: e.g. jaundice, anemia, sepsis, respiratory distress…. etc.

2.3.2 Well newborn and child care:
   2.3.2.1 Anticipatory guidance appropriate to age and developmental stage:
      2.3.2.1.1 Feeding: options & variations
      2.3.2.1.2 Developmental stages and milestones
      2.3.2.1.3 Developmental screening tests
      2.3.2.1.4 Normal growth and variants, including dental development
      2.3.2.1.5 Temperament and behavior
      2.3.2.1.6 Family and social relationships

2.3.3 Prevention and screening:
   2.3.3.1 Developmental disabilities: Developmental delay, learning disorders e.g. dyslexia, ADHA and autism …etc.
   2.3.3.2 Injury prevention: e.g. drowning, choking, burns and poisoning…
   2.3.3.3 Child abuse: detection & channels of reporting e.g.: SCAN Team.
   2.3.3.4 Immunization
   2.3.3.5 Screening: e.g. Anemia, hypertension…etc.
   2.3.3.6 Sudden infant death syndrome (SIDS)

2.3.4 Genetics:
   2.3.4.1 Screening issues
   2.3.4.2 Appropriate referral for necessary genetic diagnosis and counseling.

2.3.5 Medical problems of infants and children: recognition, management and appropriate referral:
   2.3.5.1 Allergic: Asthma, atopy, allergic rhinitis…etc.
2.3.5.2 Inflammatory: Juvenile rheumatoid arthritis, Kawasaki disease, Henoch-Schonlein purpura...etc.

2.3.5.3 Renal and urologic: Glomerulonephritis, urinary tract infections, vesico –ureteric reflux, enuresis, hypospadias, urethral prolapse, fused labia, enuresis and undescended testis...etc.

2.3.5.4 Endocrine/metabolic and nutritional problems: Thyroid disorders, diabetes mellitus, obesity, failure to thrive, abnormal growth patterns...etc.

2.3.5.5 Neurologic problems: Seizure disorders, headache, syncope, psychomotor delay, cerebral palsy and movement disorders...

2.3.5.6 Common skin problems: Skin rash (Atopic dermatitis, diaper rash, urticarial & erythema multiform), skin infections (Viral, bacterial, parasitic and fungal), bites, stings and burns

2.3.5.7 Musculoskeletal problems: see orthopedic section

2.3.5.8 Gastrointestinal problems: Gastroenteritis, constipation, encopresis, hepatitis, colic, gastro-esophageal reflux, food intolerance, malabsorption, pyloric stenosis, recurrent and chronic abdominal pain, hernia and GI emergencies (Intussusception, appendicitis,).

2.3.5.9 Cardiovascular problems: Evaluation of heart murmurs, congenital heart disease and valvular disease and others e.g. hypertension

2.3.5.10 Respiratory tract problems: Upper & lower respiratory tract infections, reactive airway disease and asthma, cystic fibrosis, bronchiolitis, foreign body aspiration, snoring and obstructive sleep apnea....etc.

2.3.5.11 Ear problems: see ENT section

2.3.5.12 Eye problems: see ophthalmology section

2.3.5.13 Other serious infections: Sepsis, meningitis, encephalitis and osteomyelitis.... etc.

2.3.5.14 Childhood malignancies: e.g. Leukemia, lymphoma neuroblastoma, nephroblastoma, retinoblastoma and others.

2.3.5.15 Children with special needs.

2.3.5.16 Psychiatric problems: see psychiatric section.
2.1 Skills:

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / appropriately refer:

2.1.1 Resuscitation of newborns, infants and children
2.1.2 Age-appropriate history and physical examination, and use of growth charts, with proper documentation.
2.1.3 Developmental screening tests administration and interpretation.
2.1.4 Appropriate recognition & approach, and reporting of suspected child abuse.
2.1.5 Assessment of attention/hyperactivity problems.
2.1.6 Formulating a diagnostic and management plan for common pediatrics conditions and assessing the need for expert advice.
2.1.7 Coordination of patient care and specialty services when required.
2.1.8 Running ideal well baby clinic.

3. Adolescent’s health

3.1 Competencies:
At the completion of residency training, a family medicine resident should:

3.1.1 Be able to establish rapport with the patients and their families, and obtain a focused history, perform appropriate examination and develop patient centered treatment plans for adolescents.
3.1.2 Demonstrate the ability to communicate effectively with the adolescent and his / her family.
3.1.3 Awareness of the local community resources that is available for Adolescent’s wellbeing & care.
3.1.4 Be aware of the ethical & medico-legal issues related to adolescent patients and their families.
3.1.5 Recognize the red flags for adolescent health conditions.
3.2 **Attitudes:**

The resident should demonstrate attitudes that encompass:

3.2.1 Realize the importance of adolescent’s relationship with peers, parents, school and community, for adolescent’s successful development.

3.2.2 Being aware that adolescence is a time of invulnerability, confrontational attitudes toward society and tendencies toward experimentation and high risk behavior.

3.2.3 Confidentiality and the encouragement of the adolescent to communicate with his or her parents (and other supportive adults).

3.2.4 Utilizing each consultation as an opportunity to act as a caring adult and to promote healthy living.

3.2.5 Being professional & non – judgmental during consultation of patients with gender dysphoria, all within the legal boundaries of the state of Kuwait.

3.2.6 Be aware of the ethical & medico-legal issues related to adolescent patients and their families.

3.3 **Knowledge:**

The resident should demonstrate the ability to apply knowledge of:

3.3.1 Normal growth and development in the adolescent years that include physical, mental, emotional and sexual.

3.3.2 Assessment and prevention of primary behavioral risks affecting health and life of adolescents.

3.3.3 Provision of preventive services, immunizations and health promotion to adolescents during both annual visits and routine acute care visits.

3.3.4 The challenges facing an adolescent to establish his or her identity and to learn responsible behaviors, including self-care, attention to mental health, sexual health and reproductive health.

3.3.5 The core conditions that may affect the health of an adolescent, such as family problems, poverty, depression, school failure, obesity, eating disorders, violence, drug use & sexually transmitted diseases.
3.4 Skills:

The resident should demonstrate the ability to perform / observe / appropriately refer:

3.4.1 In the general care of the adolescent patient:
   3.4.1.1 Effective communication
   3.4.1.2 Familiar with use of common assessment tools e.g. HEADSSS questionnaire (Home, Education, Activities, Drugs, Sex, Suicide/Depression, Safety).
   3.4.1.3 Perform a complete exam and a focused adolescent exam.
   3.4.1.4 Assess for eating disorders /obesity
   3.4.1.5 Assess well-being at home and counsel regarding family relationships.
   3.4.1.6 Assess progress at school and counsel regarding school failure.
   3.4.1.7 Assess peer relationships and counsel about healthy and ethical decision making (e.g. STD, abuse…etc.)
   3.4.1.8 Assess tobacco, alcohol, drug experimentation and illicit drug use (including anabolic steroids) and counsel accordingly.
   3.4.1.9 Assess mental health status.
   3.4.1.10 Assess exposure to violence, accident and safety risks and counsel accordingly.
   3.4.1.11 Appropriate approach of adolescents with conduct disorders (e.g. delinquency, vandalism, stealing, lying…etc.)

