LOG BOOK

Residency Training Programme-Phase A (2 years)
Discipline: Orthopaedic Surgery (M.S)
Faculty: Surgery

Department of Orthopaedic Surgery
Bangabandhu Sheikh Mujib Medical University
Shahbag, Dhaka.

Index

Personal details of the Residents

Stamp size photo

Name of the resident:

University Registration No:

BMDC Registration No:

Date of entry in the program:

Date of birth:

Father’s name:

Mother’s name:

Address for Communication:

Permanent address:

Telephone No:
E-mail:
Nationality:
National ID No:
Passport No.(for foreign student)

Profile of the teachers/supervisors

Name	Designation	Discipline	Specimen Signature	Specimen Initial

General information

1. The log book (Daily Training Record) is day to day record of the clinical and academic work done by the resident
2. The log book will be a pre-requisite for appearing in the phase I summative examination
3. The log book has to be maintained by all the residents throughout the period of training
4. The resident will obtain the log book from the course-coordinator of the parent discipline immediately after joining
5. The resident will make the required entries in the log book on the same day of the event and get it signed by the supervisor.
6. It is the responsibility of the resident to keep the log book safe and secured
7. Entries in the log book will be block-wise

Objective of the training program:

The aim of the training in phase A of the residency program is to guide the students to acquire broad based knowledge on before entering the final part (part B) of the respective specialty. In this context it is expected that the students will be able to (i) acquire knowledge of common conditions, [emergencies & rehabilitations], (ii) acquire skills [diagnostic, clinical and decision making] and (iii) develop attitude [caring, learning & ethical]. The components of the objectives are as follows. The resident should

- acquire sufficient theoretical knowledge (the “core” knowledge defined in the syllabus)
- be able to take full history and be competent in performing a full physical examination
- formulate a working diagnosis
- decide whether the patient requires ambulatory care or hospitalization or referral to other health professionals
- become competent in interpreting and evaluate the presenting symptoms and physical sings
- be able to interpret and evaluate the laboratory reports lying with the patients
- to know the cardinal feature of disorders commonly encountered in clinical practice
- plan investigations and interpret them
- decide and implement suitable treatment
- maintain follow up of patients
- maintain record of patients
- present the patient’s clinical data in both detailed and salient form highlighting the problem(s)

- competent and confident enough to handle common emergencies and common chronic conditions including rehabilitation
- develop skill of good prescribing
- establish appropriate doctor-patient relations
- be able to maintain the ethical and professional standard
- be able to advise the community on promoting health and preventing illness
- well conversant with commonly prescribed drugs
- develop sufficient expertise in performing the enlisted procedures :[the list is not exhaustive and the level of performance may very]

1. Aseptic principles and practices with emphasis on hand wash and universal precaution
2. Urethral catheterization
3. Venepuncture
4. Water seal drainage
5. Intercostals drain insertion
6. Safe blood transfusion
7. Intra-articular injection
8. Joint fluid aspiration
9. Blood glucose monitoring
10. Method of close reduction
11. Plaster Technique

- SABS
- LABS
- LAFP
- Cock-up plaster
- Colle’s plaster
- Scaphoid plaster
- U-cast
- Shoulder spica
- Hip spica
- PTB Plaster
- Cylinder cast
- SLFP
- SLBS
- LLBS
- SLFP with toe Platform
- Cast brace
- Cast with caliper application
- Cast for taller neck fracture
- Complication of plaster
- plaster splitting

Be able to interpret the following lab data and investigation reports:

1. EMG
2. NCV
3. X-ray
4. CT scans
5. MRI
6. Haemoglobin electrophoresis
7. Protein electrophoresis
8. Electrolyte reports
9. ABG analysis
10. Angiography
11. Ultrasonography
12. Joint fluid analysis
13. Serum Calcium
14. Other biochemical test
15. Parathormon
16. Tumur marker
17.
18. Serum alkaline phosphatase
19. Acid phosphatase

20. Traction
    - Gallows traction
    - Surface traction
    - Skeletal traction
    - Holter traction
    - Tong traction
    - Olecranon traction
    - UTST

- LTST
- Calcaneal fraction
- Lateral femoral traction
- Pelvic traction
- Complication of traction
- patient transport

The objective of the training may be achieved through different modes like

- Ward duties
- Emergency duties
- OPD duties
- Academic sessions: Journal club, clinical meeting, Grand round, Case presentation session, Morbidity/mortality review meeting/medical audit
- Seminars, conferences, workshops
- Lectures
- Bed side teaching
- Tutorials

Rotation for MS Residency in Orthopaedic Surgery

Total duration: 24 months

- Last 3 months of the part A : will be allotted for Assessment
- The remaining 21 months will be divided into 7 BLOCK as follows:

BLOCK	SPECIALITY	DURATION (MONTH)
1	Applied Anatomy, Pathology, Microbiology	3
2	General Surgery	3
3	General Surgery	3
4	General Surgery	3
5	General Surgery	3
6	Neurosurgery, Urology, Anesthesia & I.C.U, Radiology & Imaging, Physical Medicine	3
7	Physiology, Biochemistry, Pharmacology, Biostatistic	3

- ❖ First 6 months in Internal Medicine may be divided into first 3 months and last 3month..
- ❖ Placement will be either in Gastroenterology or Hepatology unit same person will not be placed in both units.

Section A : Case records (POMR) of patients managed by the resident

Block.....

Supervisor.....

