‘P’ & ‘T’ Standards for OMSB Residency Program

Program Standards ‘P’ compliant with ACGME-I "Foundational Program Requirements"

Training Center Standards ‘T’ compliant with ACGME-I "Institutional Requirements"

Fourth Edition June 2015
Program and Training Center Standards “P & T Standards”

Prepared by:
QA PGME Committee
Oman Medical Specialty Board

Fourth Edition June 2015
QUALITY ASSURANCE FOR POSTGRADUATE MEDICAL EDUCATION (QA-PGME)

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“P Standards” _1_ (Program Standards) = ACGME-I Foundational Program Requirements

“T Standards” _2_ (Training Center Standards) = ACGME-I Institutional Requirements
PREFACE TO THE FOURTH EDITION:

This Edition of the Quality Assurance Training Standards for Residents of OMSB includes several changes within the Domains of the “P Standards” (Program Training Standards). This is a result of the transition that OMSB decided to undertake in seeking accreditation with Accreditation Council for Graduate Medical Education International (ACGME-I).

The changes in the “P Standards” domains are intended to align the training at OMSB with the ACGME-I Foundational Program Requirements. Collectively, the new (9) nine domains covered in this booklet, covers all the (6) six sections of the ACGME-International Foundational Program Requirements for Graduate Medical Education from Program Personnel and Resources to Resident Appointment and Evaluation, Resident Duty Hours, as well as Educational Programs. Specifically, the domains that were in the third edition shuffled around and details are added in many standards to make them more in line with the ACGME-I Foundational Program Requirements. In addition, a new Standard 4C: Scholarly Activity has been added, and Domain 5: Patient Safety has been reinforced. The 9 Domains has been thoroughly reviewed by the Committee to ensure that they include all elements of the ACGME-I Foundational Program Requirements Standards and many cases, these standards contains more than the ACGME-I Foundational Program Requirements. Domain 7: Competence- Targeted Training and Domain 8: In-training Evaluation have been revised so that they now refer to the ACGME-I core competency instead of CanMEDS competency both in training and evaluation. Domain 9: Outcome Evaluation has been rearranged and updated.

A new section has been added “T Standards” (Training Center Standards). This section contains 6 Domains. The first 4 Domains are fully compliant with the ACGME-I Institutional Requirements, from Organization and Responsibility to Internal Review.
In addition, we have Domain 5: Resources at Sponsoring Institution and Participating Sites and Domain 6: Patient Safety in Participating Sites which were adapted to ACGME-I Foundational Program Requirements. The committee believed that this particular portion is more appropriate to use in our “T Standards” so it was decided to place it also in the “T Standards”. It is anticipated that the changes in the standards in this booklet will act as nidus to improve the standards of training at OMSB academic state of the faculty and training center.

We hope that this will result being more competitive physicians internationally and at the same time improve the standard of care in our patients in Oman.

Lamk M. Al Lamki
Chairman, Quality Assurance for PGME Committee
25 June 2015
PREFACE TO THE SECOND EDITION:

Oman Medical Specialty Board (OMSB) has appointed Quality Assurance Committee for Post Graduate Medical Education (PGME) in the autumn of 2009 with a mandate to set standards for quality assurance of the OMSB Post Graduate Medical Education Program.

The Quality Assurance Committee for PGME of OMSB has reviewed the existing Bylaws of the new OMSB and the Trainer’s Manual. We have also reviewed the existing Global Standards for Quality Improvement of the World Federation for Medical Education (WFME) and the Quality Directorate Documents of the Post-Graduate Medical Education and Training Board (PMETB) of United Kingdom (currently merged with General Medical Council), and also, the General Standards of Accreditation of the Royal College of Physicians and Surgeons of Canada (RCPSC). We also reviewed the ACGME (Accreditation Council of General Medical Education) of USA and the European Board Guidance for Training Centers. We then developed a set of standards for quality training of PGME at OMSB. These Standards are influenced by the Standards and various Domains that belong to these five Institutions for which we are most grateful.

The Quality Assurance Committee also reviewed the “Competencies” set by these five Institutions and after discussions; we have adopted the CanMEDS Competencies of the RCPSC. The Quality Assurance Committee recommended to OMSB that the CanMEDS be adopted (with some modifications to suit Oman conditions) as the “Medical Competencies” expected of Graduating Residents from all OMSB Programs.

The Committee has come up with two sets of Standards: The “T” standards for Training Centers and the “P” standards for the Programs. The “T Standards” are not fully developed as yet. The “P” Standards are divided according to the Domains that they cover as described in the following sections.
Each of the eight Domains contains one or more Standards. These are followed by four Appendices which enhance the understanding of the terms used in the description of the Standards, and also suggestions of evaluation methods and their relative utility.

We sincerely hope that the Scientific Committees, Trainers and Residents take guidance from these Standards to fortify the quality of their training and learning process.

The QA-PGME Committee is planning to periodically revise these Standards and it is their sincere wish that the Stakeholders will adopt the revised and improved versions of the Standards as they are published.

Lamk M. Al Lamki
Chairman for Quality Assurance for PGME Committee
June 2012
ACKNOWLEDGEMENT

We in the OMSB Quality Assurance for Post Graduate Medical Education Committee would like to express our sincere appreciation to the people who have given support in accomplishing of revising this new edition of this booklet. Thank you for the contributions you provided and endless support in making the release of this book possible.

The committee would like to thank H.E. Dr. Abdullah Al Futaisi, adviser to SQU, during his period serving as the Executive President in OMSB, giving his full support, encouragement and patience. The committee would also like to thank H.E. Dr. Hilal Al Sabti, Executive President of OMSB and to Prof. Neela Al Lamki, Vice President of Academic Affairs and Designated Institutional Official, we are thankful for their continuous guidance and support. We wish to thank the Program Administrators for their support in the distribution of the Standards to their designated programs and committees.

The committee would also like to thank Ms. Azucena D. Visda, the administrator assigned to this committee. She contributed as what an administrator does and in reviewing the world of literature in addition to her usual job. We wish to thank the other administrators who have helped significantly, in particular Ms. Xyllene Reynaldo for her help throughout the years of the existence of this committee. And more recently, we also wish to thank Ms. Kristel Malibiran who has recently joined us and contributed to the merits of this committee.

And lastly, Thank You to the Committee Members of Quality Assurance for PGME Committee, for their endless patience, hard-work and support for making this revision possible.

Lamk M. Al Lamki
Chairman Quality Assurance for PGME Committee
25 June 2015
OMAN MEDICAL SPECIALTY BOARD

“P STANDARDS”
Compliant with ACGME-I
“Foundational Program Requirements”
DOMAIN 1: ADMINISTRATION

STANDARD P.1: There must be an appropriate administrative structure for each residency program. Education and training must be planned and maintained through transparent processes which show who is responsible at each stage.

INTENTION: This standard sets the minimum organizational & management requirements at all levels for Quality training of Residents.

ACCOUNTABILITY: OMSB Vice-President for Academic Affairs Designated Institutional Official (DIO), Associate DIO, Education Committee of the Program, Chairman, Residency Program Director, Associate Program Directors, Educational Supervisors, Education Committee of the Program Members and Trainers.

AFFIRMATION: Education Committee of the Program Meeting Minutes and Data, Subcommittee Reports and Data, Annual Report of the Program, Internal Review Committee Reports, and Internal/External Review Reports, and any other relevant reports or minutes.
BASIC MANDATORY QUALIFICATIONS:

1.1 Institutions
   1.1.1 Sponsoring Institution
   
   i) As the sponsoring institution, OMSB must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to cover residents’ assignments at all participating sites.

   ii) OMSB and the program must ensure the program director has sufficient protected time and support for his/her educational and administrative responsibilities to the program.

   iii) For each program, OMSB must ensure there is a single program director with appropriate qualifications and authority.

1.2 Participating Sites
   1.2.1 There must be a Program Letter of Agreement (PLA) between the program and each participating site. The PLA must be renewed at least every five years.

   The PLA should:
   a) identify the Trainer who will assume both educational and supervisory responsibilities for residents;

   b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified in this document;
c) specify the duration and content of the educational experience; and,
d) state the policies and procedures that will govern resident education during the assignment.

1.2.2 The Program Director must submit any additions or deletions of participating sites routinely providing educational experiences for the majority of residents through the DIO and GMEC, and then the ACGME-I Accreditation Data System (ADS).

1.2.3 Resident assignments away from their own program should not prevent residents’ regular participation in required didactics of their own program.

1.3 Education Committee of the Program:

There must be an Education Committee of the Program as per OMSB Regulations. The Committee will be responsible for the planning and its implementation, organization, and supervision of the program.

1.3.1 Every Education Committee of the Program of OMSB will be headed by the Education Committee of the Program Chairman. He/ She will be elected by the Education Committee of the Program members.

1.3.2 The Education Committee of the Program shall elect a Program Director who will assist the Chairman in the planning and its implementation, organization, and supervision of the program.
1.3.3 The Education Committee of the Program must include a representative from each major Training site.

1.3.4 The Education Committee of the Program must meet regularly, at least 8 times a year, keep minutes and submit them to OMSB.

1.3.5 The Education Committee of the Program must ensure that the goals and objectives of the program are developed and met.

1.3.6 The full functions and responsibilities of the Education Committee of the Program are laid out by OMSB Academic Bylaws.

1.3.7 The Education Committee of the Program must include representation from the Residents in the program.

1.4 Education Committee of the Program Chairman:

There must be an Education Committee of the Program Chairman, who will head the Education Committee of the Program. There must be active liaison between the Program Director and the Education Committee of the Program Chairman.

1.4.1 The Chairman is responsible for overseeing that the Program Director carries out the items described in Article 1.3 of Domain 1.

1.4.2 The Chairman must provide an overall vision of the program.

1.4.3 The Chairman is responsible for submitting all decisions of the Education Committee of the Program and all the
reports of the Program to the Executive President of OMSB and to the appropriate OMSB Departments.

1.4.4 All outbound Education Committee of the Program-related correspondences from the program must go through the Chairman.

1.4.5 The detailed responsibilities of the Chairman are outlined in the OMSB Bylaws.

1.5 Program Director:

There must be a single Program Director responsible for the program. The person designated with this authority is accountable for the operation of the program. He/she must meet the qualifications and documented experience as laid out by OMSB. The Program Director must be assured of sufficient protected time and support to supervise and administer the program. His/her term of office must be adequate to maintain continuity of leadership and program stability, as defined by OMSB.

1.5.1 The Program Director must oversee and organize the activities of the educational program in all institutions that participate in the program. Program Director together with the Education Program Committee, selects the Associate Program Director, supervising trainers and other program personnel at each participating center, and monitor appropriate Resident supervision at all participating centers.

1.5.2 The Program Director is responsible for preparing an accurate statistical and narrative description of the program as required by the OMSB.
1.5.3 The Program Director *must* ensure the distribution of all educational policies and procedures to residents and trainers.

1.5.4 The Program Director *must* ensure the implementation of fair policies, grievance procedures, and due process, including the number of working hours, as established by OMSB and in compliance with its regulations and guidelines.

1.5.5 The Program Director ensures that there are mechanisms to provide career planning and counseling for Residents.

1.5.6 The Program Director is responsible for providing semi-annual feedback/evaluations to the Residents regarding their performance over the respective periods by their Trainers and also the general progress of the Resident in that particular period.

1.5.7 The Program Director ensures that there are mechanisms and available services that will deal with problems that the Residents may encounter.

1.5.8 The Program Director provides an ongoing review of the program to assess the quality of the educational experience and to review the resources available to ensure maximum benefit is being derived from the integration of the components of the program. The opinions of the Residents *must* be among the factors considered in this review. Appropriate Trainer/Resident interaction and
communication must take place in an open and collegial atmosphere so that a free discussion of the strengths and weaknesses of the program can occur without hindrance. This review must include:

i. An assessment of each component of the program to ensure that the educational objectives are being met.

ii. An assessment of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness.

1.5.9 The Program Director must ensure regular and periodic assessment of Trainers and Residents.

1.5.10 The Program Director must seek prior approval of the Education Committee of the Program and OMSB for any changes in the program that may significantly alter the educational experience of the Residents. Such changes, for example, include:

i. The addition or deletion of a participating center.

ii. Any changes in Resident’s complement

iii. A change in the format of the educational program;

1.5.11 The Program Director must obtain approval from the sponsoring institution’s GMEC/DIO before submitting to the ACGME-I information for any changes related to the program.

1.5.12 The Program Director has to ensure an acceptable balance between service and training/education at all participating institutions.
1.5.13 The Program Director *must* monitor duty hours and ensure that schedules are adjusted as necessary to mitigate excessive service demands and/or fatigue.

1.5.14 The Program Director is responsible for verification of Residency education for all Residents even after the Residents have left the program.

1.5.15 The Program Director *should* present progress reports to the Education Committee of the Program and the Chairman. The Chairman *must* get approval of the appropriate OMSB authorities prior to communicating the reports to the Accrediting body.

1.5.16 The Program Director *should* monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged.

1.6 Associate Program Director:

The Program Director will be assisted by Associate Program Directors.

1.6.1 There *should* be an Associate Program Director at each Training Center that the Program uses for required core rotations.

1.6.2 The qualifications are as per OMSB requirements.
1.6.3 He/she has to assist the Program Director, specifically in matters related to that Training Center.

1.6.4 He/she has to be the Resident advocate while representing the Education Committee of the Program.

1.6.5 He/she must be a member of the Education Committee of the Program.

1.7 Sub-Committees:

Each Education Committee of the Program must establish Sub-Committees (as addressed below). Each Sub-Committee must have a Chairman who will provide periodic reports to the Education Committee of the Program about the progress and achievements of the Sub-Committee. The following are the 6 required Sub-Committees:

I. Curriculum
II. Clinical Competency Committee
III. Examination
IV. Program Evaluation Committee
V. Research
VI. Simulation

1.7.1 The Curriculum Sub-committee is responsible for managing and updating the curriculum. The curriculum has to be reviewed at least annually with respect to changing accrediting bodies’ requirements and also be up-to-date with the world literature on resident education.
The Chairman of the Sub-Committee reports to the Program Director, the Chairman, and the Education Committee of the Program. He/she has to give periodic reports to the Education Committee of the Program.

1.7.2 The Clinical Competency Committee (CCC) must be chaired by the Program Director and must consist of at least 3 members from the Education Committee of the Program. Residents are not eligible to join the CCC. This Committee has the following functions:

1.7.2.1 Review all Resident Evaluations,

1.7.2.2 Monitor Resident Progress including: promotion, graduations, dismissal & remediation of residents,

1.7.2.3 Develop intervention strategies for struggling Residents,

1.7.2.4 Provide Career Development strategies for successful residents,

1.7.2.5 Establish and implement Milestones and outcome reporting

1.7.2.6 Ensure Residents meet or exceed requirements for promotion and graduation,

1.7.2.7 Provide input to the Program Evaluation Committee to facilitate curriculum development evaluation effectiveness, and program improvement.
1.7.3 The Examination Sub-committee is responsible for all examinations that are developed or adopted by the Education Committee of the Program. The Sub-Committee Chairman must inform the Residents about the timing and the nature of all examinations involving their Residents.

1.7.4 The Program Evaluation Committee (PEC) must consist of at least 3 members from the Program’s Education Committee of the Program. The Committee should include at least one Resident member. The Committee has the following functions:

1.7.4.1 Planning, developing, implementing, and evaluating educational activities of the program,

1.7.4.2 Reviewing and making recommendations for revision of competency-based curriculum goals and objectives,

1.7.4.3 Addressing areas of non-compliance with ACGME-I standards,

1.7.4.4 Reviewing the program annually using evaluations of trainer & residents,

1.7.4.5 Submit a systemic evaluation of the curriculum at least annually, and is responsible for rendering a written Annual Program Evaluation,
1.7.4.6 The program must monitor and track each of the following areas:

1.7.4.6.1 Resident Performance,

1.7.4.6.2 Trainer Development, Graduate Performance, including performance of the program graduates on the certification examination, Program quality and progress on the previous year’s action,

1.7.4.7 The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as, delineate how they will be measured and monitored- The action plan should be reviewed and approved by the teaching trainer and documented in meeting minutes.

1.7.5 The Research Sub-committee is responsible for facilitating and supervising the involvement of Residents in research and scholarly activities. An environment of inquiry, research and scholarship must be maintained among the Residents and the Trainers, as evidenced by:

1.7.5.1 awarded peer-reviewed grant/funding;

1.7.5.2 publication of original research in peer-reviewed journals and/or publication of review articles or textbook chapters;

1.7.5.3 recognized innovation in medical education and clinical care
1.7.6 The Simulation Sub-Committee is responsible for integrating simulation into the curriculum and also that the required simulation equipment are available and updated.

1.8 Educational Supervisor:

Each training site must have Educational Supervisors.

The Educational Supervisor must:

1.8.1 Oversee the medical education of trainees and ensure that trainees make the necessary clinical and academic progress.