3.4.2 In the community:
   3.4.2.1 Promote educational programs in community that advocate healthy teen behavior.
   3.4.2.2 Promote the support of adolescents clinical & social services in the community.
4. **Women’s problems**

4.1 **Competencies:**

A family medicine resident should:

4.1.1 Be able to perform a comprehensive women’s health assessment and develop appropriate treatment plan for women.
4.1.2 Be able to communicate effectively with the patients and their families.
4.1.3 Be aware of the ethical & medico-legal issues related to consulting female patients.
4.1.4 Awareness of the local community resources that is available for Women’s wellbeing & care.
4.1.5 Recognize the red flags for women health conditions.

4.2 **Attitudes:**

The resident should demonstrate attitudes that encompass:

4.2.1 Realizing that women need sensitive approach as they are often more conservative in dealing with issues e.g. mental health, sexual dysfunction, alcohol, smoking…etc.
4.2.2 Recognize that a woman's health is affected by biological, psychological, occupational and social factors.
4.2.3 A gender-specific understanding of the importance of disease prevention, wellness and health promotion for adding quality years to women’s lives.
4.2.4 Understand the importance of involving women in solving their own health problems.
4.2.5 Being professional & non – judgmental during consultation of female patients with gender dysphoria, all within the legal boundaries of the state of Kuwait.

4.3 **Knowledge:**

In the appropriate setting, the resident should have appropriate:

4.3.1 Knowledge of diagnosis and management:
4.3.1.1 Appropriate history and physical examination for women of all age groups

4.3.1.2 Gynecology:
  4.3.1.2.1 Disease prevention, health promotion and periodic health evaluation
  4.3.1.2.2 Physiology of menstruation
  4.3.1.2.3 Abnormal uterine bleeding
  4.3.1.2.4 Gynecologic problems in adults & children (e.g. Vaginal Discharge)
  4.3.1.2.5 Infections and diseases of the female reproductive and urinary systems
  4.3.1.2.6 Breast health and diseases of the breast
  4.3.1.2.7 Sexual assault/ Domestic violence: Recognition, management & channels of reporting.
  4.3.1.2.8 Pelvic pain
  4.3.1.2.9 Benign and malignant neoplasms of the female reproductive system
  4.3.1.2.10 Menopause and geriatric gynecology
  4.3.1.2.11 Indications for surgical intervention
  4.3.1.2.12 Cervical lesions and abnormal cytology
  4.3.1.2.13 Ectopic pregnancy

4.3.1.3 Obstetrics:
  4.3.1.3.1 Pre-pregnancy planning and counseling
  4.3.1.3.2 Prenatal care (including risk assessment)
  4.3.1.3.3 Labor and delivery
  4.3.1.3.4 Postpartum care
  4.3.1.3.5 Indications for cesarean delivery
  4.3.1.3.6 Obstetric complications and emergencies
  4.3.1.3.7 Lactation

4.3.1.4 Family life education:
  4.3.1.4.1 Family planning
  4.3.1.4.2 Fertility problems
  4.3.1.4.3 Inter-conceptional care
  4.3.1.4.4 Family and sexual counseling

4.3.1.5 Consultation and referral:
  4.3.1.5.1 The role of the obstetrician, gynecologist and subspecialist
  4.3.1.5.2 Women's health care delivery systems
  4.3.1.5.3 Collaboration with other health care providers (i.e., dietitian. etc.)
4.4 Skills:

Emotional preparation for and thorough performance / observation of the gynecologic examination and appropriately refer in patients of all ages:

4.4.1 Gynecology:
- 4.4.1.1 Appropriate screening e.g. breast, cervical ...etc.
- 4.4.1.2 Awareness regarding:
  - 4.4.1.2.1 Obtaining vaginal and cervical cytology
  - 4.4.1.2.2 Colposcopy
  - 4.4.1.2.3 Cervical biopsy and polypectomy/Endometrial biopsy
  - 4.4.1.2.4 Cryosurgery and cautery for benign disease
  - 4.4.1.2.5 Microscopic diagnosis of urine and vaginal smears
  - 4.4.1.2.6 Bartholin duct cyst drainage
  - 4.4.1.2.7 Dilation and curettage for incomplete abortion

4.4.2 Family planning and contraception:
- 4.4.2.1 Contraceptive counseling and prescribing including emergency contraception.
- 4.4.2.2 Intrauterine contraceptive device counseling
- 4.4.2.3 Parenteral contraceptives and counseling.

4.4.3 Pregnancy:
- 4.4.3.1 Pre-pregnancy evaluation
- 4.4.3.2 Initial pregnancy visit
- 4.4.3.3 Risk assessment
- 4.4.3.4 Counseling throughout pregnancy
- 4.4.3.5 Management of common postpartum problems.
5. **Men’s health**

5.1 **Competencies:**

At the completion of residency training, a family medicine resident should:

5.1.1 Have a good knowledge regarding specific health problems and their unique characteristics in men.
5.1.2 Be able to take a comprehensive men’s health history e.g. sexual & occupational histories.
5.1.3 Perform male physical examination e.g. urogenital, rectal and prostate examination.
5.1.4 Communicate effectively and sensitively with the patient / others involved in his care as appropriate.
5.1.5 Appropriate application of relevant guidelines regarding men’s health.
5.1.6 Being professional & non – judgmental during consultation of male patients with gender dysphoria, all within the legal boundaries of the state of Kuwait.
5.1.7 Be aware of the ethical & medico-legal issues related to men patients and their families.
5.1.8 Recognize the red flags for men’s health conditions

5.2 **Attitudes:**

The resident should develop attitudes that encompass:

5.2.1 Being aware that men visit the physicians less frequently and usually at the late stages of problems.
5.2.2 Realizing that men need sensitive approach as they are often more conservative in dealing with issues e.g. mental health, sexual dysfunction, alcohol, drugs…etc.
5.2.3 Recognize that a man's health is affected not only by biological, psychological, social and occupational factors.
5.2.4 A gender-specific understanding of the importance of disease prevention, wellness and health promotion for adding quality years to men’s lives.
5.3 **Knowledge:**

The resident should demonstrate the ability to apply knowledge of the followings among all age groups:

5.3.1 Health promotion and disease prevention:
   5.3.1.1 Nutritional needs
   5.3.1.2 Exercise programs
   5.3.1.3 Weight management and obesity
   5.3.1.4 Substance abuse /performance enhancing drugs e.g. anabolic steroids
   5.3.1.5 Avoidance of sexually transmitted infections
   5.3.1.6 Occupational health and injury prevention.
   5.3.1.7 Coronary artery disease
   5.3.1.8 Cancer screening guidelines (e.g. skin, colon, prostate, . etc.)
   5.3.1.9 Oral health

5.3.2 Reproductive tract infections and problems:
   5.3.2.1 Sexually transmitted infections
   5.3.2.2 Urethritis/ epididymitis/orchitis/prostatitis
   5.3.2.3 Benign & Neoplastic diseases of the male ano-genital tract.
   5.3.2.4 Lower urinary tract symptoms
   5.3.2.5 Bladder dysfunction
   5.3.2.6 Kidney diseases
   5.3.2.7 Genital trauma
   5.3.2.8 Inguinal hernias
   5.3.2.9 Reproduction: Normal physiology and anatomy, infertility, effects of aging…
   5.3.2.10 Sexuality: Erectile/ Ejaculatory dysfunction, changes in libido, variety of sexual behaviors……..

