



GOVERNMENT OF KERALA

Abstract

Health & Family Welfare Department – Medical Education Service – Academic – Implementation of Residency Programme in Government Medical Colleges in the State - Orders issued.

HEALTH & FAMILY WELFARE (S) DEPARTMENT

GO(MS)No.20/09/H&FWD

Dated, Thiruvananthapuram, 13.01.2009

Read:- Letter No.B2 - 28788/07/DME dated 18.10.07, 12.12.07, 02.08.08, 13.01.2009
And Letter No.G2-28355/07/DME dated 15.10.2007 from the Director of
Medical Education, Thiruvananthapuram.

ORDER

In 1995 Government had appointed a Committee under the leadership of Dr. M.A.Aleykutty, the then Director of Medical Education to study and submit a proposal for the implementation of Residency Programme in Government Medical Colleges in the State. The Committee submitted its report recommending to implement the Residency Programme. The Supreme Court has also spelt out some directions on the conduct of Post Graduate Medical Courses in India for following uniform norms in all institutions. One of these norms is the introduction of Residency Programme for Post Graduate students. In Kerala the Residency System has not been implemented so far. The Medical Council of India team during their inspections for recognition of Post Graduate Courses have pointed out this as a deficiency and have asked the Government to rectify this.

2. Even though the achievement in health status has been good, Kerala now faces problems like high morbidity, low maintenance of health infrastructure, under utilized facilities and manpower. The five Government Medical Colleges which make up the backbone of the entire health care delivery system of Kerala, gives care to lakhs of patients every year in various specialties. Residency Programme will help to develop all Government Medical Colleges in the state as Centers of Excellence, to achieve internationally accepted standards in Medical Education, Research and Patient Care and to provide high quality services, which are accessible and affordable to all.

3. Government have examined all aspects and are pleased to accord sanction for introduction of Residency System in the Government Medical Colleges in the State, with the following norms.

4. Residency Programme can be broadly stated as the Postgraduate Medical Training Programme regulated by the Medical Council of India/Government of India. Practically it is a Service-Cum-Training Programme. A Resident doctor has to function as the junior most staff member in their respective departments to provide teaching and training and services to the patients. They are the first level managers of specialty departments. A Resident has to carry out emergency duties, continuous patient care, on-call duties, duties as junior consultant to other departments, conduct teaching programmes to undergraduate medical, nursing and paramedical staff etc. The residency program will help to improve the responsibility of the postgraduate students towards patient care. Thus individual patient care will be improved, resulting in the overall betterment of health care system and achievement of global standards in the field of health care. The duties of all the postgraduate students will be defined based on the above norms and strict compliance will be ensured by the Principal and senior faculties.

5. Resident doctor will be a temporary employee of the institution. There will be Academic and Non-Academic Residents. Academic Residents are trainees who are simultaneously doing patient care duties and under going Postgraduate Degree/Super specialty degree/Diploma/DNB courses. The Non-Academic Residents are the doctors working in a department by appointment on contract basis or through compulsory bonded posting or any other temporary methods. Post MBBS candidates will be called as Junior Residents and post PG degree candidates will be called as Senior Residents (Academic) and will have the following duties, responsibilities and powers.

6. Resident training will be made more patient centered and responsibility based. Each patient will be seen by a specified Resident. Each Resident will report to the specified Consultant/faculty with full medico legal responsibilities. Daily case presentations will be done by

Residents. Interns will be at the Residents' disposal. The nursing and other paramedical staff shall be bound to execute orders/instructions of a resident with respect to the care of patients and other hospital services. All patients will be attended to personally by the designated Resident. All the Residents have to stay in the campus only. Unit Chief/Consultant/Senior doctors will be informed of the patients' conditions by the Residents if required. The Residents belonging to non-clinical, pre-clinical and para-clinical departments will also have duties as envisaged in the manual annexed to this order or as directed by the Principals/Head of Departments concerned.

7. The monthly stipend for the Residents is fixed as follows, with effect from January 2009.

Post Graduate degree students : Rs.18,500/-

Post Graduate Diploma students : Rs.18,500/-

DNB students : Rs.18,500/-

Super Specialty Degree students : Rs.21,000/-

8. At the end of the Residency Programme, an experience certificate outlining the nature of duties performed will be issued by the Principal of the concerned colleges to the Residents.

9. College level and state level co-ordination and monitoring committees will be formed for the smooth, speedy and effective implementation of Residency programme. In each college the Principal will constitute the committee consisting of eight members other than the Principal. Four members each will be from the faculty side and the Residents side. The Principal will act as the Chairman of the committee. The committee will meet at least once in a month or as and when required to evaluate the progress and effectiveness of the residency programme for effective implementation. If the committee is not able to sort out any problems, the matter will be reported to DME for immediate intervention. The Principals will arrange to conduct Seminars/workshop/power point presentation etc to provide effective training to the doctors under the Residency Programme and other staff for improving the effectiveness of the system.

10. In the state level monitoring committee Director of Medical Education will be the Chairman/Chairperson. A nominee of the Health Secretary,

JDME (Medical) and Principals of Medical Colleges will be the members of the committee. The state level monitoring committee will monitor the implementation of residency programme in the colleges. The committee will meet at least once in a month and evaluate the process. If any difficulty or shortcoming is noticed, it will be rectified immediately if it is within the powers of the DME. Otherwise, it will be reported to the Government immediately for further action.

11. A manual for Residency Programme elaborating the features and working pattern, duties of the Residents and Medical Officers and other norms of the programme is annexed herewith. The Residency Programme will be implemented on the basis of this manual, which can be modified from time to time by the Government in overall public interest.