1.8.2 Monitor educational supervision, regular appraisal and feedback on the trainees’ academic and clinical progress.

1.8.3 Maintain the standards of training at each level of trainees.

1.8.4 Develop a learning agreement and educational objectives with the trainee, which is mutually agreeable and is the point of reference for future appraisal. These action plans should be agreed upon by the Program Director or Associate Program Director.

1.8.5 Guide trainees through their program, identifying learning and development opportunities.

1.8.6 Counsel the residents on issues regarding professional conduct.

1.8.7 Follow the OMSB requirements of clinical progress of the residents and make sure that the residents are progressing or receiving remedial support if necessary.
1.9 Trainers:

There **must** be sufficient number of qualified Trainers in a program as specified by OMSB guidelines.

1.9.1 The Trainers **must** undertake the day-to-day clinical and didactic training of Residents under their supervision.

1.9.2 They **must** evaluate their Residents on a regular basis at the end of each rotation.

1.9.3 They **should** give feedback to the Residents midway in the rotation and at the end of each rotation and as required.

1.9.4 The Trainers **must** be evaluated by the Residents at the end of each rotation.

1.9.5 The Trainers **must** be evaluated by the Program Director and Chairman.

1.9.6 The Trainers **should** receive their evaluation feedback from the Program Director and Chairman, and they are also given a summary of their evaluation conducted by the residents.

1.9.7 The Trainers **must** attend the required Trainer development workshops conducted by OMSB.

1.9.8 The Trainers **should** participate in the educational activities and other activities of the program.
1.9.9 The *Trainees must demonstrate at least 1 piece of scholarly activity per year, averaged over 5 years by one or more of the following:

(*Specific requirements for Core Trainer and Trainer are written in the Appendix.)

1.9.9.1 awarded peer-reviewed grant /funding;

1.9.9.2 publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

1.9.9.3 publication or presentation of case reports or peer-reviewed educational seminars, or clinical series at local, regional, national, or international professional and scientific society meetings; or,

1.9.9.4 participation in national or international committees or educational organizations.

1.10 Resident Appointments

1.10.1. Eligibility Criteria

    Resident’s eligibility must comply with the criteria for resident eligibility as specified by OMSB Requirements.

1.10.2. Number of Residents

    The program’s educational resources must be adequate to support the number of residents accepted to the program. There should be at least three residents in each year of the program unless otherwise specified by the specialty.
1.10.3. Resident Transfers

1.10.3.1. Resident Transfers *must* be according to OMSB Academic ByLaws/Guidelines.

1.10.3.2. A program director *must* provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

1.10.4. Acceptance of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties and subspecialty fellows) in the program *must* not interfere with the program’s own residents’ education. The program director *must* report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.
DOMAIN 2: STRUCTURE AND ORGANIZATION

STANDARD P.2: The program *must* be organized such that the educational experiences including mandatory and elective rotations are designed to provide Residents with the opportunity to fulfill the educational requirements and achieve the targeted competency in their specialty.

INTENTION: This standard describes the requirements for the Program structure and organization to comply with the demands of the Curriculum and its Syllabus. It covers the structures and support to acquire the necessary skills and experience through effective supervised educational training, and support available to Residents.

ACCOUNTABILITY: Chairman of the Education Committee of the Program, Residency Program Director; Education Committee of the Program & its Members and Trainers.

AFFIRMATION: The Curriculum; Education Committee of the Program Meeting Minutes and Data; Training Centers Documents; Annual Report of the Program, Evaluations, quality management data, and survey visits.
BASIC MANDATORY QUALIFICATIONS:

2.1 The program *must* provide all the components of training outlined in the specialty documents e.g. Goals and Objectives; General requirements and Specific requirements of the Specialty Accreditation.

2.2 The program *must* be organized such that Residents are given graded professional responsibility, under appropriate supervision, according to their level of training, ability, and experience.

2.3 The program *should* allow the Residents to perform their activities at a desired level according to their ability, without direct supervision. This is referred to as Entrustable Professional Activity (EPA). Trainers *should* be able to decide when a Resident may be trusted to bear responsibility to perform a professional activity, given the level of competence he/she has reached. Thus, the EPAs *should* be awarded for the purposes of both education and patient care.

2.4 The program *must* monitor and evaluate the routine professional activities of the Residents based on their specialty and subspecialty.

2.5 The Trainers *must* guide the Residents as they entrust them with the performance of their professional activities (EPAs), from history taking through physical examination, to outcome of their management.
2.6 The program must guide the Residents as they entrust them with communication with the patient and their families about the management plan, in a way that they understand, based on cultural background and health literacy.

2.7 Under appropriate Trainer supervision, each Resident must assume the role of a senior Resident as per OMSB guidelines.

2.8 Service responsibilities, rotations, and on-call duties, must be assigned in a manner that ensures the Residents are able to attain educational objectives.

2.9 Service demands must not interfere with the ability of the Residents to follow the academic program.

2.10 The program must provide an equal opportunity to Residents to take advantage of those elements of the program that are best suited for his/her educational needs.

2.11 The program should provide an adequate opportunity for Residents to pursue elective educational experiences; if possible, an elective abroad is preferred.

2.12 The role of each site used by the program must be clearly defined. There must be an overall plan which specifies how each component of the program is delivered by the participating sites.
2.13 Teaching and learning **must** take place in an environment which promotes Resident safety, free of intimidation, harassment and abuse.

2.14 During Training, the Education Committee of the Program **should** also concern itself to the general well-being of the Residents.

2.15 An environment of inquiry, Research and scholarship **must** be maintained in the program.

2.16 The program **should** encourage the Residents to participate in Quality Management activities.

2.17 Trainers **must** exercise the responsibility of providing high quality, ethical patient care and excellent teaching.

2.18 There **must** be an experience-based learning process, which provides training in collaboration with other disciplines for optimal patient care.

2.19 Postgraduate training **must** include participation of Residents in all medical activities relevant to the specialty training, including on-call duties.

2.20 The training program **must** be structured for the Residents to attain the Medical Competencies. (See Appendix I)
DOMAIN 3: RESOURCES

STANDARD P.3: The Program and the Training Centers must allow for sufficient resources including sufficient number of Trainers and variety of patients, for the respective specialty/subspecialty. There should be facilities and services at the Training Center necessary to provide the opportunity for all Residents in the program to achieve the educational objectives and fulfill the training requirements as defined by the specialty.

INTENTION: This standard addresses physical, technical and supporting resources required for the training of the Residents. These will include appropriately qualified Trainers as well as educational capacity of the Training Centers.

ACCOUNTABILITY: Trainers, Training Centers, Scientific Committee leaders and members, PGMEC, GMEC and OMSB for the Academic Resources.

AFFIRMATION: Internal and External Evaluations, surveys & Site visits, minutes and communications of relevant committees.
BASIC MANDATORY QUALIFICATIONS:

3.1 At each Training Center, there must be a sufficient number of Trainers with documented qualifications acceptable to OMSB and other resources as defined by the program to adequately instruct and supervise the Residents in the program.

3.2 The Education Committee of the Program Chairman and Program Director should all be qualified in their specialty with a recognized postgraduate degree and should have adequate experience both in the clinical and educational fields.

3.3 The total number of Trainers must be of adequate ratio to the number of trainees. (The current expected ratio for all Trainers to Resident is 1:1 and for Core Trainers to Resident is 1:6, and this may change with time.)

3.4 The clinical training opportunities, supervisory capacity by the Trainer and other resources available must be adequate for the total number of trainees in order to ensure quality training and teaching.

3.5 The Trainers must spend sufficient time to the educational program to fulfill their teaching responsibilities towards the trainees and show strong interest in the education of the trainees. They must also support the goals and objectives of the rotations and the program.
3.6 The Trainers must be qualified to train with the following as examples of qualifications needed:

3.6.1 Must possess a requisite specialty expertise and competence in clinical care and teaching abilities, as well as educational abilities and experience in their field.

3.6.2 Must possess qualifications judged to be acceptable by the OMSB. The trainer should be certified in his / her speciality, well-trained and has adequate experience.

3.6.3 Must be in good standing and clinically privileged at the Training Center participating in the program.

3.7 The Trainers must be responsible for establishing and maintaining an environment of inquiry and scholarship.

3.8 Required qualifications of the Non-Physician Trainers include the following:

3.8.1 Must be qualified in their field.

3.8.2 Must possess appropriate institutional appointment if using the Training Centers.
3.9 The necessary professional, technical, and secretarial staff _must_ be provided to support the program, and they _must_ have the appropriate training and qualifications as per their respective professional standards.

3.10 All Trainers _must_ be adequately evaluated:

3.10.1 prior to their appointment, and,

3.10.2 thereafter, at least annually and as per OMSB guidelines.

3.11 Trainers have to show evidence of Continuous Professional Development (CPD) and keep up with Continuous Medical Education (CME).

3.12 The Training Center _must_ provide facilities to encourage CME and CPD activities for the Trainers.

3.13 The number and variety of patients and supporting services available to the program on a consistent basis _must_ be sufficient to meet the educational needs of the Residents and provide appropriate experience for the specialty or subspecialty.

3.14 Clinical services and other resources used for teaching _must_ be organized to achieve their educational objectives.

The organization of patient care may be different in a setting where teaching and education take place.
3.14.1 All resources used for teaching must be organized according to the following general principles:

3.14.1.1 There should be an integration of teaching resources to include exposure to emergency, ambulatory, and community experiences.

3.14.1.2 Learning environment must include experiences that facilitate the acquisition of knowledge, skills, and attitudes relating to aspects of age, gender, culture, and ethnicity appropriate to the specialty or subspecialty as well as other training requirements in the area of focused competence.

3.14.1.3 There should be opportunities for Residents to acquire the relevant knowledge to understand and prevent adverse patient events.

3.15 There must be easy access to a major medical library either at the medical school or through a major hospital library or OMSB Library. There should also be access during evenings and weekends to the library or to a collection of appropriate reference texts and journals.

3.16 There must be appropriate access to computers and facilities for information management, on-line references and computer searches.
3.17 The Residents must have access to facilities for production of presentations and manuscripts.

3.18 The physical and technical resources available to the program must be adequate to meet the needs of the program as outlined in the Competency-based Training Requirements and “Specific Standards” of accreditation for a program in the specialty or subspecialty.

3.19 Supporting facilities and services must be available as outlined in the “Specific Standards” of accreditation for programs in the specialty or subspecialty. In addition:

3.19.1 Clinical services heavily committed to the care of seriously ill and injured patients must be supported by intensive care units organized for teaching.

3.19.2 All consultative, diagnostic and laboratory services necessary for patient care must be available.

3.19.3 The facilities available to programs in clinical specialties or subspecialties must include an emergency department with an adequate number and variety of patients presenting urgent problems in the discipline. Each resident must have opportunities, under appropriate supervision, to provide an initial assessment and consultative service to patients with emergency conditions.
3.19.4 In all clinical specialties and subspecialties, ambulatory care facilities must be available to provide Residents with experience in the care of the broad range of non-hospitalized patients seen in the specialty or subspecialty.

This experience should include, but not limited to, work-up of new patients, pre-admission work-up and post-discharge follow-up care.

3.19.5 A major portion of each Resident’s training should take place in sites in which there are other accredited programs relevant to the specialty or subspecialty.

“Education is not a preparation for life… education is life itself.”
DOMAIN 4: EDUCATIONAL PROGRAM

STANDARD P.4A: GOALS AND OBJECTIVES

The Goals of the program must be clearly stated and the Objectives must be competency-based.

The Goals and Objectives must be directed towards producing a competent physician able to undertake a comprehensive medical practice, in keeping with the needs of the community and the health care system of the country.

INTENTION: To have every program declare its Goals and Objectives and this should reflect its mission and vision. To describe and ensure the practice-based training process resulting in a competent medical specialist who can practice medicine unsupervised and professionally, either alone or in a team.

ACCOUNTABILITY: Residency Education Committee of the Program, its Chairman, Program Director and members; Trainers, and OMSB Academic Affairs Department.

AFFIRMATION: The Curriculum and its Syllabus; Test Results and Assessment reports; Post-graduation surveys of Residents, Internal and External Review Reports.
BASIC MANDATORY QUALIFICATIONS:

4A.1 Goals and objectives of the educational program must be structured to reflect the desired competencies (see Appendix I).

4A.2 There must be specific educational objectives with respect to knowledge, skills, and attitudes for each rotation or other educational experience. These must be reflected in the planning and organization of the program.

4A.3 All Residents must receive a copy of the goals and objectives when they join the program and then annually.

4A.4 At the beginning of each Rotation, individual learning strategies to meet the objectives of that rotation must be jointly discussed between the Trainers and the Resident, and if necessary tailored slightly to meet the specific needs of the Resident.

4A.5 All Trainers in the program must receive a copy of goals and objectives of the program and of their respective specialty annually.

4A.6 The goals and objectives must be reviewed and updated periodically by the Education Committee of the Program as appropriate. In this process, Trainers and Residents should be involved.

4A.7 The Goals and Objectives must be in-line with the mission of OMSB and reflect the interest of the principal stakeholders.
STANDARD P.4B: CURRICULUM

The contents of the curriculum, the extent and sequence of both practical and didactic components, must be described in sufficient and clear details. The curriculum must enable trainees to achieve the required Competencies and the learning outcomes. Didactic and clinical education must have priority in the allotment of residents’ time and energy.

INTENTION: This standard sets the basic requirements for the Program Curriculum and its Syllabus to meet internationally-accepted standards.

ACCOUNTABILITY: Chairman, Residency Program Director, Education Committee of the Program Members and Trainers, and OMSB Internal Review Committee.

AFFIRMATION: The Curriculum; Education Committee of the Program Meeting Minutes and Data; Master Rotation Schedules; Calendar of Academic Activities, Training Centers Documents; and Annual Report of the Program.
BASIC MANDATORY QUALIFICATIONS:

4B.1 All curricular elements must be clearly stated including the balance between the core and optional content. They must be detailed and include specific learning outcomes regarding knowledge, skills and professional attitudes and behaviors.

4B.2 Basic and clinical sciences must be integrated in the curriculum.

4B.3 The curriculum must contain a detailed description of the methods of teaching, supervision, assessment and feedback.

4B.4 The curriculum must include a didactic program based upon the core knowledge content and areas defined as resident outcomes in the specialty. Scheduled didactic sessions, including but not limited to:

   a. lectures
   b. case-based planned didactic experiences;
   c. grand rounds
   d. morbidity and mortality conferences;
   e. multidisciplinary conferences;
   f. journal club or evidence-based reviews;
   g. clinical audit / peer reviews
   h. seminars and workshops to meet specific competencies;

4B.5 In addition to the Goals & Objectives, the curriculum must clearly state the linkages to all the stages of the trainees’ training and education.
4B.6 The curriculum must describe the appropriateness of each stage of learning to the specialty of that program.

4B.7 The curriculum must contain Graded Responsibility for Residents as an integral part of education. The program should be able to train residents to be more proficient and entrusted with more complex or critical task, requiring less supervision.

4B.8 Methods of Assessment must be described with explanations and where needed with examples.

4B.9 The curriculum must be competency-based and must contain all major topics of the specialty or subspecialty over the course of each Resident’s training period.

4B.10 There must be evidence in the curriculum indicating the teaching of health promotion and preventive medicine and rehabilitation where appropriate for that specialty.

4B.11 The curricular elements should contain teaching of alternative and traditional medicine.

4B.12 The program should provide detailed components of the Curriculum as per the following OMSB Curriculum Guidelines:
4B.12.1 **Training Program:**

a. Aims & Objectives  
b. Duration of the Residency Training Program  
c. Rotation Outlines, Objectives & Goals  
d. Graded Responsibility for Each Training Year  
e. OMSB Competencies  
f. Academic Activities/Teaching Methods  
g. Examination Requirements  
h. Logbook/Portfolio  
i. Assessment and Progression  
j. Quality Assurance  
k. Research Requirements  
l. Evaluation of Program Effectiveness  
m. Curriculum Management  

n. Integration of Simulation Methods in Training as appropriate

4B.12.2 **Residents**

a. Admission Criteria  
b. Number of Resident Posts Available Annually  
c. Support Services  
d. Learning Environment
4B.12.3  **Trainers**

   a. Number/Members of the Teaching Trainer
   b. Qualifications and Functions

4B.12.4  **Educational Resources**

   a. Training Center Facilities & Resources
   b. Clinical Teaching Facilities
   c. Information Resources and Library Services
   d. Academic Environment
STANDARD P.4C: SCHOLARLY ACTIVITY

All Programs must maintain an educational environment of inquiry and scholarship and show evidence of Scholarly Activities in the program. The curriculum must advance residents’ knowledge of the basic principles of research and of Quality Assurance. It must also prepare Residents for lifelong self-directed learning and Professional development.

INTENTION: This standard sets the requirements for a program to incorporate scholarly activities including research, Quality Assurance and Self-directed learning in their curriculum.

