LOG BOOK OF
SURGERY and Allied Departments

FOR 3RD YEAR & FINAL YEAR STUDENT LOG BOOK

LOG BOOK

For 3rd --- Final Year MBBS

DEPARTMENT OF SURGERY

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES, THATTA

BIO DATA

Name:____

Group________________________________**Class Roll No**_______________

Examination Seat No.____

Institute Enrollment No.____

Passport Size Picture

Clinical Academic Year & Departments	Internal Evaluation	Attendance	Cumulative Marks	Signature of Teacher
Department of General Surgery				
Department of Orthopedic Surgery				
Department of Plastic Surgery				
Department of Radiology				
Skill Lab				
Third Year				
Final Year				

SIGNATURE OF PRINCIPAL
LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCE, THATTA

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Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations. 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 has 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 presented 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 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

Contents of clinical rotations

In 3rd year, the MBBS students are rotated in following departments in groups of about 10 students:

S. No	Departments
01	Department of General Surgery
02	Department of Orthopedic Surgery
03	Department of Plastic Surgery
04	Department of Radiology
05	Skill Lab

WAYS OF TEACHING AND LEARNING IN SURGERY

Locations For Learning

- Timetable – planned to allow time in the operating theatre, in clinic and on the ward
- Operating theatre
- Day case surgery
- Outpatient clinics (general)
- Outpatient clinics (specialized)
- Other clinics: DVT clinic, breast clinic, pain management, others
- Seeing emergency referrals/attendances (in the emergency unit or surgical assessment unit)
- Preoperative assessment clinic – fitness for surgery
- Surgical wards
- Intensive Care Unit
- Multidisciplinary team (MDT) meetings
- Skill Lab

Useful Ways of Learning

- Planned opportunities to follow patients through the system
- Ward rounds
- Participation in clinics
- Participation in surgery in the operating theatre
- Post-operative ward cover
- Planning of follow-up, interaction with GP and community care
- Planning administration paper work
- Case based discussion
- Discussion of tumour and other guidelines
- Team-based working
- Spending time or teaching session with allied health professionals or surgical carepractitioners
- Tutorials and one-to-one teaching
- Simulation
- Audits

LEARNING OBJECTIVES FOR KEY CONDITIONS

1. Abdominal Pain
2. Abdominal lump
3. Change in the Bowel Habit / rectal bleeding
4. Hematemesis
5. Dysphagia.
6. Jaundice
7. Lump and pain in groin
8. Lumps scrotum / scrotal pain
9. Pain loin
10. Urinary out flow obstruction
11. Hematuria
12. Leg Ulceration
13. Painful Limb
14. Breast Lumps and nipple discharge
15. Lumps in Neck
16. Peripheral nerve injuries / palsies
17. Consent for surgery including mental capacity
18. Caring for the post- operative patients, including nutrition, enhanced recovery and critical ill patient, advise re return to activities.
19. Understanding wound healing
20. Trauma
21. Sepsis and infection
22. Surgical safety
23. Caring for the patient before and after surgery including fitness
    a. Fluid optimization
    b. Nutritional Optimization
    c. Safety issues and booking patients for surgery
    d. Antibiotic / thromboprophylaxis
    e. Pre- operative assessment / investigations

General Surgery

Surgical unit: I / II

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature	
			A	B	C	D	E		
1		**History taking from patient**							
		surgical unit							
2		**General physical examination**							
		Pulse							
		BP							
		Temperature							
		Respiratory rate							
		Anaemia							
		Jaundice							
		Others (specify)							
3		**Systemic examination**							
1		Skin and soft tissue							
2		General scheme of case taking							
3		A few special symptoms and signs							
4		Examination of a lump or a swelling							
5		Examination of Ulcer							
6		Examination of sinus and fistula							
7		Examination of peripheral vascular disease and gangrene							
8		Examination of varicose veins							
9		Examination of lymphatic system							
10		Examination of peripheral nerve lesion							
11		Disease of muscles, tendons and fasciae							
12		Examination of disease of bone							
13		Examination of bone and joint injuries							
14		Examination of injuries about individual joints							
15		Examination of pathological joints							

