GYNAECOLOGY & OBSTETRICS LOG BOOK

MCM - PESHAWAR

CEO Message

The observation and assessment of performance of medical students is an integral part of curriculum. It can be accomplished by different modalities of assessments at different times. Similarly, exposing the students to different clinical activities during undergraduate medical training is essential. Supervising these activities is mandatory. For that purpose, keeping record of these events is important for student evaluation and inclusion of these activities in grading student`s performance. Logbooks system is in use for many decades in the field of medicine throughout the world, and has some weaknesses like falsification of data, but still it is considered to be a useful checklist in assessing the performance of students and record keeping of different activities.

For this purpose, the Muhammad College of Medicine is introducing the LOG BOOK for students of 4th year and 5th year to help the students as well as the faculty in streamlining the teaching, assessment and certification of student`s performance. This activity will ensure structuring and recording student`s activities during their clinical rotations based on the learning objectives assigned, and will help the faculty in assessing student`s performance. The logbook system will be converted to a portfolio system in future.

Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations in final year. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an objective evidence during assessment of student and evaluation of the overall performance of institution and curriculum. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection had been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Objectives of clinical rotations

Clinical rotation is one of the integral parts of undergraduate medical students that usually start at 3rd year. However, in contemporary programs, rotations in clinical activities starts right at the start of training as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into clinical environment. This exposure should be preceded by skill laboratory training, and should be gradual. It has to be according to the learning objectives defined in the curriculum. The objectives of these rotations include:

1. Application of concepts in real life situations which is being given in lectures, books and other reading materials
2. Acquisition of clinical skills relevant to the level and understanding of students
3. Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4. Developing communication skills, patient management skills, team work, time management skills, and interdepartmental collaboration at workplace
5. Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above-mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted during rotation, record history taking, assessment marks and student`s reflection. The 3rd part includes attributes of communication skills and professionalism. All the students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, record of research publications, co-curricular activities and many others. At the end, there is record of student's attendance, and end of module assessment marks that should be completed by the student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrieved in times of loss of log book at the end of the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer status

Level B: Assistant status

Level C: Performed part of the procedure under supervision

Level D: Performed whole procedure under supervision

Level E: Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient safety is not endangered. Students of 4th and 5th year are required to achieve level C and D and in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in the Logbook

Reflective thinking and writing demands that you recognize that you bring valuable knowledge to every experience. It helps you therefore to recognize and clarify the important connections between what you already know and what you are learning. It is a way of helping you to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includes the description about the following points:

1. Description of an event (one paragraph)
2. Thinking and feeling of student (one paragraph)
3. Good and bad about the experience (one paragraph)
4. How to avoid bad experiences and pursue good experiences in future (a few words to a paragraph).

The whole reflection document should be about between 200-300 words.

HISTORY 1

Patients Name: _____

Date: _____

Husband Name: _____

Age: _____

Date of Birth: _____

PR no: _____

Occupation of patient: _____

Occupation of Husband: _____

Address: _____

CHIEF COMPLAINTS:

HISTORY OF CHIEF COMPLAINTS: (inquire about N/V, Pain, vaginal discharge, fetal moments, pruritus)

MENSTRUAL HISTORY:

Menarche: _____

Cycle: _____

Flow: _____

Dysmenorrhea: _____

LMP: _____

EDD: _____

PAST MEDICAL HISTORY:

Thyroid: _____ Asthma: _____

Hypertension: _____ CHD: _____

Diabetes: _____ Epilepsy: _____

Hepatitis: _____ Allergies: _____

Autoimmune: _____

PAST SURGICAL HISTORY:

PERSONAL HISTORY: (Immunization, smoking, allergies, alcohol, contraception, living condition, socio-economic status)

FAMILY HISTORY: (Diabetes, hypertension, heart diseases, autoimmune disease)

OBSTETRICAL HISTORY:

Boy: _____ Girl: _____ POG: _____ Last baby born: _____

Year of Birth	POG	Mode of Delivery	Place of Delivery	Complication	Sex	Weight	Feed	Immunization

CLINICAL EXAMINATION:

GENERAL PHYSICAL EXAMINATION:

BP: _____ HR: _____

Temp: _____ RR: _____

O2 Sat: _____ lymph nodes: _____

Edema: _____ Thyroid: _____

Jaundice: _____ Anemia: _____

Cyanosis: _____ Clubbing: _____

Koilonychias: _____

CVS:

Palpation: _____

Auscultation: _____

RESP:

Palpation: _____

Percussion: _____

Auscultation: _____

CNS:

Pupils: _____

OBSTETRICAL EXAMINATIONS:

Comment: _____

Inspection: _____

Palpation: _____

Fundal height: _____

Lie: _____

FHS: _____

VAGINAL EXAMINATION:

Consent: _____

Vulva: _____

Vaginal: _____

Discharge: _____

Dilation: _____

DIAGNOSIS:

ROUTINE INVESTIGATION:

CBC: _____

Urine R/E: _____

Blood sugar level: _____

Ultrasound abdomen & Pelvis: _____

SPECIFIC:

Torch: _____

Tx/Operation plan:

Follow Up:

POST NASTAL CARE/INVESTIGATION:

ANY COMPLICATIONS:

HISTORY 2

Patients Name: _____

Date: _____

Husband Name: _____

Age: _____

Date of Birth: _____

PR no: _____

Occupation of patient: _____

Occupation of Husband: _____

Address: _____

CHIEF COMPLAINTS:

HISTORY OF CHIEF COMPLAINTS: (inquire about N/V, Pain, vaginal discharge, fetal moments, pruritus)

MENSTRUAL HISTORY:

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Autoimmune: _____

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PERSONAL HISTORY: (Immunization, smoking, allergies, alcohol, contraception, living condition, socio-economic status)

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RESP:

Palpation: _____

Percussion: _____

Auscultation: _____

CNS:

Pupils: _____

OBSTETRICAL EXAMINATIONS:

Comment: _____

Inspection: _____

Palpation: _____

Fundal height: _____

Lie: _____

FHS: _____

VAGINAL EXAMINATION:

Consent: _____

Vulva: _____

Vaginal: _____

Discharge: _____

Dilation: _____

DIAGNOSIS:

ROUTINE INVESTIGATION:

CBC: _____

Urine R/E: _____

Blood sugar level: _____

Ultrasound abdomen & Pelvis: _____

SPECIFIC:

Torch: _____

Tx/Operation plan:

Follow Up:

POST NASTAL CARE/INVESTIGATION:

ANY COMPLICATIONS:

Comments about professionalism and behaviors of students

(To be filled by the supervisor)

No	Statement	Supervisor comments			
		Yes	**No**	**Any other points**	
1	Was polite with patients, nurses, premedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoid derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of =		
8	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

For Examination Section

Details of marks of internal assessments

No	Assessment module	Marks obtained	Total Marks	MCQ	SAQ	OSCE / Viva / practical	%age	Pass / Fail
1								
2								
3								
4								
5	Total Marks of all modules							
6	Total marks of log book				Out of: 50			
7	%age							

Director Medical Education

NAME _____ **Sign** _____