ACCOUNTABILITY: Chairman, Program Director, members of the Program Education Committee, Trainers, OMSB Research Department, and OMSB Quality Assurance Department.

AFFIRMATION: The Curriculum; Education Committee of the Program Meeting Minutes and Data; Master Rotation Schedules; Calendar of Academic Activities; Research Department workshop schedule; Quality Assurance Department records for Program and OMSB Research Day; Committee for Quality Improvement Projects of Residents, and Annual Report of the Program.
4C.1 Each program must have general and specific scholarly activities organized for residents and as per OMSB Guidelines on Scholarly Activity.

4C.2 General scholarly activities must include, but not limited to, organized clinical discussions, Rounds, Journal clubs, Lectures/Seminars/Conferences, Workshops, E-learning activities, and Courses.

4C.3 Specific scholarly activities must include Research projects and Quality Improvement/Patient Safety (QI/PS) projects.

4C.4 The Program Education Committee must ensure that each Resident participates in a specific scholarly activity.

4C.5 The OMSB and the program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

4C.6 To fulfill the Research Project requirement, the Research Department of OMSB and the Program Education Committee must ensure that the Resident receives adequate training in basic principles of Research.
4C.7 To fulfill the QI/PS Project requirement, the Quality assurance Department of OMSB and the Program Education Committee of the program must ensure that the Resident receives adequate training on the concept of Quality Assurance.

4C.8 The Program Education Committee must ensure residents’ completion of research and (Quality Improvement/ Patient Safety) projects prior to graduation.

4C.9 The Program Education Committee must ensure that Residents and their Supervisors provide evidence of achievement of Scholarly Activities.

4C.10 Residents must be given an opportunity to pursue scholarly activities as dictated in the OMSB Guidelines

4C.11 The Residents must be encouraged to participate in research activities and other scholarly activities.
DOMAIN 5: PATIENT SAFETY

STANDARD P.5: The program must promote a culture of patient safety and give high priority to train the Residents to attain satisfactory level of patient safety and the safety of other health professionals. The program must be committed to promoting patient safety.

The Safety Competencies are defined as Enhancement of Patient Safety across the Health Professions, adopting the patient safety in education, and continuing professional development activities.

INTENTION: The standards in this Domain set the minimum organizational & management requirements for patient safety competencies of Residents and build safety competencies for health care professionals.

ACCOUNTABILITY: OMSB Vice-President for Academic Affairs, Education Committee of the Program Chairman, Program Director, Associate Program Directors, Education Committee of the Program Members, Trainers, Residents, and Training Centers authorities.

AFFIRMATION: Education Committee of the Program Meeting Minutes, Internal Review Committee surveys and Reports, core program committee minutes and reports, Training Centers’ quality assurance reports, and minutes of the meetings with the Trainers.
BASIC MANDATORY QUALIFICATIONS:

5A: CONTRIBUTION TO A CULTURE OF PATIENT SAFETY

5A.1 Residents must be able to commit to patient and health care providers’ safety through safe, competent, high-quality daily practice.

5A.2 Residents must be able to apply the fundamental elements of patient safety in their daily practice.

5A.3 Residents must be able to maintain and enhance patient safety practices through ongoing learning.

5A.4 Residents should be able to demonstrate a spirit of enquiry as a fundamental aspect of professional practice and patient safety.

5B: TEAMWORK FOR PATIENT SAFETY

5B.1 Residents must be able to participate effectively and appropriately in a health care team to optimize patient safety.

5B.2 Residents should be able to meaningfully engage patient as a participant in their health care teams.

5B.3 Residents must be able to appropriately share authority, leadership, and decision-making.
5B.4 Residents *should* work effectively with other health care professionals in managing professional conflicts.

5B.5 Residents *must* be involved with their Trainers in disclosing medical errors.

5C: EFFECTIVE COMMUNICATION FOR PATIENT SAFETY

5C.1 Residents *must* be able to demonstrate effective verbal and non-verbal communication skills in an effort to prevent adverse events.

5C.2 Residents *must* be able to communicate effectively in high-risk situations to ensure the safety of patients.

5C.3 Residents *must* use effective written communications for patient safety.

5C.4 Residents *must* apply approved communication technologies appropriately and effectively to provide safe patient care.

5D: SAFETY RISKS MANAGEMENT

5D.1 Residents *must* be able to anticipate high-risk situations so that they can learn to manage it appropriately and prevent recurrence.

5D.2 Residents *must* be able to recognize situations and settings in which safety hazards and risks may arise.
5D.3 Residents must be able to systematically identify, implement, and evaluate context-specific safety solutions.

5E: OPTIMIZATION OF HUMAN AND ENVIRONMENTAL FACTORS

5E.1 Residents must be able to identify the environmental factors that can affect human performance in health care setting.

5E.2 Residents should learn critical-thinking techniques in developing safety decisions.

5E.3 Residents must be able to appreciate the impact of the human and technology interface in the deliverance of safe care.

5F: MANAGEMENT AND DISCLOSURE OF ADVERSE EVENTS

5F.1 Residents must be able to recognize the occurrence of an adverse event or a close call/near miss.

5F.2 Residents must be able to mitigate harm and address immediate risks for patients and others affected by adverse events.

5F.3 Residents must learn to report the occurrence of an adverse event or close call/near miss.
5F.4 Residents *must* be able to disclose the occurrence of an adverse event to the patient and/or their families as dictated by medical ethics and relevant legislation.

5F.5 Residents *must* participate in timely event analysis, reflective practice, and planning for the prevention of adverse recurrence.

5F.6 The Residents *must* be trained context-specific adverse events management.

“Quality is… for everybody that is involved”
DOMAIN 6: TRAINING SUPERVISION

STANDARD P.6: Each Training Program must use a clear set of Supervision Standards, direct and indirect, scholarly or clinical, relevant to that particular specialty. Trainers and Residents must understand the various levels of Supervision relevant to the graded responsibility that a Resident may ultimately achieve and be granted Entrustable Professional Activities (EPAs), keeping in mind their responsibility to the patient, the community and the society at large.

INTENTION: To provide all aspects and levels of quality education supervision during residency training.

ACCOUNTABILITY: OMSB Education Committee of the Program Members, Trainers, and Educational Supervisors, Training Centers.

AFFIRMATION: Evaluation reports of Residents, Trainers, Rotations, Program and Survey Reports & Minutes of Education Committee of the Program meetings.
BASIC MANDATORY QUALIFICATIONS:

6A. Responsibilities of the Program:

6A.1 Educational supervision must include supervision of clinical, and non-clinical competencies, for example, research, teaching and other scholarly activities.

6A.2 The program must ensure that the appropriate level of clinical supervision is in place for all residents caring for patients.

6A.3 The program must clearly document in the curriculum the level of supervision needed at various stages of training and responsible supervisors.

6A.4 The program must ensure that qualified trainers are assigned for appropriate supervision of residents in specific patient care activities.

6A.5 The program must set guidelines for circumstances and events in which residents must communicate with appropriate supervising trainers.

6A.6 The Program must ensure an environment whereby Residents can raise problems or the concerns they have without fear of intimidation or fear of retaliation.
6A.7 In the clinical learning environment, each program must use appropriate forms of supervision. These include the following:

6A.7.1 **Direct supervision:** The supervising physician is physically present with the resident and patient.

6A.7.2 **Indirect supervision:** The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.

The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

6A.7.3 **Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6A.8 The Program must provide the resident quality clinical supervision through:
6A.8.1 Orientation:

6A.8.1.1 Every resident starting a new Rotation must be oriented by the Rotation Supervisor, verbally and by accompanying documents.

6A.8.1.2 The orientation must include explanation and Review of the Goals and Objectives of the rotation, the residents’ duties, reporting arrangements, their teamwork role, and workplace / department policies.

6A.8.1.3 The Educational Supervisor (or representative) must discuss with the Resident the educational Framework and support systems in the Rotation and the respective responsibilities of Resident and Trainers for learning.

6A.8.2 Clinical Supervision:

6A.8.2.1 The Resident must be provided with the contact details of the designated Clinical Supervisor.

6A.8.2.2 The Resident should have a “logbook” and/or a “learning portfolio” relevant to the specialty program.

6A.8.2.3 The Resident must receive regular feedback with respect to the entries in the logbook and/or portfolio.
6A.8.2.4 The Resident must receive feedback at the middle of and end of the rotation.

6A.8.2.5 There must be a review of progress and appraisal at the end of each Rotation, and the appraisal must be communicated to the Program Director.

6A.8.2.6 The Resident must be given an opportunity to give feedback about the Training without fear of repercussion and intimidation. Confidentiality must always be maintained.

6A.8.2.7 The Training Program must ensure that the Residents are supervised to ensure that they are not subjected to or subject others to any behaviour that undermines their professional confidence or self-esteem.

6A.8.2.8 The Resident must have access to career advice and support.

6A.8.2.9 The Resident should have a mentor during the duration of the Residency.

6A.8.2.10 The Resident must receive information on the support system available for Residents in difficulty.
6A.8.3 Training Educational Environment:

6A.8.3.1 The Resident must be supervised directly or indirectly under all circumstances, for example during Operating Sessions, Ward Rounds and Outpatient Clinics.

6A.8.3.2 The Training Programs should include supervised rotations which are long enough to meet with the objectives of the rotation, and in keeping with the program requirements and OMSB Guidelines.

6A.8.3.3 The Training Program must ensure that the Residents should make the needs of their patients their first concern, while maintaining the balance between service demands and their educational requirements.

6A.8.3.4 The Training program must ensure that the Residents are supervised while being involved in clinical audit, including planning, data collection and analysis.

6A.8.3.5 The Training Program must ensure that the Residents are under supervision while being trained in non-medical expert core competencies at all stages in their development.

6A.8.3.6 The Training Program must ensure that the Residents have appropriate supervision when they are learning from other healthcare professionals.
6A.8.3.7 The Training Program must provide information to the Residents about regulations about Training Interruptions and Re-Joining Policy.

6A.8.3.8 The Training Program must provide access and oversight to confidential counselling services for the Residents.

6A.8.4 Academic Activities:

6A.8.4.1 The Residents must be made aware of and be supervised during academic activities, available in their program.

6A.8.4.2 The Residents should be encouraged and receive additional guidance in the endeavours that they have particular skills in, and aptitude for, during their Training.

6A.8.4.3 Specialty Residents who are interested in academic path should receive guidance regarding academic career pathway.

6A.8.5 Duty Hours:

6A.8.5.1 Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled.
activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

a.) Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

b.) Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of in-house call.

c.) After in-house call, a Resident should have a minimum of 10-hour time rest.

6A.8.5.2 Duty hours should be appropriate for learning, with appropriate supervision, and in accordance with the OMSB Guidelines.

6A.8.5.3 Duty hour assignments must recognize that trainers and residents collectively have responsibility for the safety and welfare of patients.

6A.8.6 On-call Activities:

6A.8.6.1 In-house call must occur no more frequently than every fourth night, averaged over four-week period.
6A.8.6.2 Continuous on-site duty, including in-house call, **must not** exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

6A.8.6.3 Residents **should not** accept any new patients after being on continuous duty for 24 hours.

6A.8.6.4 At-home call (or pager call)

a) The frequency of at-home call is not subject to the every-fourth night, or 24+6 limitation. However, at-home call must not be so frequent as to preclude the rest and reasonable personal time for each resident.

b) Residents taking at-home call **must** be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

6A.9 The Program **should** define the competencies that a Resident **must** possess to be supervised indirectly.
6B. Responsibilities of the Trainers:

6B.1 The Trainers must understand the structure and purpose of, and their role in, the training program of their designated trainees.

6B.2 The Trainers supervising residents should delegate part of their patient care to the training of Residents.

6B.3 The Trainers supervision should be of sufficient duration to assess the knowledge and skills of the resident.

6B.4 As part of supervision, the Trainers should delegate appropriate level of patient care authority and responsibility to the Residents.

6B.5 The Trainers must provide graded supervision appropriate to the competence and experience of the Resident and decide on awarding EPAs to the Residents as deemed appropriate.

6B.6 The Trainers must participate in, and contribute to, the learning culture in which patient care and training occur.

6B.7 The Trainers must be supported in their role by their Education Committee of the Program and have suitable job plan with an appropriate workload and sufficient time to train, supervise, assess and provide feedback to the Residents.
6B.8 The Trainers and Residents *should* inform patients of their respective roles in the patient’s care.

6B.9 The Program Director and Trainers *must* assign graded responsibility in patient care and EPAs to each Resident.

6B.10 The Program Director and Trainers *must* ensure that there is a process to deal confidentially with problems or concerns Residents may have.

6C. Responsibilities of the Residents:

6C.1 Senior Residents *must* seek opportunities to serve in a supervisory role of junior residents.

6C.2 Timely communication between the Residents and appropriate supervisors *must* take place in situations of significant importance, such as, the transfer of a patient to an intensive care unit, or end-of-life decisions.

6C.3 The Residents and their Trainers *must* be acutely aware of the signs of fatigue and sleep deprivation and *must* adopt and apply policies to prevent and counteract potential negative effects on patient care and on learning.

6C.4 The Residents *must* acknowledge and accept their limits and authority under various circumstances of clinical care in which they can act with conditional independence.
DOMAIN 7: COMPETENCE-TARGETED TRAINING

STANDARD P.7A: TRAINING COMPONENTS

The clinical, academic and scholarly content of the program must be appropriate for an OMSB postgraduate education and training. It should adequately prepare Residents to attain the required level of OMSB recognized competencies and fulfill all of the roles of the specialist.

INTENTION: This standard addresses the training requirements for the Residents to achieve the OMSB medical competencies. It describes role-specific components of the training.

ACCOUNTABILITY: Education Committee of the Program, Trainers, and Residents.

AFFIRMATION: Evaluations from various rotations and results from didactic learning sessions, other patient care experiences, Research Projects reports, Residents’ feedback, examination results, Education Committee of the Program minutes, and reports of any external and internal Reviewers.
BASIC MANDATORY QUALIFICATIONS:

7A.1 The Program **must** ensure development of knowledge, skills, attitudes and personal attributes to attain the minimum satisfactory level of the various competencies expected by OMSB.

7A.2 In residency education, most time **should** be devoted to the role of the Medical Expert; however, the program **must** ensure that adequate time **must** be devoted to each of the other roles – the depth of training for the various competencies will vary among the specialties, depending on the degree of relevance of a particular competency for their specialty.

7A.3 Each program **must** assure that Residents achieve the objectives of training as outlined in the documented “Objectives of Training” and the “Specialty Training Requirements.”

7A.4 The following requirements **must** be fulfilled for each of the following medical competencies as outlined below:

7A.5 **Medical Knowledge**

7A.5.1 There **must** be effective teaching programs in place for Residents to acquire the medical expertise and decision-making skills to act as a consultant.

7A.5.2 There **must** be effective teaching in place to ensure that residents learn to consult with other physicians and health care professionals to provide optimal care of patients.
7A.5.3 There **must** be an organized teaching in the basic and clinical sciences relevant to the specialty or subspecialty.

7A.5.4 Teaching of Residents **must** be patient-centered including didactic components.

7A.5.5 Teaching **must** include issues of age, gender, culture, ethnicity, and end-of-life issues as appropriate to the discipline.

7A.5.6 Teaching **should** include essential aspects of alternative and traditional medicine.

7A.5.7 There **must** be an effective teaching to translate, promote and monitor health safety in the clinical setting including protection of the public, patients, colleagues, and oneself from infection and all other health hazards in the hospital setting as well as independent practice.

7A.5.8 The Program **must** provide adequate supervision and guidance to the Residents to allow them to provide and coordinate patient care, as they progress toward independent practice.

7A.5.9 The Program **must** provide adequate and comprehensive training to the Residents that they will demonstrate increasing knowledge, understanding and application appropriate to the level of training - putting the patient at the center of their practice by:
7A.5.9.\(i\) obtaining an appropriate and relevant history, identifying the main findings, carrying out an appropriate physical and mental health examination, and identifying possible differential diagnosis taking into consideration the relevant physical, psychological, and social factors involved.

7A.5.9.\(ii\) requesting appropriate investigations to confirm the clinically suspected diagnosis, considering treatment options using evidence-based medicine.

7A.5.9.\(iii\) obtaining patient’s informed consent as guided by medical ethics.

7A.5.9.\(iv\) involving patients in making decisions on their immediate and long-term care.

7A.5.9.\(v\) learning to prescribe medicines, including controlled drugs, safely and effectively with clear explanation to patients.

7A.5.9.\(vi\) learning to perform core clinical and procedural skills safely and keeping accurate and clear clinical records that can be easily understood by colleagues.

7A.5.10 The Program \textbf{must} train the Residents to manage acutely ill patients and resuscitate patients whenever it becomes necessary.
7A.5.11 The Program **must** teach the Residents how to recognize misconduct.

7A.6 **Interpersonal and Communication Skills**

7A.6.1 The Program **must** ensure that there is adequate training in communication skills to enable Residents to effectively:

7A.6.1. *i* interact with patients and their families, colleagues, students, and co-workers from other disciplines to develop a shared plan of care.

