PSYCHIATRY CURRICULUM
PSYCHIATRY RESIDENCY PROGRAM

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I. INTRODUCTION

Mental illnesses are universally looked upon as object of stigma and more so in our part of the world. Various folklore beliefs have been used to explain the factors triggering mental illness. In the Orient and the Middle East the age old beliefs include possessions by witches, ‘Jinn’, spirits and various magical or mystical influences are still generally thought to cause mental illnesses. Even for post-renaissance societies, many people in the Western World also believe in possession states and some believe in the influences of aliens and disembodied intelligence. In traditional society around, many people still hold a view that anthropomorphic being may be operative in at least some of the cases with mental illness. This results in social discrimination, stigma and ostracism that often results in delayed or refused treatment for mental illness all over the world.

Over the last 100 years, a wealth of modern research has brought enlightenment and psychiatry now forms the scientific basis of the understanding of the biological, psychological, and socio-cultural components of mental illness. More recently, it has becoming clear eclectic approach using both biological, social-cultural and psychological techniques improve the quality of life of people with mental illness that were deemed unfathomable just two decades ago. The most effective channels to dispense such services are to trained psychiatrists.

Through this Psychiatric Residency Programme, the future Omani Psychiatrists will be trained to deliver the highest quality of modern holistic psychiatric care for all mental health problems and also be able to prevent/reduce disability provide the best quality of life for their patients. Evidence-based amelioration of mental illness using modern psychiatric services has been shown to be essential mechanism to mitigate the stigma and discrimination of people with mental illness.

Rapid social changes are taking place all over the world and in our country, the Sultanate of Oman; this speed of this socio-cultural change has been very dramatic with rapid urbanization, modernization, industrialization, high levels of education and a shift towards nuclear families that have changed the demographics of the country within 30 to 35 years. These rapid social changes have not only altered the structure of the communities’, families’ and the individual’s psychological well being but the globalization has added social disorganization that give rise to problems like juvenile delinquency, alcohol and other substance abuse, traumatizing industrial and traffic accidents. Other factors like malnutrition, metabolic and life-style diseases as well as infections also adversely influence mental health; hence there is an increasing need for community education programs.
Improving quality of life and promoting the understanding for proper meaningful preventive, therapeutic and rehabilitative programs are essential. Central to this concept is the development of local specialised manpower to deliver the best results. The training of local doctors will give the trainees more insight in understanding the cultural factors and their effect on mental health. It is more cost-effective, efficient, and directed to more rapid community based specialised interventions.
II. DEFINITION

Psychiatry is the branch of medicine concerned with the bio-psycho-social study of the etiology, assessment, diagnosis, treatment and prevention of mental, emotional and behavioral disorders alone or as they coexist with other medical or surgical disorders across the life span.

III. GOALS

Upon completion of training, the resident is expected to be a competent specialist in Psychiatry, capable of assuming consultant's roles and responsibilities in the specialty. Residents must demonstrate the requisite knowledge, skills, and attitudes for effective patient-centered care and service to a diverse population across the life span. The resident must acquire a working knowledge of the theoretical basis of Psychiatry, including its foundations in the basic medical sciences and research.

In all aspects of specialist practice, the resident must be able to address issues of gender, age, culture, ethnicity, spirituality and ethics in a professional manner.

IV. VISION

- To disseminate knowledge with the aim of early intervention and competent management of patients with mental disorders for the relief of suffering.

- To provide mental health care and management at various levels and settings of care (primary, secondary, tertiary, community, inpatient, outpatient and emergency).

- To implement the most updated physical methods of treatment.

- To introduce and implement various forms of psychological therapies, social and rehabilitative interventions.

- To improve mental health and mental health care services for all children, adults and the elderly in Oman.

V. MISSION

To promote excellence in training and research in the field of Psychiatry.
VI. OMSB COMPETENCIES

The OMSB has adopted the ACGME-I competencies.

Our program fulfills the OMSB Objectives of Training in Psychiatry and the Specialty Training Requirements.

Upon completion of training, the resident is expected to be a competent specialist in the field of Psychiatry. Resident must demonstrate knowledge, skills and attitude appropriate to this role including incorporating gender, cultural, and ethnic perspectives.

Successful completion of training includes the capacity of the resident to demonstrate the following:

Medical Knowledge
- Mastery of theoretical knowledge of the specialty of psychiatry.
- Ability to conduct initial assessments, including developing a diagnosis, formulation, and management plan, integrating the bio-psycho-social components of each patient’s case.
- Understanding of the course of psychiatric illness, and therapeutic skills to treat patients over time.
- Ability to manage a breadth of clinical situations.
- Ability to access, integrate and apply relevant theoretical knowledge.
- Sound clinical judgment.
- Ability to problem-solve in each patient’s case.
- Ability to conceptualize each patient individually, and to have a sense of each patient’s mental life and life circumstances.

Patient Care
- Ability to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.
- Ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
- Ability to gather essential and accurate information about their patients.
- Ability to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up to date scientific evidence, and clinical judgment.
- Ability to develop and carry out patient management plans.
- Ability to counsel and educate patients and their families.
- Ability to use information technology to support patient care decisions and patient education.
- Ability to perform competently all medical and invasive procedures considered essential for the area of practice.
- Ability to provide health care services aimed at preventing health problems or maintaining health.
- Ability to work with health care professionals, including those from other disciplines, to provide patient-focused care.
Interpersonal Skills and Communication
- Ability to develop rapport with patients.
- Ability to communicate well, including listening well, with patients, families, and other members of the health care team.
- Capacity to maintain complete and accurate health records.
- Ability to work both independently and on teams.
- Capacity to build strong working relationships with colleagues.

Practice Based Learning and Improvement
- Capacity to contribute effectively to the improved health of patients and communities, and to recognize and respond to those issues where advocacy is appropriate.
- Understanding of the health care system and medical professional organizations in the country.
- Familiarity with research methods and data presentation.
- Ability to critically assess literature.
- Self-motivation in studying and ability to prepare for exams.
- Ability to pursue his/her own further learning after residency.
- Capacity to facilitate learning of others.

System Based Practice
- Ability to manage his/her own stress.
- Ability to balance patient care, learning needs, and outside activities.
- Ability to work effectively within a health care organization.

Professionalism
- Integrity: treats patients and colleagues with honesty, respect and tolerance.
- Ethical in clinical practice; responsible; trustworthy and reliable.
- Respectful of diversity.

VII. GENERAL OBJECTIVES

The program is designed to produce specialists in General Psychiatry with adequate knowledge and competency of the subspecialties including Psychotherapy, Child and Adolescent psychiatry, Substance misuse, Geriatric psychiatry, Forensic psychiatry, Rehabilitation psychiatry, Consultation-Liaison psychiatry and other relevant subspecialties.

VIII. SPECIFIC OBJECTIVES

1. To produce highly skilled, competent and ethical Psychiatrists, to deal with most of the psychiatric problems and to ensure the right attitude to deal with patients and their families.
2. To promote research orientation and environment for academic research.

3. The first two core psychiatric years of the program are directed to assisting the residents to:
   - Achieve comprehensive grounding in clinical psychiatry, basic knowledge and practical skills such as diagnostic interviewing, case presentation, treatment planning and follow-up.
   - Gain knowledge of all biological treatment modalities in the field of psychiatry and competence in their use.
   - Achieve an understanding of the classification of psychiatric illness including the areas of child psychiatry and mental retardation.
   - Acquire expertise in clinical logic and understanding.
   - Acquire expertise in the correct utilization of psychological services.
   - Understand the principles of behaviour therapy including indications, techniques available, and their proper utilization.
   - Gain expertise and experience in working with patients in a wide variety of settings, including hospitalizing patients, partial hospitalization, outpatients, crisis intervention, and emergency settings.
   - Gain a broad knowledge of psychiatric, social, or other support services available to the mentally ill.
   - Function as team coordinator with members of other disciplines.
   - Guide and assist in the education of other persons, e.g. medical student.
   - Acquire knowledge of medico-legal and ethical issues involved in the practice of psychiatry.
   - Acquire knowledge of the rights of patients, and the applications of the Mental Health Act (if applicable).
   - Attain knowledge of and options in the field of psychiatry, from which further career choices can be directed.

4. The final years introduce new emphasis in clinical experience. Increasing independence in the range and practice of clinical psychiatry is expected. In addition residents may elect to spend time in a subspecialty, in research, in a field of medicine related to psychiatry, or in a related basic science.
These years are directed towards completing a cycle of education which will:

- Consolidate knowledge and skills in general psychiatry for successfully passing the certification examination.

- Achieve expertise in a subspecialty of psychiatry such as child and adolescent psychiatry, rehabilitation psychiatry, Geriatric psychiatry, forensic psychiatry, and addictions.

- Acquire expertise in a related field of medicine.

- Acquire expertise in a related research or basic science field.

- Continue the expansion of psychotherapeutic skills.

- Demonstrate evidence of developed expertise by the presentation of material in the Department or by publication.

- Acquire skills and attitudes to continue self-evaluation and education throughout a professional career.

- Establish a longitudinal relationship of treatment with at least one patient with chronic psychotic illness.

- See residents collaborating effectively within the health care team to achieve optimal patient care.
IX. SPECIALTY ADMISSION REQUIREMENTS

1. Applicant should have Bachelor degree of medicine, or equivalent in Medical Sciences from a recognized medical College and a minimum grade of ‘Good’ or 3.00 GPA.

2. One year successful completion of internship.

3. Two recommendations letters.

4. Letter of sponsorship.

5. Clearance of OMSB selection examination.

6. Successful selection by the Specialty panel at personal interview and/or Specialty MCQ Entrance Exam.
X. STRUCTURE OF TRAINING PROGRAM

1. Duration of Program

The Psychiatry Residency Training is a five years long conjoint training program based at the Sultan Qaboos University Hospital and Al Masarra Hospital including one year selective/elective training in one of the subspecialties inside or outside the Sultanate of Oman. Selected candidates will start at (R1). In very special cases, transfers at the second-year postgraduate level (R2) may be permitted from another recognized program in another country.
2. Psychiatry Program Rotation Structure

<table>
<thead>
<tr>
<th>Year</th>
<th>General Adult Psychiatry (Inpatient &amp; Outpatient)</th>
<th>Neurology</th>
<th>Psychotherapy</th>
<th>Child and Adolescent Psychiatry</th>
<th>Addiction</th>
<th>Consultation Liaison</th>
<th>Family Medicine</th>
<th>Emergency Medicine</th>
<th>Internal Medicine</th>
<th>Pediatrics</th>
<th>Geriatric Psychiatry</th>
<th>Forensic Psychiatry</th>
<th>Emergency Psychiatry</th>
<th>Community Psychiatry</th>
<th>Research Block</th>
<th>Elective (subject to availability)</th>
<th>Annual Leave</th>
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<td>12</td>
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* Five blocks for Geriatric Psychiatry followed by one Block for research out of total 2 blocks allocated for research the first being in year II following psychotherapy rotation.

**As there are only two training centres for Psychiatry in the Sultanate, students and residents from other medical and paramedical specialties undertake their clinical training at both sites with probabilities of overlapping rotations with those of psychiatric residents with expected impact on the amount of clinical exposure as well as the impact on trainers to trainees standard ratio.

*** In the Sultanate, the candidate for Psychiatry training has to complete internship program of one year including major medical/surgical rotations. However, taking into consideration the limited availability of slots in Family and Community medicine training program and Emergency medicine, two blocks have been allocated to cover both.

**** Sub-specialty training in forensic psychiatry is yet to be established. However, it is considered essential for the senior residents to be oriented clinically to the challenges of forensic psychiatry to achieve clinical competency in undertaking comprehensive risk assessment and management. This is provided through their senior rotation in the general adult psychiatry as the forensic psychiatry is currently integrated into the general adult rotation.

Establishing therapeutic alliance and monitoring patient's progress and the implementation of the aftercare plan jointly with the multidisciplinary team and the family are considered crucial aspects of the residency training especially in the absence of community psychiatry.

+ In order to consolidate the clinical training in Psychiatry, the resident is offered an opportunity to undertake elective rotation abroad in his/her area of interest. Although an elective rotation, it is viewed as
essential to standardize the training with clinical exposure at an accredited training site especially in the subspecialties which are not fully established. Also aiming to pave the way for the fellowship.

3. Core Structure

First year (R1)
During the first year, resident should acquire basic knowledge of Psychiatry, communication skills and interviewing techniques via tutorials/interviewing skills sessions, lectures, outpatients care, inpatient care and emergency. Trainees are expected also to devote time for self reading/studying in allied basic subjects.

Resident’s clinical rotations will be in emergency medicine, family and community medicine, neurology and general adult psychiatry.

Second year (R2)
The second year will be taken up by didactic lectures, tutorials, demonstrations, etc., in general clinical psychiatry. This year will also be devoted to broadening the clinical knowledge aiming to improve clinical judgment skills. The Residents in R2 are expected to continue personal studies of related disciplines.

Resident’s clinical rotations will be divided into be general adult psychiatry, psychotherapy and research.

Third year (R3)
Special attention will be given to clinical training in child psychiatry and geriatric psychiatry. The relationship between mental health and psychosocial factors will be closely examined.

Resident’s clinical rotations will be divided to be child and adolescent psychiatry, geriatric psychiatry and research.

Fourth year (R4)
The fourth year is designed to expand the clinical training of the residents in sub-specialties, such as consultation-liaison psychiatry and addiction psychiatry.

Resident’s clinical rotations will be divided in to be addiction psychiatry, consultation-liaison psychiatry and period of elective in which the resident is encouraged to take forensic psychiatry.

5th Year Selective/Elective Training
Elective training local/abroad in one of the subspecialties at a recognized institution, subject to availability and approval.
4. Outline of Rotations and Blocks

<table>
<thead>
<tr>
<th>SN</th>
<th>Rotation</th>
<th>Number of Blocks</th>
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<tbody>
<tr>
<td>1.</td>
<td>General Adult Psychiatry</td>
<td>18 Blocks</td>
</tr>
<tr>
<td>2.</td>
<td>Family Medicine</td>
<td>1 Block</td>
</tr>
<tr>
<td>3.</td>
<td>Emergency Medicine</td>
<td>1 Block</td>
</tr>
<tr>
<td>4.</td>
<td>Neurology</td>
<td>2 Blocks</td>
</tr>
<tr>
<td>5.</td>
<td>Psychotherapy</td>
<td>5 Blocks</td>
</tr>
<tr>
<td>6.</td>
<td>Child and Adolescent Psychiatry</td>
<td>6 Blocks</td>
</tr>
<tr>
<td>7.</td>
<td>Geriatric Psychiatry</td>
<td>5 Blocks</td>
</tr>
<tr>
<td>8.</td>
<td>Addiction Psychiatry</td>
<td>4 Blocks</td>
</tr>
<tr>
<td>9.</td>
<td>Consultation Liaison Psychiatry</td>
<td>4 Blocks</td>
</tr>
<tr>
<td>10.</td>
<td>Research</td>
<td>2 Blocks</td>
</tr>
<tr>
<td>11.</td>
<td>Electives</td>
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5. Distribution of Rotations by Year

<table>
<thead>
<tr>
<th>R1</th>
<th>TRAINING SITE</th>
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<tbody>
<tr>
<td>General Adult Psychiatry</td>
<td>8 Blocks AMH/SQUH</td>
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<tr>
<td>Neurology</td>
<td>2 Blocks SQUH</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>1 Block c/o FAMCO Residency Program</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 Block c/o EM Residency Program</td>
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<table>
<thead>
<tr>
<th>R2</th>
<th>TRAINING SITE</th>
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<tbody>
<tr>
<td>General Adult Psychiatry</td>
<td>6 Blocks AMH/SQUH</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>5 Blocks SQUH</td>
</tr>
<tr>
<td>Research</td>
<td>1 Block OMSB</td>
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<table>
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<tr>
<th>R3</th>
<th>TRAINING SITE</th>
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<tbody>
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<td>Child and Adolescent Psychiatry</td>
<td>6 Blocks AMH/SQUH</td>
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<tr>
<td>Geriatric Psychiatry</td>
<td>5 Blocks AMH/SQUH</td>
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<tr>
<td>Research Block</td>
<td>1 Block OMSB</td>
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<th>R4</th>
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<td>Addiction Psychiatry</td>
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<tr>
<td>Consultation Liaison</td>
<td>4 Blocks SQUH</td>
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<tr>
<td>General Adult Psychiatry</td>
<td>4 Blocks AMH/SQUH</td>
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<tr>
<th>R5</th>
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<tbody>
<tr>
<td>Elective</td>
<td>12 Blocks Subject to availability – local/abroad</td>
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</table>
6. **Mandatory Subspecialty Rotations**

Family Medicine (1 Block), Emergency Medicine (1 Block), Neurology (2 Blocks), Psychotherapy (5 Blocks), Child and Adolescent Psychiatry (6 Blocks), Geriatric Psychiatry (5 blocks), Addiction Psychiatry (4 Blocks), Consultation- Liaison Psychiatry (4 blocks), Research (2 blocks)

7. **Elective Subspecialty - (Local/Abroad)**

XI. CURRICULUM COMPONENTS:

CORE ROTATIONS

1. GENERAL ADULT PSYCHIATRY

GOALS AND OBJECTIVES

Psychiatric residents are expected to complete at least 22 months of general adult psychiatry at the accredited training sites ensuring maximum clinical exposure in emergency, outpatient and inpatient settings, enabling residents to skillfully assess and treat full spectrum of clinical problems seen in psychiatric practice while maintaining close associations with internal medicine, surgery, neurology, family medicine and emergency Physicians.

Residents will undertake general adult rotations at junior levels (R1-R2) up to 18 blocks and at senior levels (R4) up to 4 blocks. In addition to enhancing independent management skills at the senior level rotation the focus will also be on clinical exposure to the subspecialties which are currently incorporated into the general adult services (pending the establishment of such subspecialty services locally).

General adult psychiatry rotation (locally) or the subspecialty rotations of forensic or rehabilitation or learning disability (abroad) can be undertaken as elective rotations at R5 (for up to 12 blocks).

Training sites for general adult psychiatry include Al Masarra Hospital and Behavioural Medicine Department in Sultan Qaboos University Hospital.

There must be systemic supervision, including direct observation of Residents in general adult services to ensure expertise in the diagnosis and management of all types of patients involved with adult psychiatry.

Experience in organizing and providing a general adult service is an important aspect of training.

Comprehensive training across diagnostic spectrum in adult patients is essential for the general psychiatrist, and which includes assessment, case formulation, treatment planning and implementation, consultative communication and review.

During the General Adult Psychiatry rotations, residents will be actively involved in the teaching of medical students rotating through Psychiatry. This teaching component of the general adult psychiatry rotations helps to fulfill “practiced based learning and improvement” competencies during these rotations, and prepares the resident for future involvement in teaching.
1.1 GENERAL ADULT PSYCHIATRY ROTATION:  
JUNIOR RESIDENTS: R1 and R2

1.1.1 General Objectives
At the end of 18 blocks of rotations in general adult psychiatry, residents are expected to have acquired adequate theoretical knowledge as well as appropriate skills and attitude with competence in:

1. The evaluation, treatment and disposition of common psychiatric disorders presenting at different adult settings including emergency, the outpatient and the inpatient where various levels of intervention are required.
2. Communicating of clinical findings and recommendations to all appropriate parties.
3. Implementing treatment, including the ability to refer to the appropriate health and social resources.

1.1.2 Specific Objectives
A. Medical Knowledge
The resident should have acquired information and skills concerning:

- The phenomenology, epidemiology, aetiology, course and comorbidities (including medical/surgical) of various psychopathological conditions presenting in the general adult settings (emergency, outpatient and inpatient).
- The interaction of biological, psychosocial and cultural factors involved in the etiology, prognosis and course of acute and chronic disorders, especially noting those factors which determine presentation in the different adult settings.
- The biopsychosocial factors involved in the presentation of and/or the request for consultation in violent patients, suicidal patients, substance abuse/alcohol abuse, behavioral crisis and family crisis.
- The methods of consultation and the role of the Psychiatrist in emergencies, trauma or crisis situations.
- The ability to perform specialist assessment of patients and document relevant history and examination to include:
  - Presenting or main complaint,
  - History of present illness,
  - Past medical and psychiatric history,
  - Family history,
  - Personal history,
  - Social history,
  - Forensic history, and
  - Premorbid personality
- Knowledge of international Mental Health legislations and of local policies.
- Biological/psychopharmacological intervention strategies (indications/contraindications) in patients presenting with medical and surgical comorbidities.
• Psychotherapeutic and behavioral crisis intervention strategies.
• Ethical considerations relevant to specific patients (e.g. duty to warn, confidentiality, consent, etc.).
• Social and community resources available for patients with mental health problems.
• Effective, efficient and comprehensive crisis interviewing skills, including mental status, using a variety of strategies which allow adequate collection of information while maintaining the therapeutic alliance with the range of patients presenting in the general adult settings.
• Construct formulation utilizing a biopsychosocial framework and including differential diagnoses.
• Ability to collect and use alternative sources of information.
• Appropriate use of the laboratory and other investigative techniques.
• Risk assessment in cases of suicide, violence, abuse of self or others and substance abuse.
• Identify acute organic situations requiring medical or psychiatric intervention including alcohol and drug intoxication/overdose/withdrawal and delirium in the general adult setting.
• Develop the ability to conduct specialist assessment and treatment of patients presenting with various mental disorders and demonstrate effective management of such disorders.
• Develop and implement an initial treatment plan from a biopsychosocial perspective.
• Demonstrate effective triage skills.
• Recognize clinical situations requiring consultation or expertise of other physicians.
• Manage stress, remain calm and act in a timely manner.
• Implement techniques of nonviolent crisis intervention if necessary.
• Set appropriate limits.
• Record and maintain accurate and complete medical records.

1.2 GENERAL ADULT PSYCHIATRY ROTATION:
SENIOR RESIDENTS: R4 and R5 (AS ELECTIVE)

1.2.1 General objectives:
• Advanced clinical knowledge and skills in the assessment and treatment of full range of psychiatric disorders in general adult settings
• Behavioral, psychosocial and vocational training for the chronically mentally ill.
• Forensic assessment, case formulation, treatment planning and implementations.
• How to assess and work with adult patient with mental retardation and other developmental disabilities.

1.2.2 Specific Objectives
• Demonstrate the appropriate diagnostic and therapeutic skills for the effective care of the chronically mentally ill.
• Acquire the necessary skills in relation to the treatment of chronic psychiatric disorder, particularly Schizophrenia. This should involve the ongoing
treatment and prevention of relapse, continued monitoring of each patient’s performance in rehabilitation, and the provision of appropriate follow-up.

- The ability to operate as a Specialist to colleagues in relation to the recognition of the psychosocial, vocational and behavioral deficits of patients with chronic psychiatric disorder.
- The ability to operate as a Specialist in relation to the provision of programs for the chronically mentally ill, in both inpatient and outpatient settings. The ability to liaise not only with colleagues within the psychiatric profession but also with other interdisciplinary professionals in order to provide a streamline of services to the chronically mentally ill.
- Acquire appropriate diagnostic and therapeutic skills for the effective care of the mentally ill who are in conflict with law.
- Demonstrate the necessary skills required in the treatment of forensic patients.
- Operate in relation to the provision of programs for the forensic psychiatric patient in both inpatient and outpatient settings. The ability to liaise not only with colleagues within the psychiatric profession but also with the legal system in order to provide a streamline of services for these patients.
- Participate in the assessment and treatment of patients with developmental delay.
- Appreciate the degrees of developmental delay, and patient’s level of functioning
- Awareness of community resources for patients with developmental delay.

