

CURRICULUM
FOR
M.S (UROLOGY)



POST GRADUATE MEDICAL INSTITUTE
QUETTA

CONTENTS

S #	Contents	Page #
1	Introduction	3
2	Admission Criteria	4
3	Aims and Objectives of course.	5
4	Training Program	6
5	Duration and Scheme of course.	7
6	Syllabus	8
7	Specific Objectives	21
8	Research Thesis / Dissertation.	24
9	Log Book.	27
10	Evaluation / Examination	29
11	Supervision of Post Graduate Student (TMO's)	33
12	Grievances	36
13	Training Sites	39
14	Recommended Books & Journals	40
15	Faculty	41

Section -1

INTRODUCTION

University of Balochistan was established in 1970. The University awarded its first medical undergraduate Bachelor of Medicine and Bachelor of Surgery in 1977. The University of Balochistan is oldest and the most prestigious seat of learning in Balochistan.

The University runs courses of Undergraduate Education, Postgraduate Diploma Courses, Postgraduate diploma Courses in Faculty of Medicine.

The Postgraduate Medical Institute possesses all the relevant learning facilities like qualified and well trained faculty, teaching hospitals, libraries, lecture halls, Clinicopathological conference halls, laboratories, audiovisual aids, internet access, etc.

In this document Statutes and Regulations regarding the Scheme of the Course, eligibility criteria for admission to the course, details of training program, Syllabus, Specific Objectives of the training program, Research Thesis /Dissertation and format of examination of the Postgraduate degree course of M.S. Urology of the Post Graduate Medical Institute Quetta is presented.

Section -2

ADMISSION CRITERIA

REGULATIONS REGARDING ADMISSION FOR MS UROLOGY COURSE

The requirements for Admission in Post Graduate Degree Programme in MS Urology are laid down by PGMIQ are as under:

ELIGIBILITY CRITERIA FOR ADMISSION.

1. MBBS from the University of Balochistan or equivalent recognized by PM&DC.
2. One year House job after graduation with six months compulsory in Surgery and allied.
3. Only those doctors are eligible who are in the active service of Government of Balochistan for a minimum period of two years.
4. Selection through entry test and selection committee approval.

Section -3

AIMS AND OBJECTIVES OF THE COURSE.

AIM

The aim of four years MS Programme in Urology is to train residents to acquire the competency of a specialist in the field so that they can become good teachers, researchers and clinicians in their specialty after completion of their training

GENERAL OBJECTIVES

1. That the student accepts Urology in its full sense as a life long activity and that he/she is prepared to invest time and effort to acquire, maintain and further improve his/her own knowledge and skills.
2. A critical appreciation of techniques, procedures carried out in Urology an understanding of scientific methods, reliability and validity of observations and the testing of hypothesis.
3. The ability and willingness to adopt a problem solving approach to mange clinical situations included in the definition of Urology.
4. The ability to plan and interpret a management program with due regards to the patients Comfort and economic factors.
5. His/ her awareness of the role of specialists of Urology in health / rehabilitation / welfare teams and his/ her willingness to work cooperatively within such teams.
6. The awareness that he/ she have to create his/ her own professional impact as a capable Specialist/ Teacher/ Scholar of Urology in the world.
7. To pursue and develop the basic scientific pursuits and guideline for scientific discoveries to strengthen knowledge further about human body requirements.

Section -4

TRAINING PROGRAM

As a policy, active participation of students at all levels will be encouraged.

Following teaching modalities will be employed:

1. Lectures
2. Seminar Presentation and Journal Club Presentations
3. Group Discussions
4. Grand Rounds
5. Clinico-pathological Conferences
6. SEQ as assignments on the content areas
7. Skill teaching in ICU, Operation Theatres, emergency and ward settings
8. Attend genetic clinics and rounds for at least one month.
9. Attend sessions of genetic counseling
10. Self study, assignments and use of internet
11. Bedside teaching rounds in ward
12. OPD & Follow up clinics
13. Long and short case presentations

In addition to the conventional teaching methodologies interactive strategies like conferences will also be introduced to improve both communication and clinical skills in the upcoming consultants. Conferences must be conducted regularly as scheduled and attended by all available faculty and residents. Residents must actively request autopsies and participate in formal review of gross and microscopic pathological material from patients who have been under their care. It is essential that residents participate in planning and in conducting conferences.

Section -5

DURATION AND SCHEME OF THE COURSE

A summary of Four (04) Years Course in MS Urology is presented as under:

4 YEARS COURSE

PHASE-I (1 st Year)	PHASE-II (3 Years)
<ul style="list-style-type: none"> • Basic Training in Specialty of admission (10 Weeks) 	<ul style="list-style-type: none"> • Advanced Professional Education in Urology
<ul style="list-style-type: none"> • Biostatistics & Research Methodology • Submission of Synopsis (04 Weeks) 	<ul style="list-style-type: none"> • Compulsory/Optional Rotation 06 Weeks Rotation in allied Surgical disciplines.
<ul style="list-style-type: none"> • Basic Training in Urology • Basic Sciences Theory Classes (Anatomy, Physiology, Biochemistry, Pharmacology & Pathology relevant to the specialty) • Approval of Synopsis (34 Weeks) 	<ul style="list-style-type: none"> • Log Book, Research / Thesis (assignments, assessments) Submission and approval of research Thesis / dissertation at least 06 Months before Part-II examination. • Eligibility to appear in final Examination is subject to approval of research thesis and completion of Log Book.
<p><u>INTERMEDIATE EVALUATION (PART-I EXAM)</u></p> <p>❖ Written Two Papers For Part-1 The Part-I Examination will be held at the end of 1st Calendar Year.</p> <ul style="list-style-type: none"> • Principles of Urology (100 MCQ Single Best Type) • Basic Science Education (100 MCQ Single Best Type) 	<p><u>FINAL EVALUATION (PART-II EXAM)</u></p> <p>❖ Written Four Papers For Part-II Part-II Examination will be held at the end of 4th Calendar Year</p> <ul style="list-style-type: none"> • Urology Paper-A (100 MCQ Single Best Type) • Urology Paper-B (100 MCQ Single Best Type) • Urology Paper-A (10 Short Essay Questions) • Urology Paper-B (10 Short Essay Questions) <p>❖ Oral & Practical / Clinical Examination</p> <ul style="list-style-type: none"> • Long Case 01 • Short Cases 04 • TOCS 10 Stations