7A.6.1. *ii* ensure that the Resident **must** learn to write consultation letters and patient records.

7A.6.1. *iii* communicate the plan of care using new information technologies and other electronic tools.

7A.6.2 The Program **must** ensure that the Residents are trained to effectively facilitate a dynamic doctor-patient relationship before, during, and after the medical encounter through:

7A.6.2. *i* appropriate use of language verbally and non-verbally, e.g. tone of voice, eye contact, gesture, silence, etc.

7A.6.2. *ii* attentive (active) listening without interrupting and humanly responding to all perceptual cues without being demeaning or insulting.
7A.6.2.iii different communication styles such as text, graphics, video, and audio to express ideas and facilitate understanding.

7A.6.3 The Program **must** train the Residents to use their Expertise to encourage and support patients to be involved in their own care. Residents **should** be aware that carers, supporters and advocates (who speak on behalf of patients) often have to be included in the information given to patients.

7A.6.4 The Program **must** train the Residents in demonstrating effective communication with people, both individually and in groups, including people with learning disabilities.

7A.6.5 The Program **must** train the Residents that they demonstrate sensitivity and be able to respond to the needs and expectations of patients taking into account the patient’s age, culture, religion or beliefs, or social or economic status.

7A.6.6 The Program **must** train the residents to avoid confrontation style of communication with the patients and or relatives and consult the seniors when needed.

7A.6.7 The Program **should** be innovative in teaching the Residents how to communicate in difficult situations i.e. breaking bad news, end-of-life care and “Do-Not-Resuscitate” procedure.

7A.6.8 The Program **must** ensure that there is effective teaching and development of “Interpersonal and Communication skills” to enable Residents:
7A.6.8.i to work effectively and appropriately with all Member of the inter-professional healthcare team in patient care, in research, in community health-related matters, etc.

7A.6.8.ii prevent, negotiate, and resolve inter-professional conflict.

7A.6.9 The Program **must** teach the following three essential competencies for effective collaboration in “Healthcare team”:

7A.6.9.i The Residents **should** recognize their own roles and responsibilities, and respect the diversity of others’ roles.

7A.6.9.ii The Residents **should** be taught the components and features of an effective collaborative team work.

7A.6.9.iii The Residents **should** learn to demonstrate leadership skills within healthcare teams as appropriate to their level.

7A.6.10 The Program **must**, over the course of the training of Residents, teach the competency of collaboration with medical or other professionals to achieve a common goal.

7A.6.11 The Program **must** develop and maintain a collaborative culture that routinely practices the essential features of collaboration including preventing and managing conflicts.
7A.6.12 The Program *should* use the TARGETED incremental approach to facilitate the residents acquisition of the interpersonal skills and communication competency i.e. specify two or three rotations during the junior and senior years where the interpersonal and communication skills are specifically taught.

7A.6.13 The interpersonal and communication skills *must* be taught formally (e.g. didactic lectures or small group discussions) and informally (bedside or during hand-over). Each program *should* utilize all teaching opportunities within its own context.

7A.6.14 The Program *should* adopt an appropriate teaching strategy for collaboration that matches its context and objectives, e.g. formative feedback, probing questions, Trainer role modeling etc.

7A.6.15 The interpersonal and communication skills *must* be taught along the continuum of patient care hence each stage of care requires a different set of collaborative skills i.e. those related to healthcare teamwork and those related to preventing and managing conflicts.

7A.7 Systems-Based Practice

7A.7.1 The Program *must* ensure that Residents participate in activities that contribute to the effective management of their healthcare organizations and systems.
7A.7.2 The Program **must** ensure that Residents are able to effectively manage finite healthcare resources in the most cost-effective way.

7A.7.3 The Program **must** provide effective teaching to the Residents for successful management of their practice and development of their career.

7A.7.4 The Program **must** provide opportunities for Residents to serve in administration and leadership roles, as appropriate to the specialty.

7A.7.5 The Program **should** use the TARGETED incremental approach to facilitate the residents' acquisition of the manager competency throughout their training.

7A.7.6 The Program **should** provide opportunity to the Residents to participate in management of community health-related affairs.

7A.7.7 The Program **must** ensure that the Residents are taught efficient patient management and scheduling.

7A.8 **Patient Care**

7A.8.1 The Program **must** ensure that Residents are able to respond to individual patient health needs and issues as part of patient care based on cultural understanding.
The Program must ensure that Residents are able to identify and understand the health needs of the communities that they serve.

The Program must ensure that Residents are able to understand and promote the health of individual patients, communities and populations.

The Program must ensure that the Residents are trained to participate in activities related to community health.

The Program must train the Residents on how to identify opportunities for advocacy, health promotion and disease prevention in the communities that they serve, and learn to respond appropriately.

The Program must train the Residents on how to identify the determinants of health of the populations, and barriers to healthcare access.

The Program should educate the Residents on how to identify vulnerable and marginalized populations within those they serve and to respond appropriately.

The Program should train the Resident on addressing patient safety to the community.
7A.8.9 The Program *should* train the senior Residents to teach and assess students and other colleagues how to get involved in patient and community health needs as part of their health advocacy training.

7A.9 Practice-Based Learning and Improvement

7A.9.1 The Program *must* ensure that there are opportunities for Residents to develop effective teaching skills by teaching junior colleagues and students, as well as through conference presentations, clinical and scientific reports, and patient education.

7A.9.2 The Program *must* ensure that there is effective teaching in the critical appraisal of medical literature using knowledge of research methodology, scientific data, evidence-based medicine, and biostatistics.

7A.9.3 The Program *must* ensure that the Residents are able to locate, appraise and assimilate evidence from scientific studies related to their patient’s health problems.

7A.9.4 The Program *must* ensure that the Residents contribute to the creation, dissemination, and application of new medical knowledge and its translation into their daily practice.

7A.9.5 The Program *must* promote development of skills in self-assessment and self-directed life-long learning.
7A.9.6 The Program must ensure that the Residents develop skills to systematically analyze their practice, using quality improvement methods, and implement changes to improve practice and evaluate the outcome.

- Teaching
- Research
- Self-directed learning
- Critical Appraisal

7A.9.7 The Program must ensure that the Residents are able to conduct a scholarly project appropriately.

7A.9.8 The Residents must be encouraged to participate in research during the course of the residency program. Acceptable research projects may include:

7A.9.8.i analysis of a contemporary clinical problem, involving human subjects, using acceptable statistical methods as required, the results of which are reported at local or national meetings/conference and are eligible for publication in scientific journals.

7A.9.8.ii supervised participation in an ongoing project in experimental medicine;

7A.9.8.iii quality assurance study of contemporary practice;
7A.9.8. iv research related to medical education.

7A.9.9 The Program must provide opportunities for Residents to attend scientific conferences outside their own Training Centers.

7A.9.10 The Residents must be encouraged to use information technology to manage information, access online medical literature to optimize learning.

7A.10 Professionalism

7A.10.1 The Program must ensure that there is effective teaching in appropriate professional conduct and ethical behaviors so that Residents are able to:

7A.10.1. i deliver the highest quality care with integrity, honesty, and compassion;

7A.10.1. ii exhibit appropriate professional and interpersonal behaviors;

7A.10.1. iii practice medicine in an ethically responsible manner in accordance with the Oman Code of Professional Conduct for Doctors.

7A.10.1. iv demonstrate sensitivity to cultural diversity.
7A.10.2 The Program must ensure that Residents understand the basic principles and practice of bioethics as it relates to the specific specialty or subspecialty.

7A.10.3 The Program must ensure that there is effective teaching of relevant legislation and regulations to guide Residents’ practice in the specialty or subspecialty.

7A.10.4 The Program must effectively teach and promote physician health and well-being and guide Residents in the development of a sustainable practice.

7A.10.5 The Program must ensure that Residents' sensitivity and responsiveness to patient’s culture, age, gender, and disabilities are initiated and enhanced through communication skills workshops and role modeling.

7A.10.6 The Program must ensure that the supervision provided to the Residents contributes to high-quality professional clinical practice and outcomes, and that this is combined with focused feedback.

7A.10.7 The Residents must be trained to respect patients’ wishes and opinion.
7A.10.8 The Residents *must* be trained to involve the patient in decision making that involve their health.

7A.10.9 The Residents *must* be trained to keep the relatives informed and involved in decision after seeking permission of the patient.

7A.10.10 The Residents *must* be trained to be acutely aware of the sometime fine line between Research and Clinical Practice.

7A.10.11 The Residents *must* be trained to respect and endear doctor-patient confidentiality and the special relationship.

“Quality is not an act, it is a habit”
STANDARD P.7B: LIFELONG SELF-LEARNING

All the training must be geared towards the Residents developing the spirit of enquiry. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to medical practice. The training should encourage doctors to become competent within their chosen field of medicine and should prepare them for lifelong, self-directed learning and professional development.

INTENTION: This standard refers to continuous learning and practical participation of the Resident in the services and responsibilities of patient care. It addresses generic and specific training that will enable them to develop the spirit of enquiry and lifelong self-learning.

ACCOUNTABILITY: Education Committee of the Program, Trainers, and the Residents.

AFFIRMATION: Regular formative assessment from various patient-care experiences geared towards lifelong self-learning, teaching experiences, didactic learning sessions, and research activities, Journal Clubs, and Resident’s Portfolio.
BASIC MANDATORY QUALIFICATIONS:

7B.1 The Residents must be taught the spirit of enquiry during their clinical training in clinics, in seminars, at rounds and at conferences.

7B.2 While it is appreciated that Residents learn clinical medicine maximally while offering service, there must be a balance between service and learning. The health care service should be effectively utilized for service-based training purposes. The training provided must be complementary and not subordinated to service demands. Residents must be given protected time from clinical services for pursuit of scholarly activities.

7B.3 Care must be taken to protect the academic & scholarly pursuits of the Resident from undue work overload and exhaustion.

7B.4 The training of lifelong learning should emphasize the balance of teaching basic and clinical sciences for the Residents to understand mechanism of disease and health to varying degree according to the specialty the trainee is pursuing.

7B.5 The Program should organize an interactive educational environment that would encourage the Residents to acquire lifelong self-learning habits.

7B.6 The Residents should be encouraged to participate in research activities and other scholarly activities.

7B.7 The Program must train the Residents on the essential concepts of evidence-based medicine and their application in their daily clinical encounter.
DOMAIN 8: IN-TRAINING EVALUATION

STANDARD P.8A: EVALUATION AND ASSESSMENT OF RESIDENTS

The Program *must* ensure that there are mechanisms in place for regular assessment of Residents and these are timely and systematically completed after interpretation of the data on each Resident in the program. This has to be appropriate to the level of trainee and with his/her knowledge but held in confidence with adequate feedback.

**INTENTION:** This standard refers to the process of assessment, and the trainer *must* define and state the methods used for assessment of Residents, the criteria for passing examinations, and other evaluations; with emphasis on the formative methods and constructive feedback.

**ACCOUNTABILITY:** Education Committee of the Program, Chairman of the Committee, Program Director, Trainers, and OMSB Assessment Committee/Office, Clinical Competency Committee.

**AFFIRMATION:** Minutes of Education Committee of the Program and records of Clinical Competency Committee; evaluation Reports of Residents, Training Log-Books, Residents Portfolios, Examination results, In-service test results and other records of tests & evaluations.
**BASIC MANDATORY QUALIFICATIONS:**

8A.1 The Program Director **must** appoint the Clinical Competency Committee members:

1. The Clinical Competency Committee **should**:
   
   a) be composed of members of Education Committee of the Program;
   
   b) have a written description of its responsibilities including its responsibility to the sponsoring institution and to the Program Director.
   
   c) Participate actively in:
      
      (1) reviewing all resident assessment by all assessors; and,
      
      (2) making recommendations to the Program Director for resident progress, including promotion, remediation, and dismissal.

8A.2 The Program **should** utilize reliable and valid multiple tools of assessment such as: Workplace based assessment, CEX, MiniCEX, Objective structured clinical examination (OSCE) – standardized patient encounter stations and data interpretation, Resident’s Portfolios (case logs with learning evidence and Resident reflection), Simulations and models, standardized patients, etc. to respectively evaluate all the expected Competencies.
8A.3 The Education Committee of the Program **must** explore new ways of Residents’ evaluations that are published either in the literature or in the Scientific meetings, and suggest them to the OMSB as new evaluation tools for their Specialty or for any specific Competencies.

8A.4 There **must** be a clearly defined mechanism of formal assessment of Residents to reflect the achievement of the objectives and attain the awarded EPAs.

8A.5 The Program **should** select the most appropriate evaluation tools to assess for specific competencies; and examples of this are as shown in the Appendix III for their evaluation of the Residents.

8A.6 The results of implementing all the evaluation tools **should** be tracked against measurable trainee outcomes and **should** be linked to the development of new revised tools and revised standards.

8A.7 The Program Director **must** ensure that all evaluations, feedback and assessment reports of the Residents are fair and confidentiality is maintained.

8A.8 Resident’s performance **must** be continuously monitored and evaluated throughout the block and that **must** include on-call evaluation.

8A.9 All Trainers that are involved in the Resident’s training during a block **must** participate in the evaluation of that resident.
The program must provide objective assessment of all core competencies.

The Programs must ensure that their residents are evaluated in all the following competencies. However different specialties may go to varying depths of evaluations for the various competencies, which may be more or less relevant for their specialties.

**8A.11 Medical Knowledge**

8A.11.1 The goals and objectives of the program must be the determinant of the in-training evaluation system and the methods used have to be based on these. The level of performance of Residents must be judged in accordance to the objectives.

8A.11.2 Evaluation must be based on and related to the specific requirements of the specialty or subspecialty and according to the level of training. The assessment methods must be approved by the respective Education Committee of the Program and match the progression of the Residents.

8A.11.3 The assessment methods must include formal assessment of knowledge through the use of appropriate written examinations including MCQs, MEQs, etc. Performance and clinical skills are assessed by direct observation and other methods as needed. All assessment must be documented in Resident’s file.
8A.11.4 The Program *must* assess that the Residents recognize their personal and professional limitations and ask for consultation from other health care professionals as needed.

8A.11.5 The Program *must* assess the Residents that they follow guidance and principles of OMSB Standards of competence and conduct so that they become ethical and competent consultants.

8A.11.6 The Program *must* assess the Residents’ knowledge and skills in maintaining health safety in the clinical setting and in applying the principles of risk management in hospital as well as independent practice.

8A.11.7 The Program *must* assess the Residents that they are able to utilize opportunities to promote patients’ health and prevent disease, and show awareness of public health and concerns about health care inequalities.

**8A.12 Interpersonal and Communication Skills**

8A.12.1 Direct observation of Resident interactions with patients and their families and colleagues and senior trainer *must* be used to assess communication skills.
8A.12.2 The Program *must* assess written documents of the Residents such as record/chart review (review of patient’s medical records by the Resident), communications to patients and colleagues, particularly consultation letters to referring physicians where appropriate *should* be used.

8A.12.3 Residents’ training evaluations *must* include awareness of communication issues related to age, gender, culture and ethnicity. These *must* be evaluated at the appropriate level.

8A.12.4 The Program *must* assess the Residents on how they introduce themselves to patients and colleagues with appropriate confidence and authority ensuring that patients and colleagues understand their role, objective and limitations.

8A.12.5 The Program *should* assess the Residents’ communications skills at all levels and at different clinical situations.

8A.12.6 The Program *must* assess the Residents in demonstrating knowledge of the theory and established effective relationships with patients.

8A.12.7 The Program *must* assess the Residents’ communication during research.
8A.12.8 The Program must assess the Residents that they can communicate in different ways, including spoken, written and electronic methods. The program must assess the Residents’ communication methods that meet the needs and contexts of individual patients and colleagues, including those within the team, or in other disciplines, professions and agencies where appropriate.

8A.12.9 Interpersonal and Communication Skills abilities of all the residents must be assessed formally and informally by a variety of evaluation tools especially Multisource Feedback, OSCE, Simulations, and ITER.

8A.12.10 Feedback from all members of the professional team must be included in assessing collaborative abilities of the Residents, such as interpersonal skills, conflict prevention and resolution, etc. at work.

8A.12.11 The Residents interpersonal and communicative skills related to both “teamwork” and “conflict management” must be continually assessed throughout the course of the training as appropriate to the level of training.

8A.12.12 The Residents must be assessed as a team member including supporting others, handover and taking over the care of a patient safely and effectively from other health professionals.
8A.12.13 The Residents *must* be assessed for their ability to share information and take into account the view of other professionals.

8A.12.14 The assessment of the Interpersonal and Communication skills competency *should* be based on established and predefined criteria and a well-defined benchmark scale.