5.4 **Skills:**

The resident should demonstrate the ability to independently perform / observe / appropriately refer:

5.4.1 Careful and thorough Genito -urinary examination
5.4.2 Counseling skills:
   5.4.2.1 Alcohol and other substance use and abuse
   5.4.2.2 Smoking
   5.4.2.3 Sexually transmitted infections.
   5.4.2.4 Exercise prescription
5.4.2.5 Performance-enhancing drugs
5.4.2.6 Sexual behavior
5.4.3 Foley’s catheter placement- removal.

6 Geriatric problems

6.1 Competencies

At the completion of residency training, a family medicine resident should:

6.1.1 Be able to execute a broad, consistent geriatric assessments and tailor a long-term management plans maintain—continuity of care.
6.1.2 Be able to communicate effectively family and caregiver to reach mutual management plan.
6.1.3 Awareness of own limitation and inquire other colleague as teamwork for best possible geriatric care.
6.1.4 Ability to conduct home visit for geriatric assessment (dealing with reason of visit and assessing the environment and home situation).
6.1.5 Awareness of role of geriatric clinics in PHC in Kuwait.
6.1.6 Ability to document a death related certificate
6.1.7 Awareness of the local community resources that is available for geriatric care as multidisciplinary approach aiming optimizing care.
6.1.8 Be aware of the ethical & medico-legal issues related to geriatric patients and their caregivers.
6.1.9 Recognize the red flags for geriatric’s health conditions

6.2 Attitudes:

The resident should demonstrate attitudes that encompass:

6.2.1 Recognition of own attitude toward patient, family or care giver and as well, their attitude of diversity of situation as disability, handicap, or death.
6.2.2 The promotion of the patient’s dignity through self-care.
6.2.3 Recognition of the importance of family and home in the overall lifestyle and health of patients.
6.2.4 Appropriate selection, interpretation, and performance of investigation or treatment for the elderly and avoid unnecessary ones.

6.2.5 Commitment to lifelong learning and knowledge about aging, health and the medical management of geriatrics.

6.2.6 Awareness of the importance of coordinating a multidisciplinary approach to enhance elderly care.

6.2.7 Accessibility and accountability for elderly patients.

6.2.8 An awareness of the importance of limiting cost when treating elderly patients.

6.2.9 Be aware of the ethical & medico-legal issues related to adolescent patients and their families.

6.3 Knowledge

The resident should demonstrate the ability to apply knowledge of:

6.3.1 Functional assessment of geriatrics according to local & evidence based international guidelines.

6.3.2 Home visit assessment

6.3.3 Dementia

6.3.4 CVA

6.3.5 Confusion

6.3.6 Mental health

6.3.7 Infections

6.3.8 Bed sores

6.3.9 Mobility problems and risk of falls

6.3.10 Parkinson's disease

6.3.11 Osteoporosis

6.3.12 Incontinence

6.3.13 Visual and hearing problems

6.3.14 Constipation

6.3.15 Polypharmacy

6.3.16 Geriatric abuse/ neglect

6.4 Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:
6.4.1 Basic elements of geriatric assessment, including the standardized methods for assessing physical, cognitive, emotional, and social functioning as appropriate

6.4.2 Screening examinations for mental status, depression, and functional status

6.4.3 Physical diagnosis, including:
   6.4.3.1 Recognition of normal and abnormal signs of aging
   6.4.3.2 Obtain a comprehensive history including evaluation of hearing, vision and mental status examination
   6.4.3.3 Mobility, gait, and balance assessments

6.4.4 Evaluation of the appropriate use of assistive devices (e.g. canes, walkers, wheel or power chairs, hearing aids... etc.)

6.4.5 Counsel and educate patients and their families about age-related psychological, social, and physical stresses and changes of the normal life cycle of aging, dying, and death

6.4.6 Provide health care services aimed at preventing health problems or maintaining health

7 Emergency care

7.1 Competencies:

At the completion of residency training, a family medicine resident should:

7.1.1 Take proper history and perform appropriate clinical examination for emergency medical and surgical conditions presented to the family practitioner.

7.1.2 Recognize the importance of timely and efficient evaluation and appropriate care in emergency cases.

7.1.3 Accurately and efficiently diagnose and manage common and important acute serious illnesses and traumatic conditions. In addition to the ability to use common emergency drugs appropriately (e.g. adrenaline, diazepam, narcotic.... etc.)

7.1.4 Work effectively within multidisciplinary teams to request appropriate investigations and initiate management for acute emergency cases.
7.1.5 Demonstrate decision-making skills in the effective management of acute illness and trauma presentations

7.1.6 Aware of the ethical & medico-legal issues related to emergencies in the state of Kuwait.

7.2 Attitudes:
The resident should demonstrate attitudes that encompass:

7.2.1 Prioritize tasks to manage acute illness and trauma effectively

7.2.2 Recognize their own limitations in the care of patients with acute and traumatic presentations and refer appropriately.

7.2.3 An ability to work effectively with other members of the health care team, including consultants, nursing and other staff (e.g. administrative staff, investigator, social services…etc.)

7.2.4 Awareness regarding doctor's emergency bag (importance, contents)

7.2.5 Ability to self-reflect and act promptly.

7.3 Knowledge:
In the appropriate setting, the resident should demonstrate the ability to apply Knowledge of the followings among all age group:

7.3.1 The principles of care & the initial stabilization of patients

7.3.2 Assessment and management of conditions in the following content areas:

7.3.2.1 Trauma: e.g. Blunt, penetrating, burns, drowning and near drowning, bites, stings

7.3.2.2 Acute neurologic disorders: e.g. CVA, coma, meningitis, seizure disorders …etc.

7.3.2.3 Acute respiratory disorders: e.g. Pulmonary embolism/ infections, pneumothorax, asthma…etc.

7.3.2.4 Acute cardiovascular disorders: e.g. acute coronary syndrome, dysrhythmias, heart failure…etc.
7.3.2.5 Acute endocrine disorders: e.g. diabetic ketoacidosis, acute adrenal insufficiency …etc.
7.3.2.6 Acute gastrointestinal disorders: e.g. acute appendicitis, acute abdomen…etc.
7.3.2.7 Acute urinary system disorders: e.g. urinary retention, nephrolithiasis …etc.
7.3.2.8 Acute musculoskeletal disorders: e.g. fracture, dislocated joints …etc.

7.3.3 Recognition and management in the following areas
7.3.3.1 Toxicologic emergencies and their treatment: e.g. acute overdose, accidental poisonings and ingestion, treatments and antidotes…… etc.
7.3.3.2 Special circumstances:
  7.3.3.2.1 Resuscitations (e.g., coordination, communication, recording)
  7.3.3.2.2 Metabolic disorders and acid/base imbalance.
  7.3.3.2.3 Shock and initial resuscitative measures required for each unique condition of different types of shock.
  7.3.3.2.4 Acute infectious emergencies (e.g. encephalitis, septicemia…etc.)
  7.3.3.2.5 Heat injuries
  7.3.3.2.6 Hypersensitivity reactions and anaphylaxis

7.3.4 Indications and interpretation of diagnostic tests pertinent to the urgent and emergent setting e.g.: ECG, Blood laboratory chemistry and hematologic studies…etc.