A. Medical Knowledge

- Residents will have synthesized an effective and advanced level of clinical knowledge (assessment, diagnosis and treatment) and understanding of the following, but not restricted, to:
  - Etiology, clinical presentation, and course of illness
  - Diagnostic criteria for psychiatric illness
  - Normal and abnormal development
  - Normal and abnormal psychology
  - Psychopharmacology and somatic therapies
  - Psychotherapeutic constructs - individual, family, group
  - Health care regulations - confidentiality, mental health act, dependant adults legislation, child welfare act (if available)
  - Cultural, gender, social and age specific theoretical, clinical and therapeutic issues
  - Community resources
  - Critical appraisal, scientific method, quality assurance, epidemiology
  - Population health principles

- Residents will demonstrate the skills needed to assess, diagnose and treat the full range of mental disorders in adults by being able to:
  - Establish and maintain rapport and an effective working relationship
  - Conduct a comprehensive diagnostic interview
Perform an appropriate mental status examination
Conduct a couple or family interview
Arrive at differential diagnoses and the final diagnosis.
Formulate an understanding of patients’ problems using a bio-psychosocial model
Give an effective oral presentation of the above
Determine a treatment plan using the bio-psycho-social formulation, and implement appropriate components of that plan
Use psychiatric, psychological, medical and imaging investigations for assessment and treatment
Assess suitability for, prescribe and use appropriate psychological treatments (including but not limited to psychodynamic, interpersonal, cognitive, and behavioral therapies for individuals, families and groups)
Develop level-appropriate skills in the practice of at least one individually-oriented psychotherapy modality, and at least one other modality (e.g., family therapy, couple therapy, psycho education, group therapy, etc.)
Assess suitability for, prescribe and use appropriate psychopharmacological treatments
Understand the process of combining modalities (e.g. pharmacotherapy and psychotherapy)
Respond appropriately to emergencies.
Manage own reaction to patients
Record and maintain accurate and timely medical records for each patient seen, including history, relevant physical examination, relevant investigations, diagnosis, understanding and treatment plan.
Independently assess and manage patients with mental illnesses in emergencies.
Demonstrate expertise in applying the principles of crisis intervention in emergency situations.
Acquire the ability to incorporate updated clinical information into clinical practice.
Apply in practice the principles of assessment of disability and demonstrate in clinical practice the use of structured assessment tools for the disability and social function.
Assess change in social function and predict capability to move between different settings.
Demonstrate ability to assess patients’ suitability for psychosocial and vocational rehabilitation training.
Demonstrate knowledge and practice of the pharmacological management of psychosis resistant to regimes according to standard guidelines.
Provide specific evidence based interventions for people with chronic, disabling and complex mental health problems, ensuring care plans are consistent with the patient’s strengths and level of function and that access to interventions is not precluded by disability.
o Maintain focus on the provision of work, leisure, social and educational services for patients with severe mental illness
o Acquire appropriate diagnostic and therapeutic skills for the effective care of the mentally ill who are in conflict with law.
o Demonstrate practical knowledge of the relevant mental health legislation, guidelines, local policies, procedures, codes of practice and guidance relating to: mental health, capacity, confidentiality data protection, freedom of information, disability and discrimination, consent, bullying and harassment, human rights, public protection, criminal, civil and case law relating to forensic patients.
o Develop an awareness of the impact of legal context on patient evaluation.
o Understand the philosophy of retribution, incapacitation, and deterrence.
o Understand the balance between the primary duty of care to patients and protection of public safety.
o Understand the links between psychopathology, victimisation, mental disorders and crime.
o Assess safety of environment for patient examination.
o Ability to elicit psychopathology and phenomenology relating to risk.
o Ability to collate and integrate of information from clinical, risk and legal evaluation into a comprehensive formulation.
o Formulate risk management plan arising from risk assessment with the multidisciplinary team.
o Acquire knowledge and skills of application of management strategies including de-escalation and breakaway in addition to the protocol of control and restraint and seclusion.
o Acquire knowledge of the causes of developmental delay.
o Competently assess patients with learning disability who may have significant communication problems.
o Explain and initiate a range of psychological therapies in patients who have learning disability with appropriate supervision.

B. Interpersonal and Communication Skills
- Ability to listen effectively.
- Ability to communicate to patients and family an accurate and thorough explanation of the diagnosis, investigations, treatment and prognosis.
- Discuss appropriate information with health care team, effectively providing and receiving information.
- Effectively convey to medical colleagues pertinent information and opinions.
- Prepare documentation that is accurate and timely.
- Develop ability to write a comprehensive medical report, including forensic reports by the senior residents.
• Consult effectively with other health care professionals and Physicians.
• Ability and willingness to teach and learn from colleagues.
• Ability to work collaboratively with other members of the health care team, recognizing their roles and responsibilities.
• Work collaboratively with the patients to explore all relevant issues to enhance understanding, insight and motivation and view self-management as an essential part of the recovery process.
• Work collaboratively with the patient and carers to develop a coherent management plan.
• Work collaboratively with the patients to identify early signs of deterioration in mental state in addition to the potential factors which may lead to recurrence of risk behavior.
• Contribute to interdisciplinary team activities.
• Ability to facilitate the learning of patients, students and other health professionals and contribute to new knowledge.

D. Systems Based Practice
• Make cost effective use of resources based on sound judgment.
• Set realistic priorities and use time effectively in order to optimize professional performance.
• Evaluate the effective use of resources.
• Understand and make use of information technology to optimize patient care and life-long learning.
• Ability and willingness to direct patients to relevant community resources.
• Coordinate the efforts of the treatment team, effective delegation.

E. Practice Based Learning and Improvement
• Identify and understand determinants of health affecting patients and hospital wards and responding in a role-appropriate fashion to the issues where advocacy for the patient and hospital wards are appropriate.
• Awareness of major regional, national and international advocacy groups in mental health care.
• Awareness of governance structures in mental health care.
• Demonstrate an understanding of and a commitment to the need for continuous learning; develop and implement an ongoing personal learning strategy.
• Ability to critically appraise current medical/psychiatric/theoretical knowledge and intervention strategies in crisis situations in the general hospital setting.
• Help others learn through guidance and constructive feedback.

G. Professionalism
• Demonstrate integrity, honesty, compassion and respect for diversity.
• Fulfill medical, legal and professional obligations of a specialist.
• Collaborative and respectful patient relationships that demonstrate gender and cultural awareness.
• Responsibility, dependability, self-direction and punctuality.
• Patience and flexibility in the face of complex clinical/administrative situations.
• Acceptance and constructive use of supervision and feedback.
• Awareness and application of ethical principles.
• Awareness of own limitations, seeking advice when necessary.

1.1.3 Enabling Circumstances
1. Maximum education benefit is obtained when the resident receives supervision and feedback about a general adult consultation in a timely fashion. Feedback should be suitable to the resident’s level of training.
2. Information about the outcome of a general adult consultation in both the short and long term provides additional educational value and opportunity for self-appraisal.
3. Facilities with formal adult services offer additional training benefits and residents should spend most of their training in such settings where possible.
4. Sites which offer the widest possible range of diagnoses over the age range should be utilized. Further, sites that have a full array of departments (general surgery, medicine, subspecialty surgery, subspecialty medicine, family medicine, obstetrics and gynecology) will ensure competency in all areas of consultation within the general hospital setting.

1.3 ELECTROCONVULSIVE THERAPY
At the end of training in psychiatry, residents are expected to have acquired adequate theoretical knowledge as well as appropriate skills to apply electroconvulsive therapy (ECT). Both training site have facilities to apply ECT.

1.3.1 General Issues:
The Psychiatric Residency Program will provide comprehensive training in ECT to all residents. Didactic instruction and individual hands-on experience with a simulator will take place during the R1 year with supervision by the ECT team during the residency training.

1.3.2 Didactic Material to be covered:
Formal didactic education should include at least 2-4 hours of lecture and discussion covering the following topics:
• Indications and potential risks
• Patient selection and evaluation
• Consent procedures, including applicable and legal ramifications
• Technique of ECT administration:
  o Including anesthetic and relaxant agents
  o Oxygenation and airway maintenance
  o Stimulus electrode placement
1.3.3 **Practical Training:**

**A. General Aspects**

Staff members who are privileged in ECT administration should supervise psychiatry residents involved in the delivery of ECT and management of patients receiving ECT.

The Program Director and/or his/her assistant overseeing the practice of ECT within the department should provide specific guidelines for this experience. The practical training will be augmented by assigned readings when appropriate.

**i. Specific Aspects**

1. Under the direct supervision of a privileged ECT psychiatrist, each resident will actively participate in at least 50 ECT treatments involving several patients.
2. Each resident will actively participate in the care of several patients during the ECT work-up, course of treatment, and post-ECT management.
3. Advanced training for elective options in ECT should be available.
4. Encouragement in participating in ECT research protocols with a view toward publishing and poster presentations will be a part of the training.

**Assessment Form:** Evaluation of Procedural Skills

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1.4 **TRAINING SITES IN GENERAL ADULT PSYCHIATRY**

1.4.1 **SULTAN QABOOS UNIVERSITY HOSPITAL (SQUH)**

**A. Site Description**
Sultan Qaboos University Hospital is a tertiary care facility of 470 beds in total. It provides a comprehensive range of both inpatient and outpatient psychiatric services to adults, children and adolescents and the old age.

The SQUH building is attached to the College of medicine and medical sciences with an access to the medical library. In addition the Department of behavioral medicine has its own library with current selected psychiatry journals and textbooks that are available to residents.

The SQUH has a busy Emergency Department. The SQUH site trains medical students and residents from other medical disciplines in psychiatry rotations both on an outpatient and inpatient basis.

Academic day activities will be held on weekly basis at SQUH site where all residents will alternatively attend as per their level of training.

Rotations that exist at the SQUH site include general adult psychiatry (inpatient & outpatient), Child and Adolescent Psychiatry, Geriatric Psychiatry, Consultation - Liaison, and Psychotherapy (in addition to Neurology).

1.4.2 AL MASARRA HOSPITAL

A. Site Description
Al-Masarra hospital is the only specialized psychiatric hospital with 245 beds, established in 2013, staffed with the multidisciplinary teams including Psychiatrists, Physicians, Dentist, Psychiatric nurses, Pharmacists, Psychologists, Social Workers, Occupational therapists, Physiotherapists and Speech therapists. The hospital provides a wide range of mental health services including General Adult Psychiatry (with the integrated services for forensic psychiatry), Geriatric psychiatry, Addiction Psychiatry, Child and Adolescent Psychiatry, intellectual disability and Consultation-Liaison Psychiatry.

In addition, for the investigations there are laboratory services, psychometric tests, EEG, X-ray and CT imaging. Therapeutic modalities include psychotropics, psychotherapy, occupational therapy (with recreational and sports facilities), ECT and rTMS.

The Psychiatric inpatient department includes:

- 100 beds for male patients with total of 4 wards for General adult, Geriatric and intellectual disability.
- 50 beds for female patients with total of 2 wards for General adult, Geriatric and intellectual disability.
• 50 beds (2 wards) for addiction psychiatry unit.
• 20 beds (one ward) for forensic patients with 24- hour security by Royal Oman Police.
• 25 beds (one ward) for child and adolescents.

In addition to the emergency department, there is an outpatient service covering various areas of the sub-specialties.

Al-Masarra hospital is a recognized training centre in the country which provides clinical training in mental health to medical and nursing students in addition to the residents of Oman Medical Specialty Board (OMSB).

The hospital has designated facilities for academic activities such as the auditorium and seminar rooms in addition to the medical library.

B. Standard Rotation Organization and Description

Inpatient setting: at the rounds all inpatients are discussed at a conference attended by the treating multidisciplinary team.

Outpatient department:
The outpatient service provides opportunities for the resident to follow-up the recently discharged patients and those on long term psychiatric treatment. Also it enables the resident to learn how to deal with acutely ill patients at first presentation or during relapses of chronic mental disorders.

Emergency department:
Residents are assigned on-call duties to maximize exposure to various psychiatric emergencies with on-site supervision provided by senior colleagues.

C. Generic Considerations:

Residents are given clinical responsibility graded to their years of training.

Clinical supervision and informal teaching at emergency/ outpatient/ inpatient settings occur daily. Residents also gain experience in teaching the medical students.

Formal clinical teaching is conducted by OMSB trainers on weekly basis at Al-Masarra Hospital, where residents attend as per their level of training.
**Assessment Tools**
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
- Case Based Discussion Form (CBD)
- Evaluation Form For Resident's Teaching Sessions (If Applicable)
- Research Block Evaluation Form
- Resident Professionalism Evaluation Form
- Critical Incident Form if applicable
- 6 month Evaluation/Annual Evaluation
- Research Mentor Evaluation Form
- Trainer Evaluation by Residents
- Rotation Evaluation Form

**2. NEUROLOGY**

Residents are expected to undertake this rotation at the R1 year. The duration of the rotation is 2 blocks.

The following is an overview of the goals and objectives of the clinical training in neurology for psychiatry residents.

Considered as an essential part of the psychiatric residency training program, clinical neurology rotation is therefore a mandatory rotation for the psychiatric residents. While this rotation is not aimed at training the resident to become an expert in neurology, it will however enable the resident to acquire essential knowledge and skills for the detection and first line management of wide range of neurological conditions particularly those at interface with psychiatric disorders, presenting as a manifestation or as comorbidity.

**2.1 OVERALL GOAL**

The overall goal of the program is to enable the resident to develop essential and broad knowledge and skill for assessment of common neurological presentations, case formulation, treatment planning and implementations.

**2.2 SPECIFIC OBJECTIVES**

**A. Medical Knowledge**

The resident, at the end of training, should have adequate information, understanding and skills concerning:

- Pathophysiology, neurobiology, aetiology, risk factors, prognostic factors, and natural history/course of the neurological disorders.
- Common neurological disorders with manifestations of psychiatric symptoms.
- Comorbidities between neurological disorders and psychiatric illness and recognition of the organic causes of some psychiatric presentations.
• Good neurological history taking and complete neurological examination.
• Relevant neuroradiological and neurophysiological tests to support/confirm diagnosis.
• Different treatment approaches to neurological conditions including pharmacotherapies.

B. Interpersonal and Communication Skills
• Ability to communicate to patients and family an accurate and thorough explanation of the diagnosis, investigations, prognosis and treatment plan.
• Effectively convey to medical colleagues pertinent information and opinions
• Discuss appropriate information with health care team, effectively providing and receiving information.
• Prepare documentation that is accurate and timely.
• Work with the patient and his/her family/carers.
• Ability and willingness to teach and learn from colleagues
• Ability to work collaboratively with other members of the health care team, recognizing their roles and responsibilities.
• Work within the integrated health system.

D. System Based Practice
- Utilize available resources.
- Manage the patient load and assigned consultations.
- Understand and make use of information technology to optimize patient care and life-long learning.
- Coordinate the efforts of the treatment team, effective delegation.

E. Practice Based Learning and Improvement
- Advocate for your patients.
- Identify and understand determinants of health affecting patients and hospital wards and responding in a role-appropriate fashion to the issues where advocacy for the patient and hospital wards are appropriate.
- Understand how to make changes within the health system to facilitate more collaboration between neurological and psychiatric health services.
- Commit to lifelong learning.
- Know key articles and textbooks in the field.
- Critically appraise literature.
- Critically review treatment plans and justify treatment plan.

G. Professionalism
• Demonstrate integrity, honesty, compassion and respect for diversity.
• Behave in a professional manner with patients, staff, and other health agencies.
• Responsibility, dependability, self-direction and punctuality.
• Acceptance and constructive use of supervision and feedback.
• Awareness of own limitations, seeking advice when necessary
2.3 TRAINING SITES IN NEUROLOGY
The training sites assigned for neurology rotation is Sultan Qaboos University Hospital and Royal Hospital.

Both Hospitals have well established departments of neurology consisting of both inpatient and outpatient facilities. Each department consists of at least two specialised neurology teams working in parallel to take care of wide range varieties of cases. Both centres provide tertiary level of health care.

Assessment Tools
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
- Case Based Discussion Form (CBD)
- Evaluation Form For Resident's Teaching Sessions (If Applicable)
- Resident Professionalism Evaluation Form
- Critical Incident Form if applicable
- 6 month Evaluation/Annual Evaluation
- Trainer Evaluation by Residents
- Rotation Evaluation Form

3. FAMILY MEDICINE and EMERGENCY MEDICINE

In the Sultanate of Oman the candidate for Psychiatry training has to complete internship program of one year including major medical/surgical rotations. However, in attempt to adhere to the ACGME-I requirement in this regard and taking into consideration the limited availability of slots in Family and Community medicine training program and Emergency Medicine training program, two blocks rotation will be allocated for primary health care.

Residents are expected to undertake these rotations during their R1 year. The duration of the rotation is 1 block each.

Residents are provided with structured clinical experiences that are organized to provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment phase during their Family Medicine and Emergency Medicine Rotations.

3.1 SPECIFIC OBJECTIVES

A. Patient Care:

Residents must be able to provide patient care that is compassionate, appropriate, and
effective for the treatment of health problems and the promotion of health.

Residents must demonstrate competence in:

1. Establishing an appropriate doctor/patient relationship

2. Formulating a clinical diagnosis by conducting patient interviews, eliciting a clear and accurate history; performing physical, neurological, and mental status examination, including appropriate diagnostic studies; completing a systematic recording of findings; relating history and clinical findings to the relevant biological psychological, behavioral, and socio-cultural issues associated with etiology and treatment;

3. Using pharmacological regimens, including concurrent use of medications and psychotherapy;

4. Care and treatment for the ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;

5. Encourage leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;

6. Recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse and/or neglect) and its effect on both victims and perpetrators.

B. Medical Knowledge:

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Residents must demonstrate knowledge of:

1. The broad spectrum of clinical disorders seen in the practice of Family Medicine/Emergency Medicine;

2. The core content of Family Medicine and Emergency Medicine, which includes the subspecialties, and relevant non-clinical topics at a level sufficient to practice medicine.

C. Practice-based Learning and Improvement:

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based
on continuous self-evaluation and life-long learning.

Residents are expected to develop skills and habits to be able to meet the following goals:

1. Identify strengths, deficiencies, and limits in one’s knowledge and expertise;
2. Set learning and improvement goals;
3. Identify and perform appropriate learning activities;
4. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
5. Incorporate formative evaluation feedback into daily practice;
6. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
7. Use information technology to optimize learning; and,
8. Participate in the education of patients, families, students, residents and other health professionals.

**D. Interpersonal and Communication Skills:**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents are expected to:
1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
2. Communicate effectively with physicians, other health professionals, and health related agencies;
3. Work effectively as a member or leader of a health care team or other professional group;
4. Act in a consultative role to other physicians and health professionals; and,
5. Maintain comprehensive, timely, and legible medical records.

**E. Professionalism:**

Residents must demonstrate a commitment to carrying out professional responsibilities and
an adherence to ethical principles. Residents are expected to demonstrate:

1. Compassion, integrity, and respect for others;
2. Responsiveness to patient needs that supersedes self-interest;
3. Respect for patient privacy and autonomy;
4. Accountability to patients, society and the profession; and,
5. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

F. Systems-based Practice:

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents are expected to:

1. Work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2. Coordinate patient care within the health care system relevant to their clinical specialty;
3. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4. Advocate for quality patient care and optimal patient care systems;
5. Work in inter-professional teams to enhance patient safety and improve patient care quality; and,
6. Participate in identifying system errors and implementing potential systems solutions.

Reference:
ACGME-International Specialty Program Requirements for Graduate Medical Education in Psychiatry.

3.2 TRAINING SITES IN FAMILY MEDICINE AND EMERGENCY MEDICINE
The training site assigned for Family Medicine rotation is Ministry of Health’s Local Health Centers.
The training site assigned for Emergency Medicine rotation is Royal Hospital or Al Nahdah Hospital.

Both training sites provide structured clinical experiences that are organized to provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment phase.

**Assessment Tools**
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
- Case Based Discussion Form (CBD)
- Evaluation Form for Resident's Teaching Sessions (If Applicable)
- Resident Professionalism Evaluation Form
- Critical Incident Form if applicable
- 6 month Evaluation/Annual Evaluation
- Trainer Evaluation by Residents
- Rotation Evaluation Form

## 4. PSYCHOTHERAPY

### 4.1 INTRODUCTION

Psychotherapy remains central to the practice of psychiatry but its input in resident programs has been ill-defined. Psychotherapy is operationalized here as clinical process that is primarily focused on a person's emotional life, cognitive and behavioral functioning. Learning psychotherapy is a process involving both understanding and acquiring strategies for intervention. Basic understanding must begin with the teaching of various theories of development, personality and psychopathology. Theory is consolidated into a useful integrated whole through the supervised practice of psychotherapy. It is important that residents in psychiatry have access to role models who convey the sense that psychotherapy is a part of every psychiatrist's identity, irrespective of their fundamental interests. The psychotherapeutic modalities utilize psychological methods to resolve emotional, behavioral, and cognitive distress in order to improve the quality of life for those afflicted with cognitive, emotional or behavior distress.

The goal therefore is to enable people with psychological distress to utilize their newly acquired awareness, insight and understanding as catalyst for mitigating cognition, emotion and ultimately behavior dysfunction. The following are some of obvious and well known rationales for teaching psychotherapy for psychiatrists:

- Psychotherapy is an effective treatment for many disorders.
- Psychotherapy is practiced by many non-medical mental health professionals who are supervised by psychiatrists. Psychiatrists must possess a high degree of competence to carry out this supervisory task.
The process of psychotherapy fosters an understanding of the psychological and social concepts of the doctor / patient relationship. By extension, this allows the psychiatrist to effectively provide consultation to other colleagues regarding aspects of the therapist/doctor/patient relationship.

Psychotherapy training facilitates the learning and management of other relationships, including supervision, consultation and mental health administration.

Psychotherapy allows observation of 'abnormal' and 'normal' mental functioning over time, providing access to information that fosters theoretical understanding, enhances basic interviewing skills and results in earlier recognition of mental phenomena, with greater accuracy and more confidence. In addition it fosters awareness of both conscious and unconscious mental functioning. Success requires an ongoing relationship between the patient and the psychiatrist in order to negotiate the inevitable struggles that such relationships present.

By focusing on the nature of the dyadic relationship, psychotherapy fosters awareness in psychiatrists of their feelings and reactions to their patients so that ethical dilemmas and transgressions can be anticipated, analyzed and avoided.

It enhances biopsychosocial understanding of the patient.

Psychotherapy training helps the resident to develop his/her therapeutic identity.

**Table 1:** Different schools of psychotherapy drawn from different perspectives of theoretical models

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<th>PSYCHODYNAMIC-RELATIONAL THERAPIES</th>
<th>EXPERIENTIAL-EXPRESSIVE THERAPIES</th>
<th>SYSTEMIC THERAPIES</th>
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<td>communities</td>
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<td>Interpersonal therapy</td>
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<td>Cognitive-analytic therapy</td>
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<td>Psychodynamic interpersonal therapy</td>
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Human relationships are central to the process of psychotherapy. Such therapeutic relationship provides powerful impetus to precipitate, perpetuate or ameliorate emotional and/or interpersonal difficulties. Regardless of theoretical orientations, the common denominator of all psychotherapeutic modalities is meant to underpin the three interrelated factors as shown in Table 2.
Table 2: Some of the common factors that are integral part of psychotherapy regardless of theoretical orientation.

<table>
<thead>
<tr>
<th>SUPPORT FACTORS</th>
<th>LEARNING FACTORS</th>
<th>ACTIONS FACTORS</th>
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<tbody>
<tr>
<td>Release of tension</td>
<td>Advice</td>
<td>Facing fear</td>
</tr>
<tr>
<td>Trust</td>
<td>Feedback</td>
<td>Mastery</td>
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<tr>
<td>Reassurance</td>
<td>Insight</td>
<td>Working through</td>
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<tr>
<td>Structure</td>
<td>Exploratory rationale</td>
<td>Modeling</td>
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<tr>
<td>Warmth</td>
<td>Assimilation of the problematic experiences</td>
<td>Testing solutions</td>
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<tr>
<td>Therapeutic alliance</td>
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<tr>
<td>Acceptance</td>
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In addition to three interrelated factors that underpin all psychotherapies, irrespective of their theoretical tenets, all psychotherapies share nonspecific factors which define successful psychotherapeutic transactions. These nonspecific factors include:

1. A relationship with a helping person;
2. Explanations of the cause of the patient's distress, serving to strengthen the patient's confidence in the therapist;
3. Provision of new information concerning the nature and sources of the patients' problems in addition to the possible alternative ways of dealing with them;
4. The instillation of hope;
5. Facilitation of success experiences which serve to heighten interpersonal competence;
6. The facilitation of emotional arousal. The enlightened use of empathic understanding, warmth and respect for another human being is central to the process.

3.1.1 Teaching Psychotherapy is Important for a Number of Reasons

In psychiatric training, it is pertinent to be aware of what constitute 'health'. Health has been formally defined as to owe to its integrity to psychological, physical and social functioning. This means psychological approach to distress is related to biopsychosocial model. As shown in Figure, it is widely accepted that most illnesses, whether physical or psychiatric, are influenced by biopsychosocial phenomena. The biopsychosocial factors are central to the predisposition, onset, course and outcome of most disorders. More importantly in our discussion on psychotherapy, biopsychosocial factors are of major importance in designing interventions and management plans.
Fundamental to the process of psychotherapy is an understanding and awareness of the contributions of developmental psychology and the social sciences to the evolution of personality and psychopathology. The resident should be exposed, through the organization of formal seminars, to the work of a broad range of developmental theorists and social scientists, providing a framework for the broad work of psychotherapy. Material covered in seminars includes supportive, psychodynamic, cognitive-behavior, interpersonal, dialectical behavior therapy, motivational interviewing, mindfulness-meditation, and relaxation therapy, as well as couple’s-family, group, and play therapy, and partial hospitalization. Seminars also include formulation, therapeutic alliance, boundaries, defenses, personality disorders, and the neurobiology of psychotherapy. Various seminars review psychotherapeutic techniques in different modalities; teaching methods include didactic teaching, role play, and group supervision.

4.2 GOALS AND OBJECTIVES

These Objectives are informed by the Objectives for Training in Psychiatry, published in June 2007 by the Royal College of Physicians and Surgeons of Canada.