8A.12.15 The assessment of the resident collaborative skills *must* include the essential important features of an effective collaborator:

8A.12.15.i Accountability; shares responsibility relative to the final decision
8A.12.15.ii Assertiveness - shares opinions safely
8A.12.15.iii Autonomy - independent enough to contribute their expertise
8A.12.15.iv Clarity - knows own culture of collaboration
8A.12.15.v Communication - with professionals and other team members.
8A.12.15. vi Cooperation - value the other collaborators

8A.12.15. vii Coordination - enables efficiency

8A.12.15. viii Responsibility - towards patients and the profession.

8A.12.15. ix Transparency - shares information readily

8A.12.15. x Trust and Respect of the health team members

8A.12.15. xi Conflict prevention and resolution

8A.12.16 The Program **must** document the assessment of the interpersonal and communication skills (collaborator) competency using the following assessment tools or equivalent:

8A.12.16. i The Collaborator Assessment tool (CAT)

8A.12.16. ii Sample Encounter cards

8A.12.16. iii Mini Collaborator Clinical Evaluation Exercise (MiniCEX-Collaboration)
8A.13 Systems-Based Practice

8A.13.1 The Program *should* ensure the availability of evaluation tools that can assess the residents' ability to appropriately manage the available information as well as other managerial skills of the Residents (refer to Appendix III).

8A.13.2 The Program *should* ensure that each Resident keeps a Portfolio that is regularly updated by the Resident and monitored by the Supervisor to aid in the assessment of the Residents' management skills as applied in actual situations.

8A.13.3 The Program *should* ensure that Residents' portfolios include a variety of evidence such as workplace-based assessments, committee work, practice organization innovations, audits and quality assurance projects, along with reflections generated by his/her managerial experiences that promotes longitudinal learning.

8A.13.4 The Program *must* ensure that the Manager role is assessed by appropriate evaluation tools, e.g. multi-source feedback that includes specific questions addressing each of the key features of the Manager role. This *should* be computerized to improve efficiency and feasibility.
8A.13.5 The Program should ensure that simulation is used to assess a Resident's ability to handle complex and critical situations using his/her managerial abilities.

8A.13.6 The Program leaders should assess time management skills of the Residents including efficient patient management, scheduling, and balancing work/rest.

8A.13.7 The Program leaders should assess Residents for effective mobilization of health care resources and appropriate delegation to other team members in various clinical situations.

8A.13.8 The Program leaders should assess Residents in their ability to properly manage the booking and flow of patients through various departments of the hospitals such as emergency, operating rooms, wards, etc.

8A.14 Patient Care

8A.14.1 The Program should use available tools and develop new assessment tools as needed to evaluate health advocate competencies of the Residents (refer to Appendix III).

Assessment tools that may enable this assessment include:

- Completing ITER
- Short answer questions on written examination
- OSCE
- Essay
- Direct (daily) observation by staff
- Peer Evaluations or Informal feedback from other members of the health care team (formal feedback only when problems are reported)
- Portfolios

8A.14.2 The Program *should* ensure that each Resident keeps a Portfolio and that it is regularly updated by the Resident and checked by the Supervisor.

8A.14.3 The Program *must* assess the Residents on their health advocacy by various methods at different settings, e.g. direct observation during clinics, consults, in-patient rounds, out-patient clinical care, etc.

8A.14.4 The Program *should* assess the Residents’ ability on teaching their peers and allied health care workers regarding patient and community health advocacy issues using various methods.

8A.14.5 The Residents’ assessment of their Health Advocacy Role *should* be obtained by evaluating his or her understanding of the determinants of health, affecting patients’ attentiveness to preventive measures.
8A.14.6 The Program **must** assess the Residents’ Health Advocacy in both in-patient and out-patient clinical care scenarios.

8A.14.7 The Program **should** use simulated scenarios to assess Residents’ knowledge of Health Advocate.

8A.15 **Practice-Based Learning and Improvement**

8A.15.1 The Program **must** develop formative and summative evaluation tools to evaluate the scholarly ability of the residents as mandated by the OMSB QA Standards for relative utility (refer to Appendix III).

8A.15.2 The Residents' teaching abilities **must** be assessed in multiple settings, including written student evaluations, direct observations at seminars, lectures, case presentations and other settings.

8A.15.3 The Program **should** ensure that each Resident keeps a Portfolio and Logbook and that it is regularly updated by the Resident and checked by the Supervisor.

8A.15.4 The Residents **must** be able to utilize information technology to manage information, access online medical information. This **should** be assessed using multiple assessment tools such direct observation and chart stimulated recall.
8A.15.5 The Residents *must* be assessed regarding their ability to analyze their own practice and perform practice-based improvement activities using a systematic methodology.

8A.15.6 The Residents *must* be able to locate, appraise, and utilize scientific evidence to their patients’ health problems and the larger population from which they are drawn. This *should* be assessed using multiple assessment tools.

8A.15.7 The Program *must* assess the ability of the Resident to design, perform and present their research both orally and in print.

**8A.16 Professionalism**

8A.16.1 The Program *should* assess the Residents to ensure that all the components of professionalism including sensitivity to cultural diversity, ethical conduct, participation in bioethics and legislation, and sustainable practice are assessed by as many assessment tools as possible such as ITER, Multisource Feedback, and Portfolio.

8A.16.2 The Program *should* ensure that each Resident keeps a Portfolio which includes the Resident’s reflection of his/her professional behavior and that it is regularly updated by the Resident and checked by the Supervisor.
8A.16.3 The Program *should* assess the Residents' knowledge about their responsibilities to look after their health, including maintaining a suitable balance between work and personal life, and knowing how to deal with personal illness to protect their patients and the public.

8A.16.4 The Program *must* assess the Residents' sense of responsibility, and professionalism, in line with OMSB Quality Standards, as regards the actions they take to keep their own health in the interests of public safety, and to consult an expert doctor regarding possible risks to patients when contacting them while being sick themselves.

8A.16.5 The Program *should* assess the Residents' honesty as regards their relationships with patients (and their relatives and carers), professional colleagues and employers.

8A.16.6 The Program *must* assess the Residents’ ability to share appropriate information with the patient and/or relatives in the appropriate time.

8A.16.7 The Program *must* assess the Residents' abilities to demonstrate sound knowledge concerning confidentiality, show respect and uphold patients’ rights to refuse treatment.
8A.16.8 The Program must assess the Residents' ability to take appropriate action (including admission of their mistake or misconduct) when their own performance or conduct puts the patient or the public at risk.

8A.16.9 The Program should assess the competency of the Residents as regards to medical record keeping and the perfect completion and submission of legal documents such as those certifying sickness, time off work, and death certification.

8A.16.10 The Program should assess the Residents' knowledge and application of regulations and legislations relevant to their day-to-day activities.

8A.16.11 The Program must assess the Residents' conduct of respect for patients and everyone they work with, whatever is his/her professional qualifications, age, color, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, or socioeconomic status.

8A.17 In-Training Assessment and Feedback:

8A.17.1 Constructive formative feedback must be given to the Resident at regular intervals by the Rotation Supervisor after their evaluations. Feedback must occur at the end of each rotation and should also occur in mid rotation during informal sessions.
The feedback sessions must be held face-to-face and used as learning experiences for the Residents. The Resident must be given an opportunity to respond to the feedback. These all have to be documented in the Resident File “In-Training Evaluation Report (ITER)”.

8A.17.2 The Program Director or designee should provide feedback to the Resident regarding his/her evaluations. This has to be done face-to-face at 6 months and annually and also receive feedback from the Resident about the program, rotations, trainer and any other issues. All this must be documented in the Resident file and confidentiality must be maintained.

8A.17.3 Any concern, academic and / or behavioral / attitudinal, with the Resident, especially the serious concerns, must be given as a feedback to the Resident early so that he/she gets the opportunity to improve and correct the deficiencies. Remedial support mechanism must be available if needed.

8A.17.4 The Program Director must send Summative assessment reports of Residents’ progress to GME office on six monthly and annual basis during the Residency and upon completion of the Residents’ training - “Final In-Training Evaluation Report (FITER).”
The Assessment report must represent views of trainer members as a whole, directly involved in the Residents’ training and not the opinion of only a single member of the faculty. It must also include evidence of feedback to and from the Resident, and any remedial plan, if applicable.

8A.17.5 The Program must ensure that the Residents receive feedback generated through formative assessment which can be used to improve teaching. The Formative Assessment used should include a variety of tools.

8A.17.6 The Program must provide feedback to the Residents that is goal-directed (e.g. skills-related), response-directed (e.g. knowledge-related), and competency oriented.

8A.17.7 Effective feedback should provide the learner with both verification (correct or incorrect) and elaboration (explanation why).

8A.17.8 Feedback should be specific and not too complex or too long.
STANDARD P.8B: EVALUATION AND ASSESSMENT OF TRAINERS

The Program *must* ensure that there are mechanisms in place for regular evaluation of Trainers. Residents *must* evaluate the Trainers anonymously regularly every rotation. The Trainers *must* also be evaluated by the Chairman, Program Director, and Associate Program Directors. These evaluations *must* be systematically compiled and discussed by the Program Director or designee with the Trainers.

**INTENTION:** This standard refers to the process of continuous assessment of the Trainers.

**ACCOUNTABILITY:** Program Director, Education Committee of the Program Chairman, Education Committee of the Program Members, and OMSB Administration.

**AFFIRMATION:** Minutes of Education Committee of the Program, evaluation reports of Trainers, Minutes of Meeting with the Trainers, and OMSB database.
BASIC MANDATORY QUALIFICATIONS:

8B.1 The Program must have a systematic review of the Trainers’ teaching performance and skills using OMSB Trainer Evaluation forms.

8B.2 The Trainer’s evaluation should be done at the end of each rotation for the involved Trainers; and a separate comprehensive annual evaluation of clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

8B.3 The Education Committee of the Program through the program director or his designee must meet with Trainers at least once yearly.

8B.4 The Program must have a mechanism to counsel the Trainers who have problems with teaching or monitoring the Residents.

8B.5 The Trainers should be competent and active in their relevant field and their appointment should be reviewed periodically by OMSB.

8B.6 The Education Committee of the Program must give feedback at least once a year (written or verbal) to all the Trainers about their performance. The Head of their Department must also be informed.

8B.7 The Trainers must satisfy the CME requirements of OMSB and the program must ensure that the Trainers participate in some form of Trainer Development Program such as “Train the Trainers’ Course or Workshop.

8B.8 The evaluations must be fair to the Trainer and he/she should be given a copy of the compiled evaluations.
STANDARD P.8C: EVALUATION AND SSESSIONMENT OF THE PROGRAM

There must be a mechanism in place for regular evaluation of the Program. The Education Committee of the Program is primarily responsible for regular evaluations of the program. The regular evaluations should include Residents and Trainers.

INTENTION: This standard refers to the process of regular evaluation of the program by the different stakeholders involved.

ACCOUNTABILITY: Education Committee of the Program, Chairman of the Education Committee of the Program, Program Director, Program Evaluation Committee, and Internal Review Committee.

BASIC MANDATORY QUALIFICATIONS:

8C.1 The Program Evaluation Committee participates actively in:

(1) planning, developing, implementing, and evaluating all significant activities of the residency program;

(2) developing competency-based curriculum goals and objectives;

(3) reviewing annually the program using evaluations from Trainers, residents and others;

(4) reviewing the Internal Review Committee report of the residency program with recommended action plans; and,

(5) assuring that areas of non-compliance with ACGME-I standards are fulfilled.

8C.2 The Program Evaluation Committee must review the program at least once yearly according to OMSB guidelines.

8C.3 The PEC must monitor that the program tracks each of the following areas:

a) resident performance;
b) trainer development;
c) graduate performance, including performance of program graduates taking the certification examination; and,
d) program quality. Specifically:
i. Resident and Trainer must have the opportunity to evaluate the program confidentially and in writing at a minimum of once per year, and

ii. The program must use the results of Resident’s assessments of the program together with other program evaluation results to improve the program.

8C.4 The program must document formal, systematic evaluation of the curriculum at least once per year.

8C.5 There must be a mechanism for Residents to evaluate the Program at least once yearly in writing and confidentially.

8C.6 The Education Committee of the Program must review all Accreditation reports and Site Visit reports as well as Internal Review reports; and draw an action plan for correction of any deficiencies.

8C.7 If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance. The action plan should be reviewed and approved by the Education Committee of the Program and documented in meeting minutes.
8C.8 The Program Evaluation Committee *must* assess any new Training Center to be added to the program, and produce a written report to the Education Committee of the Program for approval. The evaluation of a new Training center *must* include the number of patients and variety of illnesses, and resources, to ensure that it does meet the training objectives.

8C.9 The added Training Center *must* be approved by the OMSB Internal Review Committee.

8C.10 The Annual Report of the program *should* include the summary of the reports, Internal and External; record of its calendar of Academic Activities; its achievements and weaknesses; and future plans.

“Education is not a preparation for life…
Education is life itself”
DOMAIN 9: OUTCOME EVALUATION

STANDARD P.9: The impact of the standards *must* be measured against trainee outcomes and clear linkages *should* be established. The outcomes for the competencies for the Junior and Senior levels of Residency *must* be recorded for the Residents and collectively for the Program. All doctors *should* meet these outcomes and competencies before successfully completing the training program.

INTENTION: This Domain is intended to look into the Training Programs’ actual accomplishments through assessment of the Program Outcomes. The need for Programs to provide evidence of Structure and Processes as required in Domains 1 to 8 will not disappear as the importance of Outcomes is getting more critical.

ACCOUNTABILITY: Chairman of the Education Committee of the Program, Program Director, Education Committee of the Program its Members, Educational Supervisors, Trainers, and Assessment Committee of OMSB.
AFFIRMATION: Education Committee of the Program Meeting Minutes and Data; The Curriculum; Training Centers Documents; Data from Trainers; Annual Report of the Program, Evaluations, Quality Management Data, Survey visits, Results of all Outcome Evaluation tools used, Previous Accreditation Reports.

BASIC MANDATORY QUALIFICATIONS:

9.1 The approach used to assess Outcomes *should* provide valid data and evidence *should* be used to infer validity.

9.2 The approach used to assess Outcomes *should* provide reliable data – yields consistent results regardless when it is used or by whom. Evidence *should* be shown to infer test-retest reliability.

9.3 The approach used to assess Outcomes *should* be feasible. Evidence *must* consider level of training, equipment/technology needed, number of assessments per examinee, and financial cost.

9.4 The approach used to assess Outcomes *should* provide valuable information e.g. that can be used to improve the training or the curriculum.
9.5 Multiple assessment approaches must be used to assess Outcomes by multiple Observers/Raters and according to pre-specified standards or criteria and they have to be fair.

9.6 The Graduating Residents must show evidence of respect for human life, and ability to care for patients without supervision.

9.7 There must be evidence that patients can trust the Graduating Resident.

9.8 There must be evidence that the Graduating Resident has achieved all the “Medical Competencies” as defined by the Quality Standards of OMSB and pertinent to his/her Specialty.

9.9 There must be evidence that required Outcome for his/her specialty is achieved in each of the 8 Domains as defined in the OMSB Training Quality Standards.

9.10 There must be evidence that the Resident has achieved the required Quality and Competencies required to practice in Oman as defined by the Oman licensing authority and Ministry of Health.
9.11 The required outcomes must be demonstrated on different occasions and in different clinical settings of the workplace.

9.12 The Outcome Objectives for the various Specialties and Sub-specialties should be clearly defined for each training program.

9.13 The Training process must result in a Doctor competent to undertake practice in his/her specialty in a Professional manner independently or within a team according to healthcare needs of Oman.

9.14 There should be evidence that the training program encourages innovation that the Trainees strive for competencies broader than minimally required, and constantly striving to improve patient care.

9.15 There should be evidence that the Training Program has encouraged Trainees to be Scholars in their specialties; and have developed lifelong self-directed learning habits and readiness for Professional Development.
"T STANDARDS"
Compliant with ACGME-I
“Institutional Requirements”
DOMAIN 10: INSTITUTIONAL ORGANIZATION AND RESPONSIBILITIES

STANDARD T.10A: SPONSORING INSTITUTION

OMSB is the Sponsoring Institution. The residency programs accredited by the Accreditation Council for Graduate Medical Education International (ACGME-I) or OMSB Accreditation Committee must operate under the authority and control of one Sponsoring Institution (OMSB).

BASIC MANDATORY QUALIFICATIONS:

10A.1 OMSB responsibility extends to resident assignments at all participating sites. However, OMSB may assign this responsibility to the program Education Committees of an Accredited Program.

10A.2 The OMSB must be in substantial compliance with the ACGME-I Institutional Requirements and must ensure its ACGME-I accredited programs are in substantial compliance with the Institutional, Foundational and Advanced Specialty-Specific Program Requirements**, and the ACGME-I Policies and Procedures.

10A.3 If OMSB fails to maintain its accreditation as a Sponsoring Institution with ACGME-I, this will result in loss of ACGME-I accreditation of all its accredited programs.