7.4 Skills
In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:
7.4.1 Airway management:
  7.4.1.1 Heimlich maneuver
  7.4.1.2 Ensuring airway patency and the use of advanced airway techniques
  7.4.1.3 Needle thoracentesis and tube thoracostomy
  7.4.1.4 Cricothyroidotomy
7.4.2 Anesthetic techniques: e.g. Local anesthesia
7.4.3 Diagnostic and therapeutic procedures
  7.4.3.1 Repair of skin lacerations: methods and techniques.
  7.4.3.2 Management of wounds/ foreign bodies in the skin and body orifices
  7.4.3.3 Use of Automated Electrical defibrillator (AED)
  7.4.3.4 Management of acute cardiorespiratory arrest in all age groups. (e.g. BLS)

8 Care of surgical patient

8.1 Competencies:

By the end of residency training, a family medicine resident should:

8.1.1 Be able to perform a surgical assessment and develop an appropriate treatment plan, ensuring that the diagnosis and treatment plan are clearly understood.
8.1.2 Demonstrate the ability to communicate effectively with the surgeon about the patient’s symptoms, physical findings, test results and proposed management.
8.1.3 Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care.
8.1.4 Be aware of the ethical & medico-legal issues related to surgical patients and their caregivers.
8.1.5 Recognize the red flags for surgical patient’s conditions

8.2 Attitudes:
The resident should develop attitudes that encompass:
8.2.1 Recognizing the importance of shared management between family physician and surgeon regarding the care of surgical patients as appropriate.

8.2.2 Being sensitive to concerns and anxieties of the patient and his family regarding the need for surgical intervention.

8.2.3 Recognizing the importance of prevention of surgical problems and patients' responsibility for his/her own health promotion and improvement.

8.2.4 Involving patient and his/her family in the prevention of complications and post-operative care management.

8.3 Knowledge:

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of the followings among all age group:

8.3.1 Basic principles of surgical diagnosis: e.g. basic surgical anatomy, wound physiology and healing processes

8.3.2 Differential diagnosis of key signs and symptoms of surgical conditions

8.3.3 Recognition of surgical emergencies.

8.3.4 Bariatric surgeries: types, indications, contraindications, and short & long-term care of post-surgery patients.

8.3.5 Ethical & legal considerations of surgical interventions.

8.3.6 Preoperative assessment.

8.3.7 Intra-operative care: for minor surgical interventions e.g. basic principles of asepsis, sterile technique, use of basic surgical instruments…etc.

8.3.8 Postoperative care: e.g. wound care, pain management, infection, follow up care …etc.

8.4 Skills:

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:
8.4.1 Clinical assessment, including history, physical examination, X-Rays & laboratory evaluation. Invasive versus noninvasive diagnostic tests
8.4.2 Patient counseling on indications and contraindications for surgical or medical management of given cases.
8.4.3 Psychological and physical preparation of patients/ career’s for surgical interventions.
8.4.4 Recognition and management of common post-operative complications.
8.4.5 Management of common conditions in the primary care setting: e.g. lumps, wounds, abscesses, lacerations, burns…etc.
8.4.6 Carrying out common minor surgical interventions in family physicians clinics (e.g. abscess drainage, suturing, foreign body extraction…etc.)

9  Orthopedics & physical medicine

9.1 Competencies:

At the completion of residency training, a family medicine resident should:

9.1.1 Perform an appropriate musculoskeletal history and physical examination.
9.1.2 Formulate an appropriate diagnosis and recommend treatment.
9.1.3 Demonstrate the ability to communicate effectively with the orthopedic surgeon and other team members about the patient’s symptoms, physical findings, test results and proposed management.
9.1.4 Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care.
9.1.5 Perform an evidence-based, age-appropriate and activity-specific preparticipation physical evaluation and provide guidance for an appropriate exercise prescription.
9.1.6 Be aware of the ethical & medico-legal issues related to orthopedic conditions in the state of Kuwait.
9.1.7 Recognize the red flags for orthopedics’ conditions
9.2 **Attitudes:**

The resident should develop attitudes that encompass:

9.2.1 The importance of shared management between family physician and orthopedic surgeon and other team members regarding the care of orthopedic patients as appropriate.

9.2.2 The importance of prevention of musculoskeletal problems and the benefits of exercise for patients’ lives.

9.2.3 Emphasis of the involvement of patient and his/her family in prevention of complications and post-operative care management.

9.2.4 Awareness of the special needs of patients who have acute injuries.

9.2.5 Understanding of the importance of proper rehabilitation of acute musculoskeletal injuries to help speed recovery, maximize function and minimize the risks of re-injury, chronic pain and chronic disability.

9.3 **Knowledge:**

The resident should demonstrate the ability to apply knowledge of the followings among all age group:

9.3.1 Normal anatomy and physiology of locomotor system.

9.3.2 Normal growth and development of locomotor system.

9.3.3 Pathogenesis/pathophysiology and recognition of:

9.3.3.1 Joint pain, Muscular pain

9.3.3.2 Musculoskeletal trauma and common sport related injuries (e.g. Fractures, dislocations, tendon ruptures and nerve injury ..etc.)

9.3.3.3 Tendinopathy

9.3.3.4 Bone and joint deformities

9.3.3.5 Bone and joint infections

9.3.3.6 Metabolic bone diseases

9.3.3.7 Compartment syndrome

9.3.3.8 Avascular necrosis

9.3.3.9 Overuse syndromes

9.3.3.10 Back pain syndromes

9.3.3.11 Bone neoplasms: Benign and malignant.

9.3.3.12 Pediatric problems:
9.3.3.12.1 Joint dislocation
9.3.3.12.2 Legg-Calvé-Perthes disease
9.3.3.12.3 Osgood-Schlatter disease
9.3.3.12.4 Slipped capital femoral epiphysis
9.3.3.12.5 “Clubfoot” (talipes equinovarus)
9.3.3.12.6 In-toeing (metatarsus adductus, tibial torsion, femoral anteversion)
9.3.3.12.7 “Bowleg” (genu varum) and “knock knee” (genu valgum)
9.3.3.12.8 Epiphyseal injuries.
9.3.3.12.9 Transient synovitis
9.3.3.12.10 Child abuse patterns of injury
9.3.3.12.11 Rickets
9.3.3.12.12 Osteogenesis imperfecta
9.3.3.12.13 Thoracolumbar scoliosis.