By Order of the Governor

DR.VISHWAS MEHTA
Secretary to Government

To

The Director of Medical Education, Thiruvananthapuram
The Director of Health Service, Thiruvananthapuram
The Director of NRHM, Thiruvananthapuram
The Principal, Medical College, Thiruvananthapuram/Alappuzha/Kottayam/
Thrissur/Kozhikode
The Superintendents, Medical College Hospitals, Thiruvananthapuram/
Alappuzha/Kottayam/Thrissur/Kozhikode
The Director of Public Relations, Thiruvananthapuram
The Accountant General (A&E/Audit), Kerala, Thiruvananthapuram
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Section Officer



**GOVERNMENT OF KERALA
HEALTH & FAMILY WELFARE DEPARTMENT
MEDICAL EDUCATION SERVICES**

**RESIDENCY PROGRAMME
IN GOVERNMENT MEDICAL COLLEGES**

MANUAL

2009



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RESIDENT STATEMENT OF COMMITMENT

The Medical College expects its learners to adhere to the highest standards of ethics and professionalism in the discharge of their duties in their relationships with their patients, faculty, colleagues and the staff of programmes and institutions associated with their training. The Residents' Statement of Commitment is as follows:

1. We acknowledge our fundamental obligation as physicians to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.
2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behavior required to fulfill all objectives of the educational programme and to achieve the competencies deemed appropriate for our chosen discipline.
3. We embrace the professional values of honesty, compassion, integrity, and dependability.
4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all our interactions. We will respect all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability, or sexual orientation.
5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.

7. We recognize the need to be open and truthful to our patients, faculty, and colleagues about matters related to patient care including medical errors that may affect the safety and well-being of patients, the care team, or associated institutions.

8. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.

9. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.

10. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.

11. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

12. We shall keep scientific while discharging as clinical works, by applying the Principles of evidence based medicine practice and use every opportunity to share our knowledge with our colleagues and faculty.

13. We will try to involve in, assist and support all ongoing research activities in the institution or initiate new research under the supervision and guidance of senior faculties, with the permission of the head of departments.

14. We will not disclose any information regarding the patients, workplace or colleagues to anybody other than the persons legitimately concerned with this information as a part of the team is the department and by all means only for providing genuine benefit to the patient. Any disclosure of information to media or private investigating will be with the prior permission of our senior faculty or responsible senior officer.



THE RESIDENCY PROGRAMME

The Director of Medical Education, Kerala State conducts Post Graduate Medical Courses in various disciplines. A total of 276 seats in P.G. Degree courses, 41 seats in Super Specialty degree courses, 172 seats in Diploma Courses and 226 seats in DNB are available in all the five Government Medical Colleges in the State as on 1.1.2009. As part of improving the quality of health care delivery system, medical education and training, the government have decided to implement Residency Program in Post Graduate Medical Education in Government Medical Colleges in the state.

Residency is a phase of transition from a mature student to a fully competent and confident consultant. This is the phase of accumulating clinical knowledge, acquiring skills, especially leadership and organizational skills in ward and OP setting, procedural and therapeutic skills, communication and counseling skills and also developing positive attitude in clinical work, reflecting confidence, competence and empathy to patients. Building positive work culture and keeping better interpersonal relations are important in the complex hospital environment and Residency period provide a unique opportunity to the medical students to gain expertise in clinical workmanship, develop intimacy with patient. It will also help the Residents to understand the intricacies of health care system and notional health programme development.

The Residency program is considered as '**patient-centered**' and '**responsibility based**'. This will improve the commitment of the post graduate students towards patient care as they will be looked upon as responsible staff members of their respective departments. Each patient will have a designated resident and designated consultant and an array of senior consultants to help. Individual care and attention to each patient by the resident or consultant will help to improve the quality of patient care in Government Medical Colleges to a level in par with the national Medical Institutes. The Post Graduate Academic Training will also receive a major boost as Residents become responsible first level managers in patient care in Medical College Hospitals.

- The Residency programme consists of Senior Residents and Junior residents.
- The Residency Programme consists of Academic Residents and Non Academic Residents.
- All postgraduate students (defined as one who is studying for MD/MS/Diploma/DNB/DM/Mch programme in Government Medical Colleges of Kerala) shall be Academic Residents.
- The Doctors appointed through Contract Basis or through Compulsory Bonded obligation in Medical Colleges shall be Non Academic Residents.

- All doctors doing MD/MS/Diploma/DNB (General specialties) courses shall be regarded as **Junior Residents (Academic)**.
- All doctors doing DM/MCh/ (Super specialty) courses shall be regarded as **Senior Residents (Academic)**.
- The doctors who have MBBS degree and have been appointed on Contract basis or as per bonded obligation shall be **Junior Residents.(Non Academic)**
- The doctors who have Postgraduate degree and have been appointed on Contract basis or as per bonded obligation shall be **Senior Residents (Non Academic)**.
- A Resident will be on duty for 24 hours. The duty Register will be issued by the concerned Heads of Departments.
- All the Residents have to stay in the campus and for which Government will try family accommodation with in the campus. In case accommodation is not provided and if they are staying outside the campus they must be within reach for emergency call duty.
- For Non-Clinical, Pre-Clinical and Para - Clinical departments also, suitable ward/ patient care duty will be assigned along with laboratory and other similar duties as decided by the HOD/Principal.
- The Residency program is a Service-cum-Training program. The focus of Post graduate training will shift to "Learning by doing"
- Residents shall be considered as temporary employees of the institution .
- The post graduate students will have to sign a contract with the Government before commencing their course to be counted as a Resident. Ordinarily, the period of residency will be 36 months for MD/MS/DM/Mch/DNB courses and 24 months for Diploma courses.
- The course period of Academic Residents and the period of service of Non Academic Residents shall be counted as teaching experience and a certificate to that effect shall be issued by the Principal at the end of the training.

Note:- Duties and responsibilities of Residents and Lecturers doing M.D/M.S/Mch/DM/DNB/Diploma courses shall be fixed by the concerned institutions from time to time in consultation with the DME and Government if necessary. They will be required to perform such work as may be needed in the legitimate interest of patient care in the hospital.

GENERAL DUTIES AND RESPONSIBILITIES OF RESIDENT/TRAINEE

The primary function of patient care lies with the doctors ranging from the Senior Consultant (faculty) to the Senior and Junior Residents. After the patients are advised admission by the treating doctors, the patient reaches the ward and is admitted over the allotted bed in the ward. The bed of the patient is prepared by the nursing staff. The Junior Residents in the ward now work out the case and discuss with the Senior Residents. After the final consultation with the consultant, the patient is advised investigations and treatment in the ward is commenced. This is carried out with the help of nursing and other paramedical staff. Interns will be at Residents' disposal. The Interns, Nurses and other Paramedical Staff are bound to execute orders and instructions of a Resident in the interest of patient care. While in the ward, the patient is looked after by the faculty members and residents, besides the other staff. The Resident in charge of a patient is directly responsible for the clinical care of the patient, but he/she would be under the supervision of his/her consultant or Senior Faculty. He/She shall follow-up patients under his/her care until the patient is discharged.