16			Examination of individual joint pathologies						
17			Examination of head injuries						
18			Investigation of intracranial space – occupying lesions						
19			Examination of spinal injuries						
20			Examination of spinal abnormalities						
21			Examination of the hand						
22			Examination of the foot						
23			Examination of the head and face						
24			Examination of jaws and temporomandibular joint						
25			Examination of the palate, cheek, tongue and floor of the mouth						
26			Examination of salivary glands						
27			Examination of neck						
28			Examination of the thyroid gland						
29			Examination of injuries of chest						
30			Examination of disease of the chest						
31			Examination of breast						
32			Examination of case of dysphagia						
33			Examination of abdominal injuries						
34			Examination of acute abdomen						
35			Examination of chronic abdominal condition						
36			Examination of abdominal lump						
37			Examination of Rectal case						
38			Examination of a urinary case						
39			Examination of a case of hernia						
40			Examination of a swelling in the inguinoscrotal region						
41			Examination of male external genitalia						

SUMMARIZATION OF HISTORY

1. Particular of the patients
2. Chief complaints
3. History of present illness
4. Past history
5. Drug History
6. History of allergy
7. Personal history
8. Family history
9. History of immunization

A. Physical Examination

B. Systemic / Local Examination

C. Provisional Diagnosis

D. Investigations

Skills laboratory

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		IV line insertion						
2		Nasogastric tube insertion						
3		Foley`s catheter insertion						
4		Fluid aspirations						
		❑ Ascitic:						
		❑ Pleural:						
		❑ CSF:						
		❑ Joint fluid:						
		❑ Others (specify)						
5		CPR						
6		Endotracheal intubation						
7		DRE Others						

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to Common symptoms and diseases in general surgery	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)		
End of the ward assessment	Marks:__________out of _____________	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Details of other activities

Competencies	**Details**	**Supervisor`s comments / signature**
Skill lab.	Presented by:	
BLS workshop	Conducted by:	
Other activities	prepare the patient for and know the procedure of doing X-Ray , chest, abdomen, KUB, barium studies, ultrasound, CT scan, MRI and others	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

<table>
<tr><th rowspan="2">S. No</th><th rowspan="2">Statement</th><th colspan="4">Supervisor comments</th></tr>
<tr><th>Yes</th><th>No</th><th colspan="2">Any other point</th></tr>
<tr><td>1</td><td>Was polite with patients, nurses, paramedical staff, seniors and colleagues</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>2</td><td>Was ready to take responsibility</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>3</td><td>Kept calm in difficult situations</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>4</td><td>Maintained an appropriate appearance / dress</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>5</td><td>Avoided derogatory remarks in the unit</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>6</td><td>Presentation skills were up to the mark</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>7</td><td>Total attendance</td><td></td><td>Out of=</td><td colspan="2"></td></tr>
<tr><td rowspan="2">7</td><td rowspan="2">Overall assessment of professional conduct</td><td colspan="2">A:
High</td><td>B:
Moderate</td><td>C:
Low</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
</table>

Other academic and co-curricular activities

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

*The student can paste photocopies of certificates of presentations on this page

List of certificates of participation in other academic and co-curricular activities*

S. No	Name of activity / society / other	Position	From ---- to (date)	Signature of organizer / incharge

*Student can paste the proof / certificate / office order of the activities / events

Evaluation / Assessment Chart

S. #	Date	Duration	Activity	Performance	Assessed By	Student Sign	Teachers Sign
			Department of General Surgery				
			Department of Orthopedic Surgery				
			Department of Plastic Surgery				
			Department of Radiology				
			Skill Lab				

For student affairs / examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book							
	%age							

Deputy / Controller of examination

Sign_________________________
_

Director Medical Education

Sign________________________
_