9.4 **Skills:**

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:

9.4.1 Musculoskeletal history taking & physical examination
9.4.2 Indications, contraindications and interpretation of laboratory data (e.g., inflammatory markers: RF, CRP...etc.)
9.4.3 Indications, limitations, contraindications of musculoskeletal procedures such as: Common joint aspirations and intra articular injections
9.4.4 Imaging & other tests:
   9.4.4.1 Interpretation of radiographs
   9.4.4.2 Awareness regarding use of magnetic resonance imaging (MRI), computed tomographic scanning (CT-scan) and bone scanning
   9.4.4.3 Awareness regarding indications for arthrogram, myelogram and arthroscopy
   9.4.4.4 Awareness regarding application of electromyography (EMG) and nerve conduction studies
9.4.5 Basic management of:
   9.4.5.1 Fractures / Ligament sprains & tears/ Muscular strains/ Dislocations.
9.4.5.2 Other problems (Acute and chronic low back pain, nerve entrapment syndromes, Overuse syndromes.)
9.4.5.3 Procedures (indications, contraindications and complications e.g. Joint injection, aspiration, splint, Dislocation reduction ... etc.).
9.4.5.4 Orthopedic emergency recognition and stabilization (e.g. Spinal cord injury, fractures & dislocations)
9.4.5.5 Common arthroplasty procedures (e.g. knee / hip replacement ... etc.)
9.4.6 Functional rehabilitation (Prescription of home exercise programs and referral for physical therapy)
9.4.7 Exercise Prescription: Evidence based, age appropriate and tailored exercise prescription, in partnership with patient.

10 Dermatology

10.1 Competencies:

By The end of training, a family medicine resident should:

10.1.1 Provide compassionate and culturally appropriate patient centered care
10.1.2 Be proficient in the diagnosis and treatment of common dermatologic conditions.
10.1.3 Utilize diagnostic and evidence-based treatment guidelines as well as maintain up to-date knowledge of appropriate usage of evolving dermatologic treatment technology.
10.1.4 Communicate effectively with patient having dermatologic problems.
10.1.5 Know his limitation and refer appropriately & understand how to coordinate needed referrals to specialty providers
10.1.6 Aware of the ethical & medico-legal issues related to dermatological practice in the state of Kuwait.
10.1.7 Recognize the red flags for dermatologic conditions
10.2 **Attitudes:**

The resident should demonstrate attitudes that encompass:

10.2.1 A willingness to manage the majority of dermatologic conditions.
10.2.2 A positive approach to psychosocial issues in patients who have skin disorders.
10.2.3 The consideration of counseling of patients who have dermatologic conditions as appropriate.
10.2.4 A willingness to learn and perform common dermatologic procedures as appropriate.
10.2.5 A constructive collaboration with dermatologists when appropriate.
10.2.6 A professional & non-judgmental approach to patients presenting with dermatological manifestations of STIs.
10.2.7 Ability to self-reflect on performance and act promptly.

10.3 **Knowledge:**

By the end of training the resident should demonstrate the ability to apply knowledge of:

10.3.1 Specific diseases/conditions *(among all age groups)*:
   10.3.1.1 Dermatitis: Atopic, contact, seborrheic……etc.
   10.3.1.2 Psoriasis and scaling diseases
   10.3.1.3 Acne and rosacea
   10.3.1.4 Infections (bacterial, viral and fungal)
   10.3.1.5 Infestations including scabies and head lice
   10.3.1.6 Leg ulcers and lymphedema
   10.3.1.7 Disorders of hair and nails
   10.3.1.8 Cornification disorder: calluses, corns……etc.
   10.3.1.9 Reaction to sunlight
   10.3.1.10 Pigmentation disorders: vitiligo, hyperpigmentation……etc.
   10.3.1.11 Hypersensitivity and inflammatory disorders:
      Erythema
      multiforme, urticaria, vasculitis, drug eruptions……. Etc.
   10.3.1.12 Bullous diseases
   10.3.1.13 Prevention of skin diseases
   10.3.1.14 Management of common skin condition
10.3.1.15 Prevention, recognition and management of skin cancers: Melanoma, basal & squamous cell carcinoma......etc.
10.3.1.16 Dermatologic medications; systemic & topical
10.3.1.17 Basic awareness regarding common Aesthetic procedures to guard patient’s safety: i.e. precautions & post-procedure complications e.g. Injectables: fillers & Botox; Skin Rejuvenation …etc.

10.4 Skills:

In the appropriate setting, the resident should demonstrate the ability to perform / observe / appropriately refer:

10.4.1 History and physical examination appropriate for dermatologic conditions
10.4.2 Preventive skin examination
10.4.3 Biopsy of skin lesions
10.4.4 Scraping and microscopic examination
10.4.5 Destruction of lesions: Cryosurgery, electrodesiccation & curettage
10.4.6 Formulating a diagnostic and management plan for common dermatological diseases and assessing the need for expert advice.... etc.
10.4.7 Counseling for dermatologic disorders.
10.4.8 Identifying & promptly referring dermatologic problems that need urgent referral.

11 Ophthalmology

11.1 Competencies:

At the completion of residency training, a family medicine resident should:

11.1.1 Demonstrate an understanding of the impact of ocular illness and dysfunction on patients and their families.
11.1.2 Demonstrate an understanding of the ophthalmic consultant’s role, including the different responsibilities of ophthalmologists and optometrists.
11.1.3 Recognize own practice limitations & importance of consulting ophthalmologists and others when necessary to provide optimal patient care.

11.1.4 Be aware of the ethical & medico-legal issues related to dermatological conditions in the state of Kuwait.

11.1.5 Recognize the red flags for ophthalmological conditions

11.2 **Attitudes:**

The resident should demonstrate attitudes that encompass:

11.2.1 Recognizing the importance of supportive and sympathetic attitude towards the patients with impaired vision and an awareness of the impact on their lives.

11.2.2 Recognizing the effects of loss of visual function and the importance of support systems in the health of patients who have ocular disease.

11.3 **Knowledge:**

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of the followings among all age groups:

11.3.1 Normal anatomy and physiology of the eye, age-specific changes in the visual function.

11.3.2 Impact of medication and toxins on the eyes and visual function. In addition to the effects of ocular drugs on systemic function.

11.3.3 Understanding of geriatric ocular problems & importance of regular assessment.

11.3.4 Ocular complications of systemic illness.

11.3.5 Guidelines for appropriate vision evaluation.

11.3.6 Initial diagnosis, management and appropriate referral criteria for common eye problems:

11.3.6.1 Diseases of the Conjunctiva: Trachoma, conjunctivitis, pinguecula and pterygium.

11.3.6.2 Corneal diseases: Superficial trauma and infection e.g. corneal abrasion, keratitis,
corneal ulcers, Dry eye and associated diseases