A. Medical Knowledge

1. The resident at the end of training should:
   - demonstrate proficiency in assessing suitability for, prescribe and deliver appropriate psychological treatments including:
     - Cognitive behavioral
     - Crisis intervention
     - Family
     - Psychodynamic
     - Supportive
   - Demonstrate working knowledge in assessing suitability for, prescribe and deliver appropriate psychological treatments including:
     - Behavioral
o Dialectic Behavior Therapy
o Group Therapy
o Interpersonal therapies
- **Demonstrate introductory knowledge in assessing suitability for prescribing and delivery of appropriate psychological treatments including:**
  o Brief Psychotherapy
  o Mindfulness training
  o Motivational interviewing

2. Have an awareness of confidentiality, informed consent, boundary issues, and therapeutic alliance.

3. Be aware of psychotherapeutic constructs - individual, family and group.

**Medical Expert - Skills**

1. **The resident after a concurrent period of training in psychotherapy will be able to:**
   - Conduct an open ended diagnostic interview that generates adequate information for initial psychiatric assessment and enlist the cooperation of patients in a collaborative manner to participate in treatment.
   - Facilitate increasingly more personal revelations by the patient about interpersonal and intrapsychic experience.
   - Recognize the patient’s emotional experiences and states.
   - Recognize his/her own reactions to patients that may interfere with or facilitate the doctor-patient relationship in the process of therapy.
   - Recognize the importance of empathy and help the patient feel understood.
   - Convey empathic understanding.
   - Develop awareness of the multiple meanings and determinants of symptoms, thoughts and feelings.
   - Establish a therapeutic contract.
   - Integrate psychotherapy with other interventions including treatment with psychotropic agents and other medical interventions.
   - Develop awareness of the patient’s tolerance for various psychotherapeutic interventions by accurately detecting conflict and/or anxiety in the patient’s thoughts, behaviors and/or affects.
   - To formulate and deliver interpretations appropriately and in a timely and sensitive fashion.
   - Identify and deal with the real relationship with the patient, as well as real life events, including emergencies.
   - Use supervisory feedback constructively and in a non-defensive way in order to facilitate ongoing psychotherapeutic work.
   - Manage anger, aggression, anxiety, acting out, resistance, silence, and seductive or erotic behavior by patients.
   - Organize themes and reformulate hypotheses within a session and over the course of therapy.
   - Evaluate the patient’s progress in therapy.
B. Interpersonal and Communication Skills
- Ability to listen effectively
- Ability to communicate to patient and family with an accurate and thorough explanation of diagnosis, investigations, treatment and prognosis.
- Discuss appropriate information with health care team, effectively providing and receiving information.
- Effectively convey information and opinions to medical colleagues.
- Prepare documentation that is accurate and timely and concise.
- Be able to engage in peer supervision or the supervision of other professionals.
- Establish positive therapeutic relationships with patients and their families.
- Respect patient confidentiality, privacy and autonomy.
- Consult effectively with other health care professionals and physicians.
- Be able and willing to teach and learn from colleagues.
- Be able to work collaboratively with other members of the health care team, recognizing their roles and responsibilities.
- Contribute to interdisciplinary team activities.
- Be able to facilitate the learning of patients, students and other health professionals and contribute to new knowledge.

D. Systems Based Practice
- Make cost effective use of resources based on sound judgment.
- Set realistic priorities and use time effectively in order to optimize professional performance.
- Evaluate the effective use of resources.
- Understand and make use of information technology to optimize patient care and lifelong learning.
- Have the ability and willingness to direct patients to relevant community resources.
- Coordinate the efforts of the treatment team with effective delegation.

E. Practice Based Learning and Improvement
- Identify and understand determinants of health effecting patients and responding in a role appropriate fashion to the issues where advocacy for patient are appropriate.
- Possess an awareness of major regional, national and international advocacy groups in mental health care including that pertinent to psychotherapy.
- Attune him/herself to the wider impact of therapy with respect to the patient’s family and community
- Demonstrate an understanding and commitment to the need for continuous learning, developing and implementing an ongoing personal learning strategy.
- Able to critically appraise current medical psychiatric theoretical knowledge, interventions, strategies, the various stages of engagement with psychotherapy including crisis situations.
- Help others learn through guidance and constructive feedback.

G. Professionalism
- Demonstrate integrity, honesty, compassion and respect for diversity.
- Develop a sense of respect, empathy and understanding of patients in the context of legitimate expectations and limitations of therapy.
- Be able to recognize, discuss and deal appropriately with ethical and/or moral issues as they arise in therapy with supervisor and/or patient, including boundary issues.
- Fulfill medical, legal and professional obligations of a specialist.
- Engage in collaborative and respectful relationships with patients that demonstrate gender and cultural awareness.
- Demonstrate responsibility, dependability, self-direction and punctuality.
- Demonstrate patience and flexibility in the face of conflicts in both clinical and administrative situations.
- Accept and constructively use supervision and feedback.
- Demonstrate awareness and application of ethical principals in general.
- Demonstrate awareness of own limitations, be able to work effectively within own limitations and seek help when appropriate.

4.3 TRAINING SITE IN PSYCHOTHERAPY

The site assigned for training in psychotherapy is Sultan Qaboos University hospital but, when required and suitable person is available to dispense supervision, other centers could dispense psychotherapy.

There are opportunities for the residents to acquire and learn psychotherapeutic skills and techniques required for the management of different mental health problems.

Residents who are interested in Psychotherapy would be highly encouraged to undertake further clinical training in this field during the elective period at recognized training sites abroad.

Assessment Tools
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
Residents are expected to undertake this rotation at the R3 year.

Child and Adolescent Psychiatry constitute an important part of general psychiatric training. Child Psychiatry focuses on prevention, assessment, diagnosis, and treatment of mental and behavioral disturbances/disorders seen in infancy, childhood, and adolescence. It does so in the context of the family and wider cultural environment, including schools.

A unique body of knowledge exists with respect to distinct and separate child psychiatric disorders - their assessment and treatment. Many disorders of adulthood have their origin in childhood. The impact of adult psychopathology and/or functional disturbance has repercussions on the development of the child. For these reasons, Psychiatric residents are expected to spend at least six months devoted exclusively to the psychiatric care of children, adolescents, the mentally retarded (developmentally delayed), and their families.

As there is local shortage of child psychiatrists and the likelihood that general psychiatrists will encounter child and adolescent patients in clinical practice, this rotation is therefore considered essential and mandatory.

5.1 OVERALL GOAL

5.1.1 General Objectives
As the general psychiatrist may be expected to treat problems of children, adolescents and families; all general psychiatry residents will acquire:

- A developmental perspective which requires the understanding of normal neuroanatomical, neurophysiological and psychosocial development across the life span.
- Comprehensive assessment ability which integrates biological, psychological, social and cultural factors.
- An overview of common problems affecting the development, thinking and behavior for children of all ages.
- The capacity to assess the child in the context of the family, and the wider cultural environment, across community, hospital and school settings.
- A clear understanding of problems of children that contribute to adult psychopathology.
• A clear understanding of the effect on children of adult psychopathology, violence and substance abuse.
• Awareness and appropriate skills in a range of biological and psychological treatment modalities, including social interventions - the indications, what to expect and how to deliver.
• Capacity to work in an interdisciplinary setting.
• Knowledge of community and hospital based treatment resources.

5.1.2 General Goals
The resident should be able to:
• Interview the child, adolescent and family.
• Assess presenting problems in a developmental bio-psycho-social context while remaining mindful of family factors.
• Write a detailed medical report including the diagnosis, treatment and management.
• Be familiar with and deliver some psychological and behavioral therapies.
• Have knowledge of and deliver pharmacological and other somatic therapies.
• Work in an interdisciplinary setting and be aware of contribution of other relevant disciplines in the process of understanding the child/adolescent.
• Describe and use community resources and services.
• Understand problems of normal and abnormal development.
• Assess implications to the child and family of parental mental illness.

5.1.3 Specific Objectives
At the completion of training the resident is expected to have acquired the following competencies and will function effectively as:

A. Medical Knowledge
Resident is expected to possess a defined body of knowledge and procedural skills which are used to collect and interpret data, make appropriate clinical decisions, and carry out diagnostic and therapeutic procedures within the boundaries of discipline and expertise. His/her care is characterized by up-to-date, ethical, and cost-effective clinical practice and effective communication in partnership with patients, other health care providers, and the community. The role of medical expert/clinical decision-maker is central to the function of the child psychiatrist and draws on the competencies including practiced based learning and improvement, Interpersonal and communication skills, practice based learning and improvement, system based practice, and professionalism.

• Ability to assess, diagnose and treat the wide range of mental disorders in male and female children and adolescents and in all clinical contexts.
• Synthesize the clinical knowledge and develop an in-depth knowledge of the theoretical basis, clinical manifestations and therapeutic issues in hospital and community settings.
• Demonstrate diagnostic and therapeutic skills for ethical and effective patient care.
• Establish and maintain an effective working / therapeutic relationship.
• Conduct and organize an appropriate diagnostic interview for children/adolescents and families.
• Conduct and organize an appropriate "abuse / neglect" assessment interview.
• Perform an appropriate mental status including developmental examination.
• Synthesize a diagnosis with appropriate differential diagnosis.
• Integrate and present a bio-psycho-social understanding.
• Develop and implement an integrated bio-psycho-social treatment plan.
• Use psychiatric, psychological, relevant medical and imaging investigations for assessment and treatment.
• Access, integrate, and apply relevant information to clinical practice.
• Demonstrate effective and timely consultative services with respect to patient's care, education and legal opinions.
• Consultation and liaison psychiatry from other child medical specialties.
• Knowledge and assessment of developmental delays across the life cycle.
• Knowledge and assessment of substance abuse and comorbidity in children and adolescent.

B. Interpersonal and Communication Skills
• Develop communication skills to obtain and convey the information to children and their families.
• Listen effectively.
• Discuss appropriate information with the health care team, and integrate the information from the team.
• Convey to children, adolescents and family an accurate, clear and coherent developmentally appropriate account of the diagnosis, treatment plans and prognosis in all clinical cases.
• Effectively convey to medical colleagues, including referring physicians, pertinent information and opinion on clinical cases, in verbal and written formats, which is efficient and timely.
• Provide humane, high-quality care, by establishing effective relationships with patients, other physicians, and other health professionals.
• Ability to elicit patients' beliefs, concerns, and expectations about their illnesses, and to assess key factors impacting on the child's health.
• Consult effectively with other physicians and health care professionals.
• Provide treatment cooperatively with primary care physicians in a "shared care" relationship.
• Contribute effectively into the interdisciplinary team activities.
• Demonstrate the ability and willingness to teach and learn from colleagues and students.
• Demonstrate an ability to work collaboratively with other members of the health care team recognizing their roles and responsibilities.
• Demonstrate an ability to listen to and integrate information and therapies from other members of the health care team.
• Demonstrate an ability to facilitate learning of patients, residents, students and other health professionals and contribute into the development of new knowledge.

D. Systems Based Practice
• Ability to function as a manager when making everyday practice decisions involving resources, co-workers, tasks, policies, and one's personal life.
• Utilize personal and system resources effectively to balance patients' care, learning needs, and outside activities.
• Understand and make effective use of information technology to optimize patients' care, lifelong learning and other activities.
• Make cost effective use of resources based on sound judgment.
• Evaluate the effective use of resources.
• The ability to plan a work schedule consistent with personal/professional goals and obligations including consideration of service needs, administrative tasks, teaching and research.
• Set realistic priorities and use time effectively in order to optimize professional performance.
• Coordinate the efforts of the treatment team by effectively using the varied skills of other health care professionals.
• Demonstrate knowledge of important community resources for patients show ability and willingness to direct patients to relevant resources.

E. Practice Based Learning and Improvement
• Identify and understand the determinants of health affecting patients and communities - recognize and respond to issues where advocacy is appropriate for patients or community.
• Demonstrate awareness of structures of governance in mental health care for children and adolescents.
• Demonstrate awareness of the major regional, national, and international advocacy groups active in mental health matters concerning children and adolescents.
• Recognize that health advocacy is appropriately expressed both by the individual and the collective responses of specialist physicians in influencing public health and policy.
• Demonstrate an understanding of and commitment to the need for continuous learning.
• Critically appraise sources of medical information.
• Successfully integrates information from a variety of sources.
• Facilitate learning of patients, house staff/students and other health professionals.
• Contribute to the development of new knowledge.
• Demonstrate ability to access and critically appraise sources of medical information.
• Develop, implement and monitor a personal and continuing medical education strategy.

G. Professionalism
• Demonstrate awareness of personal limitations.
• Fulfill medical, legal and professional obligations of a psychiatrist including the ability to practice psychiatry within the guidelines of the local health authorities.
• Deliver highest quality care with integrity, honesty, compassion, and respect for diversity.
• Demonstrate dependability, self direction and punctuality.
• Demonstrate collaborative and respectful patient relationships taking into consideration gender, cultural, and spiritual awareness.
• Demonstrate acceptance and constructive use of supervision and feedback.

5.2 TRAINING SITE OF CHILD AND ADOLESCENT PSYCHIATRY

The sites assigned for training in Child and Adolescent psychiatry are Sultan Qaboos University hospital and Al-Masarra hospital. Both institutes provide specialized services for children and adolescents.

Comprehensive multidisciplinary bio-psycho-social assessment and management of children and adolescent with mental health problems are carried out.

There are opportunities for the residents to acquire psychotherapeutic skills required for the management of children and adolescents with mental health problems and their families.

Residents who are interested in child and adolescent psychiatry would be highly encouraged to undertake further clinical training in this field during the elective period at recognized
training sites abroad.

**Assessment Tools**
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
- Case Based Discussion Form (CBD)
- Evaluation Form For Resident’s Teaching Sessions (If Applicable)
- Research Block Evaluation Form
- Resident Professionalism Evaluation Form
- Critical Incident Form if applicable
- 6 month Evaluation/Annual Evaluation
- Research Mentor Evaluation Form
- Trainer Evaluation by Residents
- Rotation Evaluation Form

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**6. GERIATRIC PSYCHIATRY**

The Geriatric Psychiatry Rotation is a five months rotation based at the department of behavioral medicine at Sultan Qaboos University Hospital or at Al Masarra Hospital. The residents will be responsible for assessing and managing both inpatient and outpatient. In SQUH residents are also involved in assessing patients referred from other inpatients wards (Liaison Geriatric Psychiatry)

Residents are expected to undertake this rotation at the R3 year. The duration of the rotation is 5 blocks.

Residents will have direct systemic supervision by Geriatric Consultant Psychiatrist including direct observation. This is to ensure expertise in the diagnoses and management of the broad spectrum of clinical problems in geriatric psychiatry.

**6.1 GOALS AND OBJECTIVES**

**A. Medical Knowledge**
- Demonstrate ability to perform a comprehensive assessment including a history, physical examination and cognitive assessment of an elderly patient.
- Discuss the differential diagnosis of each new patient presenting to the clinic.
- Demonstrate ability to diagnose and treat common disorders of mood in the elderly.
- Demonstrate ability to diagnose and treat common anxiety disorders in an elderly
patient.
- Demonstrate ability to diagnose and treat cognitive impairment in an elderly patient.
- Discuss appropriate therapeutic interventions in the management of an elderly patient using the bio psycho social approach.
- Discuss Medico legal and ethical issues including assessment of capacity and competency, abuse, and ethical issues at the end of life.
- Demonstrate ability to identify acute organic disorders requiring medical or psychiatric intervention including acute confusional state (delirium), acute neurologic and neuropsychiatric emergencies, alcohol and drug intoxication, overdose or withdrawal.

B. Interpersonal and Communication Skills
- Communicate effectively with patients, their family and other health care professionals
- Demonstrate appropriate documentation of the Psychiatric history and Physical examination.
- Communicate effectively with medical colleague’s pertinent information and opinions.
- Consult effectively with other health care professionals.
- Be capable of involving patients in decisions making when appropriate
- Work with other members of the health care team, recognizing their role and responsibilities.
- Participate in interdisciplinary team activities.
- Facilitate the learning of new patients, students, and other health professionals and contribute to new knowledge.

D. Systems Based Practice
- Effective use of resources based on sound judgment.
- Set priorities and use time effectively in order to optimize professional performance.
- Work at a pace that is appropriate for the level, maintaining appropriate patient load.
- make use of information technology to optimize patient care and lifelong learning.
- Manage competing interests between patients and their families.

E. Practice Based Learning and Improvement
- Be the patients advocate at all times.
- Develop an Awareness of major regional, national and international advocacy groups in mental health care for the elderly.
- Intervene on behalf of the patient obtaining appropriate social services involvement.
• Demonstrate an understanding of and a commitment to the need for continuous learning.
• Develop and implements an ongoing personal learning strategy.
• Develop the ability to critically appraise current medical / psychiatric / theoretical knowledge.
• Help others learn through guidance and constructive feedback.

G. Professionalism
• Demonstrate integrity, honesty, compassion and respect for diversity.
• Fulfill medical, legal and professional obligations of a specialist.
• Develop collaborative and respectful Doctor-patient relationships that demonstrate gender and cultural awareness.
• Demonstrate responsibility, dependability, self direction, punctuality.
• Display patience and flexibility in the face of complex clinical / administrative situations.
• Demonstrate constructive use of supervision and feedback.
• Develop Awareness and application of ethical principles.
• Be mindful of own limitations and know when to seek advice.

6.2 TRAINING SITES OF GERIATRIC PSYCHIATRY

Residents are required to complete a five months' rotation in geriatric psychiatry at the department of Behavioural Medicine, Sultan Qaboos University Hospital (SQUH) or at Al Masarra Hospital. The teams is made up of a Consultant Psychiatrist specialized in geriatric psychiatry, a senior specialist, a specialist Psychiatrist psychologist, social worker and a counselor. The service is provided in both inpatient and outpatient settings. In SQUH, Residents also join the Behavioural neurologist who joins the Memory clinic once per week.

Residents will have opportunity in developing educational materials for patients and carers as well as conducting workshops and presentations to raise awareness about geriatric psychiatry among other medical professionals.

Seminars on topics related to geriatric psychiatry will be covered during the academic day program.

Residents will have opportunity to present at the ward rounds and discuss topics relevant to geriatric psychiatry during supervision.

Assessment Tools
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
- Case Based Discussion Form (CBD)
7. CONSULTATION - LIAISON PSYCHIATRY

7.1 GOALS AND OBJECTIVES

Residents are expected to undertake this rotation in the R4 year for four blocks.

At the completion of Consultation Liaison Psychiatry rotation the Resident will have acquired the following competencies and will function effectively as a:

A. Medical Knowledge

As Medical Experts, physicians integrate all of the ACGME-I Competencies, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient centered care.

General Requirements:
- Function effectively as consultants, integrating all of the CanMEDS Roles to provide optimal, ethical and patient-centered medical care.
- Establish and maintain clinical knowledge, skills and attitudes appropriate to their practice.
- Perform a complete and appropriate assessment of a patient.
- Use preventive and therapeutic interventions effectively.
- Demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic.
- Seek appropriate consultation from other health professionals, recognizing the limits of their expertise.

Specific Requirements:
1. Knowledge

The Resident will demonstrate an effective level of clinical knowledge and understanding relevant to Consultation-Liaison Psychiatry across age, gender and cultural domains especially the assessment and management of:
- Delirium and Dementia
- Somatoform Disorders
- Psychological factors affecting physical conditions
- Adjustment Disorders with physical complaints
- Problems related to intoxication, dependency and withdrawal from alcohol
and drugs
- Depression associated with medical conditions
- Biopsychosocial factors associated with death, dying and grief

The Resident will be able to:
- demonstrate the principles of assessment and management of psychiatric symptoms on medical wards
- assess competency
- assess the risk of violence, suicide or homicide
- understand treatment considerations in the medically fragile patient
- understand the effect of the psychiatric illnesses on the recovery from a medical problem
- implement the Mental Health Act and define the Duty to Protect

2. Skills
The Resident will demonstrate the general ability to assess, diagnose and treat the full range of psychiatric disorders in males and females of all ages and cultures that present within the Consultation-Liaison setting and will demonstrate the following specific skills:
- the ability to prioritize consultations based on urgency
- perform a diagnostic interview focused to the concern
- obtain a history to assess the potential for suicide, aggression or AWOL risk
- assess the need for transfer to Psychiatry once medically cleared
- complete and present a detailed Mental State Examination
- generate a complete differential diagnosis
- develop a biopsychosocial formulation
- define the indications, contraindications, dosage and side-effects of psychotropic medications
- make appropriate discharge plans for patients
- maintain comprehensive, accurate and timely medical records

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

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

General Requirements:
- Develop rapport, trust and ethical therapeutic relationships with patients and families.
- Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals.
- Accurately convey relevant information and explanations to patients and families, colleagues and other professionals.
Develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care.
Convey effective oral and written information about a medical encounter.
Participate effectively and appropriately in an inter-professional healthcare team.
Effectively work with other health professionals to prevent, negotiate, and resolve inter-professional conflict.

**Specific Requirements:**

The Resident will:
- Listen effectively
- Discuss appropriate information with the health team
- Convey to patients and family an accurate, clear, coherent and timely account of the diagnosis, treatment plans and prognosis in all clinical cases
- Convey pertinent information and opinions to medical colleagues in a timely and effective manner in both verbal and written formats
- Consult effectively with other physicians and health care professionals
- Contribute effectively to interdisciplinary team activities with the Consultation-Liaison setting
- Demonstrate an ability and willingness to teach and learn from colleagues and students
- Demonstrate an ability to work collaboratively with other members of the health care team – recognizing their roles and responsibilities

C. **Systems Based Practice**

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

**General Requirements:**
- Participate in activities that contribute to the effectiveness of their healthcare organizations and systems.
- Manage their practice and career effectively.
- Allocate finite healthcare resources appropriately.
- Serve in administration and leadership roles, as appropriate.

**Specific Requirements:**

The Resident will:
- utilize personal and system resources effectively to balance patient care, learning needs and outside activities
- understand and make effective use of information technology to optimize patient care, lifelong learning and other activities
- make cost effective use of resources based on sound judgment and assess the risks and benefits of hospitalization
• evaluate the effective use of resources
• set realistic priorities and use time effectively in order to optimize professional performance consistent with personal/professional goals and obligations
• coordinate the efforts of the treatment team
• demonstrate an ability and willingness to direct patients to relevant community resources

D. Practice Based Learning and Improvement
As Health Advocates, physicians responsibly use their expertise and influence to advance the health and wellbeing of individual patients, communities, and populations.

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

**General Requirements:**
- Participate in activities that contribute to the effectiveness of their healthcare organizations and systems.
- Manage their practice and career effectively.
- Allocate finite healthcare resources appropriately.
- Serve in administration and leadership roles, as appropriate.
- Maintain and enhance professional activities through ongoing learning.
- Critically evaluate information and its sources, and apply this appropriately to practice decisions.
- Facilitate the learning of patients, families, students, residents, other health professionals, the public, and others, as appropriate.
- Contribute to the creation, dissemination, application, and translation of new knowledge and practices.

**Specific Requirements:**
The Resident will:
- Demonstrate an awareness of structures of governance in mental health care
- Demonstrate an awareness of regional, national and international advocacy groups in mental health care
- Identify and understand the determinants of health affecting patients and communities, recognizing and responding to those issues where advocacy is appropriate for the patient or their community
- Demonstrate an awareness of community resources (e.g., Alcohol and Drugs
- Demonstrate a synthesis of an effective level of basic science knowledge physiology, neuroanatomy, neurochemistry, genetics medical statistics, pharmacology, research methodology.
- Demonstrate an understanding of and a commitment to the need for continuous
learning; develop, implement and monitor a personal and continuing medical education strategy

- Critically appraise medical information; successfully integrate information from a variety of sources
- Facilitate the learning of patients, students, Residents and other health professionals through guidance, teaching and constructive feedback
- Contribute to the development of new knowledge

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

General Requirements:
- Demonstrate a commitment to their patients, profession, and society through ethical practice.
- Demonstrate a commitment to their patients, profession, and society through participation in profession-led regulation.
- Demonstrate a commitment to physician health and sustainable practice.

Specific Requirements:
The Resident will:
- demonstrate integrity, compassion and respect for diversity
- demonstrate usual professional standards though manner, behaviour and dress
- fulfill the medical, legal and professional obligations of a psychiatrist practicing within the Code of Ethics
- maintain collaborative and respectful patient relationships that demonstrate gender, cultural and spiritual awareness
- demonstrate responsibility, dependability, self-direction
- be punctual
- demonstrate acceptance of feedback and use it constructively
- demonstrate awareness of and the application of ethical principles
- demonstrate an understanding and capacity to apply the regulations pertaining to access to the health care record by patients or others

7.2 GENERAL DESCRIPTION AND TRAINING SITES

7.2.1 Sultan Qaboos University Hospital
The Consultation & Liaison Service meets a growing demand for assessment of psychiatric patients on the medical floors and to supply proper pre-admission assessments for medical, surgical and emergency room patients. The goal is to supply
timely psychiatric assessment as well as to arrange proper assessment and follow up of patients with combined psychosomatic and medical and psychiatric illnesses.

1. Psychiatric Consultation Liaison services are provided to all services within the hospital. Approximately 3 consultations are provided per day. Aim is for the resident to complete 20 consults during the 4-block rotation.

2. Standard rotation organization and description R4 resident is assigned to the service. The resident will attend referred consultations, assess the patient, following which the assessment and treatment planning will be discussed with the supervisor as required. As much as possible and when time permits, the Resident will be observed while doing the assessments; or the Resident will observe the supervisor completing the assessments. Family meetings, staff liaison, and other activities can be scheduled. When the liaison Resident is not available, all referrals will be seen by the on-call resident.