* These OMSB “T Standards” are in compliance with ACGME-I Institutional Requirements

**Advanced specialty specific program requirements may not apply if a program is not under consideration for the specific specialty accreditation.
STANDARD T.10B: COMMITMENT TO GRADUATE MEDICAL EDUCATION (GME)

The Sponsoring Institution as well as the Participating Sites must provide Graduate Medical Education (GME) that facilitates and encourages Residents’ professional, ethical and personal development. The GME programs of all the Participating Sites involved through curricula, evaluation, and resident supervision must support safe and appropriate patient care.

BASIC MANDATORY QUALIFICATIONS:

10B.1 A written statement must document the OMSB and the Participating Site’s commitment to provide the necessary educational, financial, and human resources to support GME. It must be reviewed, dated, and signed by representatives of OMSB administration and GME leadership within a minimum of one year prior to the institutional site visit.

10B.2 An organized administrative system, led by a Designated Institutional Official (DIO) in collaboration with a Graduate Medical Education Committee (GMEC), must oversee all ACGME-I-accredited programs of the Sponsoring Institution.

10B.3 The DIO and GMEC must have authority and responsibility for the oversight and administration of the OMSB programs and responsibility for assuring compliance with ACGME-I Institutional, Foundational and Advanced Specialty- Specific Program Requirements.
10B.4 The DIO and/or the Chair of the GMEC must present an annual report to OMSB. This annual report will review the activities of the GMEC during the past year with attention to resident supervision, responsibilities, evaluation, compliance with duty-hour standards, and participation in patient safety and quality of care education.

10B.5 The OMSB and Participating Sites must provide sufficient resources to ensure the effective implementation and support of the programs in compliance with the ACGME-I Institutional, Foundational, and Advanced Specialty/Subspecialty Program Requirements.

10B.6 The OMSB and the Institutions must ensure that the DIO and the Program Directors are given adequate support including financial, and protected time that are required for proper and effective training of Residents.

10B.7 Faculty and residents must have ready access to adequate communication resources, technological support, access to specialty specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

10B.8 OMSB must have a policy that addresses administrative support for GME programs and residents in the event of a disaster or interruption in patient care takes place in one of the participating sites, including assistance for continuation of resident assignments.
STANDARD T.10C: LETTER OF AGREEMENT

The Sponsoring Institution must ensure that a “Program Letter of Agreement” (PLA) between each Program and Training Center that the program uses is agreed upon and signed. Each PLA will remain in effect for up to five years and is renewable, unless changes are made by the program.

BASIC MANDATORY QUALIFICATIONS:

10C.1 The OMSB retains responsibility for the quality of GME, including when resident education occurs in other sites.

10C.2 The OMSB must have “Program Letters of Agreement” with its participating sites in compliance with the ACGME-I Foundational Program Requirements.
STANDARD T.10D: ACCREDITATION FOR PATIENT CARE IN SPONSORING AND MAJOR PARTICIPATING SITES THAT ARE HOSPITALS

The Sponsoring Institution must ensure that the Participating Sites are accredited hospitals for patient care, e.g. Accreditation Canada International, The Joint Commission International, or International Standards Organization (ISO) or equivalent organization.

BASIC MANDATORY QUALIFICATIONS:

10D.1 Participating Sites that are accredited hospitals by another entity, may be reviewed by ACGME International Review Committee (ACGME-I RC), who will determine the credibility of that accrediting body.

10D.2 When a Participating Site is not an accredited or a recognized hospital, the Sponsoring Institution must provide an explanation satisfactory to the ACGME-I RC of why the Accreditation was not sought or granted.

10D.3 When a Participating Site loses its accreditation or recognition as a hospital, OMSB must notify the ACGME-I RC and provide a plan of response within 30 days of such loss.
DOMAIN 11: INSTITUTIONAL RESPONSIBILITIES FOR RESIDENTS

STANDARD T.11A: ELIGIBILITY AND SELECTION OF RESIDENTS:

The Sponsoring Institution must have written policies and procedures for resident recruitment and appointment and must monitor each program for compliance.

BASIC MANDATORY QUALIFICATIONS:

11A.1 OMSB must set selection criteria that are required prior to consideration of a potential Resident for Training.

11A.2 Resident selection must be based on guidelines set out by OMSB including guidelines for interview that every Resident must undergo prior to acceptance.

11A.3 Financial Support of Residents joining OMSB is by the Resident’s sponsors such as Ministry of Health, Armed Forces, or as per OMSB guidelines.

11A.4 Benefits and Conditions of Appointment must be transmitted to the Resident in writing to include references to the appropriate OMSB ByLaws and Guidelines. These will include financial support, leaves, and other benefits.
11A.5 All Residents must sign the agreement of appointment provided by OMSB. The resident agreement/contract must contain or provide a reference to a minimum of the following institutional policies:

a) Residents’ responsibilities;
b) Duration of appointment;
c) Financial support; and,
d) Conditions for reappointment.

11A.6 The OMSB must monitor the implementation of terms and conditions of appointment recommended by the educational committee of the program.

STANDARD T.11B: BENEFIT, CONDITIONS AND AGREEMENT OF APPOINTMENT

BASIC MANDATORY QUALIFICATIONS:

11B.1 The OMSB and educational committee must ensure that residents are informed of all the established educational and clinical practices, policies, and procedures of all participating sites involved in their training.

11B.2 Appointment and promotion guidelines that are in the OMSB ByLaws, Guidelines and Resident Handbook must be handed to the Residents upon appointment.
11B.3 The OMSB must provide residents with fair, reasonable, and readily available written institutional policies and procedures for grievance and due process. These policies and procedures must minimize conflict of interest by adjudicating parties as detailed in OMSB ByLaws and Guidelines.

11B.4 Residents must be allowed to invoke the OMSB’s grievance procedures whenever they feel it is necessary.

11B.5 OMSB policies in its ByLaws and Guidelines must address leaves of absence, duty hours, counseling services, physician impairment, harassment, accommodation of disabilities.

11B.6 OMSB must have Guidelines and Policies in place, related to the placement of Residents in case of closure or non-accreditation of its program.

**STANDARD T.11C: RESIDENT PARTICIPATION IN EDUCATIONAL AND PROFESSIONAL ACTIVITIES**

**BASIC MANDATORY QUALIFICATIONS:**

11C.1 OMSB must ensure that each program provides effective educational experiences for residents that lead to measurable achievement of educational outcomes in the medical competencies.
11C.2 OMSB must ensure that residents participate on committees whose actions affect their education and/or patient care.

11C.3 OMSB must ensure that residents participate in an educational program regarding physician impairment, including substance abuse and sleep deprivation.

STANDARD T.11D: RESIDENT EDUCATIONAL AND WORK ENVIRONMENT

BASIC MANDATORY QUALIFICATIONS:

11D.1 OMSB and Participating Sites must provide a safe environment for Residents with adequate resources required to achieve their educational goals.

11D.2 Facilities that should be provided by the Participating Sites should include Parking, On-call rooms, access to appropriate food services while on duty, and security services as called upon, etc.
DOMAİN 12: GRADUATE MEDİCAL EDÜCATİON COMMITTEE (GMEC)

STANDARD T.12A: GRADUATE MEDİCAL EDÜCATİON COMMITTEE (GMEC)

The Sponsoring Institution *must* have a GMEC, which is responsible for overseeing the ACGME-I Accreditation process and for other functions listed below. It monitors, and develops policies for graduate medical education to ensure the maintenance of high quality residency training programs. It is led by the Designated Institutional Official (DIO).

**BASIC MANDATORY QUALIFICATIONS:**

**12A.1 Membership:**
- Designated Institutional Official
- Residents nominated by their peers
- Representative Program Directors
- Post Graduate Medical Education Officers (Associate DIOs)
- Hospital Deputy Director Generals

**12A.2 GMEC Responsibilities:** GMEC has the following responsibilities as part of its functions in the ACGME-I Accreditation process and in ensuring and maintaining high-quality residency training program.
12A.2.1 **Communication with Chairmen & Program Directors:** The GMEC *must*:

a) Ensure that communication mechanisms exist between the GMEC and all OMSB Chairmen & Program Directors.

b) Ensure that Program Directors maintain effective communication mechanisms with the associate program directors at each participating site for their respective programs to maintain proper oversight at all clinical sites.

12A.2.2 **GMEC function is to receive feedback from the Training Center PGME Committee regarding the safety and quality of patient care:**

There will be communication between Training Center Director of PGME and the Scientific Committees (OMSB leadership) regarding the safety and quality of patient care that includes:

a) Description of resident participation in patient safety and quality of care education; and,

b) The accreditation status of programs and any citations regarding patient care issues

c) The Training Center Postgraduate Medical Education Committee will then report directly to the Graduate Medical Education Committee regarding the above.
12A.2.3 **Resident duty hours:** The GMEC *must* develop and implement written policies and procedures regarding resident duty hours to ensure compliance with the ACGME-I Institutional, Foundational, and Advanced Specialty/Subspecialty Program Requirements.

12A.2.4 **Resident supervision:** Monitor programs’ supervision of residents and ensure that supervision is consistent with:

a) Provision of safe and effective patient care;

b) Educational needs of residents;

c) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and,

d) Other applicable Foundational and Advanced Specialty/Subspecialty-specific Program Requirements.

12A.2.5 **Curriculum and evaluation:** Assurance that each program provides a curriculum and an evaluation system that enables residents to demonstrate achievement of the ACGME-I general competencies as defined in the ACGME-I Foundational and Advanced Specialty/Subspecialty Program Requirements.

12A.2.6 **Resident status:** To assure that the selection, evaluation, promotion, transfer, discipline, and/or dismissal of residents are in compliance with the ACGME-I’s Institutional and Foundational Program Requirements and the OMSB by-laws.
12A.2.7 **Review of OMSB Policies and Procedures:** All policies and procedures related to Resident education *must* be reviewed periodically.

12A.2.8 **Program accreditation:** Review of all ACGME-I program accreditation letters of notification and monitoring of action plans for correction of citations and areas of non-compliance, in addition to OMSB accreditation (for the non-ACGME-I accredited programs).

12A.2.9 **Management of institutional accreditation:** Review of the Sponsoring Institution’s ACGME-I letter of notification from the Institutional Review Committee and monitoring of action plans for correction of citations and areas of non-compliance.

12A.2.10 **Oversight of program changes:** Review of the following for approval prior to submission to the ACGME-I by Chairmen/Program Directors:

a) All applications for ACGME-I accreditation of new programs;
b) Changes in resident complement;
c) Major changes in program structure or length of training;
d) Additions and deletions of participating sites;
e) Appointments of new Chairmen & Program Directors;
f) Progress reports requested by any Review Committee, including OMSB Accreditation Committee;

g) Responses to all adverse actions;
h) Voluntary withdrawal of program accreditation;
i) Requests for an appeal of an adverse action; and,
j) Appeal presentations to a Board of Appeal or the ACGME-I.

12A.2.11 **Oversight of reductions and closures:** Oversight of all processes related to reductions and/or closures of:

a) Individual programs;
   b) Major participating sites

12A.2.12 **Position allocation:** Annual review and recommendations to OMSB regarding resident positions.

12A.2.13 **Vendor interactions:** Provision of a statement or institutional policy (not necessarily GME-specific) that addresses interactions between vendor representatives/ corporations and residents.

12A.2.14 **Meetings:** The GMEC **must** meet at least quarterly.
STANDARD T.12B: TRAINING CENTER RESIDENCY COMMITTEE OF GRADUATE MEDICAL EDUCATION COMMITTEE (TCC-GMEC)

GMEC must have Training Center Residency Committee for each Participating Site. This Committee monitors the quality and availability of educational facilities provision to OMSB Residents at the assigned Training Center.

BASIC MANDATORY QUALIFICATIONS:

12B.1 Membership:

- Post Graduate Medical Education Officer (Associate DIO)
- Chairman or Program Director in the Training Center. Associate Program Director if neither assigned in the Training Center.
- Chief Residents or Assistant Chief Residents or Representatives
- Hospital Deputy Director (Clinical Affairs)
- Assistant Dean for Clinical Affairs – College of Medicine *(Where applicable)*

12B.2 TCC-GMEC Responsibilities:

12B.2.1 Ensure implementation & monitoring of the ACGME-I Institutional & Program Requirements at the Training Center on ongoing basis.
12B.2.2 Facilitate and participate in the ACGME-I continuous accreditation process and assist in preparation for site visits.

12B.2.3 Monitor quality and access to the educational facilities provision to OMSB Residents at the assigned Training Center.

12B.2.4 Review the feedback from OMSB Accreditation Committee, Associate DIO, Program Scientific Committees, Trainers, & Residents regarding training and educational concerns in the Training Centers.

12B.2.5 Evaluate the performance of the Residency Program & Trainers in the Training Center.

12B.2.6 Facilitate monitoring of the evaluation of Trainers including their continuous professional development.

12B.2.7 Communicate with the GMEC on training and education matters on regular basis.

12B.2.8 Liaise with Training Centers’ Administration.
DOMAIN 13: INTERNAL REVIEW

STANDARD T.13: The GMEC must develop, implement and oversee an internal review process. It can do so by appointing the OMSB Accreditation Committee as Standing Internal Review Committee of all OMSB Programs that are seeking ACGME-I accreditation.

BASIC MANDATORY QUALIFICATIONS:

13.1 The GMEC must appoint the members of Accreditation Committee.

13.2 The Chairman of Accreditation Committee must be a member of GMEC.

13.3 The Accreditation Committee will form Survey (Review) Teams from its members together with the help of experts from different specialties for the purposes of periodic review and re-review of OMSB programs.

13.4 Each OMSB program has its own Program Evaluation Committee which evaluates its own program annually and submits the report to the Accreditation Committee through their Scientific Committee. This will help the Accreditation Committee survey teams in their periodic review of that program.
13.5 In addition to the members from the Accreditation Committee and the Experts, the Survey Teams will also include a Resident in their review or re-review of programs.

13.6 The internal review and re-review of programs will be carried out by the Survey Teams in accordance to the written protocol as approved by GMEC and OMSB.

13.7 Each OMSB program will be reviewed by the Accreditation Committee through its Survey Teams at least once in mid-cycle after accreditation by ACGME-I.

13.8 If the review indicates that there are “Areas for Improvement” or “Citations”, then the program may be assigned probation or conditional approval status, and it will be re-reviewed after a prescribed time given for it to improve - typically this is between 6 to 18 months.

13.9 Internal review reports must be documented in the GMEC minutes. The accreditation cycle is calculated from the date of the meeting at which the final accreditation action was taken to the time of the next site visit.

13.10 The internal review should assess each program’s:

a) Compliance with the ACGME-I Institutional, Foundational, and Advanced Specialty/Subspecialty Program Requirements, as applicable;
b) Curriculum and Educational objectives and effectiveness in meeting those objectives;

c) Educational resources and facilities available for Residency training;

d) Effectiveness in addressing areas of non-compliance and concerns in previous ACGME-I accreditation letters of notification and previous internal reviews;

e) Effectiveness of educational outcomes in the ACGME-I general competencies;

f) Effectiveness in using evaluation tools and outcome measures to assess a resident’s level of competence in each of the ACGME-I general competencies; and,

g) Annual program improvement efforts in:

(1) Resident performance using aggregated resident data, e.g. OMSB’s New Innovation Resident management data;

(2) Trainers development and feedback of their performance;

(3) Graduate performance including performance of program graduates taking the certification examination; and,

(4) Program quality as outlined in the protocol approved by GMEC.
13.11 Materials and data to be used in the review process *must* include:

a) The ACGME-I Institutional, Foundational and Advanced Specialty/Subspecialty Program Requirements in effect at the time of the review;

b) Accreditation letters of notification from previous ACGME-I reviews or other external expert reviewers and progress reports.

c) Reports from previous internal reviews of the program;

d) Previous annual program evaluations and reports of Program Evaluation Committee; and,

e) Results from internal or external resident surveys, if available.

f) Program Information Form

13.12 The Survey (Review) Team of the Accreditation Committee *must* conduct interviews with the Scientific Committee Chairman, Program Director, Associate Program Director, Trainers, and Residents from each level of training in the program, and from each Participating Site.
13.13 Internal Review Report

13.13.1 At a minimum, the written report of the Accreditation Committee (the Internal Review Report) for each program must contain all the details that are required by the protocol approved by the GMEC and OMSB.

13.14 The DIO and the GMEC must monitor the response by the program to actions recommended by the GMEC in the internal review process.

13.15 The OMSB must submit the most recent internal review report for each training program as a part of the Institutional Review Document (IRD). If a survey team conducts an individual program review while an institutional review is in progress, the internal review reports for those programs must not be shared with the survey team.
DOMAIN 14: RESOURCES AT SPONSORING INSTITUTION AND PARTICIPATING SITES

STANDARD T.14: The Sponsoring Institution and Participating Sites must provide sufficient resources including sufficient number of Trainers and variety of patients, for the respective specialty/subspecialty. There should be facilities and services at the Training Center necessary to provide the opportunity for all Residents in the program to achieve the educational objectives and fulfill the training requirements as defined by the specialty.