11.3.6.3 Disease of sclera: episcleritis and scleritis
11.3.6.4 Disease of iris and ciliary body: hyperemia, hemorrhage and Iritis, synechia, mydriasis, meiosis.
11.3.6.5 Disease of choroid: hemorrhage, choroiditis, degeneration and Atrophy (myopic, senile, colloid) and detachment.
11.3.6.6 Disease of retina: retinitis (If due to syphilis, malaria, tuberculosis, etc., or due to diabetes or due to effects of sunlight or electric light), diseases associated with visual loss: e.g. central retinal vein & artery occlusion and retinal detachment and those associated with medical conditions: e.g. hypertension & diabetes mellitus, detachment and optic neuritis
11.3.6.7 Disease of lens: cataract (If due to diabetes, toxic conditions, traumatism or due to keratitis)
11.3.6.8 Affections of the eyeball: glaucoma, diplopia (binocular, uniocular) and ametropia: myopia (simple), hyperopia (simple), astigmatism, anisometropia and presbyopia; contact eye lenses
11.3.6.9 Disease of the lid: blepharitis, abscess, tarsitis, chalazion, emphysema (When due to injury), trichiasis, entropion and ectropion, blepharitis, ptosis
11.3.6.10 Disease of the lacrimal apparatus: dacryocystitis, obstruction of duct
11.3.6.11 Disease of the ocular muscle: myositis and strabismus.
11.3.6.12 Disease of the orbit: cellulitis and exophthalmos
11.3.6.13 Affection o organs on eye: disorders of associated movements (Paralysis of convergence, spasm of convergence, nystagmus), optic neuritis, orbital cellulitis, optic-nerve atrophy, eczema of lids, cranial nerve palsies
11.3.6.14 Macular degeneration and age-related changes
11.3.6.11 Trauma: Blunt & Penetrating.
11.3.6.12 Pediatrics eye conditions
11.3.6.13 Appropriate indications for special procedures in ophthalmology Awareness of: Indications, limitations and follow-up care of elective eye procedures e.g. refractive surgery
11.3.6.14 Basic awareness regarding common Aesthetic procedures to guard patient’s safety: i.e. precautions & post-procedure complications e.g. Injectables: fillers & Botox…etc.

11.4 Skills:

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:

11.4.1 Evaluation:

11.4.1.1 Perform specific procedures and interpret results:

11.4.1.1.1 Tests of visual acuity, visual fields and ocular motility.
11.4.1.1.2 Direct ophthalmoscopy.
11.4.1.1.3 Flashlight examinations.
11.4.1.1.4 Fluorescein staining of the cornea.
11.4.1.1.5 Awareness of: Tonometry / Slit-lamp examination
11.4.1.1.6 Perform physical examination in patients of all ages, with emphasis on understanding normal neurologic and motor responses as well as appearance.
11.4.1.1.7 Localize the problem and generate an appropriate differential diagnosis and management planning.

11.4.2 Management:

11.4.2.1 Formulate a plan for management, investigation and the need for expert advice with regard to the expected potential risks,
costs and value of information that can be obtained.

11.4.2.2 Manage and recognize the common prevalent and treatable diseases.

11.4.2.3 Familiar with the use of different medications e.g. mydriatics, topical anesthetics, corticosteroids, antibiotics and glaucoma agents

11.4.2.4 Prevention and screening of eye problems among different age groups

12 ENT

12.1 Competencies:

At the completion of residency training in ENT, a family medicine resident should:

12.1.1 Be able to recognize the early presentation of common ENT problems.

12.1.2 Be competent in managing common ENT problems encountered in the primary care setting

12.1.3 Demonstrate an understanding of the impact of ENT illnesses on patients and their families

12.1.4 Demonstrate an understanding of the role of each member of the ENT team (ENT surgeons, technicians…etc.)

12.1.5 Recognize his/her own practice limitations and seek consultation with other healthcare providers when necessary

12.1.6 Be aware of the ethical & medico-legal issues related to ENT problems in the state of Kuwait

12.1.7 Recognize red flags of ENT conditions

12.2 Attitudes:

The resident should demonstrate attitudes that encompass:

12.2.1 A supportive and compassionate approach to the care of patients with ENT disease, especially in cases of deteriorating hearing and incurable disabling ENT conditions
12.2.2 Describing strategies for effective communication with patients with hearing impairment and deafness
12.2.3 Demonstrating effective strategies for dealing with parental concerns regarding ENT conditions, e.g. recurrent tonsillitis and glue ear
12.2.4 Empowering patients to adopt self-treatment and coping strategies where possible, e.g. hay fever, epistaxis, chronic sinusitis, dizziness, vertigo and tinnitus

12.3 Knowledge

The family medicine resident is required to demonstrate the knowledge of the following among all age groups:

12.3.1 Inner ear disorders: ENT causes of dizziness/vertigo e.g.: benign paroxysmal positional vertigo, drug induced ototoxicity, Labyrinthitis and vestibular neuritis, Meniere's disease and acoustic neuroma
12.3.2 Middle ear and tympanic membrane disorders: acute otitis media (serous, suppurative), chronic otitis media, otosclerosis, presbycusis, tympanic membrane perforation, mastoiditis, barotrauma and eustachian tube dysfunction.
12.3.3 External ear disorders; dermatitis of the ear canal, otitis externa, external ear obstructions
12.3.4 Oral and pharyngeal disorders: salivary stones and sialadenitis, adenoid disorders, tonsillitis, pharyngitis and obstructive sleep apnea, uvulitis
12.3.5 Nose and sinus disorders: infections, foreign bodies, nasal polyps, allergic rhinitis, septal deviation and sinusitis (acute and chronic)
12.3.6 Laryngeal disorders: laryngitis, laryngocele, vocal cord disorders (paralysis), polyps and nodules
12.3.7 ENT malignancies
12.3.8 Emergencies: epistaxis, epiglottitis, peritonsillar and retropharyngeal abscess, sudden sensorineural hearing loss, foreign bodies
12.3.9 Prevention: screening for hearing impairment in adults and children
12.3.10 Basic awareness regarding common Aesthetic procedures to guard patient’s safety: i.e.
precautions & post-procedure complications e.g. Injectables: fillers & Botox; Skin Rejuvenation …etc. (Add to derma, Ophthalm)

12.4 Skills:
In the appropriate setting, the resident should demonstrate the ability to perform / observe / & interpret:
12.4.1 Otoscopy
12.4.2 Tuning fork tests (Weber and Rinne's tests)
12.4.3 Dix-Hallpike maneuver
12.4.4 Interpretation of tympanometry and audiometry
12.4.5 Watchful waiting and use of delayed prescriptions

13 Mental health

13.1 Competencies:
By the end of residency training, a family medicine resident should:
13.1.1 Understand normal and abnormal psychosocial development and behavior.
13.1.2 Ability to effectively interview and evaluate patients for mental health disorders using appropriate techniques and skills.
13.1.3 Recognize, initiate treatment for and appropriately refer for mental health disorders to optimize patient care.
13.1.4 Rational & evidence-based management (drug & non-drug) for patients with mental health problems.
13.1.5 Be aware of the ethical & medico-legal issues related to mental health problems
13.1.6 Recognize red flags of mental health conditions

13.2 Attitudes:
The resident should demonstrate attitudes that encompass:
13.2.1 Appreciate the common frequency of psychological problems in general practice.
13.2.2 Ability to manage psychological problems within the primary health care system and when to refer as appropriate.
13.2.3 Recognize the importance of interaction between family and social factors and individual health.
13.2.4 Understanding the issue of patient’s autonomy for patients with psychiatric problems.
13.2.5 Appreciate the psychosocial dynamics that influence human behavior and the doctor/patient relationship.
13.2.6 Recognition of the prevalence of abuse in society and willingness to help patients to prevent abusive situations.
13.2.7 Awareness about the importance of a multidisciplinary approach to the care of patients with psychiatric problems, when indicated.
13.2.8 Have sensitivity to and knowledge of the emotional aspects of organic illness.
13.2.9 Awareness about the ethical & medicolegal boundaries related to dealing with patients having mental health problem(s) e.g. drug addicts, psychosis...etc.
13.2.10 Awareness of role of mental health clinics in PHC in Kuwait.