SL No	Date	Name of patient with age & sex	Date of admission with hospital reg, Number, Ward & Bed No	Diagnosis	Grading	Signature of supervisor
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Grading: Excellent: 4, good: 3, Satisfactory: 2, unsatisfactory: 1

NB: (POMR) sheet should maintain & preserve by the resident

Section B: Procedures

Block.....

Supervisor.....

SL No	Date	Name of patient with age & sex	Diagnosis/ Indication	Procedure Performed	Performance of the candidate	Signature of supervisor
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Key for performance of the candidates:
Observer status – O
Assistant status – A
Performance under supervision –Ps, Performed independently -PI

Section C: OPD consultation

Block.....

Supervisor.....

Date	Consultation	Problem / Diagnosis	No		Signature of the supervisor
	1st FU				
	1st FU				

Section E: Journal clubs

Block.....

Supervisor.....

Sl. No	Date	Topic/Article	Source/ Re-source person	Performance level	Signature of supervisor
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Key for performance of the candidates:, Attended – A, Presented himself –P

Section F: Case presentation in clinical meeting, grand & ward round

Block.....

Supervisor.....

Sl. No	Date	Patient's name (age) Ward / bed, PIN	Level of performance	Diagnosis / Problem	Signature of supervisor
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Key for performance of the candidate:
Attended – A
Presented himself – P

Section G: Presentation / attendance in seminars, symposium/ workshops, Conference

Block.....

Supervisor.....

Date	Topic/Article	Source/ Re-source person	Performance level	Signature of supervisor
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Key for performance of the candidates:
Attended –A
Presented himself –P

H. Lectures attended

Block.....

Supervisor.....

Date	Topic	Lecturer	Signature

Section I. Interpretations of lab data and investigation reports

Block.....

Supervisor.....

Sl No	Items	Abnormality	Interpretation	Signature of supervisor

Section J. Leave record

Duration	From	To	Reason	Signature of supervisor

Section K. Summary Records : PAY1

Events	Performed				Signature of the yearmanager1
	Block-1	Block-2	Block-3	Block-4	
A) Case records(POMR)					
B) Procedures					
C) OPD consultation					
D) Emergency encountered					
E) Journal club					
F) Case presentation in clinical meeting, grand & ward round					
G) Presentation/attendance in seminars, symposium/workshop, conferences					
H) Lectures attended					
I) Data Interpretation					

Section L. Summary Records : PAY2

Events	Performed				Signature of the yearmanager2
	Block-1	Block-2	Block-3	Block-4	
A) Case records					
B) Procedures					
C) OPD consultation					
D) Emergency encountered					
E) Journal club					
F) Case presentation in clinical meeting, grand & ward round					
G) Presentation/attendance in seminars, symposium/workshop, conferences					
H) Lectures attended					
I) Data Interpretation					

Section M. Summary Records: PAY3 (if applicable)

Events	Performed				Signature of the yearmanager3
	Block-1	Block-2	Block-3	Block-4	
A) Case records (POMR)					
B) Procedures					
C) Outdoor duty					
D) Emergency encountered					
E) Journal club					
F) Case presentation in clinical meeting, grand & ward round					
G) Presentation/attendance in seminars, symposium/workshop, conferences					
H) Lectures attended					
I) Data Interpretation					

Section N. Summary Records: Phase A completion

Events	Performed				Signature of the Coordinator
	Block-1	Block-2	Block-3	Total	
A) Case records (POMR)					
B) Procedures					
C) OPD consultation					
D) Emergency encountered					
E) Journal club					
F) Case presentation in clinical meeting, grand & ward round					
G) Presentation/attendance in seminars, symposium/workshop, conferences					
H) Lectures attended					
I) Data Interpretation					

Section O. CERTIFICATION of satisfactory completion of the log book

I, to the best of my knowledge, certify that

Dr.....

has satisfactorily completed that logbook as required by the university

Signature of the Course coordinator

Name:

Discipline:

Date:

Section: D Emergency Duty Room

Block.....

Supervisor.....

SL No	Date	Name of patient with age & sex	Registration with Bed No	Diagnosis	Management	Signature of supervisor
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Grading: Excellent: 4, good: 3, Satisfactory: 2, unsatisfactory: 1

NB: (POMR) sheet should maintain & preserve by the resident

Clean Operation Theatre (COT)

Block.....

Supervisor.....

SL No	Date	Name of patient with age & sex	Registration with Bed No	Diagnosis	Management	Signature of supervisor
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Grading: Excellent: 4, good: 3, Satisfactory: 2, unsatisfactory: 1

NB: (POMR) sheet should maintain & preserve by the resident

Dirty Operation Theatre (DOT)

Supervisor.....

SL No	Date	Name of patient with age & sex	Registration with Bed No	Diagnosis	Management	Signature of supervisor
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Grading: Excellent: 4, good: 3, Satisfactory: 2, unsatisfactory: 1
NB: (POMR) sheet should maintain & preserve by the resident

Section C: OPD consultation

Block.....

Supervisor.....

SL. No	Date	New Patient	Old Patient	Approx No. of Cases	Signature of Supervisor

Note: If the pages are inadequate in number the candidate may inset extra photocopied sheets

Emergency Operation Theater (E.O.T)

Block.....

Supervisor.....

SL No	Date	Name of patient with age & sex	Registration with bed No	Indication	Operation	Level of Participation	Signature of supervisor
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Grading: Excellent: 4, good: 3, Satisfactory: 2, unsatisfactory: 1

NB: (POMR) sheet should maintain & preserve by the resident