Section-6

SYLLABUS FOR M.S UROLOGY.

Principles of Surgery:

- History of surgery
- Preparing a patient for surgery
- Principles of operative surgery: asepsis, sterilization and antiseptics
- Surgical infections and antibiotics
- Basic principles of anaesthesia and pain management
- Acute life support and critical care:
- Pathophysiology and management of shock
- Fluids and electrolyte balance/ acid base metabolism
- Haemostasis, blood transfusion
- Trauma: assessment of polytrauma, triage, basic and advanced trauma
- Accident and emergency surgery
- Wound healing and wound management
- Nutrition and metabolism
- Principles of burn management
- Principles of surgical oncology
- Principles of laparoscopy and endoscopy
- Organ transplantation
- Informed consent and medico-legal issues
- Molecular biology and genetics
- Operative procedures for common surgical manifestations e.g. cysts, sinuses, fistula, abscess, nodules, basic plastic and reconstructive surgery
- Principles of basic diagnostic and interventional radiography
- Principles and interpretation of conventional and advanced radiographic procedures

Common Surgical Skills

- Incision of skin and subcutaneous tissue:
 - Langer's lines
 - Healing mechanism
 - Choice of instrument
 - Safe practice

- **Closure of skin and subcutaneous tissue:**

- o Options for closure
- o Suture and needle choice
- o Safe practice
- **Knot tying:**
 - o Choice of material
 - o Single handed
 - o Double handed
 - o Superficial
 - o Deep
- **Tissue retraction:**
 - o Choice of instruments
 - o Placement of wound retractors
 - o Tissue forceps
- **Use of drains:**
 - o Indications
 - o Types
 - o Insertion
 - o Fixation
 - o Management/removal
- **Incision of skin and subcutaneous tissue:**
 - o Ability to use scalpel, diathermy and scissors
- **Closure of skin and subcutaneous tissue:**
 - o Accurate and tension free apposition of wound edges
- **Haemostasis:**
 - o Control of bleeding vessel (superficial) o Diathermy
 - o Suture ligation
 - o Tie ligation
 - o Clip application
 - o Plan investigations
 - o Clinical decision making
 - o Case work up and evaluation; risk management
- **Pre-operative assessment and management:**
 - o Cardiorespiratory physiology
 - o Diabetes mellitus
 - o Renal failure

- o Pathophysiology of blood loss
- o Pathophysiology of sepsis
- o Risk factors for surgery
- o Principles of day surgery
- o Management of comorbidity

- **Intraoperative care:**
 - o Safety in theatre
 - o Sharps safety
 - o Diathermy, laser use
 - o Infection risks
 - o Radiation use and risks
 - o Tourniquets
 - o Principles of local, regional and general anaesthesia

- **Post-operative care:**
 - o Monitoring of postoperative patient
 - o Postoperative analgesia
 - o Fluid and electrolyte management
 - o Detection of impending organ failure
 - o Initial management of organ failure
 - o Complications specific to particular operation
 - o Critical care

- **Blood products:**
 - o Components of blood
 - o Alternatives to use of blood products
 - o Management of the complications of blood product transfusion including children

- **Antibiotics:**
 - o Common pathogens in surgical patients
 - o Antibiotic sensitivities
 - o Antibiotic side-effects
 - o Principles of prophylaxis and treatment

- **Safely assess the multiply injured patient:**
 - o History and examination
 - o Investigation
 - o Resuscitation and early management
 - o Referral to appropriate surgical subspecialties

- **Technical Skills**

- o Central venous line insertion
 - o Chest drain insertion
 - o Diagnostic peritoneal lavage
 - o Bleeding diathesis & corrective measures, e.g. warming, packing
 - o Clotting mechanism; Effect of surgery and trauma on coagulation
 - o Tests for thrombophilia and other disorders of coagulation
 - o Methods of investigation for suspected thromboembolic disease
 - o Anticoagulation, heparin and warfarin
 - o Role of V/Q scanning, CT angiography and thrombolysis
 - o Place of pulmonary embolectomy
 - o Awareness of symptoms and signs associated with pulmonary embolism and DVT
 - o Role of duplex scanning, venography and d-dimer measurement
 - o Initiate and monitor treatment
- **Diagnosis and Management of Common Surgical Conditions:**
 - o abdominal pain
 - o Vomiting
 - o Trauma
 - o Groin conditions
 - o Hydrocoele
 - o Penile inflammatory conditions
 - o Undescended testis
 - o Acute scrotum
 - o Abdominal wall pathologies
 - o Urological conditions
 - o Constipation
 - o Intussusception
 - o Abscess

Clinical components

- Anatomy and embryology of genitourinary system
- Urologic laboratory examination including renal function tests..
- Radiology & radio nuclide imaging of urinary tract.
- Vascular interventional radiology.
- Urodynamics.
- Principles of chemo-, radio- & immunotherapy as applied to urologic practice.
- Genetics as applied to genitourinary surgical conditions.
- Management of oliguria & acute renal failure.