Junior Residents (Academic & Non Academic)

The duties of Junior Residents shall be patient care and undergraduate teaching. The norms of patient care by Junior Residents shall include, but not limited to the following: -

- Each Junior Resident shall be given the charge of a specific number of patients in a unit or ward by the Unit Chief/Senior Faculties and he/she has to plan and execute the requisite patient care in concurrence with Unit Chief /Senior Resident / faculty members on duty if required.
- Examination of the patient and formulation of a diagnosis.
- Planning and implementing the treatment protocol. It will be in concurrence with Unit Chief/Senior Resident / Faculty Members on duty if required.
- Ensure that the Medical Records of the patients are kept in proper order.
- House-surgeons, Nursing and Paramedical Staff are to be under the supervision of the Junior Residents also in patient care. They are bound to execute orders /instructions of the Resident in this regard.
- Declaration of deaths and issuing Death certificate in wards.
- In case of death in medico legal / complicated cases, declaration and certification of death should be done by the Senior Resident (non academic) or faculty member on-duty only.

- Junior Residents are not permitted to issue wound certificates, medical certificates, treatment certificates or any other medico legal certificates.
- Junior Residents of Non-clinical, pre-clinical and para-clinical departments shall adequately support the clinical services of the institution. Duty hours and working pattern shall be similar to clinical departments. They have to provide the necessary laboratory and other ancillary services in time. They shall involve in research activities and inter-departmental clinical discussions, journal clubs, seminars and other academic programs.
- Junior Residents may be directed to take classes for undergraduate medical students. The course period of Academic Residents shall be counted as teaching experience.
- The Junior Residents shall involve in research activities.

Senior Residents (Non-Academic)

- The duty of Senior Residents (Non-academic) will include patient care, teaching, research and handling of medico legal responsibilities.
- Senior Residents (Non-academic) will be actively involved in patient care and teaching with concurrence of senior staff members or unit chief/HOD.
- All Junior Residents, House surgeons, nursing staff and paramedical staff will be under the supervision of Senior Residents also in patient care. They are bound to execute orders of the Senior Residents.
- The service period of Senior Residents shall be counted as teaching experience.
- The Senior Residents (Non-academic) shall involve in research activities.
- The norms of patient care by Senior Residents(Non-academic) shall include, but not limited to the following:
- Each Senior Resident (Non-academic) shall be given the charge of a specific number of patients in a unit or ward by the Unit Chief or Senior Faculties.
- Examination of the patient and formulation of a diagnosis.
- Planning and implementing the treatment protocol. It will be done in concurrence with the Unit Chief/Senior staff members if required. Ensuring that the Medical Records of the patients care are kept in proper order.
- In case of death in medico legal / complicated cases, declaration and certification of death should be done by the Senior Residents (Non- academic) or faculty member on-duty only.
- Writing or issuing wound certificates, medical certificates, treatment certificates or any other medico legal document is the responsibility of the faculty member or the Senior Resident (Non-academic).
- Senior Residents of Non-Clinical pre-clinical and para-clinical departments shall adequately support the clinical services of the

institution. Duty hours and work pattern shall be similar to clinical departments. They have to provide the necessary laboratory and other ancillary services in time. They shall involve in research activities and interdepartmental discussions, journal clubs, conferences and other academic programmes.

Senior Residents (Academic)

The duties of Senior Residents (Academic) are to be patient care, research and teaching the Junior Residents and undergraduates. The norms of patient care by Senior Residents (Academic) shall include but not limited to the following :-

- Each Senior Resident (Academic) shall be given the charge of a specific number of patients in a unit or ward by the Unit Chief and he has to plan and execute the requisite patient care. It will be in concurrence with the Unit Chief/Senior staff member or medical officer on-duty if required.
- Examination of the patient and formulation of a diagnosis.
- Planning and implementing the treatment protocol. It will be in concurrence with senior staff members or medical officer-on-duty.
- Junior Residents, House-surgeons, Nursing and Paramedical Staff are to be under the supervision of the Senior Residents (academic) also in patient care. They are bound to execute orders of the Senior Resident.
- Declaration of deaths and issuing death certificate in wards.
- In case of death in medico legal / complicated cases, declaration and certification of death should be done by the Senior Resident (non academic) or faculty member on-duty only.
- Senior Residents (Academic) are not permitted to issue wound certificates, medical certificates, treatment certificates or any other medico legal documents.
- The Senior Residents (Academic) may be directed to take classes for Undergraduates and Junior Residents. The period of service as Residents shall be counted as teaching experience.
- The Senior Residents (Academic) shall involve in research activities.

Rotation

The duty assignment for each resident / trainee will be noted in the following areas;

1. Ward
2. Casualty/Emergency Room
3. Out- Patient Department
4. Medical/Surgical ICU
5. Sub specialties

Hours of work

- A 60-hour weekly limit, averaged over four weeks;
- An adequate rest period, which should consist of 10 hours of rest between duty periods;
- A 24-hour limit on continuous duty, and up to six added hours for continuity of care and education;
- One day in seven, free from patient care and educational obligations, averaged over four weeks;
- In-house call no more than once every three nights, averaged over four weeks;
- The option, for programs in some specialties, to request an increase of up to 8 hours in the weekly hours, if this benefits resident education.
- 72-hours was chosen as the upper limit to safeguard against the negative effects of chronic sleep loss, and a limit of 24 hours plus up to six hours selected to address the effects of acute sleep loss, and to allow for adequate time for patient hand-off and didactic learning.

Attendance and Leave

All the 365 days of the year are working days for Residents. The Resident should have a minimum percentage of attendance as stipulated by the Universities. During the term of course work/employment, the Residents shall be entitled to 20 days casual leave in a year and 15 days special leave to participate in conferences and seminars. Maternity leave upto four months would be allowed with full stipend for women.

All Residents are eligible for weekly off for one day. This will be allowed by the Head of the Department concerned without affecting the routine functioning of the department. Weekly-off cannot be accumulated.