BASIC MANDATORY QUALIFICATIONS:

14.1 At each participating site, there must be a sufficient number of Trainers with documented qualifications acceptable to OMSB and other resources as defined by the program to adequately instruct and supervise the Residents in the program.

14.2 The OMSB must ensure that the Scientific Committee Chairman and Program Director are all qualified in their specialty with a recognized postgraduate degree and should have adequate experience both in the clinical and educational fields.

14.3 For each Program, the OMSB must ensure that the number of Trainers is adequate for the number of trainees (Resident to trainers ratio is 1:1).
14.4 The clinical training opportunities, supervisory capacity by the Trainer and other resources available must be adequate for the total number of trainees in order to ensure training and teaching of adequate quality.

14.5 At the Participating Sites, the Trainers must be allowed to spend sufficient time to the educational program and teaching responsibilities towards the trainees and they must show strong interest in the education of the trainees. They must also support the goals and objectives of the rotations and the program.

14.6 OMSB must ensure that the Trainers are qualified to train with the following examples of qualifications needed. The Trainers:

14.6.1 Must possess a requisite specialty expertise and competence in clinical care and teaching abilities, as well as educational abilities and experience in their field.

14.6.2 Must possess qualifications judged to be acceptable by the OMSB. The faculty should be certified in his/her speciality, well trained and has adequate experience.

14.6.3 Must be in good standing and clinically privileged at the Training Center participating in the program.

14.7 The Trainers must be responsible for establishing and maintaining an environment of inquiry and scholarship.
14.8 OMSB *must* ensure that Non-Physician Trainers are qualified to train. The Non-Physician Trainers:

14.8.1 *Must* be appropriately qualified in their field.

14.8.2 *Must* possess appropriate institutional appointment if using the Training Centers.

14.9 Additional necessary professional, technical, and secretarial staff *must* be provided to support the program, and they *must* have the appropriate training and qualification as per their respective professional standards.

14.10 The OMSB and Participating Sites *must* ensure that all Trainers are adequately evaluated:

14.10.1 prior to their appointment, and,

14.10.2 thereafter, at least annually and as per OMSB requirements.

14.11 Trainers have to show evidence of Continuous Professional Development (CPD) and keep up with Continuous Medical Education (CME).

14.12 The Training Center *must* provide facilities to encourage CME and CPD activities for the Trainers.
14.13 The number and variety of patients and supporting services available at the Participating Site, to the program on a consistent basis must be sufficient to meet the educational needs of the Residents and provide appropriate experience for the specialty or subspecialty.

14.14 Clinical services and other resources at the Participating Site, used for teaching must be organized to achieve their educational objectives. The organization of patient care at any of the Participating Site may be different in a setting where teaching and education take place and must be organized according to the following general principles:

14.14.1. There should be an integration of teaching resources to include exposure to emergency, ambulatory, and community experiences.

14.14.2 Learning environment must include experiences that facilitate the acquisition of knowledge, skills, and attitudes relating to aspects of age, gender, culture, and ethnicity appropriate to the specialty or subspecialty as well as other training requirements in the area of focused competence.

14.14.3 There should be opportunities for Residents to acquire the relevant knowledge to understand and prevent adverse patient events.
14.15 At the Participating Site, there **must** be easy access to a major medical library, either at the medical school or through a major hospital library. There **should** also be access during evenings and weekends to the library or to a collection of appropriate reference texts and journals.

14.16 The Participating Sites **must** ensure that there is appropriate access to computers and facilities for information management, on-line references and computer searches for Residents.

14.17 The physical and technical resources available at the Participating Site to the program **must** be adequate to meet the needs of the program as outlined in the Competency-based Training Requirements and “Specialty-Specific Standards” of accreditation for a program.

14.18 Supporting facilities and services **must** be available at the Participating Site as outlined in the “Specialty-Specific Standards” of accreditation for programs. In addition:

14.18.1 Clinical services heavily committed to the care of seriously ill and injured patients **must** be supported by intensive care units organized for teaching.

14.18.2 All consultative, diagnostic, and laboratory services necessary for patient care **must** be available.
14.18.3 The facilities available to programs, in clinical specialties or subspecialties that require emergency training must include an emergency department with an adequate number and variety of patients presenting urgent problems in the discipline. Each Resident must have opportunities, under appropriate supervision, to provide an initial assessment and consultative service to patients presenting with emergency conditions.

14.18.4 In all clinical specialties and subspecialties, ambulatory care facilities must be available to provide Residents with experience in the care of the broad range of non-hospitalized patients seen in the specialty or subspecialty. This experience should include, but not be limited to, work-up of new patients, pre-admission work-up and post-discharge follow-up care.

14.18.5 A major portion of each Resident’s training should take place in sites in which there are other accredited programs relevant to the specialty or subspecialty.
DOMAIN 15:  PATIENT SAFETY AT PARTICIPATING SITES

STANDARD T.15: The Sponsoring Institution and Participating Site must promote a culture of patient safety and give high priority to train the Residents to attain satisfactory level of patient safety and the safety of other health professionals. The Safety Competencies are defined as “Enhancement of Patient Safety across the Health Professions”, adopting the patient safety in education, and continuing professional development activities.

BASIC MANDATORY QUALIFICATIONS:

15.1 OMSB and Participating Site are responsible for ensuring that Culture of Patient Safety is inculcated amongst the Residents.

15.2 The Participating Site should apply fundamental elements of patient safety as part of their commitment to Residents’ training.

15.3 At the Participating Site, the Residents must be taught to work with meaningfully engage in healthcare teams to optimize patient safety. In the process of their training, the Residents must engage the patients as active participants in their own safety as well as part of the healthcare team.
15.4 OMSB *must* ensure that Residents are trained to manage professional conflicts and appropriately accomplish disclosure of medical errors.

15.5 OMSB and Participating Site are responsible for training residents in management and disclosure of adverse events.

15.6 Residents *must* also be trained on the disclosure of an occurrence of an adverse event to the patient and/or family, and also to participate in timely event analysis, reflective practice, and planning for the prevention of adverse recurrence.

15.7 OMSB and Participating Site *must* ensure effective communication (verbal and non-verbal) for patient safety amongst the healthcare teams.

15.8 At the Participating Site, there *must* be effective communication in high-risk situations, both written communications and through technologies for patient safety.

15.9 OMSB and Participating Site *must* ensure that Residents are trained how to anticipate high-risk situations and how to prevent their recurrence and evaluate context-specific safety solutions.
15.10 Training of Residents at Participating Site must include identification and management of environmental factors that can affect human performance in health care setting.

15.11 The Participating Site must ensure that Residents are trained to appreciate the impact of the human and technology interface in the deliverance of safe care.

15.12 The Participating Site must provide an effective incident-reporting system and the Residents must be adequately trained on using such a system.

15.13 The Participating Site must have guidelines in place to protect Residents from intimidation upon reporting of adverse events / medical errors.
These Quality Assurance Standards for OMSB Residency programs are the main guidelines for all residency training under OMSB.

The program Education Committee will use the “P Standards” in everyday training their residents for predominantly training of residents. However, they will have to refer to the “T Standards” in certain situations such as training in patient safety, and at times a need will arise for the Education Committee of the program to discuss the Training center administration in situations when resources are adequate.

The Internal Review Committee will also have to use both the “P & T Standards” on their review of the programs to ensure compliance in their standard of training that both the Foundational and Training Center Requirements are fulfilled. The process of Accreditation is shown in Appendix V.

The Internal Review Committee is obliged to give citations to programs that do not conform to these standards. A separate set of citations will be issued against the “P Standards” and a separate set for “T Standards”. Programs are advised to heed these citations to ensure that their residents are getting training to the expected standard.
All Trainers and trainees are reminded that these standards are evolving and in constant flux. Trainers and in particular members of the Education Committee are therefore requested to keep in constant touch with the literature on resident training so they can supplement the standard booklet in the training of their residents until our new edition of the booklet is published.

“This booklet should not be undeservedly forgotten,… but deservedly remembered.”
OMAN MEDICAL SPECIALTY BOARD

APPENDICES
APPENDIX I
MEDICAL COMPETENCIES

These are competencies that are adapted and modified from ACGME-I to suit the postgraduate medical training in Oman. These are the Competencies that OMSB expects the graduating Specialist Physicians to have achieved at the completion of their training.

Medical Knowledge
Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

• Demonstrate an investigatory and analytic thinking approach to clinical situations.

• Know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

Interpersonal & Communication Skills
Interpersonal Skills and Communication requires the resident/fellow to skills that are effective in the exchange of information and collaboration with patients, their families, and health professionals. Residents/fellows are expected to develop skills and habits to be able to:
• Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

• Communicate effectively with physicians, other health professionals, and health related agencies;

• Work effectively as a member or leader of a health care team or other professional group;

• Act in a consultative role to other physicians and health professions, and health related agencies;

• Work effectively as a member or leader of a health care team or other professional group;

• Act in a consultative role to other physicians and health professionals; and

• Maintain comprehensive, timely and legible medical records, if applicable.

**Systems-Based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

• Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice.

• Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
- Practice cost-effective health care and resource allocation that does not compromise quality of care.
- Advocate for quality patient care and assist patients in dealing with system complexities.
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

**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 are expected to:

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
- Gather essential and accurate information about their patients.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
- Develop and carry out patient management plans.
- Counsel and educate patients and their families.
- Use information technology to support patient care decisions and patient education.
- Perform competently all medical and invasive procedures considered essential for the area of practice.
• Provide health care services aimed at preventing health problems or maintaining health.
• Work with health care professionals, including those from other disciplines, to provide patient-focused care

Practice-Based Learning & Improvement
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

• Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
• Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
• Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
• Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
• Use information technology to manage information, access online medical information; and support their own education.
• Facilitate the learning of students and other health care professionals
Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and ongoing professional development.

- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practice.

- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

The Core Competencies

<table>
<thead>
<tr>
<th>ACGME-I</th>
<th>CanMEDS</th>
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<tbody>
<tr>
<td>Medical Knowledge</td>
<td>Medical Expert</td>
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<td>Interpersonal &amp; Communication Skills</td>
<td>Communicator</td>
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<td>Systems - Based Practice</td>
<td>Manager</td>
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<td>Patient Care</td>
<td>Health Advocate</td>
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<tr>
<td>Practice - Based Learning &amp; Improvement</td>
<td>Scholar</td>
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<tr>
<td>Professionalism</td>
<td>Professionalism</td>
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APPENDIX II
GLOSSARY OF TERMS
(In Alphabetical Order)

1. **ACCOUNTABILITY**: Indicates who is responsible for implementation of the Standard.

2. **ACGME-I**: Accreditation Council for Graduate Medical Education International

3. **ACGME-I FOUNDATIONAL PROGRAM REQUIREMENTS**: ACGME-I standards for residency training that are common to all programs.

4. **ACGME-I INSTITUTIONAL REQUIREMENTS**: ACGME-I Standards for residency training that are common to all Training Center.

5. **ACGME-I ADVANCE SPECIALTY REQUIREMENTS**: Standards for training residents in their specialty.

6. **ADVERSE EVENT**: Undesirable change in health; or side effect that occurs during the delivery of healthcare.

7. **AFFIRMATION**: Supporting evidence for the fulfillment of the Standard.
8. **ASSESSMENT:** System of evaluation of professional accomplishment with feedback, using defined criteria including an attempt at measurement.

9. **ASSOCIATE DESIGNATED INSTITUTIONAL OFFICIAL (ADIO):** The individual at each training center who assists the DIO in the monitoring of the ACGME-I accredited and non-accredited programs of OMSB in the respective training center. The ADIO Chairs the Training Center Postgraduate Medical Education Committee (PGMEC).

10. **CITATIONS:** A finding of a Review Committee that a program or an institution is failing to comply substantially with a particular accreditation standard or ACGME-I policy or procedure.

11. **CLINICAL COMPETENCY COMMITTEE (CCC):** A required body comprising three or more members of the active teaching faculty that is advisory to the program director and reviews the progress of all residents/fellows in a program.

12. **CORE TRAINER:** All physician faculty members who have a significant role in the education of residents/fellows and who have documented qualifications to instruct and supervise. Core faculty members devote at least 15 hours per week to resident, or 10 hours per week to fellow, education and administration.
All core faculty members should evaluate the competency domains, work closely with and support the program director, assist in developing and implementing evaluation systems, and teach and advise residents/fellows.

13. DESIGNATED INSTITUTIONAL OFFICIAL (DIO): The individual in a sponsoring institution who has the authority over and responsibility for all ACGME-I accredited GME programs.

14. EDUCATION COMMITTEE OF THE PROGRAM: The committee of the each program responsible for training OMSB Residents. It is made up of Chairman, Program Director, Associate Program Directors and members. It is also formerly known as the “Scientific Committee”.

15. ENTRUSTABLE PROFESSIONAL ACTIVITY (EPA): is a task or a responsibility to be entrusted to a trainee once sufficient competence is attained to allow for unsupervised practice.

16. EVALUATION: Systematic process used to characterize and appraise trainee, Trainers and programs using criteria against a set of standards.

17. GRADUATE MEDICAL EDUCATION (GME): The period of didactic and clinical education in a medical specialty that follows the completion of a recognized undergraduate medical education and which prepares physicians for the independent practice of medicine in that specialty area, also referred to as 'residency education.'
The term ‘graduate medical education’ also applies to the period of didactic and clinical education in a medical subspecialty which follows the completion of education in a recognized medical specialty and which prepares physicians for the independent practice of medicine in that subspecialty area (or 'fellowship education').

18. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC): The Committee responsible for overseeing the ACGME-I Accreditation process. It monitors and develops policies for graduate medical education to ensure the maintenance of high quality residency training programs.

19. INTENTION: The purpose of the existence of the standard.

20. INTERNAL REVIEW COMMITTEE (IRC): A committee of the GMEC to review training programs (at OMSB it was formally referred to as the Accreditation Committee) that they are in compliance with the ACGME-I Requirements and the OMSB Standards of training. The committee reports to the GMEC.

21. INTERPERSONAL & COMMUNICATION SKILLS: That result in effective information exchange and teaming with patients, their families and other health professionals.
22. **MAJOR PARTICIPATING SITE:** A site for core rotations of the Trainees.

23. **MANDATORY QUALIFICATIONS:** Requirements that must or should be attained by the programs to accomplish the Standard.

24. **MEDICAL COMPETENCIES:** Measurable or observable knowledge, skills, abilities, and behaviors (KSABs) critical to successful performance of a medical doctor.

25. **MEDICAL KNOWLEDGE:** Established and evolving biomedical, clinical and cognate (e.g. epidemiological and social behavioral) sciences and application of knowledge to patient care.

26. **MILESTONES:** is a significant point in development. For accreditation purposes, the Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties.

27. **MUST:** Accomplishment of the requirement is mandatory.
28. **NEAR MISS/CLOSE CALL**: Unplanned event during the delivery of healthcare that did not result in injury, illness, or damage but had the potential to do so.

29. **NON-PHYSICIAN TRAINERS**: Healthcare professionals who are involved in the education of the Residents other than medical doctors.

30. **PATIENT CARE**: Identify, respect and care about patient’s differences, values, preferences and expressed needs; listen to, clearly inform, communicate with and educate patients; share decision making and management; and continuously advocate disease prevention, wellness and promotion of healthy lifestyles, including a focus on population health.

31. **PATIENT SAFETY**: Defined as freedom from unnecessary harm or potential harm associated with healthcare provided to the patient.

32. **P STANDARDS**: (Program Training Standards) OMSB structured in training standards that are compliance with ACGME-I Foundational Program Requirements.

33. **PRACTICE BASED LEARNING & IMPROVEMENT**: Involves investigation and evaluation of one’s own patient care, appraisal and assimilation of scientific evidence and improvements in patient care.
34. **PROGRAM EVALUATION COMMITTEE (PEC):** Participate in the development of the program’s curriculum and related learning activities, to annually evaluate the program to assess the effectiveness of that curriculum, and to identify actions needed to foster continued program improvement and correction of areas.

35. **POSTGRADUATE MEDICAL EDUCATION COMMITTEE (PGMEC):** Training Center based Committee that monitors quality and access to the educational facilities provision to OMSB Residents at the assigned Training Center.

36. **PROFESSIONALISM:** Commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.

37. **SHOULD:** Accomplishment of the requirement is desirable to enhance Quality.

38. **SPONSORING INSTITUTION:** The organization (or entity) that assumes the ultimate financial and academic responsibility for a GME program. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, and a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner’s office, a consortium, or an educational foundation).
39. **SYSTEMS-BASED PRACTICE**: Actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

40. **T STANDARDS**: (Training Center Standards) OMSB structured standards for training centers that are compliance with ACGME-I Institutional Requirements.

41. **TRAINEE**: Resident in a Training Program.

42. **TRAINER**: Qualified staff with expertise in their field who provides medical education and training to the Residents.