- Ch. Renal failure & dialysis, angioaccess
- Immunology, immune suppression, immune response
- Pathophysiology of rejection., tissue typing & lymphocyte cross match
- Congenital anomalies of kidney, ureter, bladder, urethra and genitalia, ambiguous genitalia
- Infections of urinary tract, sexually transmitted diseases, specific urologic infections)
- Disorders of kidneys, ureters, bladder, prostate, seminal vesicles and urethra
- Pathophysiology of obstruction, stasis & reflux
- Pathophysiology of neurogenic bladder.
- Pathophysiology of incontinence (neuromuscular dysfunction)
- Disorder of scrotum, testis, and spermatic cord
- Skin disease of external genitalia
- Urolithiasis
- Extracorporeal shockwave lithotripsy
- Hypertension with reference to kidney & adrenals, secondary hypertension, malignant hypertension.
- Principles of endourology, laparoscopic urology, lasers as applied to urology.

Operative Urology

- Urethral catheterization/ urethral dilatation
Suprapubic cystostomy
- Tumors of renal parenchyma
- Prostatectomy
for benign and malignant disease, principles of radical surgery
- Principles of retroperitoneal surgery
- Radical cystectomy
- Urethroplasty, principles of hypospadias surgery, anastomosis & substitution
- Techniques in urethral stricture disease
- Urinary diversion, ureterosigmoidostomy, orthotopic pouches & continent
- Urinary diversion , resume of current technique in vogue
- Principles of surgery in hydrocele, epididymal cysts & spermatoceles.
- Surgery for vesico vaginal/ uterine fistulae
- Pediatric urology: principles of orchidopexy, pyeloplasty , anti-reflux
- Procedures & scrotal swellings
- Kidney transplantation

- Endourology, retrograde catheterization, cystourethroscopy, ureterorenoscopy.
- Endoscopic management of urethral, prostatic, bladder, ureteral & renal pathologies, retrograde instrumentation of ureter, laparoscopic urological surgery, percutaneous renal surgery.

Uro-Oncology

- Diagnosis, management of renal tumors, bladder malignancies, other neoplasms of urothelium and prostatic carcinoma; testicular tumors; adrenal masses.
- Carcinoma penis, metastatic tumors involving genitourinary tract

Genitourinary Trauma

- Mode/ mechanics of renal, ureteric, bladder, urethral & scrotal injuries, clinical presentation, management & complications

Incontinence

- Classification; indication of surgical intervention, artificial sphincters and bladder substitution
- Neurogenic bladder, immediate as well as long term management

Female Urology

- Urethral stenosis
- Etiology, diagnosis and management of stress, urge, true incontinence and genitourinary fistulae

Paediatric Urology

- Antenatal diagnosis, PUJ, vesicoureteric reflux, posterior urethral valves
- Childhood tumors & disorders of penis and male urethra

Andrology

- Male Infertility
- Etiology, pathophysiology of erectile dysfunction
- Clinical presentation, diagnosis and therapeutic modalities including drugs & prosthesis;
- Management of priapism; Peyronie's disease

The adrenal glands

- Secondary Hypertension
- Cushing's Syndrome (hypercortisolism)
- Adrenocortical Insufficiency
- Aldosteronism and the adrenogenital syndrome
- Pheochromocytoma
- Adrenalectomy

Renal failure and transplantation

- The principles of dialysis
- Transplantation and tissue rejection
- Brain stem death
- Suitability of donors for organ transplantation
- Clinical management of renal failure
- Ethical considerations in transplantation

TRAUMA

Initial assessment and resuscitation after trauma

- A system for managing injured patients
- Management of the injured patient
- Physiological response to injury
- Primary Survey
- The secondary survey
- Major Injuries
- Resuscitation from major injury
- Resuscitation from major injury – the child
- Resuscitation from major injury – the adult
- Another injured patient

Central nervous system trauma

- CNS trauma
- Pathophysiology of raised intracranial pressure
- Head injuries: general principles of management
- Skull fractures
- Cerebrospinal fluid loss as a result of local trauma
- Spinal column and cord injury
- Rehabilitation
- Brain tumours
- Intracranial vascular anomalies

Special problems

Pre-hospital care

- When things go wrong – a salutary tale
- The concept of pre-hospital care
- Delivery of pre-hospital care

Multiple casualty management

- Triage

Trauma scoring systems

Traumatic Wounds

- Ballistic injury
- Blast injury

Skin loss

Burn injury

- Burn injury – immediate management – fluid replacement
- Burn injury – complications
- Burn injury – later management
- Maxillofacial injuries

INTENSIVE CARE

Cardiovascular

Cardiac anatomy

- The heart
- Valves and chambers
- Anatomy of the great vessels
- Coronary arteries and conducting system

Cardiac physiology

- The heart as a pump
- The cardiac cycle
- Cardiac conduction and the ECG
- Coronary circulation
- Pressure, flow and resistance in the circulation
- Regulation of Cardiac contraction
- Control of the cardiac output