**Assessment Tools**
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
- Case Based Discussion Form (CBD)
- Evaluation Form For Resident’s Teaching Sessions (If Applicable)
- Resident Professionalism Evaluation Form
- Critical Incident Form if applicable
- 6 month Evaluation/Annual Evaluation
- Trainer Evaluation by Residents
- Rotation Evaluation Form

**8. ADDICTION PSYCHIATRY**

**8.1 GOALS AND OBJECTIVES**

The following is an overview of the goals and objectives of training in addiction psychiatry. As part of the psychiatric residency training program, senior residents (R4) will spend four months rotation in addiction psychiatry. The rotation will provide the resident with a broad exposure to the field of addiction. While this rotation is not aimed to graduate expert specialized residents in addiction psychiatry, it will however enable the resident to acquire essential knowledge and skills for assessment and management of patients with addiction problems. At the completion of addiction rotation, the resident will have acquired the following competencies and will function effectively as a:

A. **Medical Knowledge**
   - Understanding the nature of addiction as a chronic disorder of multi-factorial causes that needs multi-disciplinary approaches.
   - Understand the pathophysiology, neurobiology, aetiology, risk factors,
prognostic factors, and natural history/course of the disorder.

- Demonstrate ability to perform a comprehensive assessment including a history, physical examination, mental state examination of a patient with substance misuse disorder.
- Demonstrate ability to diagnosis patient with addiction problem according to classification systems of mental and behavioral disorders (DSM-IV and ICD-10).
- Understand biopsychosocial, cultural, and spiritual model of treatment (including pharmacotherapies, behavioral and other psychological treatment options).
- Ability to understand the principle of community based treatment programs and after-care programs.
- Ability to understand the role of community support groups and anonymous group in the treatment of patients with substance use disorder.
- Demonstrate ability to diagnose and provide essential treatment for:
  - Patient with alcohol use disorder
  - Patient with delirium tremens
  - Patient with cannabinoid use disorder
  - Patient with solvent use disorder
  - Patient with opioid use disorder
  - Patient with stimulant disorder
  - Patient with hallucinogens use disorder
  - Patient with benzodiazepines use disorder
  - Special cases such as IDUs during pregnancy, sicklers with opioid dependency
  - Patient with medical and physical co-morbidity
  - Patient presented with emergencies such as drug over-dose, acute intoxication and severe withdrawal syndrome.
- Understand the concepts related to the stages of Change model and type of intervention at each stage.
- Discuss the principles of harm minimization programs.
- Understand the structure and the role of the National Committee of Narcotic and Psychotropic Affairs.
- Be aware of the Oman legislation of narcotics and psychotropics.

**B. Interpersonal and Communication Skills**

- Develop rapport, trust and ethical therapeutic relationships with patients and families
- Develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care
- Communicate effectively with patients, their family and other health care professionals
- Demonstrate appropriate documentation of the Psychiatric history and Physical examination.
- Communicate effectively with medical colleague’s pertinent information and opinions.
- Understand specific communication methods for this population e.g. use of motivational interviewing vs. confrontational techniques.
- Communicate with allied professionals and agencies.
• Work with the patient and his/her family/friends.
• Be capable of involving patients in decisions making when appropriate.
• Consult effectively with other physicians and health care professionals.
• Work with multidisciplinary team members.
• Work within an integrated mental health system.
• Demonstrate an ability and willingness to teach and learn from colleagues and students.
• Have multi-sectorial approach.

ii. Systems Based Practice
• Effective use of resources based on sound judgment.
• Manage the patient load and assigned consultations.
• Manage time and supervision of medical students.
• Set priorities and use time effectively in order to optimize professional performance.
• Make use of information technology to optimize patient care and lifelong learning.
• Maintain the spirit of the team.

E. Practice Based Learning and Improvement
• Advocate for your patients.
• Advocate for mental health and addiction at higher levels.
• Understand how to make changes within the system.
• Demonstrate an awareness of structures of governance in mental health care.
• Demonstrate an awareness of regional, national and international advocacy groups in mental health care.
• Identify and understand the determinants of health affecting patients and communities, recognizing and responding to those issues where advocacy is appropriate for the patient or their community.
• Commit to lifelong learning
• Know key articles and textbooks in the field
• Critically appraise literature
• Critically review treatment plans and justify treatment plan
• Help others learn through guidance and constructive feedback
• Contribute to the development of new knowledge

G. Professionalism
• Behave in a professional manner with patients, staff, and community agencies.
• Demonstrate responsibility, dependability, self direction, punctuality.
• Display patience and flexibility in the face of complex clinical / administrative situations.
• Demonstrate constructive use of supervision and feedback.
• Develop Awareness and application of ethical principles.
• Treating patients as a whole, able to fulfil their needs, their families and community.
Fulfil the medical, legal and professional obligations of a psychiatrist practicing within the Code of Ethics

Demonstrate acceptance of feedback and use it constructively

8.2 TRAINING SITES IN ADDICTION PSYCHIATRY

The training site assigned for addiction psychiatry is Al-Masarr Hospital. The Addiction Department (Substance Misuse Unit) is a specialized unit which consists of inpatient and outpatient facilities. It has a total of 50 beds, 25 beds for detoxification and 25 for rehabilitation.

Comprehensive multidisciplinary bio-psycho-social assessment and management of patient with addiction problems are undertaken.

The multidisciplinary team in the Addiction Unit includes psychiatrists, physicians, psychiatric nurses, psychologists, counselors, social workers, occupational therapists and physiotherapist.

Community-based spiritual and anonymous groups have taken part in the treatment programs under supervision and guidance of the department.

The department has good link with the National Narcotic Committee and with other concerned sectors like social development services, labor services, social society and police.

Assessment Tools
- Monthly In Training Evaluation Form (ITER)
- Mini Clinical Evaluation Exercise Form (Mini-CEX)
- Multisource Feedback Form (360-Degree Evaluation)
- Case Based Discussion Form (CBD)
- Evaluation Form For Resident’s Teaching Sessions (If Applicable)
- Resident Professionalism Evaluation Form
- Critical Incident Form if applicable
- 6 month Evaluation/Annual Evaluation
- Trainer Evaluation by Residents
- Rotation Evaluation Form

XII. RESEARCH

The research work is a prerequisite for granting the completion of training certificate to a graduate. It can be started from the beginning of R2 and presented at an appropriate time during the residency program, NO LATER than one year prior to the date of final board examination. The topics chosen must be relevant to the Omani society need. It can be done with patients in the hospital (retrospective, prospective or combined), or in the community (schools, different centers) as surveys.

The research paper must include:
Case reports are not considered as research. The research must be:
- Presented publicly
- Evaluated by three Education committee members
- The passing mark is 60%

In case of getting less 60%, another trial will be allowed and they will be given a year to do so.

**XIII. RESIDENT ACADEMIC ACTIVITIES**

The academic day program will run during the protected allocated time for residents during which they are to be exempted from attending clinical duties, and it will be conducted on weekly basis i.e. every Thursday.

However, residents concerned are expected to resume their clinical work at the end of the day program if they are on-call.

The residents will be divided into two joint groups: Junior (R1 and R2) and Senior (R3 and R4). Both groups will alternate in attending the respective day programme activities at both training sites: Sultan Qaboos University Hospital (SQUH) and Al Masarra Hospital (AMH).

R5 residents are expected to utilize their Thursdays to complete research, update and consolidate their clinical knowledge, study for exams, and get actively involved in teaching of the medical students rotating in Psychiatry at both training sites. R5 residents will participate in presentations on updates in Psychiatry which will take place on the academic day also.

**Attendance record of the scheduled academic activities will be maintained.**

**Residents must ensure satisfactory level of attendance i.e. mandatory attendance is for 75% of the academic days.**
The day program has two main integrative components:
1. Theoretical component, which will run at the seminar room in the department of behavioral medicine, SQUH.
2. Clinical/Practical component, which will be held at Al-Masarra Hospital. This will include interviewing skills and patients' management problems (PMPs).

1. NEUROSCIENCE AND CLINICAL KNOWLEDGE
This constitutes the "theoretical" component of the academic day programme which will run at SQUH and through interactive sessions, it will focus on establishing knowledge of the basic sciences of behavioral medicine, mental and behavioral disorders, clinical subjects relevant to the subspecialties e.g. substance misuse, child psychiatry, geriatric psychiatry, forensic psychiatry etc.

These sessions will be tailored according to the residents' level of training.

2. INTERVIEWING SKILLS/PATIENT MANAGEMENT PROBLEM
This constitutes the clinical component of the academic day programme which will run at Al-Masarra Hospital and will focus on training the residents how to conduct a standard psychiatric interview to elicit relevant history and psychopathology.

It will enable the residents to perform a supervised interview with a real patient following which he/she will get feedback from the trainer and other residents.

PMP sessions will discuss in depth patients’ management in various clinical scenarios relevant to the level of training. This would assist the resident in exam preparation.

3. CLINICAL CASE PRESENTATION
Residents are expected to conduct comprehensive clinical case presentation at least twice per year and this will contribute into their ongoing assessment.

Case presentation will take place on the academic day program at both training sites.

It is the responsibility of the resident to arrange for a swap in case if he/she was unable to present as scheduled.

4. JOURNAL CLUB
Residents are expected to present and critically appraise articles/studies at least twice per year and this will contribute into the overall assessment of residents.

Journal club will be part of the academic day program at both training sites and residents will elect a representative to coordinate between residents and to ensure running it as scheduled.
Ultimately, it is the responsibility of the resident to arrange for a swap in case if he/she was unable to present as scheduled.

<table>
<thead>
<tr>
<th>No.</th>
<th>Year</th>
<th>Title</th>
<th>Type of format</th>
<th>Required or Elective</th>
<th>Brief Description</th>
<th>Frequency, length of session and total number of sessions</th>
<th>TRAINING SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Year 1-4</td>
<td>Journal Club /Clinical Case Presentation</td>
<td>Discussion groups</td>
<td>Required</td>
<td>An article will be presented by the resident and will be evaluated by his colleagues</td>
<td>Weekly</td>
<td>AMH/SQUH</td>
</tr>
<tr>
<td>2</td>
<td>Year 1-4</td>
<td>Clinical Updates</td>
<td>Discussion groups</td>
<td>Required</td>
<td>A publication for psychiatrist that highlights trends in the practice of psychiatry will be presented by the resident and will be evaluated by his colleagues</td>
<td>Weekly</td>
<td>SQUH</td>
</tr>
<tr>
<td>3</td>
<td>Year 1-4</td>
<td>Interviewing Skills</td>
<td>Discussion groups</td>
<td>Required</td>
<td>This will develop and enhance the examination skills of the residents to elicit the relevant psychopathology while conducting detailed mental state examination on “real” patients</td>
<td>Weekly</td>
<td>AMH</td>
</tr>
<tr>
<td>4</td>
<td>Year 1-4</td>
<td>Psychopharmacology Case Study</td>
<td>Discussion groups</td>
<td>Required</td>
<td>A case will be presented from Stehl Case studies in Psychopharmacology book. Residents will be allocated a case and given the documents needed to present</td>
<td>Weekly</td>
<td>SQUH</td>
</tr>
<tr>
<td>5</td>
<td>Year 1-5</td>
<td>Breakaway Techniques</td>
<td>Discussion groups</td>
<td>Required</td>
<td>The Breakaway Techniques course has been developed to promote personal safety in the work environment and to generate a better understanding of the law surrounding reasonable force and its application. The techniques are non-abusive and designed for escape and de-escalation ensuring minimal impact on all involved</td>
<td>Once a year</td>
<td>AMH</td>
</tr>
</tbody>
</table>
XIV. OUTLINED SYLLABUS OF THE TRAINING PROGRAM

- Anxiety disorders
- Adjustment disorders and
- V codes (noncompliance, malingering, antisocial behavior, borderline IQ, bereavement, academic and occupational problems, cognitive decline, phase of life)
- Alcohol and other substance abuse disorders
- Attention Deficit Hyperactivity Disorder
- Delusional disorders and other psychoses
- Dementias
- Organic brain syndromes/delirium
- Personality disorders
- Psychiatric disorders secondary to medical conditions
- Mood disorders
- Schizophrenia
- Boundary issues
- Burden of medical, surgical and psychiatric illness to individuals, families and systems
- Capacity / Competence
- Confidentiality
- Co-morbidity – medical, psychiatric, developmental or substance abuse
- Consent
- Culture and spirituality
- End of life issues
- Family issues
- Legal and forensic matters
- Long term illness and rehabilitation
- Psychiatric manifestations of medical and neurological illness
- Stigma
- Suicide, self harm, or harm directed towards others
- Assessment and management of safety/risk for patient and provider in all settings
- Policy, procedure and practice dealing with patient and provider safety, including violent and potentially violent situations in all settings
- Systems issues
- Therapeutic alliance
- Trauma, abuse or neglect
• Psychopharmacology and somatic therapies
• Conduct Disorders
• Developmental disabilities including mental retardation
• Eating disorders
• Impulse control disorders
• Learning Disorders
• Movement disorders
• Oppositional Defiant Disorder
• Other disorders first presenting in childhood
• Pervasive developmental disorders
• Sexual dysfunction
• Sleep disorders
• Somatoform Disorders
• Forensics
• Genetics
• Medical statistics
• Neuroanatomy
• Neurochemistry
• Pharmacology
• Physiology
• Public health principles
• Research methodology
• Psychological investigations
• Neuropsychological investigations
• Neuroimaging
• Sexual and gender identity disorders
• Complementary and alternative care modalities
• Medical investigation or consultation
• Cognitive Behavioural Therapy
• Psychodynamic Therapy
• Supportive Therapy
• Dialectic Behaviour Therapy
• Group Therapy
• Interpersonal therapies
• Brief psychodynamic psychotherapy
• Mindfulness training
• Motivational interviewing
• Relaxation
• Crisis intervention, de-escalation or nonviolent intervention techniques
• Electro convulsive therapy (ECT)
XV. GRADED RESPONSIBILITIES FOR EACH ACADEMIC YEAR

Objectives for First Year of Training (R1)

During the first year, resident should acquire basic knowledge of psychiatry, communication skills, and interviewing techniques via tutorials, lectures, outpatients care, inpatient care and emergency. Trainees are expected also to devote time for personal studies in allied basic subjects.

Residents’ clinical rotations will be in general adult psychiatry.

By the end of the first year, the resident is expected to:

- Use effective communication skills with patients, relatives, colleagues and other members of the healthcare team with compassion, respect, and professional integrity. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances.
- Be able to perform a complete initial history and physical examination.
- Can recognize the physical symptoms of no organic base in relevance to the psychological bases.
- Be especially aware of interactions between psychiatric treatments and medical and surgical treatments.
- Develop the ability to relate to patients and their families.
- Learn the habits of self learning.
- Act in a professional manner at all times.

Methods of Assessment

- Written Tests, ITER/ Direct Observation, Observed Structured Clinical Examination (OSCE/SP), Mini Clinical Evaluation Exercises (Mini-CEX), Multi-Source Feedback Evaluation, Case Based Discussion.
**Objectives for Second Year of Training (R2)**

This year will also be devoted to broadening the clinical base of knowledge aiming to improve clinical judgment skills. The Residents in R2 are expected to continue personal studies of related disciplines.

Resident’s clinical training will be mostly in general psychiatry, neurology, and psychotherapy.

By the end of the second year, the resident should be able to:

- Perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include: presenting complaint, history of present illness, past medical and psychiatric history, systemic review, family history, socio-cultural history & developmental history.

- Be familiar with contemporary ICD-10 or DSM-IV-TR diagnostic systems with the ability to discuss the advantages and limitations of each State the typical signs and symptoms of psychiatric disorders as they manifest across the age range, including affective disorders; anxiety disorders; disorders of cognitive impairment; psychotic disorders; personality disorders; substance misuse disorders; organic disorders; developmental disorders; and common disorders in childhood Formulate a differential diagnosis for major presenting problems.

Describe the various biological, psychological, spiritual and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorder.

**Methods of Assessment**

- Written Tests, ITER/ Direct Observation, Observed Structured Clinical Examination (OSCE/SP), Mini Clinical Evaluation Exercises (Mini-CEX), Multi-Source Feedback Evaluation, Case Based Discussion
Objectives for Third Year of Training (R3)

Special attention will be given to clinical training in child psychiatry and geriatric psychiatry. The relationship between mental health and psychosocial factors will be closely examined.

R3 resident and will conduct OPD Clinics and attend to patients referred from primary care clinics as well as from the accident and emergency departments.

R3 residents will be expected to start their research project, and will actively participate in teaching and supervision responsibilities to undergraduate students.

By the end of the third year, the resident is expected to be able to:

- Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains.

- Based on a comprehensive psychiatric assessment, demonstrate the ability to comprehensively assess and document patient’s potential for self-harm or harm to others. This would include an assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimize risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies.

- Develop the ability to conduct and complete audit in clinical practice.

- Develop the ability to teach medical students & junior colleagues, assess and appraise them.

- Develop an understanding of research methodology and critical appraisal of the research literature.

Methods of Assessment

- Written Tests, ITER/ Direct Observation, Observed Structured Clinical Examination (OSCE/SP), Mini Clinical Evaluation Exercises (Mini-CEX), Multi-Source Feedback Evaluation, Case Based Discussion.
Objectives for Fourth/Fifth Years of Training (R4/R5)

The fourth year is designed to increase the experience of the residents in the sub-specialties, including addiction psychiatry, Consultation-Liaison and rehabilitation of the chronically patients. Mental health administration and involvement of the Community will receive due emphasis. The resident is expected to perform the duties of specialist and they will be a second on call. Also shall be involved in teaching medical students and first and second year residents. During the final year (R5), residents are expected to spend it in elective in the area that interests them; they can spend it abroad as well in a recognized center.

Residents expected to complete their research by end of R5 to be granted the completion of program.

By the end of the fourth/Fifth years, the resident is expected to be able to:

- Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The resident will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions
- Demonstrate the ability to concisely, accurately and legibly record appropriate aspects of the clinical assessment and management plan
- Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states
- Demonstrate the ability to work effectively with colleagues, including team working
- Develop appropriate leadership skills
- Demonstrate the knowledge, skills and behaviors to manage time and problems effectively.

Methods of Assessment

- Written Tests, ITER/ Direct Observation, Observed Structured Clinical Examination (OSCE/SP), Mini Clinical Evaluation Exercises (Mini-CEX), Multi-Source Feedback Evaluation, Case Based Discussion
XVI. PROGRESSION CRITERIA

The evaluation of the resident (strengths and weakness) will be a continuous process throughout the five-year programme and the following will be considered:

1. Satisfactory completion of each of the clinical rotations with regard to academic knowledge, attitude, clinical competence, maintains patient confidentiality and professional behavior.

2. Satisfactory attendance and active participation at lecture, tutorials, teaching skills (peers), ability for self-directed learning, seminars and other academic activities.

3. Satisfactory evidence of competence to carry out good psychiatric interview including standardized mental state examination, interpretation and differential diagnosis, decision making and management plan, verbal and written communication, provides comprehensive care, ability to manage emergency conditions, consultation skills, physical method of treatment (use of drug and electroconvulsive therapy), CBT, individual and group psychotherapy and ability to assess children and adolescents.

4. Performance at annual examinations conducted at the end of each training year, for the first three years written examination. Disciplinary action for unsatisfactory performance or behavior will be taken according to the rules and regulations of OMSB Psychiatric Residency Board.

1. EXAMINATION OUTLINE:

A. END OF YEAR EXAMINATION
   This examination is conducted at the end of each academic year. It consists of written MCQ exam and OSCE.

B. EXIT EXAMINATION
   1. Primary Specialty Board Examination (PART I OMSB)
      • This is a qualifying examination which is held every year and can be attempted at R2.
      • This will consist of Multiple Choice Questions (MCQ).
      • A resident is allowed three attempts to pass the OMSB Part 1 exam.
      • No R3 Resident will be allowed to progress to R4 level without passing the OMSB Part 1 exam.
      • OMSB Registration will be cancelled if a resident does not pass the OMSB Part 1 exam in three attempts.

   2. Final Fellowship Examination (PART II OMSB)
      • This should consist of 100 Multiple Choice Questions (MCQ) and Clinical Examination.
      • This examination is held annually. To be eligible for entry for the examination, the candidate must successfully complete the five year programme and pass successfully the annual examinations.
      • Upon successful completion of the five year programme and on passing the final examination, the candidate shall be awarded the Fellowship of Oman Medical Speciality Board in Psychiatry (FOMSB-Psych) after successful research submission and completion of elective year.
C. INTERNATIONAL EXAMINATION

- Arab Board of Psychiatry
- PRITE (Psychiatry In-Training Examination)

Completion of Training Requirements
Excerpts from OMSB Institutional Policies and Guidelines 2015

After completion of training in the specialty training program and passing all required examinations, OMSB Resident shall obtain the Oman Medical Specialty Board Certificate. This Certificate is professionally equivalent to PhD in medical specializations. OMSB requires each Resident to sit for three examinations namely: yearly End of Year Exam, Written Part I exam for the specialty certificate which requires a passing grade of at least 60%, and the final Exit Examination for the specialty certificate which is conducted by OMSB in collaboration with Omani professors and external examiners from different Arab, European, and North American countries. This collaboration is related to training and evaluation including the basic and clinical aspects of the specialty, and a final oral and clinical exam.

Criteria for receiving Completion of Training Certificate:
1. Passed all End-of-Year Exams
2. Achieved Satisfactory Evaluations
3. Passed OMSB Part I or equivalent
5. Completed successfully the Resident Development Program
6. Provided evidence of a research project during residency.

Criteria for receiving Specialty Certificate:
Article (28): The OMSB shall issue the Oman Medical Board Specialty Certificate following the completion of the training program and passing the Exit examination.
ASSESSMENT TOOLS
Residents are continuously assessed during the duration of their residency training programs. The assessment can be done on daily basis, mid-block, at the end of the block and at the end of the training program.

Direct observation is central to assessment. Information gathering about residents must be based on direct observations that must be matched to the learning objectives of that encounter and the level of residents. The observations must be made by different observers at different times and places. The concept is to assess pattern of behaviors rather than formative judgment based on single incident. Assessors must use different assessment tools as no single tool can give all the information about the Resident’s competence.

1. ASSESSMENT OF RESIDENTS

The following formative assessment forms are completed by the Trainers/Rotation Supervisors to assess the performance of the Residents during their training.

In-Training Evaluation Report (ITER)
The In-Training Evaluation Report (ITER) is an assessment instrument to document direct observation. The OMSB ITER is designed to assess the competencies outlined in the OMSB Quality Assurance Standards. It aims to highlight the strengths, identify the weaknesses and aids in developing a plan of action for improvement. Residents at the beginning of each block should be familiar with the specific objectives of the rotation. The Trainers should give midblock feedback to the Residents. Residents are assessed at the end of each block for successful meeting of the rotation’s objectives.

Assessment of Procedural Skills
Procedural skills involve the mental and motor activities required to execute a manual task. This tool assesses safe technical performance, appropriate knowledge and decision making. Furthermore, it addresses pre and post-procedural skills including consent taking, communication skills, and complications of procedure and their appropriate management.

Mini Clinical Evaluation Exercise (Mini-CEX)
Mini-CEX is a structured assessment of an observed clinical encounter or a “snapshot” of a Resident-patient interaction. This tool assesses a clinical encounter with a patient to provide an indication of competence in skills essential for clinical care such as history taking, examination and clinical reasoning. It is designed to assess the Resident’s medical knowledge, patient care competencies and professionalism. The assessor may focus on one or two competencies per encounter.

The Resident receives immediate feedback to aid learning. It can be used at any time and in any setting when there is a Resident and patient interaction and an assessor is available.

The Mini-CEX should be conducted at least four times per resident per academic year.

Presentation Evaluation
The purpose of evaluating the Resident’s presentation is to recognize strengths and identify areas of needed improvement. This evaluation may be used to assess the Resident’s oral presentation skills, systematic way of presentation and medical knowledge.

Residents are required to have four Presentation Evaluations per year.

**Journal Club Evaluation**

Journal club is defined as an educational meeting in which a group of individuals discuss current articles providing a forum for a collective effort to keep up with the literature. Its main purpose is to facilitate the review of a specific research study and to discuss implications of the study for clinical practice.

The Journal Club Evaluation Form has been developed to assess the Residents’ ability to understand the research process and improve his/her ability to critically appraise literature. It helps in building the Residents’ medical knowledge as well as interpersonal and communication skills. The Residents are expected to be assessed using this form whenever they are presenting during journal club meetings. A minimum of 1 Journal Club Evaluation per resident per academic year is required.

**Case-Based Discussion (CbD)**

Case-Based Discussion (CbD) is a structured discussion of clinical case managed by the Resident.

CbD is aimed to assess the Resident’s clinical approach and reasoning, analytical, deductive and decision making skills, and the application of medical knowledge. This provides the resident opportunity to present and discuss his/her case with the trainer enabling the discussion of the ethical and legal framework of practice. The resident receives systematic and structured feedback.

The Resident with his supervisor will select a case in which he/she has been directly involved and agree on a time of discussion. A minimum of 30 minutes will be allotted for the CbD. A minimum of 3 CbD is required per resident per academic year.

**Multisource Feedback (MSF)**

Multisource feedback (MSF) is often called 360-degree assessment. MSF uses specific instruments designed to gather data about particular behaviors or professional constructs (e.g. professionalism and communication skills of the Resident). There should be at least 12 assessors in addition to self-assessment. The assessors can be Resident peers, supervising physicians, allied health professionals, patients and family members, etc. Feedback is provided in aggregate form for each source. MSF can be used to provide formative and summative assessments, and identify learners in difficulty.