13.3 Knowledge:

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

13.3.1 Basic behavioral knowledge:
13.3.1.1 Normal, abnormal and variant psychosocial growth and development across the life cycle
13.3.1.2 Recognition of interrelationships among biologic, psychologic and social factors in all patients
13.3.1.3 Mutual effects of acute and chronic illnesses on patients and their families.
13.3.1.4 Factors that influence adherence to a treatment plan.
13.3.1.5 Family functions and common interactional patterns in coping with stress
13.3.1.6 Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality and quality of life

13.3.2 Mental health disorders:

**13.3.2.1 Mood disorders:** depression, dysthymia & bipolar disorders

**13.3.2.2 Anxiety disorders:** Panic attack, phobias, obsessive compulsive disorder, post-traumatic stress disorder, acute stress disorder, generalized anxiety disorder

**13.3.2.3 Disorders principally diagnosed in infancy, childhood or adolescence:** e.g. Mental retardation, learning disorders, pervasive developmental disorders (e.g. autism), attention deficit and disruptive behavior disorders

**13.3.2.4 Delirium, dementia, amnestic and other cognitive disorders**

**13.3.2.5 Substance-related disorders:** e.g. Alcohol, Cannabis, Opioids

…etc.

**13.3.2.6 Schizophrenia and other psychotic disorders.**

**13.3.2.7 Somatoform disorders:** Conversion disorder, pain disorder, hypochondriasis

**13.3.2.8 Dissociative disorders**

**13.3.2.9 Sexual and gender dysphoria.**

**13.3.2.10 Eating disorders:** Anorexia nervosa, bulimia nervosa

**13.3.2.11 Sleep disorders**

**13.3.2.12 Personality disorders:** e.g. paranoid, schizoid, antisocial

…etc.

**13.3.2.13 Problems related to abuse or neglect**

**13.3.2.14 Others:** e.g. malingering, factitious disorders, bereavement

**13.3.2.15 Commonly abused drugs with potential risk for addiction:** e.g. bupropion, tramadol, barbiturares, pregabalin…etc.
**13.4 Skills:**

In the appropriate setting, the resident should demonstrate the ability to independently perform, observe / appropriately refer:

13.4.1 Use of evaluation tools and interviewing skills, which enhance data collection in short periods of time and optimize the doctor/patient relationship

13.4.2 Mental status examination and assessment particularly in common psychiatric problems e.g. Depression and anxiety

13.4.3 Elicit and recognize the common signs and symptoms of the psychiatric disorders.

13.4.4 Management of emotional aspects of non-psychiatric disorders

13.4.5 Techniques for enhancing compliance with medical treatment regimens

13.4.6 Initial management of psychiatric emergencies: e.g. the suicidal patient, the acutely psychotic patient…etc.

13.4.7 Proper use of common psychopharmacologic agents:
   - 13.4.8.1 Diagnostic indications and contraindications
   - 13.4.8.2 Dosage, length of use, monitoring of response, side effects and compliance
   - 13.4.8.3 Drug interactions
   - 13.4.8.4 Associated medical problems

13.4.9 Behavioral modification techniques:
   - 13.4.9.1 Stress management
   - 13.4.9.2 Smoking cessation, obesity management and other lifestyle changes
   - 13.4.9.3 Chronic pain management

13.4.10 Appropriate referral procedures to ensure continuity of care, provide optimal information sharing and enhance patient compliance.
14 Palliative Care

14.1 Competencies

By the end of residency training, a family medicine resident should:

14.1.1 Understand the concepts of palliative care and end-of-life care and its contribution to the social well being
14.1.2 Promote concept of palliative care in the primary health care centers, home visits and communities
14.1.3 Demonstrate whole patient approach to caring for the terminally ill patients and their families
14.1.4 Be aware of the ethical & medico-legal issues related to terminally ill patients and their caregivers / family.
14.1.5 Recognize the red flags for terminally ill patient’s conditions

14.2 Attitudes:

The resident should demonstrate attitudes that encompass:

14.2.1 Show compassion and empathy towards dying patients and members of their families.
14.2.2 Keep ethical rules in relationship with patients and their relatives.
14.2.3 Understand the importance of confidentiality as the basis for establishing trusting relationship with patients and their relatives.
14.2.4 Pay special attention to issues of care, pain and other symptom control, the patient’s choice and control over treatment decisions and the patient’s dignity.
14.2.5 Appreciate the diverse of specific family and community traditions related to death and mourning rituals.
14.2.6 Pay special attention to psychological condition of children and adolescents who have experienced the loss of one of their family members.
14.3 Knowledge

The family medicine resident is required to demonstrate the knowledge of the following:

14.3.1 Basics of palliative care: the complexity of the end-of-life; the physician’s task in terminal care and the multi-professional and interdisciplinary approach of Palliative Care
14.3.2 Pain and symptom management: curative therapy, palliative therapy and palliative medicine
14.3.3 Recognition of chronic pain features: the concept of "total pain", principles of pharmacological treatment, pharmacodynamics of opioids, non-opioids & adjuvant analgesics
14.3.4 Non-pharmacological pain management: oncological interventions (chemotherapy, radiotherapy), neurolytic procedures (anesthetic or neurosurgical), nursing interventions, psychotherapy and counselling, physiotherapy, alternative therapy
14.3.5 Gastrointestinal symptoms: constipation, diarrhea, ileus, nausea and vomiting
14.3.6 Pulmonary symptoms: dyspnea and cough
14.3.7 Neuropsychiatric symptoms: delirium, insomnia, depression and other mood disorders, anxiety and fear, hallucinations, confusional states, anorexia, cachexia, loss of appetite, fatigue, weakness, lethargy, thirst, dry mouth, sore mouth and swallowing problems
14.3.8 Dermatologic symptoms: bedsores, wound breakdown, lymphoedema, itching
14.3.9 Terminal care
14.3.10 Psychosocial and spiritual aspects: psychological reactions to chronic illness, grief and loss, impact on patient and family of loss of independence, role, appearance and perceived self-worth during a terminal illness, family dynamics, ethnic, social and religious differences.
14.3.11 Grief and bereavement as a process of each concerned person, anticipatory mourning, risk factors for difficult mourning
14.3.12 Ethical and legal Issues related to terminal care.
14.3.13 Communication: Differentiation: verbal vs. non-verbal communication
14.3.14 Special situations of communication: patient’s information, prognosis, decision-making, conflict and conflict resolution and talking with relatives
14.3.15 Teamwork and Self-reflection: “Burn-out” avoidance and prophylaxis

14.4 Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform / observe / or appropriately refer:

14.4.1 Assessing the physical status of a terminally ill patient – consciousness, neurological reflexes, vital signs, medical causes of discomfort and pain and the ability for self-service.
14.4.2 Communicating with patients and their families, ability to “share the bad news” including choice of appropriate place, time, words and expression of thoughts.
14.4.3 Psychological counseling to patients and members of their families.
14.4.4 On-going communication and work with patients and their families, including the period following patient’s death.
14.4.5 Education of care givers and family members on providing appropriate home medical treatment and care.
Introduction to Workplace Based Assessment (WPBA)