The Cardiovascular system in clinical practice

- Cardiovascular monitoring
- Shock
- Cardiac failure and pulmonary oedema
- Cardiac arrest and resuscitation

Cardiac surgery and mechanical circulatory support

Respiratory

Applied anatomy and physiology of respiration

- The surgical anatomy of the airways, chest wall, diaphragm and thoracic viscera
- The mechanism and control of respiration

Interpretation of special investigations

- Lung function test
- Flow volume loops
- Gas transfer
- Arterial blood gases
- Arterial line
- Pulse oximetry

Radiology

- Chest radiography
- Pulmonary infection
- Non – infective conditions

Disorders of respiratory function caused by trauma, acute surgical illness and surgical intervention

Respiratory failure

Endotracheal intubation and tracheostomy

Artificial ventilation and respiratory support

Acute respiratory distress syndrome (ARDS)

Problems in intensive care

Terminology in sepsis

Predisposing factors in developing sepsis

- Infecting organisms
- Impaired host defences

Management of sepsis

- Pneumonia in ICU
- Empyema and lung abscesses
- Opportunistic pneumonia

Septic shock

- Management of septic shock

Problems of Intensive Care

- Complications of thoracic operations
- Air leak problems
- Specific problems related to pneumonectomy
- Retained secretions
- Pain control

Principles of intensive care

Principles of Intensive Care

- Admission criteria
- Discharge

- Inter – hospital transfers
- Organization and staffing of the ICU
- Configuration
 - Patient Procedures
- Costs in Intensive Care
- Comparative expenditure on ICU / HDU
- Scoring and outcome

PRE OPERATIVE MANAGEMENT

Skin and wounds

Wound Healing

- Growth factors and wound healing
- Delayed wound healing

Surgical wounds

Incisions and their closure

Sears and contractures

Wound dehiscence

Dressings

Fluid balance and nutrition

Fluid and electrolyte balance

Body fluid compartments

Body fluids and their replacement

- Normal Saline
- Dextrose Saline

Acid – base balance

- Henderson – Hasselbach equation
- Anion gap (AG)

Blood Gases

Central and peripheral venous access

- The anatomy of venous access
- Peripheral venous access
- Central venous access
- Infraclavicular subclavian route
- Supraclavicular subclavian vein cannulation
- Percutaneous internal jugular venous cannulation
- Complications of venous access techniques

Nutrition in the Surgical Patient

- Dietary intake
- Weight loss
- Muscle mass
- Biochemical Markers
- Anaemia

Nutritional Support

Total parenteral nutrition

Blood

Blood

Anaemia

- Presentation and causes of Anaemia
- Management of anaemic patients

Practical aspects of blood transfusion

- Safe administration of blood and blood products

Disorders of coagulation

- Disseminated intravascular coagulation (DIC)
- Anticoagulation

Correction of intra – and postoperative blood loss

- Massive transfusions
- Fresh frozen plasma
- Use of platelet transfusion
- Indications for albumin infusion

Adverse effects of transfusion

Autologous blood

Post-operative complications

Postoperative complications

- Preoperative risks
- Intraoperative risk factors
- Classifications of postoperative complications

Respiratory disease and Ventilatory support

- General recognition of respiratory diseases
- Preoperative risk factors for respiratory diseases
- Definitions of respiratory failures
- Ventilatory support

Post operative sequelae

Pain control

- Pain pathways
- Pathophysiology of nociception
- Modulation

Acute Pain

Analgesics

- 1. Non-steroidal anti – inflammatory drugs (NSAIDs)
- 2. Opioid μ agonists and high efficacy partial agonists
- 3. The opioid agonist – antagonists
- Strategies for effective postoperative analgesia
- Recording post operative pain

- Analgesic techniques for a few common procedures

Chronic Pain

Acute Inflammation

- Cellular events
- Chemotaxis
- Phagocytosis
- Chemical mediators of inflammation
- The effects of inflammatory mediators

Pathophysiology of the body's response to trauma

The Immune system

- Complement and antibody
- Disorders related to the immune system
- Hypersensitivity
- Autoimmunity

The Immunocompromised patient

- Recognition of the Immunocompromised patient
- Protection of the patient
- Prophylactic antibiotics

PAEDIATRIC DISORDERS

Child specific

Differences in the management of children and adults

- Differences of Scale
- Differences of Physiology
- Differences in Communication
- Differences in diseases

Principles of fluid and electrolyte balance

- Maintenance requirements
- Resuscitation

Vascular Access

- Peripheral Veins
- Trepine Needle
- Central Veins
- Arterial Access
- Congenital Anomalies
- Urological Conditions
- Acute Scrotum
- Idiopathic Scrotal Oedema
- Torsion of the Testis
- Epididymitis

Elective Surgery of the External Genitalia

- Malescent of Testis
- Testicular Malignancy
- The Foreskin
- Pediatric Oncology
- Nephroblastoma (Coilm's tumor)
- Rhabdomyosarcoma
- Germ Cell Tumors

Abnormalities of the External Genitalia

- Hypospadias
- Intersex
- Epispadias

- **Outcome of surgery**

- Clinical decision – making
- Clinical audit
- Statistics and computing in surgery
- Numeracy and statistics
- Critical evaluation of innovations – technical and pharmacological
- Economic aspects of surgical care

Ethics and the law

- Moral and legal rights
- Obtaining informed consent
- Claims against surgeons
- The prudent patient
- Difficulties in obtaining informed consent of the unconscious patient
- Informed consent and children
- Informed consent and psychiatric patients
- Not providing life saving treatment and euthanasia
- Confidentiality
- Communication skills and informed consent

Section -7

SPECIFIC OBJECTIVES.