The OMSB requires the Resident to be evaluated via the MSF at least once a year. The Program Director/Assistant Program Director will choose the assessors. Each assessor will complete the form and this will be submitted to the Program Director/Assistant Program Director or the Program Administrator. The Resident will not see the individual responses and the Program Administrator will summarize the results and the Program Director will discuss the aggregate result and feedback with the Resident.

**Research Block Evaluation**

OMSB mandates all Training Programs to allocate two blocks for Research. These rotations should be utilized in assisting the Residents in their research proposal, data collection and analysis, as well as manuscript writing. During the Research Block, residents should be evaluated using the Research Block Evaluation Form, which assesses the Residents’ performance in relation to their research project. This form must be completed at the end of each Research block.
**Portfolios and Logbooks**

A portfolio is a dynamic collection of work that exhibits the Residents’ efforts, progress and achievements in multiple areas over time. The portfolio encourages the Resident to reflect on the learning process. Logbook, on the other hand, is used to track the educationally relevant activities, such as the number of procedures performed, and it documents that a learning activity has taken place. The portfolios and logbooks assist in formative and summative assessment of the performance of the Residents.

The portfolio may include: i) the logbook, ii) a summary of the research literature reviewed when selecting a treatment option, iii) a quality improvement project plan and report of results, iv) ethical dilemmas faced and how they were handled, vi) self-reflection, etc. The logbook and portfolio are owned by the Resident and are reviewed by the Program Director/Associate Program Director during the face-to-face six-month and annual feedback sessions.

**II. SUMMATIVE ASSESSMENT**

**Six-Month/Annual Evaluation**

Residents undergo a biannual evaluation using the Six-Month and Annual Evaluation forms. This is a summative assessment of their progress during the year.

The Program Director, together with the Clinical Competency Committee members, reviews all the resident assessments prior to the feedback sessions. This includes reviewing examination results, workplace-based assessment reports, logbook and portfolio, research progress, and incomplete rotations, if any. The Committee provides recommendation to the Program Director regarding residents’ performance.

The Program Director meets with the Residents individually to conduct the face-to-face feedback session. Residents are counseled regarding their strengths and weaknesses at the end of six blocks and at the end of the academic year. Remedial action plan will be discussed with the resident if applicable.

These face-to-face meetings provide an opportunity for the Resident to provide feedback on their current training and identify specific training needs, which will be taken into consideration by the Program Education Committee in improving the training program.

The annual evaluation will confirm the progress of the resident through the Training Program. The resident progression is in accordance to the OMSB Academic Bylaws Article 21-23 (OMSB Resident Manual 6th edition, pages 16-17), as well as the specialty-specific promotion criteria specified by each training program.

**Examinations**

Examinations are given to assess the overall knowledge of the Resident in a particular subject matter. There are multiple examination formats that are used by the various Training Programs.

**Written tests**
**Short-answer questions** – A written test that consist of a brief, highly directed question answerable by few short words or phrases.

**Multiple Choice Questions** – A written exam that uses an opening question or stem and asks the learner to choose the most correct answer from a list that includes two to five plausible yet incorrect distracters. This is usually the format of the End-of-Year Examination and the OMSB Part 1.

**Extended Matching Questions** – A written exam that uses an opening question or stem with a list of 10 to 20 items that are matched to a series of corresponding responses. An item may be matched to more than one response.

**Oral Examinations**

**Structured oral examinations (SOE)** – A type of examination that assesses a number of standardized cases using anticipated probing questions based on the range of expected candidate performance and anchored rating schemata to increase the reliability of the evaluation.

**Objective structure clinical examinations (OSCEs)** – A type of examination designed to test clinical skill performance and competence in skills such as communication, clinical examination, medical procedures/prescription, etc.

**Final In-training Evaluation Report (FITER)**
The Final In-Training Evaluation Report (FITER) is a composite record of a Resident’s training progress and performance during the entire duration of his/her residency training. This record indicates whether or not the resident has acquired the minimum required competencies, as per the objectives of the Training Program, and is competent to practice as an independent specialist.

The FITER should be completed by the Program Director/Associate Program Director three (3) months before a Resident completes or exits the training program.

**Frequency of evaluation**
Resident Performance Assessment

<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Frequency (Minimum)</th>
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<tbody>
<tr>
<td>In-Training Evaluation Report (ITER)</td>
<td>1 per block</td>
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<tr>
<td>Evaluation of Procedural Skills</td>
<td>Program specific (min. 50 all throughout training.)</td>
</tr>
<tr>
<td>Mini-CEX</td>
<td>4 per academic year</td>
</tr>
<tr>
<td>Presentation evaluation form</td>
<td>4 per academic year</td>
</tr>
<tr>
<td>MSF</td>
<td>1 per academic year</td>
</tr>
<tr>
<td>Case-based Discussion</td>
<td>3 per academic year</td>
</tr>
<tr>
<td>Journal Club Presentation Evaluation</td>
<td>1 Resident Presentation per year</td>
</tr>
<tr>
<td>Research Block Evaluation</td>
<td>1 per Research Block</td>
</tr>
<tr>
<td>Six-month &amp; Annual Evaluation</td>
<td>Twice per year (mid-year and end of year)</td>
</tr>
<tr>
<td>FITER</td>
<td>Once (3 months prior to leaving the program)</td>
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</table>
SULTAN QABOOS UNIVERSITY HOSPITAL

Sultan Qaboos University Hospital (SQUH) was established in 1991 as the first teaching hospital in Oman. In partnership with the College of Medicine and Health Sciences, strived to assume a strong leadership role in academic excellence and maintain reputation as a Premier Referral Centre for teaching, training, research and clinical care. The mission of SQUH is to provide high quality teaching and training of students at the College of Medicine and Health Sciences in addition to offering general and distinguished specialized clinical services while adhering to continuing professional development for the staff. It will serve as a base for research and innovations in healthcare for the benefit of the community. Sultan Qaboos University Hospital is committed to provide compassionate, ethical, and accessible general and specialized tertiary care to the community with integrity, commitment and respect towards patients and their families. The current number of beds is about 470 beds with different specializations including neurosurgery and cardiac surgery.

AL MASARRA HOSPITAL

Al-Masarra Hospital is the only specialised psychiatric hospital in the country.

It was recently inaugurated on 14.04.2013, offering a wide range of services including General Adult Psychiatry (with the integrated services for forensic, rehabilitation and learning disability patients), Addiction Psychiatry, Child and Adolescent Psychiatry, Emergency Psychiatry, Consultation-Liaison Psychiatry and the recently commenced subspecialty service of geriatric psychiatry.

The Psychiatric inpatient department of total bed capacity of 245 includes:
- 100 beds for general adult male patients.
- 50 beds for general adult female patients.
- 50 beds in addiction psychiatry unit.
- 20 beds for forensic patients
- 25 beds for child and adolescents

In addition to the emergency department, there is outpatient service covering various areas of specialization.

The hospital has designated facilities for academic activities such as the auditorium and seminar rooms in addition to the library.

The hospital with its specialised outpatient and inpatient services provides all levels of mental health care for patients presenting as an emergency at first encounter from within Muscat.
region, also for patients referred from primary health care in Muscat and secondary mental health clinics from various regions throughout the country.

In addition, patients referred from specialised psychiatric departments in Sultan Qaboos Hospital, Royal Oman Police and military psychiatric services.

Also, the referrals from the public prosecution/courts are assessed and managed in Al-Masarra Hospital.

Al-Masarra Hospital provides specialised training with exposure to various mental and behavioural disorders. In addition to general adult psychiatric services there are substance misuse, geriatric and child psychiatric services yet to be fully established. Forensic, rehabilitation and learning disability patients are managed within the general adult psychiatric services at this stage as specialized teams are yet to be established.

General adult (GA) psychiatric services at Al-Masarra Hospital are provided by the specialised multidisciplinary teams in both outpatient and inpatient settings.

The multidisciplinary team includes: psychiatrists, physicians, psychiatric nurses, psychologists, social workers, occupational therapists, physiotherapists, speech therapists and pharmacists.

Also newly established secondary mental health clinics in Muscat region are run by the visiting psychiatrists from Al-Masarra Hospital.

Internal medical board of senior psychiatrists provide assessment and medical reports as requested for patients referred from the public prosecution/courts or from medical committees for assessment of fitness for work.

For the general adult inpatients, there are 4 secure male and 2 female wards.

There is an ECT (electroconvulsive therapy) suite and also another suite for TMS (trans-magnetic stimulation therapy) located in close proximity to the wards.

There is one forensic ward with 20 beds for male patients with high security provided by the Royal Oman Police.

Substance misuse unit (SMU) with its multidisciplinary team also provides outpatient and inpatient services.

SMU wards have total bed capacity of 50 beds allocated for detoxification and for drug rehabilitation.

Specialised geriatric services have started recently with expert care provided to both inpatients and outpatients.

Child mental health services are provided at this stage in outpatient settings.
Al-Masarra Hospital has other essential departments to facilitate complete assessment of the patients with relevant investigations including EEG department, radiology including X-ray and the CT in addition to the laboratory.

There is occupational therapy department with various therapeutic sports and leisure facilities for the patients in addition to the assessment of activities of daily activities.

Psychology department undertakes psychometric assessments as planned. There is social services department with social workers attached to the teams to facilitate social assessment and management of the patients in liaison with the Ministry of social development and the ministry of manpower.

Al-Masarra Hospital (formerly Ibn Sina Hospital) has been recognised as a training centre in psychiatry by the Arab board. It has also been included by College of Medicine And Health Sciences, SQU and Oman Medical College among the teaching centres for medical students undertaking clinical rotations in Psychiatry.

Oman Medical Specialty Board (OMSB) residents in psychiatry have been rotating since the beginning of OMSB training programme in Psychiatry. Also, residents from other specialty training programmes such as Family and Community medicine have also been getting their clinical training in Psychiatry through rotations at the hospital.

Al-Masarra Hospital at this stage is considered to be the cornerstone for training of the residents locally in psychiatry and in collaboration with the department of behavioural medicine at Sultan Qaboos University hospital (SQUH) it serves to provide specialized training complemented with training abroad for maximizing the learning opportunities.

MEMBERS OF THE TEACHING FACULTY

<table>
<thead>
<tr>
<th>SULTAN QABOOS UNIVERSITY HOSPITAL</th>
<th>AL MASARRA HOSPITAL</th>
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<tbody>
<tr>
<td><strong>Education Committee Members</strong></td>
<td><strong>Education Committee Members</strong></td>
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<tr>
<td>Prof. Samir Al-Adawi</td>
<td>Dr. Nasser Al-Sibani</td>
</tr>
<tr>
<td>Dr. Rodger Martin</td>
<td>Dr. Jamila T.Al-Rahman</td>
</tr>
<tr>
<td>Dr. Yousif Abdel Noor</td>
<td>Dr. Mahmoud Al-Abri</td>
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<tr>
<td>Dr. Ather Sajjad Jafri</td>
<td>Dr. Saleha Al Jadidi</td>
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<td>Dr. Ehab Khatab</td>
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<td></td>
<td>Dr. Hussein Al Abri</td>
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<td><strong>Trainers</strong></td>
<td><strong>Trainers</strong></td>
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<tr>
<td>Dr. Hamed Al-Sinawi</td>
<td>Dr. Abdul Hamid Choudhry</td>
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<tr>
<td>Dr. Ziad Zaidan</td>
<td>Dr. Shahnawaz Khan</td>
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<tr>
<td>Dr. Nonna Viernes</td>
<td>Dr. Mohammed Haki</td>
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<tr>
<td>Dr. Aziz Al Naamani</td>
<td>Dr. Khadija Al Attabi</td>
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<tr>
<td>Ms. Zena Al Sharbati</td>
<td>Dr. Muna Al Shekeili</td>
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<td>Dr. Ghaniya Al Ghafri</td>
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<td></td>
<td>Dr. Amal Al Fahdi</td>
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XIX. VACATION AND LEAVE

- The resident shall be entitled to an annual leave of 30 days in addition to a maximum of 10 days in lieu of Eid holidays, official holidays and emergency leaves if the resident is required to work during these holidays and leaves. Please note that annual leave can be taken as whole block or divided into two weeks period at a time.

- In case the residents prefer to divide his/her leave, Residents will be allowed to choose 2 weeks period at a time as below:
  
  **Last week of the block and first week of the following block** – In this case, resident will be having 75% of the block which is a minimum requirement to get a full credit of the block.

**For Example: (VALID)**

<table>
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<tr>
<th>GAP</th>
<th>AL. 5 days</th>
<th>AL. 5 days</th>
<th>GAP</th>
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<tr>
<td>BLOCK 3</td>
<td>SQUH</td>
<td>SQUH</td>
<td>BLOCK 4</td>
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- The training period shall be extended for an equivalent period to compensate for sick leave, maternity leave and exceptional “emergency” leaves before the resident is awarded a certificate of completion of training if the leave exceeds seven days.

- Annual leave which is not utilized in due time within the year shall not be transferred to the following year.

- The resident may be granted a leave for scientific purposes (attending scientific conferences and seminars, specialty examinations, etc.) not exceeding 10 days in each training year provided that resident presents the proof of attendance of such activities and had prior approval to attend from the Scientific Committee.
XX. ON CALL DUTY

- The resident must not take more than one in-house call every 4 days and maximum of six in-house calls per block.

- A trainee’s shift must not exceed consecutive 24 hours and the trainee should make sure that he/she hands over his/her patients to the next training group/team strictly by 8 a.m.

- The weekend call must not exceed twice each block and each weekend call must be one day long – 24 hours – only.

PSYCHIATRY RESIDENTS ON CALL RESPONSIBILITIES

FOR JUNIOR RESIDENTS:

ALL JUNIOR RESIDENTS MUST COMMUNICATE WITH SECOND ON CALL FOR ALL ER CASES.

FOR SENIOR RESIDENTS:

1. Next day morning, the senior residents on call has to notify the third on call about all cases they have seen.
2. Other ER/Wards issues or cases under discretion of the senior resident as to when will notify the third on call.
3. Old/known cases at AMH, which require admission must also be communicated with the third on call. For SQUH, it is under the discretion of the site regulation.

*1st and 2nd on calls: to give a report to the 3rd on call the next morning about all cases seen during the on call. The report could be verbal (by phone) or by text/email.
*The first on call should also discuss all ER cases with the second on call, who decides whether to ring 3rd on call or not.
*If we feel patients have been inappropriately admitted (or inappropriately sent home), then take the 2nd on call to task when discussing the report the next morning.

-/saj-/aln/asj
XXI. SUGGESTED READING MATERIALS

1. CORE JOURNAL

- American Journal of Psychiatry
- Canadian Journal of Psychiatry
- Australian and New Zealand Journal of Psychiatry
- The British Journal of Psychiatry
- Psychological Medicine
- Current Opinion in Psychiatry
- Addiction
- Drug and alcohol dependence
- Psychology Journal
- British Medical Journal
- Journal of Clinical Psychiatry
- Advances in Psychiatric Treatment
- American journal of Psychiatry Archives of General Psychiatry

2. TEXTBOOKS

- New Oxford Textbook of Psychiatry
  Oxford University Press
  Gelder M, Andreasen N, Lopez J, Geddes J

- Kaplan and Sadock's Synopsis Textbook of Psychiatry
  Lippincott Williams & Wilkins
  ISBN 13: 9780781773270

- Oxford Handbook of Psychiatry
  Oxford University Press
  Semple D, Smith R
3. ADDITIONAL LIST

General Textbooks

- Campbell’s Psychiatric Dictionary
  Oxford University Press, Campbell, RJ

- Shorter Oxford Textbook of Psychiatry
  Oxford University Press, Gelder M, Mayou R

- The Maudsley Handbook of Practical Psychiatry
  Oxford University Press, Goldberg D, Murray R

- Comprehensive Textbook of Psychiatry
  Williams & Wilkins, Kaplan HI

- Organic Psychiatry: The Psychological Consequences of Cerebral Disorder
  William Alwyn Lishman, , Blackwell Science, Lishman WA

- Inpatient Psychiatry, Sederer

- Sciences Basic to Psychiatry, Puri, BK and PJ Tyrer

- Evidence-based medicine: How to practice and teach EBM
  Churchill Livingstone, Strauss Sharon E

Diagnostic Classification and Psychopathology

- Diagnostic and Statistical Manual of Mental Disorders:
  DSMV American Psychiatric Association

- Uncommon Psychiatric Syndromes
  Arnold, Enoch D, Trethowan W

- The ICD 10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines
  World Health Organization

- Fish’s Clinical Psychopathology

- Mental State Examination – Paula and Trepacz

- Symptoms in the Mind: An Introduction to Descriptive Psychopathology, illustrated
  Elsevier Health Sciences, Sims A C P

Ethics

- Psychiatric Ethics
  Oxford University Press, Bloch S
<table>
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<tr>
<th><strong>History of Psychiatry</strong></th>
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</table>
| - Healing the Mind: A History of Psychiatry from Antiquity to the Present  
  Pimlico, Stone M |

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<tr>
<th><strong>Mental Health Act</strong></th>
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</table>
| - Mental Health Law: Policy and Practice, revised  
  Oxford University Press, Bartlett P, Sandland R  
  Mental Health Act Manual  
  Sweet & Maxwell, Jones R |

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<tr>
<th><strong>Transcultural Psychiatry</strong></th>
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</table>
| - Cross Cultural Psychiatry: A Practical Guide  
  Arnold, Bhugra D, Bhui K  
 Psychiatry in Multicultural Britain, illustrated  
  RCPsych Publication, Bhugra D, Cochrane R |

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<tr>
<th><strong>Psychopharmacology</strong></th>
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| - Use of Drugs in Psychiatry: The Evidence from Psychopharmacology, illustrated  
  RCPsych Publication, Cookson J, Taylor D, Cornelius LE |

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<tr>
<th><strong>General Adult Psychiatry</strong></th>
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| - Seminars in General Adult Psychiatry, illustrated  
  RCPsych Publication, Stein G, Wilkinson |

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<tr>
<th><strong>Liaison Psychiatry</strong></th>
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| - The Psychological Care of Medical Patients: A Practical Guide (CR 108)  
  RCPsych Publication, Royal College of Physicians, Royal College of Psychiatrists |

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<thead>
<tr>
<th><strong>Primary Mental Health Care</strong></th>
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</table>
| - Common Mental Disorders in Primary Care  
  Routledge, Goldberg D, Thornicroft G, Tansella M |

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<tr>
<th><strong>Child &amp; Adolescent Psychiatry</strong></th>
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</table>
| - Child Psychiatry: A developmental Approach  
  Oxford University Press, Graham P, Turk K, Verhulst F  
 Communicating with Vulnerable Children: A Guide for Practitioners  
  RCPsych Publication, Jones D  
 Child and Adolescent Mental Health Services: An Operational Handbook |
RCPsych Publication, Richardson G, Partridge I

- Child and Adolescent Psychiatry
  Blackwell Science, Rutter M, Taylor E

**Forensic Psychiatry**
- Forensic Psychotherapy: Crime, Psychodynamics and the Offender Patient
  J Kingsley, Cordess C
- Early Prevention of Adult Antisocial Behaviour
  Cambridge University Press, Farrington D
- Faulk's Basic Forensic Psychiatry
  Blackwell Science, Faulk M
- Forensic Psychiatry: Clinical, Legal and Ethical Issues
  Hodder Arnold, Gunn J, Taylor P
- Antisocial Personality Disorder: an Epidemiological Perspective
  RCPsych Publication, Moran P

**Learning Disabilities**
- Seminars in the Psychiatry of Learning Disabilities
  RCPsych Publication, Fraser W, Kerr M
- Hallas’ Caring for People with Mental Handicaps
  , Butterworth-Heinemann, Fraser WI et al

**Geriatric Psychiatry**
- Guidelines on Depression in Older People
  Martin Dunitz, Baldwin R
- Psychiatry in the Elderly
  Oxford University Press, Jacoby R
- Depression in Old Age
  Wiley, Katona C
- Assessing and Treating Late Life Depression
- Treatment and Care in Old Age Psychiatry
  Wrightson Biomedical, Levy R, Howard R, Burns A
• Dementia
  Oxford University Press, Burns A, Brien ‘O, Ames D

• Practical Psychiatry of Old Age
  Radcliffe Medical Press, Wattis J, Curran S

**Psychotherapy**

• Cognitive Therapy of Personality Disorders
  Guilford Press, Beck A, Freeman A

• Introduction to Psychotherapy: An Outline of Psychodynamic Principles and Practice
  Routledge, Brown D, Bateman A

• Oxford Textbook of Psychotherapy
  Oxford University Press, Gabbard G, Beck J, Holmes J

• Clinical Psychotherapy for Health Professionals
  Revised & extensively updated version, Whurr Maxwell H

• The Practice of Behavioural and Cognitive Psychotherapy
  Cambridge University Press, Stern R, Drummond L

**Addiction Psychiatry (Alcohol and Substance Abuse)**

• Seminars in Alcohol and Drug Misuse
  RCPsych Publication, Chick J, Cantwell R

• The Treatment of Drinking Problems: A Guide for the Helping Professions
  Cambridge University Press, Edwards G, Marshall E, Cook C

• Drugs and Addictive Behaviour: A Guide to Treatment
  Cambridge University Press, Ghodse AH

• Substance Misuse in Psychosis: Approaches to Treatment and Service Delivery
  J Wiley & Sons, Graham H, et al

• Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide
  J Wiley & Sons, Jarvis T, Tebbutt J, Mattick RP

• The international Handbook of Addiction Behaviour; Glass, IB.

• The Nature of Drug Dependency; Edwards, G. and Lader, M.

• Drugs and Drug Abuse; Jacobs, MR. And Fear K.
- The Treatment of Drug Problems; Ghodse, AH.
- Principles of Neuropsychopharmacology; Feldman, RS., Meyer, JS. And Quenzer, LF.
- Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviour; Marlatt, GA. And Gordon, JR.
- Psychopharmacology, Spiegel, R et al.
- Working with Substance Misusers: A Guide to Theory and Practice Routledge, Peterson T, McBride A

**Clinical Psychology and Psychotherapy**
- General Psychopathology; Karl Jasper’s
- Theory and Practice of Group Psychotherapy; Yalom, I.
- Cognitive Behavioural Therapy of Depression; Beck.
- Psychodynamic Psychiatry; Gabbard.
- Introduction to Psychology; Hillgard
- I am OK, You are OK
  Games People Play

**Other Important Books**
- Handbook of Drug Therapy in Psychiatry; Bernstein, J G.
- Seminars in Liaison Psychiatry; Guthrie, E and F Creed.
- Research Methods in Psychiatry; Freeman, C
- Critical Reviews in Psychiatry; Brown, T and G Wilkinson.
- Massachusetts Handbook of General Hospital Psychiatry.
- Mental Illness in the Community; Goldberg, D and P Huxley.
- Child Psychiatry; Goodman, R and S Scott.
- Child and Adolescent Psychiatry; Rutter, M and L Hersov.
- Seminars in Practical Forensic Psychiatry; Chiswick, D and R cope
- EEG in Clinical Practice – John R. Hughes (Butterworths – London)
XXII. APPENDIX

1. Excerpts from OMSB Institutional Policies and Guidelines

1.1 Vacation and Leave

**Article (29):** The resident shall be entitled to an annual leave of 30 days in addition to a maximum of 10 days in lieu of Eid holidays, official holidays and emergency leaves if the resident is required to work during these holidays and leaves.

**Article (30):** The training period shall be extended for an equivalent period to compensate for sick leave, maternity leave and exceptional "emergency" leaves before the resident is awarded a certificate of completion of training if the leave exceeds seven days.

**Article (31):** Annual leave which is not utilized within the year shall not be transferred to the following year.

**Article (32):** The resident may be granted a leave for scientific purposes (attending scientific conferences and seminars, specialty examinations ...etc) not exceeding 10 days in each training year provided that he/she presents the proof for having attended the activity.

a. Leave Policy: Annual

1. Residents shall be entitled to an Annual Leave of 30 days in addition to a maximum of 10 days in lieu of Eid Holidays, and Official Holidays, if the Resident is required to work during these holidays and leaves.

2. Annual Leave which is not utilized within the year shall not be transferred to the following year.

3. Residents must submit their proposed leaves prior to the creation of the master rotation schedule to the person-in-charge of the rotation schedule.

4. The Annual Leave can be taken all at once (30 days) or in parts (i.e. one week per block/ 75% of the block must be attended, to receive full credit for the block) throughout the academic year.

5. If the leave is applied for after the creation of the master rotation schedule, then the application must be submitted at least 3 months of the intended annual leave.

6. Leave application forms must be submitted to the Chief Residents who will preliminarily approve the leave after checking the number of residents rotating in the affected Training Center.

7. Leave forms must then be signed and approved by the Rotation Supervisor/Associate Program Director for the affected Training Center – copy must be faxed to the Program Administrator but not encoded in the database without the approval of the Program Director.