Definition

The evaluation of resident’s performance in the work place 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 (kfmrp.wpba@gmail.com). 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)
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>
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</thead>
<tbody>
<tr>
<td>PGR1</td>
<td>Attendance of all/passing 75% of the Rotations and Courses of R1</td>
<td>45 days/ year</td>
<td>Minimum 220 Hours / year</td>
<td>Clinic:</td>
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<td>-4COT/month</td>
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<td>-4CBD/month</td>
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<td>-8 CTS/month</td>
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<td>-4 Tutorial/month</td>
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<td>- DOPES (2 procedures/month)</td>
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<td>-CCR for each 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 form at the end of rotation</td>
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<tr>
<td>PGR2</td>
<td>Attendance of all/passing 75% of the Rotations and Courses of R2</td>
<td>45 days / year</td>
<td>Minimum 220 Hours / year</td>
<td>Clinic:</td>
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<td>- 4 COT/month</td>
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<td>- 4 CBD/month</td>
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<td>- 8 CTS/month</td>
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<td>- 4 Tutorial/month</td>
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<td>- mid rotation verbal feedback</td>
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<td>- KIMS forms (trainee + tutor+ clinic) evaluation form at the end of rotation</td>
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<td>- Life support (BLS &amp; ACLS) certifications</td>
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<td>- ITER</td>
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</table>

**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>Course</th>
<th>Attendance Requirements</th>
<th>Duration</th>
<th>Minimum Hours</th>
<th>Clinic:</th>
<th>Hospital:</th>
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</thead>
<tbody>
<tr>
<td>PGR3</td>
<td>Attendance of all/passing 75% of the Rotations and Courses of R3</td>
<td>45 day / year</td>
<td>Minimum 220 Hours / year</td>
<td>- 4COT/month</td>
<td>- 12 DOPES (2/month)</td>
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<td>- 4CBD /month</td>
<td>- CCR for the course</td>
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<td>- DOPES (2/month)</td>
<td>- mid rotation verbal feedback</td>
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<td>- mid rotation verbal feedback</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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<tr>
<td>PGR4</td>
<td>Attendance of all / passing 75% of the Rotations and Courses of 4</td>
<td>45 day / year</td>
<td>Minimum 220 hours / year</td>
<td>- 4 COT/month</td>
<td>- 5 SGT</td>
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<td>- 4 CBD/month</td>
<td>- Audit Project Report (Pass)</td>
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<td>- DOPES (2/month)</td>
<td>- mid rotation verbal</td>
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<td>Feedback</td>
<td>PGR5</td>
<td>Attendance of all/ passing 75% of the Rotations and Courses of R5</td>
<td>45 day / year</td>
<td>Minimum 220 hours / year</td>
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<td>- KIMS forms (trainee + tutor+ clinic) evaluation form at the end of rotation</td>
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<td>- Life support (BLS &amp; ACLS) revalidation of certifications</td>
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</table>

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

<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>
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<tbody>
<tr>
<td>Consultation observation tool</td>
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<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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<td>DOPES</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.
- Four hours of teaching should be scheduled for each resident per week in the clinic:
  - one hour tutorial
  - One COT
  - One CBD
  - Twice /week discussion of Dr consultation time sheet

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

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R3 Schedule

- Each month trainees should get minimally 2 COT’s and 2 CBD’s teaching sessions.
- 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 2 CBD’s and 2 COT’s teaching sessions.
- 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. Medicolegal 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.
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>Capital</th>
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</table>
| 1. | Shwaikh Healthcare center | Sameera Alkanderi  
Consultant FM  
Rawan Al Turki,  
Specialist FM |
| 2. | Khalid Algunaim Healthcare center (Al Qadisiya) | Maleka Serour  
Consultant FM  
Nusaiba alkandary (potential trainer) |
| 3. | Al Mansouria Healthcare Center | Aliaa Sadeq, Senior  
Specialist FM |
| 4. | Abdulla AlAbdulhadi healthcare center (Yarmouk) | Huda Alduwaisan,  
Consultant FM  
Tasneem Al Jariki, Senior  
Specialist FM  
Mahdi Al Mousawi |
| 5. | Futooh Alsabah Healthcare center (shamiya) | Huda Al Abduljalil,  
Consultant FM  
Ghaidaa Al Mutairi,  
Consultant FM  
Fajer Al Barak,  
Specialist FM |
| 6. | Qortuba Healthcare center | Sawsan Al Bannai,  
Consultant FM  
Fatema Bushihri (senior registrar) |
| 7. | Ali Thunayan Alghanim Healthcare Center (sulaibikhat) | Deena Al Dhubaib,  
Consultant FM  
Shaimaa Al Fouderi,  
Specialist FM  
Ahmed Alarouj (potential trainer) |
<p>| 8. | Alnafeesy Healthcare center | Sana Al Mansour, |</p>
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<tr>
<th>Number</th>
<th>Healthcare Center</th>
<th>Consultant/Employee Details</th>
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<tr>
<td>9</td>
<td>Bnaid Al Ghar Healthcare center</td>
<td>Fareeda Muqadam, Consultant FM</td>
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<td>10</td>
<td>AlNuzha Healthcare center</td>
<td>Amel Al Juhaidli, Consultant FM</td>
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<td></td>
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<td>Aliaa Husain, Senior Specialist FM</td>
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<td>11</td>
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<td>Dalia Al Sane, Consultant FM</td>
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<td>Shaimaa AL Faris, Specialist FM</td>
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<td>Alihqaki healthcare center (Daiya)</td>
<td>Esraa Hassan, Senior Specialist FM</td>
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<td>Abdulmugni healthcare center (Faiha)</td>
<td>Anwar Buhamra, Consultant FM</td>
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<td>Lujaan Al Edan, Specialist FM</td>
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<td>Hessa AL Ansari (potential trainer)</td>
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<td>Abbas Maarafi, Senior FM</td>
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<td>Dalal Al Hajeri, Consultant FM</td>
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<td>Hamad Al Hamad, Consultant FM</td>
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<td>Anood Al Juwaihil, Specialist FM</td>
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<td>Al Qairawan Health Center</td>
<td>Amina AL Atwan, Consultant FM</td>
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<td>18</td>
<td>AlShaab Health Center</td>
<td>Yasmin Yahya, Senior</td>
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<td>AL Salam Health Center</td>
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<td>Al Osaimi Clinic (Khaitan )</td>
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<td>29.</td>
<td>Abdulla Almubarak health center</td>
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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.

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<tr>
<th>Name of Hospital</th>
<th>Specialty</th>
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<td>Asaad Al Hamad</td>
<td>Dermatology</td>
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</table>
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.

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>
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<tr>
<td>Asthma</td>
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<td>Diabetes</td>
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<td>Hypertension</td>
<td>Nice / ACC</td>
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<td>Hyperlipidemia</td>
<td>ACC</td>
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<tr>
<td>Osteoporosis</td>
<td>Kuwait Guidelines for the Management of osteoporosis.</td>
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</tbody>
</table>
Contacts

**KIMS:**
www.kims.org.kw

@kims_news

kims_news

22410027

*Family Medicine Residency Program:*

Official site [www.kfmrp.com](http://www.kfmrp.com)

[Elearning.kfmrp.com](http://Elearning.kfmrp.com)

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The curriculum is last reviewed and updated on June 2019; by scientific committee members.