The objective of M.S postgraduate programme is as follows:-

- ❖ Block-1. First one year of training.
- ❖ Block-2. Four years of training.

Block-1.

A postgraduate student of M.S Urology programme at the end of the one year training is able to:-

- After attending research methodology works synopsis develop the skill to
 - Write synopsis
 - Write Research work
- The goals are to develop knowledge of surgical diseases and complications, develop surgical judgment, learn basic pre- and post-operative care, and develop elementary skills in surgical technique.
- Perform and document comprehensive surgery history and physical examination [H&P] abilities
- Understand and interpret indications for laboratory studies and imaging
- Develop skills necessary to establish and implement an effective patient management plan
- Perform service examination
- Demonstrate a solid foundation of knowledge
- Develop accuracy in clinical evaluation skills
- Provide compassionate ward and outpatient care as determined by patients, families, colleagues and ancillary health
- Develop and nurture sound and appropriate interpersonal and communication skills

Block-2.

A postgraduate student of M.S Urology programme at the end of 04 years training is able to:-

- Teach medical students the fundamentals of the surgical H&P
- Accurately interpret complex laboratory and imaging tests and other

fundamental skills

- Develop complex patient diagnostic and managerial skills
- Perform selected surgical procedures under direct supervision.
 - Assist in major surgical procedures and perform those portions of the operation that are appropriate to the resident's level of training under direct supervision
- Demonstrates competency regarding performance of inpatient and surgical procedures
- Demonstrate clear and concise patient care plans
- Demonstrate the ability to implement the aforementioned patient care plans.
- Acquire trauma and commensurate critical care skills
- Demonstrate the ability to evaluate medical literature in journal clubs and on rounds
- Demonstrate an ongoing and improving ability to learn from errors
- Develop critical care and trauma care and technical skills
- Perform a clinical or basic research project that is appropriate
- Develop fundamental research skills
- Begin to direct ward and clinic patient care
- Instruct residents and medical students regarding their performance of selected non-complex surgical procedures appropriate to their level of training
- Demonstrate competency regarding performance of inpatient and surgical procedures
- Demonstrate clear and concise patient care plans
- Demonstrate the ability to implement the aforementioned patient care plans
- Provide high level non-operative care
- Manage and administrate the complexities of a large clinical and academic service
- Demonstrate ability to perform all major surgical procedures.
- Demonstrate the highest level of patient care skills, problem solving

skills and technical skills

- Have a working knowledge of the necessary pre-operative work-up and post-operative management of the complex surgical patient.
- Perform a focused surgical evaluation in context with the patient's complaint.
- Demonstrate an ability to prescribe appropriate parenteral and enteral feeding.
- Recognize and treat the complications of parenteral and enteral feeding.
- Demonstrate an ability to manage the fluid and electrolyte requirements, including acid- base issues of pediatric and adult surgical patients.
- Demonstrate an ability to perform an initial evaluation and management of critically ill surgical patients.

Section -8

RESEARCH THESIS / DISSERTATION

(a) CHARACTERISTICS OF THE RESEARCH TOPIC.

The Research Topic in clinical subjects should address 20% to the Related Applied Basic Sciences and in Basic Sciences should address 20% to the Related Applied Clinical Sciences. The research topic must consist of a reasonable sample size and sufficient number of variables to give training to the candidate to conduct research to acquire data, analyze data and reach results, discuss results and draw conclusions and thus test the hypothesis.

During course on Research Methodology and Biostatistics held during Phase-I of the Course, the Candidate is expected to develop synopsis of Research.

(b) GUIDELINES FOR PREPARATION OF SYNOPSIS

The applicants should organize the synopsis to address the following points:-

a) Title :

b) Introduction : Should clearly manifest why the present work is undertaken.

c) Literature review : Place the project in academic context by referring to the major work by others on the topic.

d) Objectives : Define clearly the aims of the research proposal.

e) Significance : Explain the significance of the proposal for the field and the country.

f) Plan : Give year wise tentative plan of the work.

g) Methodology : Explain the approach and methods he will follow.

h) Bibliography : Upto dated references.

(c) SUBMISSION / EVALUATION OF SYNOPSIS.

Synopsis of research project will be submitted during the year-1 of the course. The synopsis will be submitted through the supervisor to the Dean / Director PGMI, Quetta. The synopsis will be evaluated by the following committee.

- | | |
|---|-------------------|
| 1. Dean / Director or his representative. | Chairman |
| 2. Supervisor of the student | Member/ Secretary |
| 3. One Prof. appointed by the Dean / Director | Member |
| 4. Co-opted member whenever required | |

After the approval, by the Committee the synopsis will be submitted to the Board of Higher Studies in the University of Balochistan for further approval by the Vice Chancellor University of Balochistan.

(d) GUIDELINES FOR THESIS / DISSERTATION FORMAT

The thesis must be bound in accordance with the following specification:

- Four hard copies and one soft copy (CD) of thesis / dissertation to be submitted.
- A4 paper size to be used, except for drawings and maps on which no restriction in placed.

A margin 1.5 inches to be left on left hand side. Thesis copy should be properly hard bounded.

- The front should bear the title, name of the candidate and the insignia of the University.

(e) SUBMISSION OF THESIS / DISSERTATION.