CMEs, Workshops and other academic programs conducted by recognized academic bodies are essential aspects of postgraduate training program. All Residents may be permitted to attend such programs without affecting the routine working of the departments concerned. The Heads of the Departments shall sanction 15 days special leave to the Residents provided they apply for leave four weeks prior to the CME program and the Heads of the Department is convinced about the genuineness of the program and utility for the particular course. The Resident on returning from the program should submit attendance certificate and report to the Head of the Department.

The candidate will be eligible for "leave under exceptional circumstances", supported by medical certificates (subject to verification by medical board) recommended by the Head of the Department, sanctioned by the Head of the Institution and approved by the Director of Medical Education. If extra leave is taken over and above the eligible leave on medical grounds certified by medical board, stipend would be given either during the period of leave or during the period of extension.

Those who take leave without prior sanction are to be considered as on unauthorized absence. If he/she is on unauthorized absence for more than 10 days, he/she will be terminated from the training program and liquidated damages will be levied.

No Resident shall leave the country without prior sanction of the Director of Medical Education. Any violation will be seriously warranting termination of his/her training.

Private practice

Residents shall not engage in private practice of any sort during the course of study. They shall not refer patients under their care to outside institutions without approval of the Unit Chief/HOD.

Resident-Faculty Relation

This will be mostly informal. The Resident can approach any faculty member for academic doubts during office hours. Infra unit presentations, seminars or assignment may be given and evaluated by the Unit Chief or senior faculty nominated by HOD/Unit Chief.

Dress Guidelines

The Medical Colleges have no formal dress code for residents. However, given the special nature of dealing with patients and their families, there are certain guidelines that are appropriate. Professional appearance and demeanor are a demonstration of respect for the patient and the profession, and of self-respect. This professional appearance and demeanor should be maintained at all times by faculty, residents, and medical students. Individual department will inform residents of standards or requirements unique to that department. The resident must abide by the prevailing standards of the facility. In general, clothing should be clean and in good repair. Shorts, T-Shirts and Exercise clothing are not permissible. A clean clinical jacket, or other professionally appropriate attire, must be worn at all times while on duty. Residents should wear identity cards during duty hours.

DISCHARGE OF DUTIES

Duty of a Junior Resident during 12- hour duty

There will be a Resident on 12- hour duty for two wards. There will be a house- surgeon on duty in each ward. The House surgeon-on-duty will call the resident-on-duty (12-hour-duty) if needed.

Duty of a Junior Resident during 24- hour duty

Beds in wards will be divided among Junior Residents. He will be responsible for the patients to whom he/she is assigned. He/she can be called upon by the resident on 12-hour duty for matters pertaining to the patients to whom she/he is assigned, 24 hours. All patients, operative or non-operative, seen by him/her may be referred to the appropriate consultant. On any occasion in which the consultant on-duty is not located for a period of 30 minutes, the patient should be referred to another appropriate consultant. In extreme emergency, the patient should be referred to whoever is physically present and

in close proximity. At the end of duty the responsibility will be transferred to the incoming team without interruption in the patient care.

Senior Resident on call

It is the duty of the units-on-call (admitting units) and their Senior Residents to inform their whereabouts and the mobile numbers. They should immediately attend the call and should not wait to finish off the OPD or ward round. They should be available in their duty rooms during the night. If the Senior Resident of the concerned unit does not come to see the patient in the Casualty / ward within 30 minutes, the CMO or Duty MO can call the consultant on-call. The Senior Residents will also see the consultations from other departments, similar to that of the faculty.

The Out Patient Clinic

- All medical / surgical trainees must conduct themselves and behave as thorough professional.
- Patients must be treated with compassion and consideration.
- A trainee assigned to the OPD is expected to be at his/her post on time.
- All follow-up patients will be seen at the OPD by the Residents.
- Any difficult or unusual case or any case requiring further assessment and / or opinion must be referred to the appropriate consultant.

WARD WORK & ADMISSION PROCEDURES

Admission procedure for General Wards

Patient needing admission to the wards for further management can be admitted from the OPD / Casualty directly through the central admission counter.

Types of patients to be admitted

1. Patients seen in general OPD, who are sick enough or have a diagnostic problem needing detailed evaluations, are admitted directly.
2. Patients seen in Specialty clinics, being run under the purview of general disciplines, needing admission may also be admitted in general ward under the unit-on-call for that day of the week.
3. Patients presenting in the Casualty with acute and serious illness needing hospitalization can also be admitted in general wards.

When and whom not to admit

Patients who can be treated and/or investigated at the OPD level as ambulatory patients should not be admitted.

1. Ambulatory patients, who are being followed up in clinics run by Specialty departments, are not admitted in general wards.
2. As a rule, irrespective of the general medical or surgical unit which may have seen the patient on his or her first visit, the patient needing admission due to acute problem on a particular day is admitted under the unit-on call for that day of the week. Such an acutely ill patient should not be referred to the unit which saw the patient on his/her first visit and is not on-call for that particular day.

Admission Procedure for the Emergency Wards

The CMO or Resident of the unit decides on the admission. The CMO or Resident directs the patient to the Central admission counter for admission. Respective departments should shift their patient from emergency wards within 36 hours of their admission day. It is the responsibility of the unit (to whom the patient belongs) to transfer the case back to their own ward at the earliest so that admission of other units does not suffer the next day.

Admission procedure for the pay wards

Generally, Pay Ward admissions are "Elective" admissions of patients, who can afford to pay the charges. A consultant advises the admission of the patient to the pay wards on the OPD card. These patients are registered and kept on a waiting list. When a room falls vacant, they are informed about the vacancy and are advised to report on a particular date and time.

Admission of the patients to the hospital from the Specialty clinics

Two different procedures for different categories of patients have been defined.

1. Specialty clinics being run within the purview of a full clinical department (e.g. Medicine, Surgery, Pediatrics, Psychiatry, Obstetrics and Gynecology, Dental Surgery, Orthopedics, Oto Rino laryngology, Dermatology and Venereology);

Patients needing admission are called on the admitting day of respective units but in case of very sick patients seen in Specialty clinics, they may be referred to Casualty for admission on beds of the unit on- call for that day. For example, if a patient of chest clinic (department of medicine), which is held on Monday, is very sick and needs admission on Monday, he will be referred to the Casualty where the admitting unit for Monday (say unit-I) will see the case and admit on their beds. The same procedure is to be followed for admission of the patients from the majority of the clinics (such as diabetic clinic, thyroid clinic,

geriatric clinic, stroke clinic, head injury clinic, stone clinic etc.) being run under the purview of general departments.