8. Leave forms must then be signed and approved by the Program Director. Copy should be sent to the Program Administrator.
9. OMSB approval

10. Encoding of leave in the Resident Database.

11. When the Resident reports to work from Annual Leave, they must complete the Return from Leave form signed by the Rotation Supervisor of the affected rotation, and Program Director or Associate Program Director and submit to the Program Administrator for encoding.

b. Leave Policy: Scientific Leave
1. Residents may be granted a leave for scientific purposes (attending scientific conferences and seminars, specialty examinations, etc.), not exceeding 10 days, during each academic year provided that he/she presents proof of attending the activity (e.g. Certificate of Attendance, Exam Certificate, etc.)

2. Residents must submit the leave form at least 3 months before the examination and/or conference.

3. The resident must obtain the approval of the Rotation supervisor/APD of the affected rotation and the PD. A copy of the form should be forwarded to the Program administrator

4. When the Resident reports to work from Scientific Leave, they must complete the following documents and submit to the Program Administrator for encoding:

   4.1. Return from Leave form signed by the Rotation Supervisor of the affected rotation, and Program Director or Associate Program Director

   4.2. Proof of attending the activity (Certificate of Attendance, Exam Certificate, etc.).

5. The Resident should submit the above listed documents to the Program Administrator within two (2) weeks from reporting to work from Scientific Leave.

c. Leave Policy: Sick Leave
1. The Resident should notify the affected rotation supervisor and Associate Program Director/Program Director, as well as the Program Administrator when the Resident leaves and reports back to work from sick leave.

2. When the Resident reports to work from Sick Leave, they must complete the following documents and submit to the Program Administrator for encoding:

   2.1. Leave Form signed by the Rotation Supervisor of the affected rotation, and Program Director of Associate Program Director

   2.2. Return from Leave form signed by the Rotation Supervisor of the affected rotation, and Program Director of Associate Program Director

   2.3. Medical Certificate (from an authorized hospital).

3. The Resident should submit the above listed documents to the Program Administrator within two (2) weeks from reporting to work from Sick Leave.
4. If the leave exceeds seven (7) days, the Resident should compensate that period for an equivalent period before he/she is awarded a Certificate of Completion of Training.

d. Leave Policy: Emergency
1. The Resident should have valid and convincing reasons for taking an Emergency Leave.

2. Emergency Leaves will be allowed under the following circumstances:
   2.1. Death of first degree (parents, siblings, spouse, children, grandparents, immediate Uncles & Aunts),
   2.2. Dealing with natural disaster, accidents, & fires that prevent the Resident from reaching the designated rotation

3. A maximum of seven (7) days will be permitted for Emergency Leave. Any other Emergency Leave not listed above will be deducted from the Annual Leave.
4. If the leave exceeds seven (7) days, the Resident should compensate that period for an equivalent period before he/she is awarded a Certificate of Completion of Training.

5. The Resident should notify the affected Rotation Supervisor and Chief Resident.

6. The Chief Resident will inform the Program Director, Associate Program Director, and the Program Administrator.

7. When the Resident reports to work from Emergency Leave, they must complete the following documents and submit to the Program Administrator for encoding:
   7.1. Leave Form signed by the Rotation Supervisor of the affected rotation, and Program Director of Associate Program Director
   7.2. Return from Leave form signed by the Rotation Supervisor of the affected rotation, and Program Director of Associate Program Director
   7.3. Letter from the Program Director, Death Certificate, or letter from the Sheikh.

8. The Resident should submit the above listed documents to the Program Administrator within two (2) weeks from reporting to work from Emergency Leave.

e. Leave Policy: Maternity
*Concerned Residents must follow through all processes
1. The Resident will be granted a leave of 50 days from the day of giving birth.

2. Residents must inform the person in-charge of the master rotation schedule of their expected date of delivery as soon as it is known, no later than the 16th week of gestation.

3. The resident must submit their Leave Form with the signature of the Program Director and Associate Program Director to the Program Administrator.

4. When the Resident reports to work from Maternity Leave, they must complete the following documents and submit to the Program Administrator for encoding:
4.1. Leave Form signed by the Rotation Supervisor of the affected rotation, and Program Director or Associate Program Director

4.2. Return from Leave form signed by the Rotation Supervisor of the affected rotation, and Program Director of Associate Program Director

4.3. Child Birth Certificate.

5. The Resident should submit the above listed documents to the Program Administrator within two (2) weeks from reporting to work from Maternity Leave.

**f. Leave Policy: Compensation for Public Holiday**

*Concerned Residents must follow through all processes*

1. The Resident is entitled to a maximum of 10 days leave to compensate days worked during Public Holidays

2. Regular On-Call or Weekend duty does not qualify as part of the Compensation Leave

3. The Resident must submit a letter signed by the Program Director or Associate Program Director, in addition to, the Rotation Supervisor of the affected rotation which proves that he/she worked during Public Holidays within two (2) weeks from the Public Holiday.

4. The Training Program will then arrange and schedule for the Resident’s Compensation Leave subsequently.

**1.2 Management of Residency Training During Disaster**

*Disaster Management*

1. In the case of anticipated disasters, or upon occurrence of an emergency situation and, immediately following up to 72 hours; Residents are expected to follow the rules in effect for the Training Center to which they are assigned, at the time. In the case of anticipated disasters, Residents who are not included in one of the clinical site’s emergency staffing plans should secure their property and evacuate, should the order come.

   If there is any question about a Resident status, he or she should contact the concerned Program Director.

2. The Hospital Director Generals at the affected Training Center verify and declare an emergency situation

3. The Heads of Departments and Associate Designated Institutional Official (DIO) of the affected training center are notified and activate the disaster management plan.

4. The Program Directors and Associate DIO(s) must notify the DIO of the status of the affected Training Center and the situation of the Residents rotating at that Training Center including their health and safety and, immediate reallocation, if necessary.
5. Within 72 hours following the occurrence of the emergency situation, if the emergency is ongoing, the DIO will request an assessment:
   o By the Program Directors and Department Chairs as to their ability to continue to provide training;
   o By the Program Directors as to the status of necessary temporary and possibly permanent Resident transfers.

6. When the emergency situation is ended, the DIO will request from the Program Directors a report on:
   o Established plans with the Training Centers to which residents have been transferred for them to resume training at the affected Training Center;
   o Decisions as to other matters related to the impact of the emergency on training will be made.

7. The DIO will call for a meeting with the Graduate Medical Education Committee (GMEC) to report on:
   o The health and safety of all residents in their training programs
   o The status and operating capabilities of all training programs at the affected training center.
   o Plan for permanent resident transfers to other training centers, as needed, in order to continue and complete their training

1.3 Residents Grievance Policy

1. A resident may file a grievance if a reasonable basis exists to support allegations that he/she has been treated contrary to the existing policies governing the residency training program.

2. Any alleged grievance must be filed in writing by the resident to the Program Director within ten (10) days of the date on which the alleged grievance occurred. Any grievance not timely filed shall be waived and to processed. The written complaint should be as specific as possible regarding the action that precipitated the grievance: date, place, people involved, including witnesses, IF ANY. A summary of the incident, efforts made to settle the matter informally, and the remedy sought.

3. The Program Director shall review and investigate the grievance, negotiate, and try to resolve it. The Program Director shall respond to the grievance in writing within 15 days of receipt of the complaint. The response shall outline the actions that will or will not be taken to resolve the grievance.

4. If a resident is dissatisfied with the Program Director’s solution, the trainee may request in writing to the Scientific Committee Chairman within fifteen (15) days of receiving the Program Director’s resolution further review of the decision. The resident shall submit copies of the original grievance and the program director’s response.

5. The Scientific Committee Chairman shall then appoint an ad hoc grievance subcommittee that will exclude the Program Director and the faculty and the resident involved in the dispute.
6. The grievance subcommittee shall review, investigate, negotiate, and come up with a resolution.

7. The grievance subcommittee shall make a recommendation to the chairman as to the merits of the appeal and an appropriate resolution of the grievance within fifteen (15) working days of the formation of the subcommittee.

8. The chairman shall then render in writing a decision to the resident and copies will be sent to the Executive President and other parties concerned.

9. If the resident is not satisfied with the resolution of the Scientific Committee Chairman, he/she may appeal to the Executive president within 15 days of receiving the resolution of the Scientific Committee Chairman.

10. The Executive President may make the decision or refer it the Executive Board. That decision will be final. The final decision on any grievance action shall be issued within 30 days of the date that the appeal was filed.

1.4 Remediation Policy:
Remediation is a formal program designed to assist the Resident who is failing to progress in clinical, academic, and/or professional performance. Specific goals and objectives for the remedial or probationary period should be developed.

Remediation: Criteria for Remediation
1. Two “UNSATISFACTORY/BELOW EXPECTATIONS” evaluations in one academic year.
2. Resident failing in assessment examinations, i.e. End-of-Year Exam, OMSB Part I exam after 2nd attempt.
3. When significant concerns about the professional conduct of the Resident have been raised and are in an area that is deemed remediable.

Remediation: Dismissal/Violation
Residents will receive written reprimands and warning letters from the Education Committee of the Program with regards to any violations. Failure to remediate and if the Resident’s deficiency is of sufficient gravity to warrant dismissal, the Resident may be dismissed and the Resident file will be closed. The Resident’s sponsor will be informed about the decision.

Remediation: Duties of Residents in Remedial Training
1. Increase their knowledge base in the areas of difficulty in basic science and clinical medicine.
2. Improve their clinical performance
3. Improve behaviors and professionalism during clinical rotations.
4. Participate in examinations
5. Meet with the remedial supervisor at biweekly or monthly intervals during the remedial period to discuss progress and ongoing objectives.
**Remediation: Evaluation**

1. The Resident must be evaluated, in writing bi-weekly by the faculty who are providing the remedial training.
2. The Resident must meet with the remedial supervisor to review the written evaluation.
3. Successful completion of a Remedial period requires “MEETS EXPECTATIONS” in global evaluation on all rotations.
4. “UNSATISFACTORY or BELOW EXPECTATIONS” evaluations during the remedial period in global evaluation will require referral to the Program Education Committee of the Program.
5. During the Remedial period, efforts will be made to assist the Resident in addressing areas of weakness.

**Remediation: Probation**

The Education Committee of the Program will look into the violations related to the training such as absence, neglect and academic attainment, or related to morals, behavior, ethics or professional conduct. After the violation is proved, the Committee is authorized to issue a final warning letter in addition to placing the Resident under probation for a period to be specified by the Education Committee of the Program.

**Remediation: Suspension**

Suspension is a remedial program where a Resident is temporarily relieved of his/her duties. The Education Committee of the Program Chairman, Program Director, and Associate Program Director (if not involved) may suspend a Resident, with pay, upon receipt of notification that:

1. A serious professional charge is brought against the Resident,
2. The Resident shows evidence of impairment, or
3. Concern that the Resident’s performance of clinical duties does not meet acceptable standards or patient care is seriously compromised.

The Chairman, Program Director, and Associate Program Director, should investigate the allegations with the Resident and any involved parties. The investigation results/decisions should be sent to the Executive President to determine if the charges warrant suspension. A suspended Resident has the right to follow the appeal process as defined in the OMSB Grievance Policy.

**1.5 Resident Supervision**

Residents are assigned patient care responsibilities commensurate with the individual’s level of training, experience and capability. In all matters of an individual patient’s care, residents are supervised by the attending physician who maintains responsibility for the care of the patient. Attending physicians will supervise residents in a manner consistent with the mandates of the resident’s program requirements. The program must demonstrate that the appropriate level of supervision is in place for all residents caring for patients. Supervision does not imply constant observation.

**1.6 Resident Assistance Counseling**

Counseling services will be available to OMSB Residents at the OMSB Headquarters through the Performance & Wellness Unit.

**1.7 Fatigue Management Policy**

**Fatigue**: term used to describe the overall feeling of tiredness and/or lack of energy.

OMSB recognizes the importance of ensuring the well-being of its residents for successful residency training and best patient care. The OMSB Fatigue management policy aims to ensure that residents appear for duty appropriately rested and fit to provide patient care. All residents comply with the required number of duty hours.

**PURPOSE/ REASONS FOR POLICY**

This policy aims to provide appropriate information, guidance and methodologies to minimize the risk of fatigue and its effects on the residents and the patients.
Specific objectives include:

- Maintain residents well-being
- Recognize signs of fatigue in residents
- Minimize fatigue related injuries, problems and medical errors
- Encourage residents suffering from fatigue to seek professional help
- Provide a framework for administrators, trainers, program directors, chairmen/chairperson, educational supervisors and residents which enables them to perform their roles and responsibilities with regard to fatigue management.

GENERAL PRINCIPLES

The OMSB Fatigue Management Policy aims to ensure that residents appear for duty appropriately rested and fit to provide patient care. To achieve that, the following must be implemented:

- All residents and trainers are educated regarding fatigue and its impact on Residents’ performance and patients’ safety.
- All residents and trainers understand their responsibilities with regard to managing fatigue.
- All residents and trainers are well informed about the guidelines and procedures of fatigue mitigation.
- All residents comply with the required number of duty hours.

SCOPE OF APPLICATION

This policy applies to all OMSB Residents, Training Centers, Trainers, Education Committee Chairmen/Chairperson, Program Directors, Associate Program Directors, and Educational Supervisors undertaking activities for or on behalf of OMSB.
LEAVE FORMS

Oman Medical Specialty Board

RESIDENT LEAVE FORM

1 Name

2 OMSB No.

3 Training Program

4 Training Level

5 Training Center

6 Sponsor (Region)

7 Type of Leave

8 Leave Period

9 Date of Leave

10 Address

11 Email

12 Contact while on Leave

13 Signature of Resident

14 Chief Resident Clearance**

Name

Signature

Date

15 Approval of Rotation Supervisor**

Name

Signature

Date

16 Approval of PD / Asst. PD

Name

Signature

Date

** Chief Resident / Designee must check the Master Rotation Schedule, number of Residents rotating in the affected training center, and must check with PA the Residents Leave Balance

** Rotation Supervisor must inform Asst. PD of Affected Training Center

* Resident must file for Annual Leave before creation of Master Rotation Schedule OR 3 months before Annual Leave
* Resident must report back from Leave immediately after the indicated date
* Copy of signed & approved form must be sent to Program Administrator & Rotation Supervisor of affected rotation
Application of Return from Leave

Name ____________________________
Staff no. ___________________________
OMSB no. ___________________________
Training Program ____________________
Training Level ______________________
Training Center ______________________
Sponsor (Region) ____________________
Type of leave ________________________
Date Leave begins ____________________
Date Leave Expires ____________________
Due date back to work __________________
No of days in access ____________________
of those approved ______________________
Reasons for any delay ____________________
Signature of Resident ____________________
Date __________________

Approval of PD or assistant PD of the Current Rotation: ____________________ Date: __________________

Approval of PD or assistant PD ____________________ Date: __________________
Evaluation Tools
## In-Training Evaluation Report (ITER)

### OMAN MEDICAL SPECIALTY BOARD

#### IN-TRAINING EVALUATION REPORT (PER BLOCK)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Resident Level:</th>
<th>OMID #:</th>
<th>Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block:</td>
<td>Training Center:</td>
<td>Rotation:</td>
<td>Date of Rotation: FROM TO</td>
</tr>
</tbody>
</table>

#### CRITERIA

<table>
<thead>
<tr>
<th>I. MEDICAL KNOWLEDGE (MK)</th>
<th>Unsatisfactory 1</th>
<th>Below Expectations 2</th>
<th>Needs Expectations 3</th>
<th>Exceeds Expectations 4</th>
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<tbody>
<tr>
<td>1. Demonstrates basic science knowledge</td>
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<thead>
<tr>
<th>II. PATIENT CARE (PC)</th>
<th>Unsatisfactory 1</th>
<th>Below Expectations 2</th>
<th>Needs Expectations 3</th>
<th>Exceeds Expectations 4</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>3. Elicits pertinent history</td>
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<tr>
<td>5. Demonstrates appropriate clinical judgment</td>
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<tr>
<th>III. PROFESSIONALISM (P)</th>
<th>Unsatisfactory 1</th>
<th>Below Expectations 2</th>
<th>Needs Expectations 3</th>
<th>Exceeds Expectations 4</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>13. Responds to patient needs before his/her own needs</td>
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<thead>
<tr>
<th>IV. INTERPERSONAL &amp; COMMUNICATION SKILLS (ICS)</th>
<th>Unsatisfactory 1</th>
<th>Below Expectations 2</th>
<th>Needs Expectations 3</th>
<th>Exceeds Expectations 4</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Works effectively as a team member</td>
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<tr>
<th>V. SYSTEMS-BASED PRACTICE (SBP)</th>
<th>Unsatisfactory 1</th>
<th>Below Expectations 2</th>
<th>Needs Expectations 3</th>
<th>Exceeds Expectations 4</th>
<th>Not Applicable</th>
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<tr>
<td>22. Utilizes resources appropriately</td>
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<td>23. Participates in quality improvement activities</td>
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<tr>
<th>VI. PRACTICE-BASED LEARNING &amp; IMPROVEMENT (PBL)</th>
<th>Unsatisfactory 1</th>
<th>Below Expectations 2</th>
<th>Needs Expectations 3</th>
<th>Exceeds Expectations 4</th>
<th>Not Applicable</th>
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<tr>
<td>27. Recognizes own strengths and limitations</td>
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<tr>
<td>30. Demonstrates appropriate teaching skills</td>
<td>![ ]</td>
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<td>32. Develops life-long learning skills</td>
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</tbody>
</table>

### OVERALL ASSESSMENT

- Difficulty in fulfilling the required criteria.
- Improvement needed in specific areas.
- Potential for enhancement in future evaluations.
Resident Leaves
During this rotation, the resident took the following leaves:

- Annual Leave, specify # of days __________
- Emergency Leave, specify # of days __________
- Scientific Leave, specify # of days __________
- Sick Leave, specify # of days __________

COMMENTS: (Strengths and Areas for Improvement/Need for Special Attention)

AGREED ACTION:

This evaluation has been reviewed with the resident:  
☐ Yes  ☐ No

Name of Supervising Trainer: __________________________ Signature: __________________________ Date: __________

Name of Resident: __________________________ Signature: __________________________ Date: __________

SCALE
1. Unsatisfactory
   Poor competency judgment. Requires continuous supervision.

2. Below Expectations
   Inadequate competency judgment. Requires frequent supervision.

3. Meets Expectations
   Effective competency judgment. Supervision needed for complex/difficult situations.

4. Exceeds Expectations
   Exemplary competency judgment including in complex/difficult situations. Can practice independently.

Not Applicable
Not relevant in the setting, not observed or unable to evaluate

Modified 4 March 2015
Evaluation of Procedural Skills

**OMAN MEDICAL SPECIALTY BOARD**

**EVALUATION OF PROCEDURAL SKILLS**

**Name of Resident:** .........................................................  **OMSB #:** ..........................................................

**Program:** ......................................................... **Resident Level:**  ........  **Rotation:** .........................................................

**Setting:** ......................................................... **Procedure being observed:** .........................................................

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable/N/A</th>
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</table>

**COMMENTS:**  (Please use this space to record areas of strengths or any suggestions for development.)

**AGREED ACTION:**

........................................................................................................

**Assessor’s Name:** ......................................................... **Signature:** ......................................................... **Date:** .........................................................

**Designation of Assessor:** .........................................................
# Mini Clinical Evaluation Exercise (Mini-CEX)

**OMAN MEDICAL SPECIALTY BOARD**  
**MINI-CLINICAL EVALUATION EXERCISE (MINI-CEX)**

Name of Resident: ................................................................. OMSIF: .................................................................

Program: ................................................................. Resident Level: ................................................................. Rotation: .................................................................

Setting: [ ] Ward  [ ] ICU  [ ] OPD  [ ] ED  [ ] Other, please specify

Types: [ ] New Case  [ ] Follow-up

Focus: [ ] History  [ ] Physical Exam  [ ] Diagnosis  [ ] Management  [ ] Counselling

Complexity: [ ] Low  [ ] Average  [ ] High

## CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Interviewing Skills.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Physical Examination Skills.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>5. Consideration for patient/Professionalism.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Counselling skills.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Overall Clinical Care.</td>
<td></td>
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</tr>
</tbody>
</table>

**SUGGESTIONS FOR DEVELOPMENT:**

**AGREED ACTION:**

Assessor’s Name: ................................................................. Signature: ................................................................. Date: .................................................................

Designation of Assessor: .................................................................

Time spent observing trainee: .................................................................  
Time spent giving feedback: .................................................................  
Total Mini-CEX Evaluation Time: .................................................................

Trainee’s satisfaction with Mini-CEX process: [ ] Very dissatisfied  [ ] Dissatisfied  [ ] Satisfied  [ ] Very Satisfied

Trainee Signature: .................................................................
### DESCRIPTORS OF COMPETENCES ASSESSED DURING THE MINI-CEX

1. **Medical Interviewing Skills:**
   - Facilitates patient’s telling of story; effectively uses questions/directions to obtain accurate, adequate information needed; responds appropriately to affect, non-verbal cues; identifies and explores the patient’s issues and concerns within the scope of a focused consultation.

2. **Physical Examination Skills:**
   - Follows efficient, logical sequence; balances screening/diagnostic steps for problem; informs patient; sensitive to patient’s comfort, modesty.

3. **Clinical Judgement:**
   - Selectively orders/performs appropriate diagnostic studies, considers risks, benefits; interprets clinical investigations and synthesizes those with patient history and symptoms; justifies treatment recommendations, based on current evidence, multidisciplinary advice, and relevant patient-related factors.

4. **Communication Skills:**
   - Communicates clearly to the patient/carers and other staff; demonstrates active listening.

5. **Professionalism/Humanistic Qualities:**
   - Shows respect, compassion, empathy, establishes trust, attends to patient’s needs of comfort, confidentiality, modesty.

6. **Organization/Efficiency:**
   - Prioritizes, is timely, succinct.

7. **Counselling Skills:**
   - Explains rationale for test/treatment, obtains patient’s consent, educates/counsels regarding management. Where appropriate, explains the natural history of the disease including prognosis and treatment options.

8. **Overall Clinical Competence:**
   - Demonstrates judgment, synthesis, caring, effectiveness, efficiency.

### PATIENT CASE COMPLEXITY

**Low Complexity Cases** includes those that are best described as:
- A patient with a single-system presentation, with minimal complications (medical and/or social) and responsive to first-line treatment.
- A patient with a self-evident diagnosis where management is straightforward.
- A stable patient with a common presentation or a clear diagnosis.

**Medium Complexity Cases** includes those that are best described as:
- A patient with multi-system problem, and minimal complications (medical and/or social).
- A patient with a single-system problem, and multiple/significant complications (medical and/or social) or who does not respond to first-line treatment.
- A stable patient with an uncommon presentation without a clear diagnosis.
- A critically ill or injured patient, who responds to first-line treatment.