- The Thesis / Dissertation must be bound in accordance with specifications.
- Four (4) copies of the Thesis must be submitted at least 6- months before the commencement of the written and oral Examination.

- 3) The minimum duration between approval of synopsis of research and submission of thesis should be 2 years; the maximum duration will be 5 years.
- 4) The Thesis will be submitted along with Bank Challan Form of amount as fixed by University of Balochistan paid in the account of University of Balochistan.
- 5) Application for Thesis Evaluation recommended by the Supervisor.

Section -9

LOG BOOK.

The residents must maintain a log book and get it signed regularly by the supervisor. A complete and duly certified log book should be part of the requirement to sit for MS examination. Log book should include adequate number of diagnostic and therapeutic procedures observed and performed the indications for the procedure, any complications and the interpretation of the results, routine and emergency management of patients, case presentations in CPCs, journal club meetings and literature review.

Proposed Format of Log Book is as follows:

Candidate's Name: _____

Roll No. _____

The above mentioned procedures shall be entered in the log book as per format

PROCEDURES PERFORMED

S #	Date	Name of Patient, Age, Sex & Admission No	Diagnosis	Procedure Performed	Supervisor's Signature

EMERGENCIES HANDLED

S #	Date	Name of Patient, Age, Sex & Admission No	Diagnosis	Procedure / Management	Supervisor's Signature

CASE PRESENTED

S #	Date	Name of Patient, Age, Sex & Admission No	Case Presented	Supervisor's Signature

SEMINAR / JOURNAL CLUB PRESENTATION

S #	Date	Topic	Supervisor's Signature

Evaluation Record

(Excellent, Good, Adequate, Inadequate, Poor)

At the end of the rotation, each faculty member will provide an evaluation of the clinical performance of the fellow.

S #	Date	Method of Evaluation (Oral, Practical, Theory)	Rating	Signature

- Log Book will be signed by the supervisor / Co- Supervisor regularly.
- Log Book completion is must before the candidate examination forms are signed.
- Log Book should be used in Practical / Clinical Examination at viva voice table or at TOCS cabin.

Section -10

EVALUATION / EXAMINATION

INTERMEDIATE EVALUATION PART-I EXAMINATION.

1. Eligibility to appear in Part – I Examination

- (a) Application by the candidate recommended by the Supervisor.
- (b) Certificate by the Supervisor , counter signed by Dean PGMI that candidate has regularly attended at least 75% of the basic sciences classes, Lectures, Seminars, Practical, demonstrations of Phase-I education.
- (c) Bank Challan Form of Payment of examination fee as fixed by the university of Balochistan.

2. REGULATIONS.

- a) All candidates admitted in MS Urology course will appear in Part – I examination at the end of 1st Calendar Year.
- b) The candidate who fails to pass the examination in 3 consecutive attempts availed or un-availed, shall be dropped from the course.
- c) The candidates who will not pass this examination within two years after their admission, their name will be removed from the course.
- d) The Part-I Examination will Consist of Paper-I on Basic Sciences Education (relevant to the specialty) and Paper-II on Principles of Urology.
- e) For Part-1 Examination the Paper-I and Paper-II will be set from the MCQ bank. The question for MCQ bank will be provided by all the subject specialist involved in teaching the curriculum of the course
- f) Paper Weight age; each paper will carry 100 Marks. Time allowed for each Paper will be three hours.
- g) The Pass Marks will be 60 % in each paper.
- h) Papers will have 100 MCQ Single Best in each paper.

3. CONTENTS OF THEORY PAPER PART-I EXAMINATION.

SUBJECT	COMPONENTS	NO OF QUESTIONS	MARKS
Basic Science Education Paper-I	MCQ's Single Best Type	100	100
Principles of Urology Paper-II	MCQ's Single Best Type	100	100

FINAL EVALUATION: (PART-2 EXAMINATION)

(a) ELIGIBILITY TO APPEAR IN PART-2 EXAMINATION.

1. The candidate has completed the prescribed period of training of the course.
2. The candidate has passed the Intermediate Evaluation.(Part-1 Examination).
3. The thesis / dissertation must be dully approved by University of Balochistan.
4. Certificate by the Supervisor that the Log Book of candidate is complete in all aspects and is signed by the Co-Supervisor and the Supervisor. The original Log Book will be presented by the candidate during Practical / Oral examination.
5. A certificate by the Supervisor /Counter signed by Dean PGMI, that the candidate has attended at least 75% of the lectures, seminars, practical/clinical demonstrations;
6. The application form for Part-II examination with recommendation of the Supervisor.
7. The Bank Challan Form for the payment of the Examination Fee of amount as fixed by University of Balochistan.

(b) COMPONENTS OF THE PART-2 EXAMINATION.

1- Theory (300 Marks)

2. Clinical / Practical (300 Marks)

Total = (600 Marks)**(i) CONTENTS OF THEORY PAPERS.**

SUBJECT	CONTENTS	NO OF QUESTIONS	WEIGHTAGE	MARKS
Urology	MCQ Paper-A Single Best Type	100	0.75/Per	75
Urology	MCQ Paper-B Single Best Type	100	0.75 /Per	75
Urology	Short Essay Paper-A	10	0.75/Per	75
Urology	Short Essay Paper-B	10	0.75 /Per	75

Total 300 Marks

❖ **Candidate must secure 60% in each paper to pass theory examination.**

(ii) CLINICAL / PRACTICAL EXAMINATION FOR M.S UROLOGY

SUBJECT	COMPONENTS	ASSESSMENT TECHNIQUES	MARKS
Urology	Long Cases	1	100
	Short Cases	4	100
	TOCS	Specimens, Instruments, Investigation for interpretation including X-ray, MRI, ICT, Nuclear scans, Table Viva on Log book, Table Viva on Thesis / Dissertation, Slides etc.	100 (10 Stations 10 Marks Each station).