2. Specialty Clinics being run by the Specialty departments (e.g. Radiotherapy, Gastroenterology, Pediatric Surgery, Nephrology, Surgical Gastro enterology and Genitourinarysurgery);If separate beds are available for these departments they can admit directly on their beds.

3. Admission procedures for the specialty wards and beds:
There are 3 inlets for admission to these wards.

1) From the Specialty clinics: Patients seen in the Specialty clinics run by the Specialty departments may be advised admission to their wards directly. The formalities of admission are the same as described above.

2) From the Casualty: Occasionally a patient seen for the first time in the Casualty may have an illness which makes him more suitable for admission and care by a specialty department. The CMO may directly, or in consultation with the Senior Resident of the general discipline, call the Senior Resident of the specialty department who may admit the patient directly under his care.

3) Ward Transfers: Occasionally a patient may be admitted to general wards and later due to the special type of care required due to patient's illness, he or she may be transferred to the specialty wards. In this case, the bed has to be provided by the concerned specialty.

Routine Investigations and Procedures

All routine investigations are done in morning hours and investigation forms for the same are filled the previous night by doctor-on-duty and handed over to night nurse so that she gets ready for collection of various samples. Routine procedures and dressing for ward patients are to be done preferably in morning hours following the rounds with consultant as maximum number of staff is available during morning hours.

For the purpose of management of indoor patients, beds are generally divided among the Junior Resident for the purpose of treatment and monitoring under the direct supervision of the Senior Resident. Senior Resident is responsible for over all supervision of all patients.

Case Sheet Maintenance

Case sheet is an important document for patient care, medical records and medico legal purposes. Case sheet is the property of the hospital. It has to be maintained properly. The final responsibility for the case sheet upkeep is that of Senior Resident, who will ensure that it is complete with the help of House Surgeons and Junior Residents. Case sheets should be modified so that the impressions and orders of the different levels of the clinical teams are explicitly stated.

The following sequence has to be adhered to in arranging the case sheet:-

1. Face sheet
 2. Consent form
 3. History and physical examination
 4. Investigation.
 5. Notes of JR In charge of bed and Senior Resident (with names)
 6. Current treatment orders
 7. Old treatment orders
 8. Progress notes (including transfer notes)
 9. Instructions of Consultant In charge (with names)
 10. Opinion of other consultants.
- After entering the data and the results of various investigations, the actual forms may be disposed off.

Progress Notes

Progress notes should be accurate and descriptive and should not contain phrases like "GC good/Fair, pulse normal; every note should be preceded by date and time. Following guidelines are suggested for writing progress report.

For acutely ill patients, progress notes of pulse, respiration, temperature, blood pressure, intake-output, treatment given and other relevant facts should be written round the clock at intervals deemed necessary by Senior Resident (2 hourly, 4 hourly etc.)

For routine patients progress is to be written under the "S" "O" "A" "P" headings.

S = Subjective findings

O = Objective findings

A = Assessment

P = Plan of action

The subjective and objective findings are noted by Junior Residents whereas the assessment and plan of action is decided by Senior Resident in consultation with Consultant In charge.

Daily notes must be noted down by Junior Resident.

A fresh progress report should be written:-

- When a sudden change in clinical picture has occurred or some new findings have appeared.
- When there is some relief or disappearance of signs and symptoms spontaneously or consequent to treatment.
- When a drug is stopped or a new drug is started.
- When some important decisions regarding management are taken.
- Prior to invasive procedures.
- Prior to surgery and post surgery.

A system of monthly **Medical Audit** in all departments should be implemented. Residents shall help the faculty in this process. Weekly **Chart meetings** are to be held in each unit. All case sheets should be completed within a week and ICD diagnosis shall be entered before it is being sent to the records library with the help of the records library staff. The residents should make sure that the case sheets and records are made available through computer online if facilities are available.

In the event that an emergency situation like cardiac arrest, shock etc occurs in the ward the Resident/trainee must respond without considering whether the patient is under one's care or not. The **emergency treatment room** in each ward with required facilities and equipment for monitoring and resuscitating patients (cardiac monitor, defibrillator, oxygen supply etc) and with a ready stock of essential life-saving medications will be supervised by the resident.

CASUALTY WORK

In casualty the CMO is the final authority and he/she is fully responsible for the complete management of the patient. It is also expected that each and every patient visiting the casualty must be seen by the concerned CMO/Resident, depending on the nature of the patient's illness, of the Medical or Surgical specialty, at least once, before the patient is finally disposed off. Patient can be directly admitted to the ICUs from the casualty after consulting with the Duty MO or Senior Resident in charge.

If the faculty posted in the casualty does not have the post graduate degree in the respective field, a JR-2 or JR-3 should be posted along with them.

Referrals to specialty centers

All acute emergencies of whatever nature arising in any other centers can be referred to and from casualty directly. The concerned department of these centers should receive such case without delay and provide immediate medical aid. Concerned departments should be informed about such a case in advance. The decision to transfer such a case will rest with the respective consultants.

Consultations in Casualty

Senior residents-on-call of the subspecialties such as Ophthalmology, Dermatology & Venereology, Psychiatry, Pulmonary Medicine, Cardiology, Neurology, Medical/Surgical Gastroenterology, Neuro surgery, Cardiothoracic Surgery, Genitourinary Surgery, Paediatric Surgery, Plastic Surgery, Gynaecology etc. may be called upon by the CMO if she/he thinks that the patient needs their evaluation and treatment. It is the duty of CMO to provide necessary emergency care before calling the senior resident-on-call. If the senior resident is not responding, immediate treatment, like I/v infusions, blood transfusions and maintenance of a clear and adequate airway must be

carried out by the CMO. If senior resident is not available the CMO should contact the consultant-on-call. Senior Residents of subspecialties can admit patients directly to their unit from casualty.