43. **TRAINING CENTER**: An institution utilized by OMSB for the education of the Resident.
# APPENDIX III
ACGME Competencies: Suggested Best Methods for Evaluation

<table>
<thead>
<tr>
<th>Competency</th>
<th>Required Skills</th>
<th>Evaluation Methods</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Record Review</td>
<td>Chart Stim. Recall</td>
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<tr>
<td>Caring &amp; respectful behaviors</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Interviewing</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Informed decision-making</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Develop &amp; carry outpatient management plans</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Counsel &amp; educate patient's families</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Performance of procedures</td>
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<tr>
<td>a) routine physical exam</td>
<td>2</td>
<td>1</td>
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<tr>
<td>b) Medical procedures</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Preventive health Services</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Work within a team</td>
<td>3</td>
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</table>

Ratings are 1= the most desirable; 2= the next best method; and, 3= a potentially applicable method.
<table>
<thead>
<tr>
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<th>Evaluation Methods</th>
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<tbody>
<tr>
<td></td>
<td>Record Review</td>
<td>Chart Stim. Recall</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>Investigatory &amp; analytic thinking</td>
<td>1</td>
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<tr>
<td></td>
<td>Knowledge &amp; application of basic sciences</td>
<td>2</td>
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<tr>
<td>Practice-Based Learning &amp; Improvement</td>
<td>Analyze own practice for needed improvements</td>
<td>2</td>
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<tr>
<td></td>
<td>Use of evidence from Science studies</td>
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</tr>
<tr>
<td></td>
<td>Application of research and statistical methods</td>
<td>2</td>
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<td></td>
<td>Use of Information technology</td>
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<tr>
<td></td>
<td>Facilitate learning of Others</td>
<td>2</td>
</tr>
<tr>
<td>Interpersonal &amp; Communication Skills</td>
<td>Creation of therapeutic relationship with patients</td>
<td>3</td>
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<tr>
<td></td>
<td>Listening skills</td>
<td>3</td>
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</tbody>
</table>

Ratings are 1= the most desirable; 2= the next best method; and, 3= a potentially applicable method.
### ACGME Competencies: Suggested Best Methods for Evaluation

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<tr>
<td></td>
<td></td>
<td>Record Review</td>
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<tr>
<td>Professionalism</td>
<td>Respectful, altruistic</td>
<td>Chart Stim. Recall</td>
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<tr>
<td></td>
<td>Ethically sound practice</td>
<td>Checklist</td>
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<td></td>
<td>Sensitive to cultural, age, gender, disability issues</td>
<td>Global Rating ITER</td>
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<td></td>
<td></td>
<td>SP</td>
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<td>OSCE</td>
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<td>Simulations &amp; Models</td>
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<td>360° Global rating</td>
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<td>Portfolio</td>
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<td>Exam MCQ</td>
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<td>Exam Oral</td>
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<td>Procedure or Case Logs</td>
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<td>Patient Survey</td>
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**Abbreviations:**
- ITER = In-Training Evaluation Report
- SP = Standardized Patient
- OSCE = Objective Structured Clinical Examination
- MCQ = Multiple Choice Question

Ratings are 1 = the most desirable; 2 = the next best method; and, 3 = a potentially applicable method.

This is only a guideline of the relative utility of the different tools...

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## APPENDIX IV
### Outcome Evaluations for the Medical Competencies

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<thead>
<tr>
<th>COMPETENCY</th>
<th>Stimulated Chart Recall</th>
<th>Objective written examinations (MCQs, SAQs, essay questions)</th>
<th>Objective structured clinical examination (OSCE)</th>
<th>Structured oral examination</th>
<th>Standardized patient</th>
<th>Simulations and Models</th>
<th>360° Global Rating (includes Patient survey)</th>
<th>Portfolio and Logbooks</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td></td>
<td>• review of medical records</td>
<td>• assessment strategies well-developed for testing most objectives</td>
<td>• as applicable</td>
<td>• assessing interviewing techniques</td>
<td>• medical procedures</td>
<td>• work within teams</td>
<td>• recording relevant clinical findings, decisions made, and information given to and management of patients</td>
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<td></td>
<td></td>
<td>• review of written consultation skills</td>
<td>• assessment strategies well-developed for testing most objectives</td>
<td>• caring and respectful behavior</td>
<td>• investigative analytic thinking and knowledge application</td>
<td>• performing routine and specialized procedures</td>
<td>• demonstrate effective consultation services</td>
<td>• appropriate and logical reflections recorded</td>
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<tr>
<td></td>
<td></td>
<td>• assessment strategies well-developed for testing most objectives</td>
<td>• assessment strategies well-developed for testing most objectives</td>
<td>• caring and respectful behavior</td>
<td>• investigative analytic thinking and knowledge application</td>
<td>• performing routine and specialized procedures</td>
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<td>• as applicable</td>
<td>• assessing interviewing techniques</td>
<td>• caring and respectful behavior</td>
<td>• investigative analytic thinking and knowledge application</td>
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<td>• demonstrate effective consultation services</td>
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<td></td>
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<td>• reviewing written consultation skills</td>
<td>• assessing interviewing techniques</td>
<td>• investigative analytic thinking and knowledge application</td>
<td>• performing routine and specialized procedures</td>
<td>• demonstrating effective consultation services</td>
<td>• appropriate and logical reflections recorded</td>
<td>• self-assessment ability</td>
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## APPENDIX IV (cont.)
### Outcome Evaluations for the Medical Competencies

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>Evaluation Methods</th>
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<tr>
<td></td>
<td>Stimulated Chart Recall</td>
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<tr>
<td>Interpersonal &amp; Communication Skills</td>
<td>• assessment of information gathering and medical communication&lt;sup&gt;1&lt;/sup&gt;</td>
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## APPENDIX IV (cont.)
### Outcome Evaluations for the Medical Competencies

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>Evaluation Methods</th>
</tr>
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<tbody>
<tr>
<td><strong>Stimulated Chart Recall</strong></td>
<td>Objective written examinations (MCQs, SAQs, essay questions)</td>
</tr>
<tr>
<td><strong>Objective structured clinical examination (OSCE)</strong></td>
<td>Structured oral examination</td>
</tr>
<tr>
<td><strong>Standardized patient</strong></td>
<td>Simulations and Models</td>
</tr>
<tr>
<td><strong>360° Global Rating (includes Patient survey)</strong></td>
<td>Portfolio and Logbooks</td>
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<tr>
<td><strong>Others</strong></td>
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<table>
<thead>
<tr>
<th><strong>Systems - Based Practice</strong></th>
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<tbody>
<tr>
<td>• assessment of organizational aspects of practice and the health care system</td>
<td>• specific OSCE may be created to test manager</td>
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<td>• answering queries and solving problems and issues as presented</td>
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<td>• managing responsibilities by making sure that the systems are in place</td>
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<td>• managing mishaps</td>
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<td>• allocate finite health care resources wisely</td>
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<td>• handover of responsibility</td>
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<td>• utilization of technology to optimize patient care</td>
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<td>• management of health care team if applicable</td>
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<td></td>
<td>• proper utilization of available information</td>
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<td>• utilize resources efficiently to balance patient care</td>
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<td>• observed behaviors necessary to assess performance</td>
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</table>
## APPENDIX IV (cont.)
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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Stimulated Chart Recall</td>
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<tr>
<td>Patient Care</td>
<td>• evaluation re:</td>
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<td>• determinants of health</td>
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<td>• clinical epidemiology</td>
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<td>• health &amp; social policy procedures</td>
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- Health Advocacy related questions
- • counseling and educating patients including preventive medicine
- • recognizing and responding to those issues where advocacy is appropriate
- • recognizing and responding to issues where advocacy is appropriate
- • identifying the important determinants of good health
- • contributing effectively to improve health of patients and communities
### APPENDIX IV (cont.)
#### Outcome Evaluations for the Medical Competencies

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>Stimulated Chart</th>
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<th>360° Global Rating (includes Patient survey)</th>
<th>Portfolio and Logbooks</th>
<th>Others</th>
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<tbody>
<tr>
<td>Practice – Based Learning &amp; Improvement</td>
<td>• may be useful if made more reliable and valid through further development</td>
<td>• critically appraise sources of medical information</td>
<td>• may be used if appropriately structured</td>
<td>• analyzing the differential diagnosis to reach a diagnosis</td>
<td>• clinical reasoning and judgment</td>
<td>• patient management</td>
<td>• clinical translation of published literature</td>
<td>• clinical translation of published literature</td>
<td>• critically appraise sources of medical information</td>
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<td>• treatment and management decision</td>
<td>• arriving at overall solutions</td>
<td>• teaching house staff/students and other health professionals</td>
<td>• critically appraise sources of medical information</td>
<td>• contribute to development of new knowledge</td>
<td>• critically appraise sources of medical information</td>
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<td>• evidence-based management decision</td>
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<td>• critically appraise sources of medical information</td>
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<td>• translation of new knowledge into medical practice</td>
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<td>• critically appraise sources of medical information</td>
<td>• critically appraise sources of medical information</td>
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<td>Stimulated Chart Recall</td>
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<td>Professionalism</td>
<td>• potentially very helpful evaluation tool, with further development</td>
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<td>• respectful and altruistic</td>
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APPENDIX V
ACCREDITATION PROCESS

The Accreditation Committee of OMSB has dual function – it acts as “Internal Review Committee” for OMSB training programs that are undergoing an External International Accreditation process with ACGME-I or are seeking such accreditation, and it also acts as the “Accrediting Committee” for the other OMSB training programs that are not seeking ACGME-I accreditation.

The Accreditation/Internal review process is based on a system of regular surveys of the residency programs on a four year cycle. If, however, the program does not get “Full Approval”, then the system to be followed is described under Accreditation Cycle.

The primary purpose of a survey is to provide the Accreditation Committee and the Executive Board and Board of Trustees of OMSB with a first-hand evaluation of each accredited program and the extent to which it meets the standards of accreditation. The accreditation committee will send a team of surveyors to assess the Specialty Program and Training Centers.

There are a number of checks and balances in the survey and accreditation of residency programs with respect to the accuracy of information and the process of deliberations and decision-making.

Accreditation process is carried out in various stages:
- Initial Review of Programs and Training Centers
- Re-review of Programs and Training Centers
- Accreditation Appeal Process, as required
ACCREDITATION PROCESS

Program & Training Center Application

OMSB Internal Review Committee/Department

Survey Team Studies the Application and Site Visits as Needed

Survey Team Report

Internal Review Committee Discusses the Report and Decides on the Accreditation Designation

Internal Review Committee Recommends its Decision to the Executive President

Report Forwarded to the Program Education Committee, Training Center and HoDs of Relevant Departments

Executive Board
INTERNAL REVIEW PROCESS

1. Formation of Survey Team by Internal Review Committee
2. Education Committee of the programs submits required forms and documents
3. Survey Team reviews submitted documents
4. Survey Team meets with Program Leaders, Trainers and Residents
5. Survey Team conducts site visits as needed
6. Final meeting with Education Committee of the program to give initial feedback.
7. Survey Team forwards its report to program Education Committee for factual review
8. Program Education Committee reviews the Survey Team report for factual accuracy
9. Survey Team presents its final report to Internal Review/Accreditation Committee
10. Internal Review/Accreditation Committee discusses Survey Team report & decides on accreditation status for recommendation
11. Internal Review/Accreditation Committee presents its recommendation to GMEC
12. GMEC discusses the report and gives its final decision to the program Education Committee and gives feedback to training centers.
The Accreditation Cycle

The program cycle is calculated from the date the final accreditation report was submitted to the OMSB Executive President to the time of the next site visit.

Typically, the maximum length of the cycle that may be awarded by the Accreditation Committee is four years. This cycle length is based upon the accreditation designation, issues identified by the Accreditation Committee, and any areas of noncompliance.

Categories of Accreditation

Each program considered by the Accreditation Committee is granted an accreditation designation as outlined below:

New programs are given “New Approval.”

For existing programs, the following designations may apply:

- “Full Approval”
- “Approval with Citations”
- “Conditional Approval”
- “Probation Status”
- “Intent to Freeze Status”
- “Freeze Status”
- “Withdrawal of Accreditation”
**New Approval**

The initial cycle is considered a developmental stage during which the proposal for the new program will be fully developed and implemented. The program should be re-reviewed within four years of the initial action.

An acceptable application for a new program is granted “New Approval.” After 4 years of a resident being enrolled in the program, the Accreditation Committee will review the program for re-categorization.

**Full Approval**

Programs that are considered to meet the general and specific standards of accreditation and which have no major weaknesses identified are granted “Full Approval.” A re-accreditation review will be carried out after four years.

**Approval with Citations**

Programs are considered to be under “Approval with Citations” if they meet most of the general and specific standards of accreditation, but are found to have relatively minor areas that need improvement. The citations refer to the minor areas that need improvement, but must be corrected within the next 6 to 12 months.

Programs which are under “Approval with Citations” must submit a progress report at the time stated by the Internal Review Committee (typically 6 to 12 months). After consideration by the Internal Review Committee, these citations may then be removed.
Conditional Approval

When a program is considered to meet the general and specific standard of accreditation and have some weaknesses that can be corrected within 1 year before the next scheduled survey, it is granted “Conditional Approval.” It then becomes the responsibility of the education committee to correct the weaknesses in the program within the first year.

The Accreditation Committee may mandate follow-up of a program with conditional approval by means of a regular survey.

Probation Status

“Probationary Status” is conferred when the Accreditation Committee determines that a program, following a site visit and review, has failed to demonstrate substantial compliance with OMSB Accreditation Guidelines and Requirements. Residents and applicants to the programs must be advised immediately by the Program Director of the status of the program. The program will be on “Probation Status” for one year, at which point, re-review and site visit should be carried out.

If major and/or continuing weaknesses have been identified which bring into question the ongoing accreditation of the program, the program will be placed on probation for one additional year.
**Intent to Freeze Status**

The OMSB has the right to give a notice of “Intent to Freeze” to training programs if they do not fulfill the accreditation requirements and conditions according to the following steps:

- After the program has been on probation for two years with continuing deficiencies which have not been corrected, a notice of “intent to freeze” will be sent.
- If the condition of the program has significantly deteriorated even after one year of being on “Probation Status” then an “Intent to Freeze” notice may be enforced.
- The specialty program will be on this status for one year from the date of issue of the warning letter.
- Residents and applicants to the programs **must** be advised immediately by the Program Director of the status of the program.

**Freezing Accreditation of Training Programs**

After the program has been on “Intent to Freeze” status for one year with continuing deficiencies which have not been corrected, freezing of accreditation for training program will follow.

- Residents and applicants to the program **must** be advised immediately of the status of the program.
- New Residents will not be accepted in the program.
• The program will be re-reviewed by the Accreditation Committee after one year.

Withdrawal of the Accreditation

After a program has been put on "Freeze Status" for one year without correcting the deficiencies, withdrawal of the accreditation will take place.

• If a program is on "Withdrawal Status" all residents will have to be transferred to other programs if available.
• Re-accreditation of the center or the training program will be based on a letter from the training program that shows the correction of deficiencies and application for reaccreditation.
• Revoking accreditation may be immediate, especially in case of severe deficiencies in the training center or the training program and if the deficiencies cannot be corrected within a short period.
Application for Accreditation of New Programs

1. The specialty program requesting accreditation of a new residency program should follow the following steps:
   - The new residency program must apply by means of special forms supplied by the OMSB.
   - Application form for Accreditation of Residency Program.
   - Application form for Accreditation of Training Centers.

2. To be accredited, a program must comply with the OMSB Program and Training Center “General Standards”.

3. Recommend specific standards of accreditation for the specialty and Sub-specialty.

4. Internal Review Committee will appoint a new program sub-committee (Survey Team) to consider the application.

5. Accreditation will be granted on the basis of an assessment of the resources to be provided within the program and the capability of the program to provide a complete education program in the specialty or subspecialty as well as the manner in which these resources will be utilized for the residency education.

6. Completed application forms and a covering letter from the Head of Department of the proposed specialty indicating that the faculty approves and supports this program plus covering letter from the hospital Directors of the major teaching institutions or training centers indicating support of the program must be submitted to OMSB.
Bibliography:

3. ACGME Core Competencies: Systems Based Practice | University of Maryland Medical Center
4. ACGME Core Competencies: http://gme.bridgeporthospital.org/aboutus/ACGMECoreCompetencies
5. ACGME Glossary of Terms - July 1, 2013
6. CanMEDS Project 2000 - Table 1 Essential Roles and Key Competencies of Specialist Physicians.
7. CanMEDS Project 2000 - Table 2 Overview of Educational Strategies for Implementation of Roles.
17. WFME (World Federation for Medical Education ) Global Standards for Quality Improvement in Postgraduate Medical Education – European Specifications 2007
“Quality means doing it right, when no one is looking.”

“Quality is something which can be improved continuously.”
OMSB QUALITY STANDARDS FOR RESIDENCY TRAINING

CONTACT DETAILS
OMAN MEDICAL SPECIALTY BOARD
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Fax no.: (00968) 24181197
Department Email: quality@omsb.org
OMSB Email: info@omsb.org; Website: www.omsb.org