❖ **Candidate must obtain 60% in total clinical component and 50% in each component to pass clinical examination.**

(d) NUMBER OF EXAMINERS.

The Final Evaluation (Part-2 Examination) will be conducted by a board of four examiners of Urology. All examiners have equal functions except the chairman who will be responsible to conduct the examination process and send result to the controller university.

(e) RESULT.

The candidates who will Pass their Theory and Clinical / Practical examination separately will be declared pass The Candidates who will Pass in Theory but fail in Clinical / Practical examination will re-appear only in Clinical / Practical examination again for another two times. After total of three attempts in Clinical / Practical examination the candidate will have to appear in all the parts of Theory and Clinical / Practical Part-II examination.

- To pass as ordinary, the candidate must obtain 60% marks in each of 2 components.
- To pass with distinction, the candidate must obtain overall marks should be 80% or above.

Section -11

SUPERVISION OF POST GRADUATE STUDENT (TRAINEE MEDICAL OFFICER)

Purpose:

To ensure that Trainee Medical Officers / residents are provided adequate and appropriate levels of supervision during the course of the educational training experience and to ensure that patient care continues to be delivered in a safe manner.

Policy and Procedure:

The Supervisor is responsible for all care delivered by trainees. Trainees shall always be appropriately supervised and the supervision of trainees is ultimately the responsibility of the supervisor, who is accountable to the PGMIQ. PGMIQ shall have a mechanism in place that communicates to the trainees the identity of the Supervisor and back-up coverage by another faculty member in the event that the Supervisor is not immediately available. All program faculty members supervising Trainee Medical Officers / residents must have a faculty or clinical faculty appointment in the Bolan Medical College Department of surgery or be specifically approved as supervisor by the PGMIQ. Faculty schedules will be structured to provide Trainee Medical Officers / residents with continuous supervision and consultation.

Trainee Medical Officers / Residents must be supervised by faculty members in a manner promoting progressively increasing responsibility for each Trainee Medical Officer / resident according to their level of education, ability and experience be provided information addressing the method(s) to access a in a timely and efficient manner at all times while on duty.

The program provides additional information addressing the type and level of supervision for each post-graduate year in the program that is consistent with the PGMI Quetta program requirements and, specifically, for supervision of Trainee Medical Officers / Residents engaged in performing invasive procedures.

1. To provide patients with quality care and Trainee Medical officers/Resident trainee with a meaningful learning experience, a supervising attending physician shall be clearly identified for each patient admitted to, or consulted by, the surgical service. It is the responsibility of the Trainee Medical Officers / Residents trainee to notify an attending physician that a consultation or admission has been initiated on his/her service, based on the call schedule and back-up mechanisms established in the department.
2. The supervising attending physician is ultimately responsible for all recommendations rendered and care delivered by Trainee Medical Officers / Residents trainee, paramedical personnel and other trainees on the surgical service.
3. Supervision shall be readily available to all Trainee Medical Officers / Residents on duty. Each program or service in the department shall maintain a clear call list of attending physicians; with appropriate back up in the event the supervising physician is not immediately available (this typically represents another attending faculty on call that same day). A comprehensive call list of Trainee Medical Officers / Residents and attending physicians is disseminated to all switchboard operators, patient affair coordinators, clinical care areas and all covering Trainee Medical Officers / Residents on a monthly basis.
4. Supervision shall be conducted to ensure that patients receive quality care and Trainee Medical Officers / Residents assume progressively increased responsibility in accordance with their ability and experience, based on curriculum objectives for the respective level of training.
5. Levels of supervision include an attending physician demonstrating a procedure, assisting with the procedure, present physically in the area where intervention is performed, attending available by telephone, senior Trainee Medical Officer / Resident or other supervisor present physically or available by telephone. The attending physician in charge of a respective procedure shall determine the level of supervision for a particular resident and the specific invasive procedure.
6. The responsible attending physician may delegate supervision of more

junior residents to a more senior resident as appropriate. These determinations shall be consistent with the individual resident knowledge base and skills, the complexity of the case and procedure, and the residents prior evaluations regarding levels of performance per the residency program core curriculum objectives for each level of training.

7. The Trainee Medical Officers / Residents must request help when the need for assistance is perceived, and responsible attending physicians must respond personally when such help is requested. When a patient's attending physician is not available, a previously designated physician or the attending on call shall assume all coverage responsibilities for the patients.
8. The Senior Trainee Medical Officer / Resident shall relay to the Department Chair or the Supervisor any incident where another Resident did not notify a responsible faculty member, a responsible faculty member was not responsive, or any other breach of supervision as outlined in this policy.

Section -12

GRIEVANCES

The entire faculty is dedicated to Trainee Medical Officer / Resident education and to providing the best possible environment in which to learn. If there are any problems that arise; personal problems, communication issues with team members, complaints about working conditions, the perception or allegation of harassment or abuse etc, the faculty encourages the residents to ask for help. The residents are welcome to contact the Registrar and Dean / Director of PGMiQ.