Responsibilities in the Casualty

There could be occasions when there is a controversy regarding the unit, departments or discipline to which a patient is to be admitted. The patient may be sick enough to deserve admission but the different department/units may not be agreeing as to who would have the primary responsibility of such a patient. Most of such situations arise in the case of patients with multi-disciplinary problems. General guide-lines for such patients are given below. But as a standing hospital rule, in all such situations, the opinion of the officer-in charge of the casualty is final.

Multiple injuries

In patients with injuries involving abdomen as well as other systems, the general surgical unit on-call would take the primary responsibility of the patient care. The management is carried out in consultation with other concerned departments or units. On the other hand, injuries involving head, neck, chest, pelvis or extremities, the patient will be admitted under the specialty which, because of a particular organ-system being mainly affected in the accident, would take the primary responsibility of the patient.

Combination of surgical and medical diseases

In such situations, the problem of immediate importance would decide the primary responsibility.

Instructions regarding deaths in the casualty

Patients who die in casualty should be given death certificate by the CMO/Resident or the senior resident/junior resident of the clinical unit. The CMO should ensure that the body is sent to the mortuary with due care and consideration. The CMO should make every effort to promptly inform the relatives of the patient who dies in the casualty. When the relatives arrive in the casualty, the CMO should show due courtesy and sympathy to them and help them in every possible way in the disposal of the dead body. Use of the hospital telephone by the relatives of the deceased may be permitted in such cases. Every death in the casualty department should be reported in writing and sent directly to the Medical Superintendent, giving particulars of the case and brief resume.

Instructions regarding patients who are dead on arrival at the casualty

All cases "brought in dead", and where the actual cause of death is not known, should be handed over to the police for suitable action. Action should be initiated as follows:

(i) The name of such cases should be entered in the casualty attendance register along with all the possible details about the dead person obtained from the accompanying relatives whose name and address should also be noted and recorded in the remarks column of the register.

(ii) In case where death has occurred due to natural causes and there is no suspicion of any foul play, the dead bodies may be handed over to the relatives on their request and this must be recorded with signatures of relatives or attendants.

(iii) All other cases where death has occurred due to accident, assault, burns, suicide, poison, rape or any other causes where it is suspected that death has not been due to natural causes, must be registered as medico-legal cases (MLC) and the police authorities informed accordingly.

(iv) In all the above cases, the out-patient tickets and the death reports duly completed must be forwarded to the medical superintendent for onward transmission to the Medical Records Section.

Instructions regarding medico-legal cases

A medico-legal situation is defined as one where there is an allegation, confession or suspicion of causes attributing to body injury or danger to life.

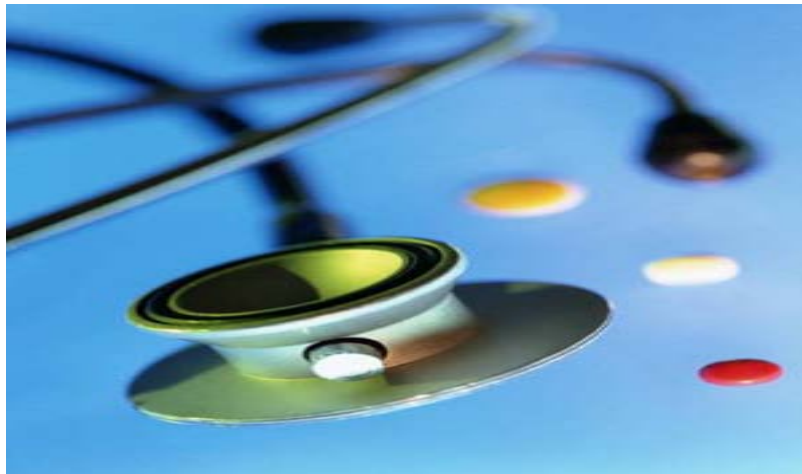
The CMO/Resident is advised not to enter into any arguments with the patient, relatives or attendants regarding the medico-legal aspects of the case. This problem must be left entirely to the Police personal on duty. The Casualty Medical Officer's/Residents foremost duty is to render medical aid to the patient. All such cases should be promptly entered in the bound medico-legal case register available in the Casualty. The CMO should see that the register pages have been properly numbered and that each entry is properly and adequately made. Special emphasis should be given to clear and legible entry of the name, address, time of arrival of the patient and to the cause and nature of injury. Signature should be in full with the name of CMO/Residents given in capital letters. At least two marks of identification should be carefully entered. A copy of the report and the register should be handed over to the police for safe custody. No unauthorized person should have access to the medico-legal records (including medico-legal register) without the written consent of Medical Superintendent or any other officer authorized by him. All exhibits of legal importance (gastric lavage etc.) should be immediately sealed and delivered to the police and their signatures obtained in the book. In all medico-legal matters, where the CMO/Resident is in need of expert advice, the faculty on call from the Department of Forensic Medicine should be contacted and proper guidance obtained.

The following points may be considered while dealing with M.L.C. cases:

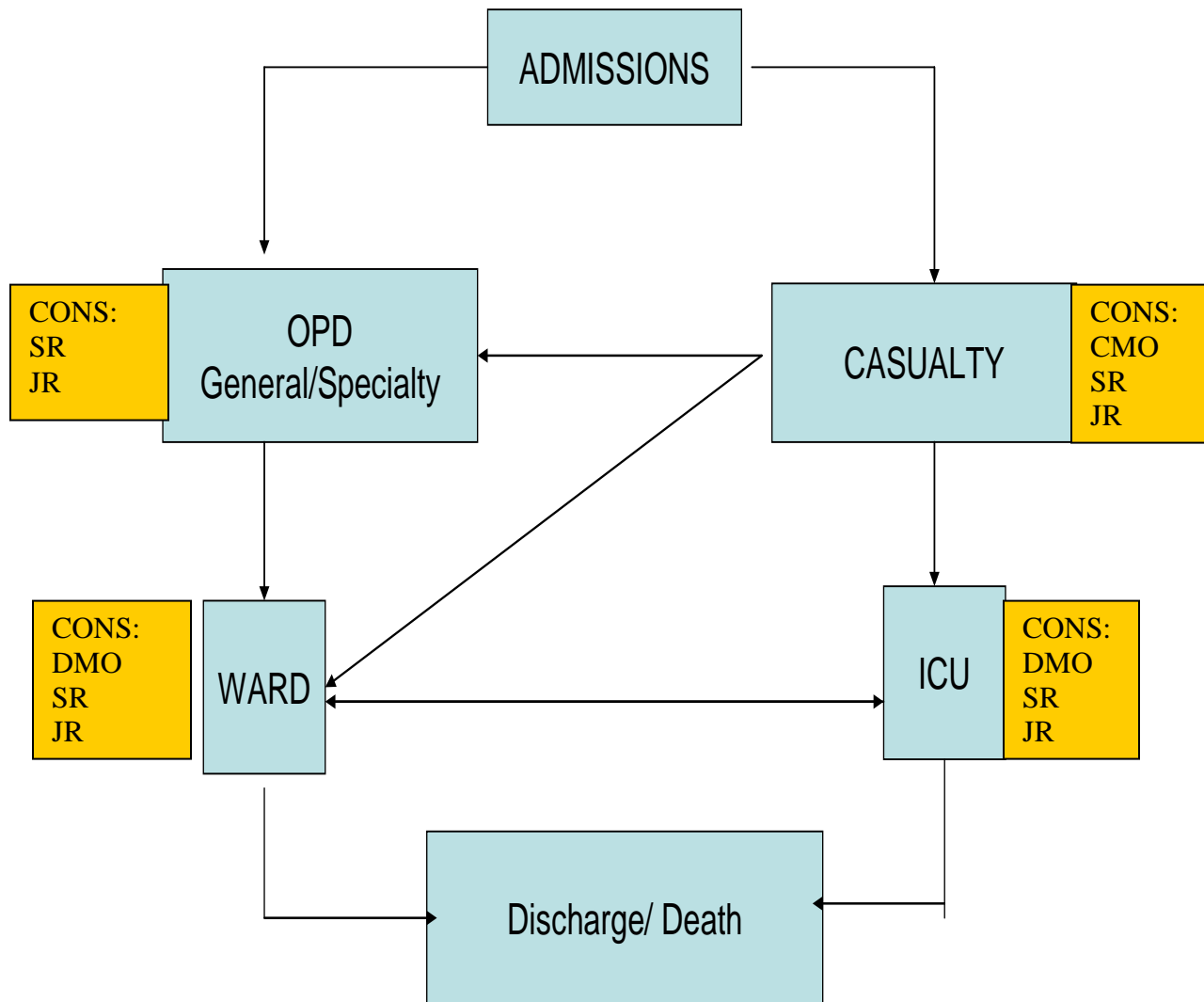
1. Each entry of identification data of patients in the MLC register should be made by the CMO and not by the Police Officer.
2. The MLC reports should be prepared by the CMO's and not by the Interns.
3. Nature of injuries should be recorded in every MLC case.
4. The CMO should write his/her full name in block letters along with the signature for adequate identification.
5. X-ray reports should be entered within 7 days in MLC register and this can be done easily by the CMO's in the morning shift.
6. X-ray department is requested to provide the X-ray report within 48 hours.
7. Remarks of the specialists should be entered in the MLC register and signed by the specialist with his/her name clearly written in block letters.
8. The police officer posted in the casualty should expedite the completion of all MLC reports within 7 days.

Instructions regarding Rational Drug use and prescriptions

All Residents should be committed to the policy of rational drug use and standard prescription practice. The prescriptions should be given for medicine from the hospital drug formulary as far as possible. It should be in strict compliance with the departmental protocols and Standard Treatment Guidelines.



MEDICAL STAFF PATTERN IN RESIDENCY PROGRAMME



CONS: Consultants
CMO Casualty Medical Officer
DMO Duty Medical Officer
SR Senior Resident
JR Junior Resident

FUNCTIONS OF DUTY MEDICAL OFFICER

1. **Shortage of beds**

As per the policy guidelines, all seriously ill patients needing admission and who cannot be transferred to the other hospital are to be accommodated in the hospital, even if no bed is available with the admitting clinical unit.

2. **Admission Blocking**

To monitor and maintain effective control of bed utilization of emergency ward, every morning, the Duty Officer blocks the routine admission of departments who have occupied the emergency beds beyond 48 hours. The Senior Resident or Duty Medical Officer of the admitting unit should shift the patients from beds occupied in emergency ward beyond 48 hours, to his/her own ward in order to get the block released for routine admissions.

3. **Referrals**

For referral of patients from Casualty to other hospitals because of non-availability of beds, the CMO shall contact the Duty Officer. He/she shall discuss with the hospital where the patient has to be shifted and arrange the logistics in the form of a vehicle under his/her control and give instructions to shift the patients to other hospitals.

4. **Communicable diseases**

As per hospital policy, no communicable disease patient should be admitted without an isolation facility. He/she shall be shifted to the Infectious Disease Department Arrange isolation or provide an ambulance for transporting such a patient.

5. **Seeing Consultations**

Duty Medical officer shall see consultations from other departments.

6. **Absence of personnel**

In the case of absenteeism of housekeeping personnel, ECG technician and radiographer, the Sister I/c. of the ward/O.T./Casualty should try to make necessary arrangements. If the things are not sorted out in spite of the efforts of Sister in-charge, then they will report it to the Duty Medical Officer. The Duty Medical Officer then should ascertain the cause of problem and take necessary action.

7. Conflict between two parties

Conflict between residents, resident and staff, resident and patient, staff and patient etc. which could not be sorted out locally should be brought to the notice of the Duty Officer. He/she should try and speak to both the parties to diffuse the conflict or to arrive at an amicable solution. If it involves public, the Superintendent and Public Relations Officer will be informed at the earliest.

8. Shortage of supply

It is the responsibility of the Sister I/c. of the ward/O.T./Casualty to arrange their supplies from the hospital store. In the absence of a particular item/any new item the resident should inform the Sister I/c. who in turn shall arrange it from stores or contact the Duty Officer for a local purchase during odd hours.

9. Engineering problems

It is the responsibility of the Sister I/c. of the ward to make complaints with the engineering section for any minor/major repair. If these faults are not rectified within a reasonable time, the users will inform the Duty Officer along with the complaint number and time of complaint. Duty Officers should ascertain the reasons for delay and if not satisfied shall directly communicate to concerned executive engineer for the needful.