**High Complexity Cases** includes those that are best described as:
- A patient with multi-system problem and multiple/significant complications (medical and/or social).
- An unstable/deteriorating patient, with an uncommon presentation or without a clear diagnosis.
- A critically ill or injured patient, who is unresponsive to first-line treatment.
- A patient presenting with a life/limb/sight-threatening condition.
# Presentation Evaluation Form

**OMAN MEDICAL SPECIALTY BOARD**
**EVALUATION FORM FOR PRESENTATION**

- **Name of Resident:** 
- **OMSB #:** 
- **Program:** 
- **Resident Level:** 
- **Rotation:** 
- **Setting:** 
- **Date of Presentation:** 

## I. INTRODUCTION

<table>
<thead>
<tr>
<th></th>
<th>Unsatistated</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable (N/A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-introduction.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Gained attention of group.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>3</td>
<td>Stated the objectives.</td>
<td>☐</td>
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<td>☐</td>
</tr>
</tbody>
</table>

## II. PROCESS AND CONTENT

<table>
<thead>
<tr>
<th></th>
<th>Unsatistated</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable (N/A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clear, concise delivery.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Logical sequence.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>3</td>
<td>Well paced.</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>4</td>
<td>Knowledge of subject and preparedness.</td>
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<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>5</td>
<td>Good use of voice/tone.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>6</td>
<td>Made appropriate eye contact and body language.</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>7</td>
<td>Effective group participation (interactive).</td>
<td>☐</td>
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</tr>
<tr>
<td>8</td>
<td>Appropriate teaching methods used.</td>
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</tr>
<tr>
<td>9</td>
<td>Slides were easy to read and see.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>10</td>
<td>Grammar, spelling, and punctuations are correct.</td>
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## III. CONCLUSION

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<tr>
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<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable (N/A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Effective use of questioning.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Summarized key points.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>3</td>
<td>Objectives are met.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Kept to time limit.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
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</table>

**COMMENTS AND SUGGESTIONS FOR IMPROVEMENT:**

**AGREED ACTION:**

---

**Assessor’s Name:** 
**Signature:** 
**Date:** 
**Designation of Assessor:**
# Cased-Base Discussion (CbD)

**OMAN MEDICAL SPECIALTY BOARD**  
**CASE BASED DISCUSSION**

<table>
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<tr>
<th>General Approach</th>
<th>Unsatisfactory</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Exceeds expectations</th>
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<tbody>
<tr>
<td>1. Case Approach</td>
<td></td>
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</tr>
<tr>
<td>2. Thought Organization</td>
<td></td>
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</tr>
<tr>
<td>3. Data Documentation</td>
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<td>4. Data Interpretation</td>
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<tr>
<td>5. Decision Justification</td>
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</tr>
<tr>
<td>6. Communication Skills</td>
<td></td>
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<tr>
<td>7. Patient’s safety</td>
<td></td>
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<tr>
<td>8. Managing Complexity</td>
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<tr>
<td>9. Ethics Considerations</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. Acceptance of feedback</td>
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<td>11. Lessons learned</td>
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<td>12. Overall performance</td>
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**Assessment**

<table>
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<tr>
<th>Do More</th>
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<tbody>
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</tr>
<tr>
<td>2</td>
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<table>
<thead>
<tr>
<th>Do Less</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<table>
<thead>
<tr>
<th>Avoid</th>
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<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

This evaluation has been discussed with the resident  
Yes [ ] No [ ]

**Trainer’s Name:** __________________________  **Signature:** __________________________  **Date:** __________

**Resident Signature:** __________________________  **Date:** __________

9 March 2013 AB/nr
<table>
<thead>
<tr>
<th>Domain</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>Case approach</td>
<td>Adequate preparation of the case for discussion.</td>
</tr>
<tr>
<td></td>
<td>Clear understanding of why this particular case is of interest.</td>
</tr>
<tr>
<td></td>
<td>Demonstration of a rational/logical approach to the case appropriate to the level of training.</td>
</tr>
<tr>
<td>Organization of Thought</td>
<td>Organisation of thoughts during the case discussion.</td>
</tr>
<tr>
<td></td>
<td>Problem solving skills</td>
</tr>
<tr>
<td>Data Documentation</td>
<td>Logical and appropriate sequence of data documentation.</td>
</tr>
<tr>
<td></td>
<td>Clarity of the clinical notes.</td>
</tr>
<tr>
<td></td>
<td>Avoidance of abbreviations.</td>
</tr>
<tr>
<td>Data Interpretation</td>
<td>Understanding the normal data.</td>
</tr>
<tr>
<td></td>
<td>Correlation of data with the clinical scenario – both normal and abnormal</td>
</tr>
<tr>
<td>Decision Justification</td>
<td>Identifying red flags pertaining to the case.</td>
</tr>
<tr>
<td></td>
<td>Decision about selecting appropriate tests, medications, admission, referral, follow up, etc.</td>
</tr>
<tr>
<td></td>
<td>Ability to explain the clinical reasoning for his/her decisions.</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Ability to communicate well with the patient and/or family, to convey results, diagnosis, management plan.</td>
</tr>
<tr>
<td></td>
<td>Communication with other team members, colleagues, nurses, pharmacist, lab technicians, etc.</td>
</tr>
<tr>
<td></td>
<td>Communication with the trainer during CBD.</td>
</tr>
<tr>
<td>Patient Safety related issues</td>
<td>Understanding own limitations.</td>
</tr>
<tr>
<td></td>
<td>Ability to give follow-up instructions.</td>
</tr>
<tr>
<td></td>
<td>Understanding of major side effects of medications prescribed.</td>
</tr>
<tr>
<td>Managing Complexity</td>
<td>Ability to involve other team members (if applicable).</td>
</tr>
<tr>
<td></td>
<td>Consulting other experts.</td>
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<tr>
<td></td>
<td>Appraisal of the literature and evidence based practice related to the case.</td>
</tr>
<tr>
<td>Ethics Consideration</td>
<td>Identification of ethical issues pertaining to the case</td>
</tr>
<tr>
<td></td>
<td>Demonstrating the ability to deal with ethical dilemmas.</td>
</tr>
<tr>
<td>Acceptance of feedback</td>
<td>Response to negative feedback.</td>
</tr>
<tr>
<td></td>
<td>Professionalism in discussing the feedback.</td>
</tr>
<tr>
<td>Reflection</td>
<td>What is the perspective of the resident about the CBD?</td>
</tr>
<tr>
<td></td>
<td>Will this case change his approach to a similar case in the future?</td>
</tr>
<tr>
<td>Overall performance</td>
<td>How do you rate the overall performance of the resident from the CBD?</td>
</tr>
<tr>
<td>Specialty Specific Domains</td>
<td>Examples: Continuity of Care (Family Medicine)</td>
</tr>
<tr>
<td></td>
<td>Addressing Parents Concerns (Pediatrics)</td>
</tr>
</tbody>
</table>
# Journal Club Evaluation

**OMAN MEDICAL SPECIALTY BOARD**

**EVALUATION FORM FOR JOURNAL CLUB PRESENTATION**

<table>
<thead>
<tr>
<th>Name of Resident:</th>
<th>OMSB #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program:</td>
<td>Resident Level:</td>
</tr>
<tr>
<td>Date of Presentation:</td>
<td></td>
</tr>
</tbody>
</table>

## CRITERIA

### I. PRESENTATION STYLE

| 1. | Introduced self. |
| 2. | Delivered presentation clearly and concisely. |
| 3. | Made appropriate eye contact and body language. |
| 4. | Encouraged interactive discussion. |
| 5. | Used appropriate teaching method. |
| 6. | Used audiovisuals effectively. |
| 7. | Utilized correct grammar and spelling. |
| 8. | Kept to time limit. |

### II. PROCESS AND CONTENT

| 9. | Selected relevant article for presentation. |
| 10. | Identified study objectives and goals. |
| 11. | Summarized research abstract. |
| 12. | Discussed suitability of study design. |
| 13. | Identified methodology issues in the conduct of study. |
| 14. | Summarized study results. |
| 15. | Assessed study statistical analysis. |
| 16. | Assessed issues related to Internal Validity (PICO). |
| 17. | Evaluated the clinical and statistical significance of the results. |
| 18. | Summarized the issues related to generalizability of the results. |
| 19. | Identified strengths and weaknesses of the research paper. |
| 20. | Made valid conclusions on the paper. |

Global rating of critical appraisal skills.

**COMMENTS AND SUGGESTIONS FOR IMPROVEMENT:**

**Strengths:**

**Suggestions for Improvement:**

**AGREED ACTION:**

Assessor’s Name: __________________________ Signature: __________________________ Date: ________________

Designation of Assessor: __________________________
Multisource Feedback (MSF)

OMAN MEDICAL SPECIALTY BOARD
MULTISOURCE FEEDBACK (360-DEGREE EVALUATION)

Name of Resident: ................................................................. OMSB #: .................................................................
Program: ................................................................. Resident Level: ................................................................. Rotation: .................................................................

Please check one of the following titles:
- Consultant
- Trainer
- House Officer
- Resident
- Patient
- Allied Health Professional
- Nurse
- Clerical or Secretarial Staff
- Self-Assessment
- Others: ____________________________

CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unacceptable</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude to staff: Respects and values contributions of other members of the team.</td>
<td></td>
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</tr>
<tr>
<td>Attitude to patients: Respects the rights, choices, beliefs, and confidentiality of patients.</td>
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<tr>
<td>Reliability and Punctuality.</td>
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<tr>
<td>Communication skills: Communicates effectively with patients and families.</td>
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</tr>
<tr>
<td>Communication skills: Communicates effectively with healthcare professionals.</td>
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<tr>
<td>Honesty and integrity.</td>
<td></td>
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<tr>
<td>Team player skills: Supportive and accepts appropriate responsibility, Approachable.</td>
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</tr>
<tr>
<td>Leadership skills: Takes responsibility for own actions and actions of the team.</td>
<td></td>
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</tr>
<tr>
<td>Professional development: Commitment to improving quality of service, keeps up-to-date with knowledge &amp; skills.</td>
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</tr>
</tbody>
</table>

OVERALL PERFORMANCE

Please circle one or more of the following words that you would use to describe the doctor:
- Helpful
- Aloof
- Professional
- Friendly
- Sensitive
- Unhelpful
- Uncommunicative
- Approachable
- Self-Interested
- Knowledgeable
- Arrogant
- In insensitive
- Disinterested
- Keen
- Punctual
- Often late
- Appropriately-dressed
- Scruffy
- Team Player
- Assertive
- Aggressive
- Unsafe
- Dependable
- Enthusiastic
- Cynical
- Responsible
- Critical
- Short-tempered
- Sincere
- Frustrated
- Cheerful
- Disrespectful

COMMENTS AREAS FOR IMPROVEMENT:

AGREED ACTION:

Assessor’s Name: .................................................................................. Signature: ................................................................. Date: .................................................................
Designation of Assessor: ........................................................................
# Research Block Evaluation

**OMAN MEDICAL SPECIALTY BOARD**  
**RESEARCH BLOCK EVALUATION FORM**

<table>
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<tr>
<th>Name:</th>
<th>Resident Level:</th>
<th>OMS#:</th>
<th>Program:</th>
<th>Date of Rotation: FROM ______ TO ______</th>
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<th>2nd</th>
<th>Training Center:</th>
<th>Date of Rotation: FROM ______ TO ______</th>
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<tr>
<td>Research Block</td>
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## CRITERIA

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<tr>
<th>I. KNOWLEDGE OF RESEARCH PRINCIPLE</th>
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<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>1. Summarizes and submits available evidence by critical review of medical literature on the topic</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>2. Develops sufficient skills to convert research ideas to a research question and to a research proposal</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Has sufficient understanding regarding choice of different research designs, its strengths and weaknesses to address the research question</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Submits research proposal for institutional ethical and Research Committee</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Demonstrates sufficient understanding about validity and reliability in the collection and management of data</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>6. Analyzes and interprets data appropriately, with supervision and support of the mentor and/or statistician</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>7. Discusses limitations of the research project and applicability of the results to patient care</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>8. Maintains adequate contact with the faculty mentor and OMSB Research Section</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Demonstrates professional skills in preparing manuscripts, abstracts, and/or presentations</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tbody>
<tr>
<td>10. Applies ethics of research, including subject recruitment and informed consent</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<th>4</th>
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<tbody>
<tr>
<td>11. Works effectively on a scholarly project as part of a team</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12. Accepts constructive criticism</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A</th>
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<tbody>
<tr>
<td>13. Demonstrates effective utilization of information technology to optimize research</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<th>VI. ADVOCATE</th>
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<th>2</th>
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<th>4</th>
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<tbody>
<tr>
<td>14. Promotes the role of basic scientific and clinical research in improving individual and public health</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<table>
<thead>
<tr>
<th>VII. MANAGER</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Displays leadership in planning the project and delegation of tasks</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16. Utilizes resources, equipment, etc. appropriately</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>17. Demonstrates appropriate time management when involved in research project</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
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<table>
<thead>
<tr>
<th>VIII. SAFETY</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Protects human and animal subjects involved in research projects</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<table>
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<tr>
<th>IX. FINAL PROJECT REPORT</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>19. Submits appropriate final project report</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A</th>
</tr>
</thead>
</table>

*Please see enclosed*
COMMENTS: (Please use this space to record areas of strengths or any suggestions for development.)

Strengths: 

Areas of improvement: 

Agreed action: 

This evaluation has been reviewed with the resident:  

Yes [ ] No [ ] 

Name of Research Mentor: __________________ Signature: _______________ Date: __________ 

Name of Resident __________________ Signature: _______________ Date: __________ 

13/03/04 JAC
Six Month/Annual Evaluation

OMAN MEDICAL SPECIALTY BOARD

Name: ___________________________ Resident Level: ______ OMSB #: _____________

Program: ________________________ Date of Rotation: FROM ________ TO _________

For Annual Evaluation: Please review previous Six-Monthly Evaluation

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Rotation</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meet Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Evaluated</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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</tbody>
</table>

Strengths Summary:

Areas of Improvement Summary (including professional issues):

Agreed Action:

EXAMINATIONS

OMSBD Examination Part 1 ☐ Part 2 ☐ International Examinations
Score: ______ Pass ☐ Fail ☐ In-Training Examination Score: ______ Pass ☐ Fail ☐
End-of-year examination Score: ______ Pass ☐ Fail ☐ Exit Examination Score: ______ Pass ☐ Fail ☐

RESEARCH EVALUATION

Research Title: __________________________

<table>
<thead>
<tr>
<th>STAGE</th>
<th>COMMENTS</th>
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Page 1
# PRESENTATION EVALUATION

<table>
<thead>
<tr>
<th>No. of Presentations Done: ______</th>
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<tbody>
<tr>
<td><strong>Strengths Summary:</strong></td>
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<tr>
<td><strong>Areas of Improvement Summary:</strong></td>
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<td><strong>Agreed Action:</strong></td>
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</table>

# MINI CLINICAL EVALUATION EXERCISE (MINI-CEX)

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<tbody>
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<tr>
<td><strong>Areas of Improvement Summary:</strong></td>
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<td><strong>Agreed Action:</strong></td>
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</tbody>
</table>

# PROCEDURAL SKILLS EVALUATION/LOGBOOK

<table>
<thead>
<tr>
<th>No. of Procedures Done: ______</th>
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<tbody>
<tr>
<td><strong>Strengths Summary:</strong></td>
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<tr>
<td></td>
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<tr>
<td><strong>Areas of Improvement Summary:</strong></td>
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<tr>
<td><strong>Agreed Action:</strong></td>
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</table>

# CASE-BASED DISCUSSIONS

<table>
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<tr>
<th>No. of Case-Based Discussion Done: ______</th>
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<tr>
<td><strong>Areas of Improvement Summary:</strong></td>
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<tr>
<td><strong>Agreed Action:</strong></td>
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</tbody>
</table>

Multisource Feedback evaluation conducted with the resident:  

- ☐ Yes  
- ☐ No

Resident Leaves

- Annual Leave, specify # of days ________
- Sick Leave, specify # of days ________
- Emergency Leave, specify # of days ________
- Scientific Leave, specify # of days ________

For Six-Month Evaluation (select one):

- ☐ Unsatisfactory  
- ☐ Meets Expectations  
- ☐ Below Expectations  
- ☐ Exceeds Expectations

For Annual Evaluation: Recommendation (select one):

- ☐ Promotion to next academic year
- ☐ Other: ________________

This evaluation has been reviewed with the resident:  

- ☐ Yes  
- ☐ No

Name of Program Director/Asst. Program Director: __________________________
Signature: __________________________ Date: ________________

Name of Resident: __________________________
Signature: __________________________ Date: ________________
# Trainer Evaluation

## TRAINER EVALUATION BY RESIDENTS

**Name of Trainer:**

**Training Center:**

**Program:**

**Rotation:**

**Block: FROM____ TO____

**A. How many weeks did you work with this consultant/trainer?**

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4

**B. The frequency of your contacts with the teaching consultant/trainer was (per week)?**

- [ ] 1 or less
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5 or more

## TRAINER

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td><strong>Medical Knowledge (MK)</strong></td>
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<tr>
<td>1. Demonstrated breadth of knowledge</td>
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<tr>
<td><strong>Patient Care (PC)</strong></td>
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<tr>
<td>2. Made rounds regularly</td>
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<tr>
<td><strong>Promotion of a comprehensive approach to patient care</strong></td>
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<tr>
<td>3. Promoted a comprehensive approach to patient care</td>
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<tr>
<td><strong>Provided opportunity for performing procedure &amp; techniques</strong></td>
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<td>4. Provided opportunity for performing procedure &amp; techniques</td>
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<tr>
<td><strong>Professionalism (P)</strong></td>
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<tr>
<td>5. Was approachable</td>
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<td>6. Provided a good role model</td>
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<tr>
<td><strong>Availability and Communication Skills (ICS)</strong></td>
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<tr>
<td>7. Was available with enough time for resident’s support &amp; supervision</td>
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<tr>
<td><strong>Interpersonal and Communication Skills (ICS)</strong></td>
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<td>8. Established good rapport with resident</td>
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<td>9. Communicated well with colleagues</td>
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<tr>
<td><strong>Communicated well with other health care professionals</strong></td>
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<td>10. Communicated well with other health care professionals</td>
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<tr>
<td><strong>Related well with patients and families, if applicable</strong></td>
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<td>11. Related well with patients and families, if applicable</td>
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<td><strong>System-based Practice (SBP)</strong></td>
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<td>12. Was well organized</td>
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<td><strong>Allowed resident protected teaching time</strong></td>
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<td>13. Allowed resident protected teaching time</td>
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<td><strong>Allowed residents to attend mandatory workshops, if applicable</strong></td>
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<td>14. Allowed residents to attend mandatory workshops, if applicable</td>
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<tr>
<td><strong>Practice-Based Learning and Improvement (PBLI)</strong></td>
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<td>15. Provided quality teaching</td>
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<td>16. Stimulated enthusiasm for knowledge</td>
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<td>17. Provided direction &amp; feedback</td>
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<tr>
<td><strong>Encouraged resident to take appropriate responsibility</strong></td>
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<td>18. Encouraged resident to take appropriate responsibility</td>
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<td><strong>My total workload was appropriate for the time available</strong></td>
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<tr>
<td>19. My total workload was appropriate for the time available</td>
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**Comments:** [Strengths and Areas for Improvement]

**Signature of Resident (optional):** ____________________________

**Date:** ____________________________

**Version 4: Updated 8 July 2015**
### OMAN MEDICAL SPECIALTY BOARD
#### TRAINER/SCIENTIFIC COMMITTEE MEMBER EVALUATION FORM

**Name of Trainer:** __________________________  **Program:** ___________________

**Training Center:** __________________________  **Academic year:** ____________

**Trainer Designation:** ________________________

1. Number of years as an OMSB trainer
   - [ ] ≤1
   - [ ] 1-5 years
   - [ ] >5 years

**Part I. For all Trainers**

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>1. Conducts regular clinical teaching sessions</td>
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<td>2. Participates in formal/didactic teaching sessions</td>
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<td>3. Covers topics that are relevant and up to date</td>
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<td>4. Facilitates residents’ attainment of program objectives</td>
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<td>5. Contributes in mentoring and academic advising</td>
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<td>6. Supervises resident’s graded responsibilities in patient care</td>
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<tr>
<td>7. Is involved in the evaluation of residents</td>
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<td><strong>ADMINISTRATIVE ACTIVITIES</strong></td>
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<tr>
<td>8. Attends trainer meetings/retreats regularly</td>
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<td>9. Contributes to the overall improvement of the program</td>
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<tr>
<td><strong>PROFESSIONALISM AND ETHICS</strong></td>
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<td>10. Models appropriate professional behavior</td>
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<td>11. Respects others including residents</td>
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<td>12. Demonstrates good work ethics</td>
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<tr>
<td><strong>COMMUNICATION</strong></td>
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<tr>
<td>13. Communicates well with the Chairman, Program Director, and Assistant Program Directors</td>
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<tr>
<td>14. Communicates well with other trainers in the program</td>
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<tr>
<td>15. Communicates well with all healthcare professionals</td>
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<td>16. Communicates well with the Residents</td>
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<td>17. Receptive to feedback</td>
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<tr>
<td><strong>COLLABORATION</strong></td>
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</table>
## CRITERIA

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<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>19  Is able to handle and resolve conflicts</td>
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<tr>
<td>PERSONAL DEVELOPMENT AND GROWTH</td>
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<tr>
<td>20  Attends OMSB Faculty Development workshops</td>
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<tr>
<td>21  Contributes to intradepartmental activities, e.g., journal club, presentations etc.</td>
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<tr>
<td>22  Attends CPO activities [provide evidence]</td>
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<td>23  Is active in publications [provide evidence]</td>
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<tr>
<td>Overall assessment of the Trainer's contribution to the Program</td>
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</table>

Please provide an overall description of the strengths and weaknesses of the trainer and areas of improvement.

## Part II. For Trainers who are also members of the Scientific Committee/Subcommittees

1. Is the trainer a member of the scientific committee? [ ] Yes [ ] No  
   If yes, has attended the minimum required number of Scientific Committee meetings? [ ] Yes [ ] No

2. Is the trainer a member of a subcommittee? [ ] Yes [ ] No  
   Please specify: [ ] Examination [ ] Curriculum [ ] Research [ ] Clinical Competence Committee (CCC) [ ] Program Evaluation Committee (PEC) [ ] Simulation [ ] Other, ________
   If yes, has attended the minimum required number of Subcommittee meetings? [ ] Yes [ ] No  
   If no, please specify ________

3. Does the trainer currently chair any of the subcommittees? [ ] Yes [ ] No  
   If yes, please specify: [ ] Examination [ ] Curriculum [ ] Research [ ] CCC [ ] PEC [ ] Simulation [ ] Other, ________

## CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>4  Contributes to the Scientific Committee activities</td>
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<tr>
<td>5  Contributes to the Subcommittee activities</td>
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Assessor's Signature: ___________________________  Date: ____________

Designation: [ ] Chairman [ ] Program Director [ ] Assistant Program Director

Last update: 17/03/14  
MM/YY/AC
# Rotation Evaluation

## Rotation Evaluation Form

**Program:**

**Academic Year:**

**Rotation:**

**Training Center:**

**Block:**

<table>
<thead>
<tr>
<th>ROTATION</th>
<th>Un satisfactory</th>
<th>Deficient</th>
<th>Good</th>
<th>Very Good</th>
<th>Outstanding</th>
<th>N/A</th>
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<tbody>
<tr>
<td>I. Clinical Volume</td>
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</tr>
<tr>
<td>1. The number of in-patient cases seen</td>
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<td>□</td>
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<tr>
<td>2. The number of outpatient cases seen</td>
<td>□</td>
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<td>□</td>
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<tr>
<td>3. Range of clinical cases/problems</td>
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<td>4. The number of procedures</td>
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<td>II. Clinical Experience</td>
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<td>5. Level of responsibility in patient care</td>
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<td>6. The opportunity to see acute emergency cases</td>
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<td>7. The opportunity to see consultations</td>
<td>□</td>
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<td>8. The opportunity to perform procedures</td>
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<td>III. Academic activities</td>
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<td>9. Formal didactic teaching</td>
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<td>10. Quality assurance activities</td>
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<td>11. Journal club</td>
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<td>12. Opportunity to do research</td>
<td>□</td>
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<td>IV. Supervision</td>
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<td>13. Discussion of learning objectives</td>
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<tr>
<td>14. Support &amp; supervision</td>
<td>□</td>
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<tr>
<td>15. Feedback from trainer on performance</td>
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<tr>
<td>16. Assessment of Resident performance</td>
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<tr>
<td>V. Educational environment</td>
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<tr>
<td>17. Physical environment (e.g. on-call rooms, lounge, etc.)</td>
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<tr>
<td>18. Learning environment (e.g. Teamwork, support, professional, etc.)</td>
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<tr>
<td>19. Learning resources (e.g. workstations, microscopes, e-learning, etc.)</td>
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<tr>
<td>Overall Quality of Rotation</td>
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</table>

**Comments:** (Strengths and Areas for Improvement)

---

**Signature of Resident (optional):** ____________________________  **Date:** ____________________________

*Updated July 8, 2015*
# Research Mentor Evaluation

## Criteria

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Encourages identification of research topics.</td>
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<tr>
<td>2 Helps me become independent in identifying research questions.</td>
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<tr>
<td>3 Provides constructive feedback on my research design.</td>
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<tr>
<td>4 Encourages identifying research methodology.</td>
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<tr>
<td>5 Helps me develop my capacity for theoretical reasoning.</td>
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<tr>
<td>6 Helps me to be critical and objective.</td>
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<tr>
<td>7 Provides guidance on writing skills for Research.</td>
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<tr>
<td>8 Provides guidance on presenting skills for Research.</td>
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<tr>
<td>9 Provides guidance on technical skills for Research.</td>
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<tr>
<td>10 Ensures ethical research practice.</td>
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<tr>
<td>11 Encourages teamwork.</td>
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<tr>
<td>12 Provides thoughtful advice on my research progress.</td>
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<tr>
<td>13 Accessible</td>
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<tr>
<td>14 Approachable</td>
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<tr>
<td>15 Is a good role model in research.</td>
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</table>

**COMMENTS:** (Please use this space to record areas of strengths or any suggestions for development.)

Residents Name: ___________________________ Signature: ____________ Date: ____________
# Program Director/ Associate Program Director Evaluation

**OMAN MEDICAL SPECIALTY BOARD**

**Program Director/Assistant Program Director's Evaluation**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Program:</th>
<th>Period Covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor's Designation:</td>
<td></td>
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<tr>
<td>[ ] Chairman</td>
<td>[ ] Self-Evaluation</td>
<td>[ ] Others, Please specify</td>
</tr>
</tbody>
</table>

## I. Program Knowledge/Improvement

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintains and suggests areas of improvement in competency-based education</td>
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<tr>
<td>2. Maintains and suggests areas of improvement in assessment systems</td>
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<td>3. Assesses program outcome data, and identifies/improves improvement strategies annually</td>
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<td>4. Utilizes OMSB resources to maximize improvement efforts</td>
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<tr>
<td>5. Participates in and supports research and scholarly activity among residents and trainers</td>
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<tr>
<td>6. Participates in annual professional development associated with Program Director responsibilities</td>
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</table>

## II. Program Administration

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>7. Achieves program compliance with all OMSB policies</td>
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<td>8. Provides timely program updates to OMSB</td>
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<tr>
<td>9. Maintains active, collaborative relationships with OMSB management</td>
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<tr>
<td>10. Provides collaborative supervision of Assistant Program Directors/Program Administrators</td>
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<tr>
<td>11. Maintains active, collaborative relationships with other Program Directors</td>
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</table>