GRIEVANCE POLICY AND PROCEDURE

Grievances are limited to allegations of wrongful suspension during the training year. The decision to suspend, recommendation to dismiss or termination is an academic responsibility of the Supervisor. If a Trainee Medical Officer / Resident believes he/she has been wrongfully suspended or recommended for dismissal or termination, the grievance process described below can be invoked. The process is intended to protect the rights of the Trainee Medical Officer / Resident and the training program and to ensure fair treatment for both parties.

In all cases of suspension, termination, or non-renewal of contract, it is expected that the appropriate probationary and remedial periods will have been performed.

All “written notification” associated with the formal grievance process shall be by certified mail.

Grievance Procedure

1. Notification of intent to appeal: After receiving the written notification of suspension dismissal or termination, the Trainee Medical Officer / Resident will have 10 calendar days to file, in writing, a formal appeal to the dean PGMiQ. The Trainee Medical Officer / Resident may be represented by an

attorney in an advisory capacity, but the attorney may not function as a spokesperson for the Trainee Medical Officer / Resident during this grievance process.

2. Assembly of Disciplinary committee: Upon receipt of an appeal, the Dean will refer to disciplinary committee to review the Trainee Medical Officer / Resident case. The committee shall seek advice from PGMI Council who shall be present for the hearing to advise the committee. The disciplinary committee may also seek advice from outside experts in the field of Trainee Medical Officer / Resident specialty if deemed necessary.

The disciplinary committee will include the deputy dean for clinical affairs (or designee), two regular faculty member from a different training program. The deputy dean for clinical affairs will chair the disciplinary committee. The Resident may object to a member of the disciplinary committee for cause. The Dean has sole discretion to replace a member if deemed warranted.

3. Hearing: The disciplinary committee will assess the merits of the case and hear evidence and arguments by the Trainee Medical Officer / Resident and the supervisor, or department chair, or division head.

The supervisor, department chair, or division head is obligated to present to the disciplinary committee the reasons for and substantiating evidence of the resident suspended / dismissed or termination. The Trainee Medical Officer / Resident may question witnesses who testify on behalf of the program director, department chair, or division head. The Trainee Medical Officer / Resident may present documents, letters of support and call the testimony of witnesses. These witnesses may be questioned by the supervisor, department chair, or division head.

The disciplinary committee shall tape / record the hearing proceedings, but not its deliberations. Either party may, at its own expense, have a verbatim transcript made of the proceedings. Both parties may request a copy of the tape / recording made by the committee.

4. Final Determination: The disciplinary committee will make its determination within 30 days from the close of the hearing. The disciplinary committee will notify the supervisor PGMI, division head, or program director; and the dean in writing of its decision. The decision of the committee to uphold the termination or to reinstate the resident is final. Should the Trainee Medical Officer / Resident be reinstated, the disciplinary committee may impose an additional period of probation and/or remediation as a condition of continuation.

Notification Required:

1. Reporting required for Resident dismissed, suspended, or required Notice will be according to the PGMI Policy, any Trainee Medical Officer / Resident “who has not progressed satisfactorily in the program or who has been dismissed from the program for inadequate performance or ethical reasons”. The phrase, “not progressed satisfactorily in the program,” means those residents who have been dismissed, suspended or required to repeat a year of the program.

2. Probation: Probation is a remedial mechanism utilized by the PGMI in a variety of circumstances. It is designed to improve the academic performance of a Trainee Medical Officer / Resident. In most instances, Trainee Medical Officers / Residents by supervisor placed on probation continue to progress satisfactorily in a program. Regular reporting of Trainee Medical Officers / Residents placed on probation to the PGMIQ is required.

3. Referral to Health Department Government of Balochistan.

If a Trainee Medical Officer / Resident is government employee and is on deputation for his postgraduate studies to PGMIQ. The PGMIQ Directorate will report the final recommendation of disciplinary committee to his parent department e.g. Health Department Government of Balochistan.

Section -13

TRAINING SITE

ATTACHED TEACHING HOSPITALS.

- (i) Bolan Medical Complex Hospital Quetta
- (ii) Sandeman Provincial Hospital Quetta.

BED STRENGTH.

SPH, QUETTA.

UNIT	MALE	FEMALE	TOTAL
Urology-I	32	08	40

Total 40

BMCH, QUETTA.

UNIT	MALE	FEMALE	TOTAL
Urology-II	32	08	40

Total 40

Grand Total:- 80

Section -14

RECOMMENDED BOOKS & JOURNALS

1. Langman's Medical Embryology T.W. Sadler
2. Short Practice of Surgery by Bailey & Love Published by Chapman and Hall.
3. Essential Surgical Practice Vol: 1 Cuschieri published by Butterworth Heimann
4. Smith's General Urology
5. Campbell's Urology
6. Scientific Foundations of Urology
7. Scheward's Surgery
8. Fathalla M. F. and Fathalla M. M. F. A Practical Guide
9. for Health Researcher. Cairo: World Health Organization; 2004.

Section-15

FACULTY MEMBERS

PROFESSORS.

Prof: Saadat Khan MBBS, DU, MS

ASSOCIATE PROFESSOR.

Dr. Hidayatullah MBBS, MS, FCPS

Dr. Haq Nawaz MBBS, MS

ASSISTANT PROFESSOR.

Dr. Masha Khan MBBS, FCPS

Dr. Pervaiz Ahmed MBBS, MS

Dr. Jan Mohammad MBBS, MS

Dr. Masha Khan MBBS, FCPS

Dr. Sultan Tareen MBBS, FCPS

Dr. Abdul Razzaq Nasir MBBS, FCPS