10. Security problem and patient absconding

In all the cases the Security and Duty Officer both should be informed. Information to the Duty Officer shall aid in expediting the security Officer's intervention.

11. Preservation of body and embalming

During odd hours, the Duty Officer can give permission for keeping the body in the mortuary after verifying the death certificate and police clearance certificate. For embalming during odd hours the Duty Officer shall coordinate with the Consultant in Anatomy and provide transportation to the team and facility.

12. VVIP Emergency and Disaster

The Duty Officer receives information from police /SPG/Collector or any other authorities for VVIP emergency and for any disaster from media or any other source, the Duty Medical Officer initiates VVIP emergency and disaster plan by consulting the concerned authorities. After initiation he/she is responsible to coordinate the activities and arrange for logistic support to aid the doctors and nurses for putting the patients in wards where optimal care can be provided.

ACADEMICS

Conferences - All trainees/Residents and consultants must attend the scheduled conferences

Schedule of Academic Conferences

- a. Grand rounds
- b. Medical/Surgical management conference
- c. Consultant's lecture
- d. Morbidity and Mortality conference
- e. Clinico- Pathological Conference
- f. Medical/Surgical Trainee's Lecture/ case presentation
- g. Didactics
- h. Continuing Medical Education programs etc.

Research Paper

All medical/surgical Residents/trainees are required to submit at least one complete research paper with a Consultant as co-author.

DISCIPLINARY ACTION AND GRIEVANCE PROCEDURE

A body to consider disciplinary action and grievance of Residents has to be formed at College level and an appeal committee will be formed at State level. The College level Grievance Redressal Committee (temporary) shall be composed of seven (7) members, four (4) selected from the faculty including Principal or Vice Principal and three (3) selected from residents by residents association of the college. Principal/Vice Principal will be the Chairman of the Committee. The Principal/Vice Principal will appoint other members of the committee. The parties shall be notified of the membership of the Committee. In State level a five member appeal committee will be formed. In the committee the DME and two JDMEs will be the permanent members. The DME will co opt a member from outside and one member from Resident Community. The member from outside must be an eminent person who have enough knowledge in Medical Field. The DME will be the Chairman of the committee. Any party have any grievance in the decision taken by the college level grievance redressal committee, he/she can prefer appeal before the state level appeal committee within seven days of the

decision pronounced by the College level committee. The decision of the state level committee shall be final and binding to all parties.

I. Grounds for Disciplinary Action

- Unethical practice of medicine
- Gross incompetence, gross negligence resulting in the compromise of the condition of patient and insubordination.

II. Disciplinary actions may be in the form of:

1. Reprimand- A resident may be reprimanded for actions/decisions contrary to the standard surgical practices however he is not deprived to go on duty, to perform surgical operations, attend conferences etc,
2. Suspension- A resident may be suspended for an offence that warrants suspension like AWOL on duty. His function to go on duty, perform operations, attend conference will be stopped for a certain period of time after which he is allowed to resume the functions.
3. Expulsion- Expulsion is total ban of his presence on the institution.

GRIEVANCE PROCEDURE

The resident shall first discuss his/her grievance with the training HOD and attempt to resolve the issue within the department.

If the resident is unable to resolve the matter at the level of the HOD and intends a formal grievance hearing, he/she should be submitted the grievance in writing to the Principal/Vice Principal within seven (7) working days for referring the matter to the Grievance Redressal Committee.

The Principal/Vice principal shall appoint an ad hoc Grievance Redressal Committee as mentioned above for the purpose of considering the specific grievance(s) of the resident.

The Chair of the Appeals Committee shall notify the parties of the date, time, and location of the hearing. Parties are responsible for (1) giving such notice to any witnesses whom they wish to call for testimony relevant to the matters in the grievance, and (2) arranging for participation of witnesses in the hearing. The hearing shall be scheduled to ensure reasonably that the complainant, respondent, and essential witnesses are able to participate.

Final decisions by the Appeals Committee shall be by majority vote of the members present and voting. If nay parties have any grievance on the decision of the appeal committee he/she may approach the State level appeal committee within 7 days by submitting an appeal petition. Belated appeals should not be entertained. The State level appeal committee should consider the appeal and take a decision within 15 days from the date of receipt of the appeal after hearing both the parties. The decision of the state level appeal committee shall be final and binding on all parties.

FACILITIES FOR RESIDENTS

Duty room: Residents on duty shall be provided with duty rooms with basic amenities attached to each ward.

Library: A resident can access library with internet facility round the clock attached to each department.

Medical facilities: All the residents and their dependents are entitled to free medical treatment in the institution. This includes the facility of admission to resident sick room, necessary laboratory investigations, imaging and medicines.

GENERAL

Notwithstanding anything contained in the manual, the Government may at any time, on their own volition or after calling the records of the case, revise any order passed by a subordinate authority. This manual is subject to modification / addition as may be considered necessary by the Government and issued as executive orders / notification.

Dr. V. GEETHA
DIRECTOR OF MEDICAL EDUCATION

APPENDIX - A

Hippocratic Oath—Modern Version

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings that sound of mind and body as well as the infirm. If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

(Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University)

APPENDIX - B

THE DUTIES OF A DOCTOR

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- * Make the care of your patient your first concern
- * Protect and promote the health of patients and the public
- * Provide a good standard of practice and care
- * Keep your professional knowledge and skills up to date
- * Recognise and work within the limits of your competence
- * Work with colleagues in the ways that best serve patients' interests
- * Treat patients as individuals and respect their dignity
- * Treat patients politely and considerately
- * Respect patients' right to confidentiality
- * Work in partnership with patients
- * Listen to patients and respond to their concerns and preferences
- * Give patients the information they want or need in a way they can understand
- * Respect patients' right to reach decisions with you about their treatment and care
- * Support patients in caring for themselves to improve and maintain their health
- * Be honest and open and act with integrity
- * Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- * Never discriminate unfairly against patients or colleagues
- * Never abuse your patients' trust in you or the public's trust in the profession.
- * You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.



"Don't waste life in doubts and fears; spend yourself on the work before you, well assure that the right performance of this hour's duties will be the best preparations for the hours and ages that will follow it."

Emerson