## III. Resident and Faculty Management

<table>
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<tr>
<th>CRITERIA</th>
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<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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</thead>
<tbody>
<tr>
<td>12. Demonstrates leadership, supervision, and organization for Residents and Trainers</td>
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<tr>
<td>13. Participates in selecting residents in accordance with OMSB and Program policies and procedures</td>
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<tr>
<td>14. Monitors resident performance and maintains appropriate documentation</td>
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<td>15. Maintains a supportive educational environment</td>
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<td>16. Monitors resident well-being and modifies training situations that produce undesirable resident stress</td>
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<tr>
<td>17. Implements fair and appropriate procedures for academic discipline and or response to complaints and/or grievances</td>
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<tr>
<td>18. Trainers: Nominates Scientific Committee Members and Trainers</td>
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<tr>
<td>19. Evaluates and monitors Trainer performance</td>
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<td>20. Mentors, facilitates professional development of Trainers</td>
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</table>

## IV. Interpersonal and Communication Skills

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<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>21. Exhibits leadership, supervision, and mentorship skills consistently</td>
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<tr>
<td>22. Models the skills and attitudes of OMSB competencies</td>
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<tr>
<td>23. Exhibits outstanding teaching skills</td>
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<td>24.Promotes development of the clinical teaching skills of Trainers</td>
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<tr>
<td>25. Demonstrates teamwork skills</td>
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<tr>
<td>26. Promotes collaborative interaction among all health professionals</td>
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</table>

## V. Professionalism

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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</thead>
<tbody>
<tr>
<td>27. Models and maintains highest professional standards of ethical behavior</td>
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<tr>
<td>28. Engages in self-improvement activities</td>
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<td>29. Creates own professional development plan</td>
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<tr>
<td>30. Conducts an annual self-assessment related to role of Program Director</td>
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<tr>
<td>31. Demonstrates advocacy and support to Trainers and Residents</td>
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</table>

## OVERALL ASSESSMENT

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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</thead>
</table>

Please see overleaf.
COMMENTS:
STRENGTHS

AREAS OF IMPROVEMENT

Assessor’s Signature (Optional): ____________________________ Date: ________________
Program Director/APD Signature: ____________________________ Date: ________________

9-Feb-13 /AF/por
Program Director/ Associate Program Director Evaluation (to be filled by Residents)

OMAN MEDICAL SPECIALTY BOARD
PROGRAM DIRECTOR/ASSISTANT PROGRAM DIRECTOR'S EVALUATION
RESIDENT FORM

Assessor Name (optional): _______________________________ Resident Level: _____ Program: ______________
Program Director/Assistant Program Director: ______________________ Academic Year: ______

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>I. RESIDENT EDUCATION</td>
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<tr>
<td>1. Promotes learner centered education</td>
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<tr>
<td>2. Manages administrative aspects of the residency program well</td>
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<td>3. Provides the residents with adequate educational activities</td>
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<td>II. GENERAL KNOWLEDGE</td>
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<td>4. Has good knowledge of institutional, foundational and Advanced</td>
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<td>Specialty/Subspecialty requirements</td>
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<td>5. Has good knowledge of policies and procedures</td>
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<td>III. INTERPERSONAL/COMMUNICATION SKILL</td>
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<td>6. Uses effective oral and written communication</td>
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<td>7. Identifies and alleviates barriers in teaching</td>
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<td>8. Provides timely and clear feedback</td>
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<td>9. Serves as a counselor, adviser, liaison and advocate for residents</td>
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<tr>
<td>10. Respects residents, allied health professionals and faculty views</td>
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<tr>
<td>IV. PRACTICE-BASED LEARNING AND PROGRAM IMPROVEMENT</td>
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<td>11. Ensures adequate resources are available for resident education</td>
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<td>and scholarly activities</td>
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<td>12. Remains current with evolving program requirements</td>
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<td>13. Appraises the residency program by looking at trends in medical</td>
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<tr>
<td>education</td>
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<td>14. Uses information technology to improve and optimize learning</td>
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<td>15. Demonstrates continuing commitment to excellence and scholarship</td>
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<td>16. Uses trainer and resident evaluations as instruments for change</td>
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<tr>
<td>V. PROFESSIONALISM</td>
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<tr>
<td>17. Is available, approachable and receptive to resident</td>
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<td>18. Respects and inspires residents to be actively involved in</td>
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<td>educational aspects of the program</td>
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<td>19. Demonstrates accountability</td>
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<td>20. Respects and trainer confidentiality</td>
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<tr>
<td>21. Adheres to high ethical and moral standards</td>
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<td>22. Works in a manner that best serves residents' interests</td>
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<tr>
<td>23. Respects the residents' and faculty's cultural beliefs, practices and</td>
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<tr>
<td>language</td>
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<td>24. Professional in appearance and communication</td>
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<td>VI. SYSTEM-BASED PRACTICE</td>
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<tr>
<td>25. Is knowledgeable about OMSS requirements.</td>
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<td>26. Participates in local and national organizations.</td>
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<tr>
<td>27. Promotes research and scholarly activity among residents</td>
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</tbody>
</table>

OVERALL ASSESSMENT

Please see overview
# Program Evaluation Form (to be filled by Residents)

**OMAN MEDICAL SPECIALTY BOARD**

**PROGRAM EVALUATION FORM**

**Resident Form**

<table>
<thead>
<tr>
<th>Program:</th>
<th>Accreditation Status:</th>
<th>Academic Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman:</td>
<td>Program Director:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Curriculum</td>
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<tr>
<td>a. Competency-based</td>
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<tr>
<td>b. General goals and objectives are clearly stated</td>
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<td>c. Rotation-specific goals and objectives are clearly stated</td>
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<tr>
<td>d. Goals and objectives are discussed with the residents during the rotation</td>
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<tr>
<td>e. Reviewed and updated regularly</td>
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<tr>
<td>2. Resident Performance</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Residents are assessed regularly</td>
<td></td>
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</tr>
<tr>
<td>b. Block evaluations (ITTR) are regularly discussed with the residents</td>
<td></td>
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<tr>
<td>c. Workplace-based assessments are conducted regularly</td>
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<tr>
<td>d. Feedback is given regularly</td>
<td></td>
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</tr>
<tr>
<td>e. Semianual and annual assessments are done face-to-face</td>
<td></td>
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</tr>
<tr>
<td>3. Training Environment Provides:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Scheduled formal teaching</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>b. Appropriate supervision of residents</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>c. Adequate opportunities for procedural skills</td>
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<tr>
<td>d. Adequate learning resources</td>
<td></td>
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<tr>
<td>e. Scholarly environment</td>
<td></td>
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<tr>
<td>f. Opportunity to discuss issues without the fear of intimidation</td>
<td></td>
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<tr>
<td>4. Program Performance</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a. Conducts regular orientation for first year residents</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>b. Adheres to the master schedule</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>c. Monitors residents’ participation at teaching sessions</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d. Monitors residents’ participation at the workplace</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>e. Adheres to the OMSB on-call policy</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>f. Maintains a procedural logbook</td>
<td></td>
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</tr>
<tr>
<td>g. Ensures residents have graded responsibilities</td>
<td></td>
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</tr>
<tr>
<td>h. Maintains that senior residents have supervisory role</td>
<td></td>
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</tr>
<tr>
<td>i. Integrates simulation in the training</td>
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</tr>
<tr>
<td>j. Encourages advanced training in the subspecialty</td>
<td></td>
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</tr>
<tr>
<td>k. Implements various OMSB Policies including Grievance, Remediation, etc.</td>
<td></td>
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<tr>
<td>l. Performs self-evaluation annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Corrects cited deficiencies</td>
<td></td>
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</tr>
<tr>
<td>n. Performs final in-training assessments</td>
<td></td>
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</tr>
</tbody>
</table>

Please see overleaf
How satisfied are you with the Program:

Strengths of the Program:

Areas of Improvement:

Suggestions for Improvement:

Date: ____________________________

30/06/2014 - MJAC
# Program Evaluation Form (to be filled by Trainers)

**OMAN MEDICAL SPECIALTY BOARD**

**PROGRAM EVALUATION FORM**

**Trainer Form**

<table>
<thead>
<tr>
<th>Program:</th>
<th>Accreditation Status:</th>
<th>Academic Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman:</td>
<td>Program Director:</td>
<td></td>
</tr>
</tbody>
</table>

## CRITERIA

<table>
<thead>
<tr>
<th>1. Administrative structure in compliance with OMSB Quality Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Strongly Disagree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Competency-based</td>
</tr>
<tr>
<td>□ General/Program goals and objectives are clearly stated</td>
</tr>
<tr>
<td>□ Rotations-specific goals and objectives are clearly stated</td>
</tr>
<tr>
<td>□ Goals and objectives are discussed with the residents during the rotation</td>
</tr>
<tr>
<td>□ Annually reviewed and updated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Resident Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Residents are assessed regularly</td>
</tr>
<tr>
<td>□ Block evaluations (ITIR) are regularly discussed with the residents</td>
</tr>
<tr>
<td>□ Workplace-based assessments are conducted regularly</td>
</tr>
<tr>
<td>□ Feedback is given regularly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Training Environment Provides:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Scheduled formal teaching</td>
</tr>
<tr>
<td>□ Appropriate supervision of residents</td>
</tr>
<tr>
<td>□ Adequate opportunities for procedural skills</td>
</tr>
<tr>
<td>□ Adequate learning resources</td>
</tr>
<tr>
<td>□ Scholarly environment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Program Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Follows OMSB selection process in appointing residents</td>
</tr>
<tr>
<td>□ Conducts regular orientation for first year residents</td>
</tr>
<tr>
<td>□ Adheres to the master schedule</td>
</tr>
<tr>
<td>□ Monitors residents’ participation at teaching sessions</td>
</tr>
<tr>
<td>□ Monitors residents’ participation at the workplace</td>
</tr>
<tr>
<td>□ Adheres to the OMSB on-call policy</td>
</tr>
<tr>
<td>□ Monitors resident supervision at the workplace</td>
</tr>
<tr>
<td>□ Mandates a procedural logbook</td>
</tr>
<tr>
<td>□ Ensures residents have graded responsibilities</td>
</tr>
<tr>
<td>□ Mandates that senior residents have supervisory role</td>
</tr>
<tr>
<td>□ Integrates simulation in the training</td>
</tr>
<tr>
<td>□ Encourages advanced training in the subspecialty</td>
</tr>
<tr>
<td>□ Identifies residents in difficulty</td>
</tr>
<tr>
<td>□ Implements various OMSB Policies including Grievance, Remediation, etc.</td>
</tr>
<tr>
<td>□ Performs self-evaluation annually</td>
</tr>
<tr>
<td>□ Corrects cited deficiencies</td>
</tr>
<tr>
<td>□ Performs final in-training assessments</td>
</tr>
<tr>
<td>□ Evaluates outcomes</td>
</tr>
<tr>
<td>□ Conducts annual trainer retreat</td>
</tr>
</tbody>
</table>

**REMARKS**

Please see overleaf.
How satisfied are you with the Program:

Strengths of the Program:

Areas of Improvement:

Suggestions for Improvement:

Date: ____________________

2/20/2011 - PM/EC
# Evaluation Form for Resident’s Teaching Sessions

**Oman Medical Specialty Board**

## EVALUATION FORM FOR RESIDENTS’ TEACHING SESSIONS

**Name:**

**Program:**

**Rotation:**

**Level:**

**Type of teaching session:**
- [ ] Clinical
- [ ] Didactic
- [ ] Other, specify

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Unsatisfactory</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduced self</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. Stated the objectives of the teaching session</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>3. Established an effective learning environment and learner-centered approach</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>4. Guided students appropriately during the session</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>5. Ensured participation by all students</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>6. Made decisions through interactive discussion</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>7. Assigned reading tasks</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>8. Demonstrated knowledge of the subject</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>9. Demonstrated enthusiasm during the session</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**Overall Impression**

**Comments:**

**Strengths:**

**Areas for Improvement:**

**What went particularly well during this teaching session? (to be answered by the Resident)**

**What would you try to do differently next time? (to be answered by the Resident)**

This form has been reviewed with the Resident: [ ] Yes [ ] No

**Name and Signature of Trainer:**

**Date:**

**Signature of Resident:**

**Date:**

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All assessment tools can be accessed at OMSB website (http://www.omsb.org/) and New Innovations (http://new-innov.com/pub/). Revised tools and newly developed assessment tools will be uploaded in the above websites.
Evaluation Form for Interviewing Skills

EVALUATION OF CLINICAL COMPETENCY
FOR PSYCHIATRY RESIDENTS

Resident: __________________ Level of Training: ______
Trainer: ________________ Date: __________

The evaluation should reflect the ability of the candidate to skillfully and compassionately address information that is needed to understand the patient in the context of his or her history and to establish a meaningful diagnosis and treatment plan, to synthesize the information obtained and to communicate this understanding.

Please note the evaluation is to be carried out according to the level of training of the concerned resident.

(1) INTERVIEW PROCESS (…)to skillfully and compassionately address information…)

<table>
<thead>
<tr>
<th>Item</th>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAPPORT</td>
<td>Does not introduce self or exam. Uncertain. Does not assume control OR begins asking direct, closed questions.</td>
<td>Introduces self, explains interview concisely. Begins in open, exploratory manner. Treats patient like a responsible adult.</td>
</tr>
<tr>
<td>Establishes Relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintains</td>
<td>Mechanistic, distant, unresponsive, disrespectful, patronizing</td>
<td>Respectful, Genuinely interested. Eye contact, body posture suggests active listening.</td>
</tr>
<tr>
<td>professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>therapeutic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INTERVIEW</td>
<td>Excessive closed or vague questions. Multiple simultaneous questions. Excessive jargon. Does not get detail. Uncomfortable with psychotic or sensitive material.</td>
<td>Mixes open and closed questions. Few leading or stacked questions. Asks clear questions in plain language.</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td></td>
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</tr>
<tr>
<td>Information Gathering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention/Listening</td>
<td>Talks over patient, OR passive, unsure, leaving awkward silences. Does not make use of nonverbal material.</td>
<td>Practices receptive listening; allows silences and seems comfortable doing so.</td>
</tr>
<tr>
<td>Empathy</td>
<td>Fail to acknowledge patient distress, OR colludes or over-identifies with patient. Does not make use of nonverbal material.</td>
<td>Acknowledges distress with non-judgmental, empathetic responses. Notes and responds to non-verbal cues.</td>
</tr>
<tr>
<td>Assuredness</td>
<td>Uncomfortable with feeling or psychotic content. Becomes flustered, freezes, or stifles such content.</td>
<td>At ease with affective, anxious or psychotic content of interview. Normalizes or helps patient understand symptoms.</td>
</tr>
<tr>
<td>Feedback</td>
<td>Provides no feedback to patient, OR</td>
<td>Reframes, paraphrases. Summarizes</td>
</tr>
</tbody>
</table>

Page 1 of 6
<table>
<thead>
<tr>
<th>Item</th>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORGANIZATION</td>
<td>Inflexible, ignores patient needs. OR conducts a disorganized, disjointed interview. Allows patient to lead interview, drift, unable to focus</td>
<td>Conducts structured but flexible interview, completing sections of interview in an orderly manner. Is able to politely redirect patient back to area under review, help patient focus.</td>
</tr>
<tr>
<td>Conducts comprehensive interview</td>
<td>Interview is not balanced. Focuses solely on principle problem, does not review for comorbidity. Ignores the person in pursuit of symptoms. Fails to allocate time efficiently.</td>
<td>Conducts balanced interview. Gets clear sense of the person. Allocates time efficiently.</td>
</tr>
</tbody>
</table>

(at high end: 7 or more) Candidate engages well with the patient, facilitates communication with a good mix of open ended and “specific” questions, and responds adequately to verbal and non-verbal, especially affective cues; is receptive to important information that patient wants to talk about, and asks about important things the patient does not volunteer but is not averse to talking about. Meets expectations. Errors or omissions are not major. A candidate around 9 or 10 does this, and helps patient overcome obstacles.

(at the low end: 6 or less) Candidate fails to engage well with the patient, and does not facilitate communication or interferes with what patient wants to say. For example, uses excessive structure, e.g. closed ended or multiple choice questions, or does not respond adequately to verbal or non-verbal, especially affective cues...

(2) INTERVIEW CONTENT (...information that is needed...)

<table>
<thead>
<tr>
<th>Item</th>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI Premorbid state</td>
<td>Fails to address pre-morbid state.</td>
<td>Adequately addresses pre-morbid state.</td>
</tr>
<tr>
<td>Illness Onset</td>
<td>Fails to address circumstances of onset of illness / episode</td>
<td>Addresses stressors and time of onset of illness</td>
</tr>
<tr>
<td>Symptoms and Course of Episode</td>
<td>Does not adequately attempt to identify symptoms or clarify evolution of current illness.</td>
<td>Address symptoms of current episode / illness, and does not blur this with previous episodes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a stable patient with no current episode, assesses current level of symptoms and functioning</td>
</tr>
<tr>
<td>Therapeutic Interventions</td>
<td>Fails to address therapeutic interventions</td>
<td>Addresses therapeutic interventions in current episode.</td>
</tr>
<tr>
<td>Comorbidity Screening</td>
<td>Preoccupied with a single diagnosis. Does not screen for comorbidity.</td>
<td>Reviews a criteria for symptoms of likely differential diagnoses and likely comorbid diagnoses.</td>
</tr>
<tr>
<td>SAFETY</td>
<td>Fails to assess or minimizes risk of self-harm, aggression or self care.</td>
<td>Asks about suicidality, aggressivity, competency to care for self. IF indicated by...</td>
</tr>
</tbody>
</table>

Page 2 of 6
<table>
<thead>
<tr>
<th>Item</th>
<th>Unsatisfactory</th>
<th>B</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment</td>
<td>OR exaggerates seriousness of threat.</td>
<td></td>
<td>patient’s mental status during interview. Systematically reviews risk factors for suicide, self harm, self care, harm to others, IF INDICATED. Does not do so if not required.</td>
</tr>
<tr>
<td>MEDS</td>
<td>Does not ask about medication.</td>
<td></td>
<td>Asks about current medication: dose, duration, effectiveness, side effects.</td>
</tr>
<tr>
<td>PSYCH HISTORY</td>
<td>Fails to review.</td>
<td></td>
<td>Reviews previous episodes, hospitalizations, evolution if illness, aggression and self harm.</td>
</tr>
<tr>
<td>Past episodes</td>
<td></td>
<td></td>
<td>Reviews past treatments, including therapists and relationship to them; medications including dose, duration, efficacy, side effects, and compliance; other treatments.</td>
</tr>
<tr>
<td>Treatments</td>
<td>Fails to review.</td>
<td></td>
<td>Reviews substance use/abuse.</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Fails to review.</td>
<td></td>
<td>Reviews legal involvements, if indicated.</td>
</tr>
<tr>
<td>Forensic History</td>
<td>Fails to review.</td>
<td></td>
<td>Reviews family psychiatric history including substance abuse.</td>
</tr>
<tr>
<td>FAMILY PSYCH</td>
<td>Fails to review.</td>
<td></td>
<td>Reviews medical history, including allergies, serious drug reactions in past, response to illness.</td>
</tr>
<tr>
<td>HISTORY:</td>
<td></td>
<td></td>
<td>Reviews early childhood and adolescent development and relationships, including abuse.</td>
</tr>
<tr>
<td>MEDICAL HISTORY</td>
<td>Fails to review.</td>
<td></td>
<td>Reviews academic achievement and work history, and current functioning.</td>
</tr>
<tr>
<td>GROWTH, PERSONAL</td>
<td></td>
<td></td>
<td>Reviews adult relationships, including current relationships and supports.</td>
</tr>
<tr>
<td>HISTORY</td>
<td></td>
<td></td>
<td>Conducts formal mental status exam if indicated. Does not do so if not indicated. Covers relevant content areas.</td>
</tr>
<tr>
<td>MSE</td>
<td>Omits important areas, or performs mental status exam when not indicated.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(at high end: 7 or more) Candidate addresses most important areas needed for understanding the patient’s illness in context, and arriving at multidimensional treatment plan. These are addressed with reasonable balance, in sufficient depth and in an organized manner. Omissions are not critical. (9 or 10): Most areas thoroughly and competently addressed.

(at the low end: 6 or less) Candidate omits important areas, or addresses important area in insufficient depth. Interview lacks adequate structure or organization.

0       1       2       3       4       5       6       7       8       9       10
### UNDERSTANDING

...ability...to synthesize the information obtained to understand the patient in the context of his/her history, to establish a meaningful diagnosis and management plan...

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>Unsatisfactory</th>
<th>B</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposes a diagnosis or principle problem unsupported by the interview</td>
<td>Provides a realistic working diagnosis supported by evidence from the interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to present or defend a differential diagnosis. OR Provides an over inclusive differential, stressing the esoteric</td>
<td>Provides a brief and realistic differential diagnosis and is able to explain process of further clarifying the diagnosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is inflexible in discussing diagnoses. Is unable to entertain alternatives.</td>
<td>Able to discuss difficulties in supporting and refuting diagnoses in a thoughtful, balanced manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is unaware of issues related to comorbidity</td>
<td>Is able to discuss comorbidity and interplay between diagnosis.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FORMULATION</th>
<th>Unsatisfactory</th>
<th>B</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is unable to provide a summative understanding of the patient. Focuses narrowly on a single aspect or phase of the illness.</td>
<td>Identifies predisposing, precipitating, perpetuating factors for patient’s problems, described in a manner which recreates a whole person and his/her life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View of patient neglects key components of his/her life, is unduly limited in its grasp. Uninterested in patient as an individual person.</td>
<td>Able to identify biopsychosocial components of patient’s illness, and describe the interplay between these elements at this time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is unable to identify dynamic or cognitive factors influencing patient’s presentation</td>
<td>Able to identify core conflicts, cognitive distortions, dependence or interpersonal needs of the patient.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MANAGEMENT</th>
<th>Unsatisfactory</th>
<th>B</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment plan has no clear goals or expected outcomes. Plan is unrealistic for the patient, or is not attainable in existing mental health system.</td>
<td>Provides realistic treatment plan covering short term, medium term and long term goals of treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has very limited understanding of indications for and limitations of pharmacotherapy and other biological therapies. Recommends inappropriate biological treatments without understanding of risks and benefits. Lacks evidence for efficacy of treatment proposed.</td>
<td>Able to recommend and defend prescription of SPECIFIC pharmacotherapies, if relevant. Aware of evidence for efficacy of therapy provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is unaware of indications for and limitations of specific types of psychotherapy. Recommends inappropriate therapy.</td>
<td>Able to recommend and defend prescription of SPECIFIC psychotherapies, if relevant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>B</td>
<td>Satisfactory</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Has poor understanding of long-term prospects for patient. Provides unrealistic outcomes, little understanding of real life, day-to-day management issues.</td>
<td></td>
<td>Able to provide realistic prognosis. Able to describe barriers to compliance / effective interventions with THIS patient.</td>
<td></td>
</tr>
</tbody>
</table>

(at high end: 7 or more) Candidate shows good understanding of patient’s illness in the context of patient’s life. Conclusions are based on evidence. Candidate addresses biological, psychological, and social aspects of management in knowledgeable, relevant manner. (Any Bs and Us are not major).

(at the low end: 6 or less) Candidate’s answers are imprecise or formulaic. Does not take into account the particular individual patient.

0 1 2 3 4 5 6 7 8 9 10

PRESENTATION: (…ability…to communicate this understanding…)

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>B</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case is disorganized or a simple repetition of symptoms without a unifying story line or sense of the person. Time sequences mix current with past episodes.</td>
<td></td>
<td>Case is presented in an orderly, systematic manner. Presentation successfully tells the patient’s story. Paints a clear picture of the course of illness.</td>
</tr>
<tr>
<td>Symptoms are not clustered to aid with diagnosis, OR symptoms are presented in excessive detail.</td>
<td></td>
<td>Presentation includes relevant positive and negative symptoms needed to support the diagnosis.</td>
</tr>
<tr>
<td>Case is rambling and overinclusive, OR presentation is unduly brief and uninformative.</td>
<td></td>
<td>Case presentation is concise, but includes relevant detail and texture.</td>
</tr>
<tr>
<td>Rigid, inflexible, confrontational in discussion. Unable to entertain other possibilities OR unable to take a position for discussion. Immediately accepts examiner’s viewpoint.</td>
<td></td>
<td>Demonstrates capacity for open mindedness, thoughtful discussion of issues identified.</td>
</tr>
</tbody>
</table>

(at high end: 7 or more) Presentation is organized, focused and relevant. Answers are precise and relate to the patient seen.

(At lower end, 6 or less) Presentation is disorganized or overinclusive. Vague.

0 1 2 3 4 5 6 7 8 9 10
Errors of Omission or Commission that would:

(1) endanger the patient or others
(2) seriously compromise the relationship with the patient
(3) lead to an incorrect or inadequate assessment of the patient’s problem (e.g., missing a major abnormality on history or examination)

If yes, please comment

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Overall

Meets expectations ______ B ______ Below expectations ______

≥ 70  65 - 69  < 65

Reference: RCPSC Oral Examination Score Sheet for Psychiatry
**DUTY HOURS and LOGBOOK**

- All data must be entered through the new innovations system.
- Website: [https://www.new-innov.com/](https://www.new-innov.com/)
- All residents must at least log 50 procedures all throughout their training.
Contact Details:

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Website: www.omsb.org