2019

DR. M. L. DHAWALE MEMORIAL HOMOEOPATHIC INSTITUTE, PALGHAR

NOTICE

JUNIOR RESIDENT/FELLOWSHIP POSTS

(Duration: 15 Oct 2019 – 18 Oct 2020)

These will be in four categories as follows:

A. Junior Resident - IPD

B. Junior Community Resident - Bhopoli

C. Junior Research Fellowships

Applications are invited for the posts of Junior Resident. PGs Part 2 should carefully study the document & apply for the posts.

PG can apply for any number of the categories. In case they are applying for more than one category then they have give preference for each category.

A. Junior Resident-IPD Palghar: (JR)

Total IPD Posts: 12

- Medicine & Surgery = 3
- ICU & Casualty =3
- Paediatrics, OBGY & Ophthalmology= 3
- Psychiatry & Orthopaedic & Geriatric = 3

Eligibility:

- Part 1 exam appeared
- Application indicating the interest with justification
- Paediatrics and Psychiatry posts will be for the subject students. Any other branch student wishing to do the post in these subjects must get clearance from the respective HODs.

Duration:

- Posts will be for 12 months (6 +6 months)duration.
- PG once opted will have to continue for a minimum of 6 months. At the end of 6 months, performance will be assessed. Based on assessment, the extension for the 2nd term will be given.
- In case any PG wishes to discontinue after 6 months, they have to write an application at the end of 5 months. College council will assess the reasons and permission for discontinuing will be given only if college council is convinced.
- In case someone wants to discontinue against college council wish then that PG will have to pay back entire stipend to the college. S/He will not be issued certificate of completion.
- New Junior resident will be selected from the list of those PGs who had earlier applied but did not get the opportunity.

Junior Resident IPD: Selection with credit points:

- OSCE will be departmental specific for the clinical posts.(50)
- Apart from OSCE, the following parameters will receive credit points. (50)

- 25 SCRs corrected in Part 1 – (Maximum 2 SCRs in a month) (1 credit point for each SCR)
- IPD case corrections:5 homoeopathic cases of the department for which the post applied. (2 credit point for each SCR)
- Practice exams including prelims – Average will be calculated and credit points will be given based on the average. E.g. 80% will be accorded 8 points. 60% will be 6 points etc. (1 credit point for 10%)
- IPR on floor – issues – Issues that were reported to the clinical committee. There will be negative credit points for each issue if the student was found to be deficient in performing his/her duty. (5 credit points)

Responsibility & duties for IPD Postings:

- Care of the IPD Patient through instituting standardized patient care procedures for the respective departments
- They will formulate and implement the SOPs for departmental functioning.
- Participate in the NABH procedures
- Increase homoeopathicity in the department
- Improve documentation on IPD records and SCR
- Participate in documentation in HIMS
- Train Junior students in clinical procedures and examination
- Junior Resident will be responsible for patient care for 24*7.
- They can relieve each other during evening hours and night by mutual understanding. However, in case of excess of work load everyone will have to be on duty.
- They will take IPD rounds at least 3 times a day.
- During day time i.e. from 9.00 to 5.00 pm there will be all Part 1 and Part 2 PG students. They and Junior Residents - both would be equally responsible for patient care. Junior Residents will take updates from them about status of patient.
- There will be one IPD duty on alternate Sunday for everyone.
- Write case reports/ articles for JISH
- Present experiences in seminar
- Junior Resident will not have Peripheral, Bhopoli and Dahisar OPD postings
- They will participate in the Virar educational programme

Stipend:

- Junior Resident will be paid Rs.7000/pm stipend

Note: JR IPD will be implemented only if all 12 posts are filled. In the absence of 12 eligible candidates, the IPD posting will be 2 days on call i.e. 24*2 days / week for the entire batch

B. Junior Community Resident:

Total JCR Posts: 1

Eligibility:

- Part 1 university exam passed
- Application indicating the interest with justification

Selection Procedure:

- Interested students should apply for the post stating their reason for application.
- They need to clear community orientation test conducted by Bhopoli team and round of interview
- Additional point that will be considered for selection are
  - 25 SCRs corrected in Part 1 – (Maximum 2 SCRs in a month) (1 credit point for each SCR)
  - IPD case corrections:5 homoeopathic cases of the department for which the post applied. (2 credit point for each SCR)
  - Practice exams including prelims – Average will be calculated and credit points will be given based on the average. E.g. 80% will be accorded 8 points. 60% will be 6 points etc. (1 credit point for 10%)
  - IPR on floor – issues – Issues that were reported to the clinical committee. There will be negative credit points for each issue if the student was found to be deficient in performing his/her duty. (5 credit points)

Responsibility of Community Posts:

- They will be responsible for IPD care – 24*7 (when they are posted)
- They will participate in community related initiatives 1 day/week. It could be survey / clinical work / community meeting
- They will do community extension programme documentation required for NAAC
- They will work as per the direction of Dr. Goda sir

Timing:

- They will be residential at Bhopoli for 12 months.
- They will be at Palghar for their departmental day. On that day they will stay at Palghar.

Stipend:

- Junior Resident will be paid Rs.7000/pm stipend
- Travelling to Palghar will be by public transport. Bhopoli management will reimburse actual travelling expenses.

C. Junior Research Fellowship (JRF)

Total Posts: 2

Eligibility:

- Part 1 university exam passed
- Application indicating the interest with justification

Selection Procedure:

- Interested students should apply for the post
- Application should have
  - Primary objective for applying for JRF
  - Reasons for which they should be selected
  - Their project topic for JRF programme with its importance
  - They need to clear aptitude test and one round of interview
- Additional point that will be considered for selection are

- 25 SCRs corrected in Part 1 – (Maximum 2 SCRs in a month) (1 credit point for each SCR)

Responsibility:

- Publishing one research article on the basis of work done on the pilot research project of their own choice
- Working on any of the institute's ongoing funded or pilot project
- They will work on CCRH – MLDMHI collaborative work
- Completing various analysis (Clinical / Survey) given by the institution
- Working on clinical documentation in HIMS assigned to them
- Teaching assignment of research and biostatistics
- Participating in MUHS – Avishkar programme
- Documentation related to innovation and research support required for NAAC.

Timing: (minimum 18hours /week apart from college hours)

- They will be given one day of their OPD posting reserved for their project.
- JRF will have to do all project related work on that day. Every day they have to complete the work diary and submit.
- In addition, they have to work on additional 18 hours for completing other responsibilities. These hours will be in addition to regular college timing.

Stipend:

- Junior Resident will be paid Rs.3500/pm stipend

Time line for selection process of Junior Resident/Fellowship Posts:

No.	Activity	Date
1	Notice circulation	24 /09/2019
2	Application by PG	27/09/2019
3	OSCE / Test / Interview by concern department	28/09/2019 to 02/10/2019
4	Selection announcement	04/10/2019
5	Orienting period	07/10/19 – 13/10 2019
6	Actual Duty	16 /10 /2019

Dr. Sachin Junagade,
Vice Principal

Panels

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OSCE 2019 orientation

Read carefully-

Day 1on admission status -

Day 2-

After 24 hrs of admission

PATIENT IS HAVING Loose watery stool, Frequency 5 times, Quantity- reduced and

Vomiting- no episodes,

Appetite- SQ

Activity- improved

Thirst- increased large quantity often for cold water+2

Irritability- decreased+1

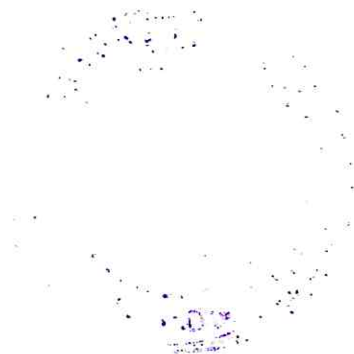
Urine - 4-5 times passed

T- afeb

P- 80/min

RR- 20/min

P/A- soft Nt/ND



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Symptom

Mental status

Irritable +1

Thirst

Increased for large quantity small interval for cold water

Heart rate- 80/min

Breathing- Normal

Eyes- n

Tears- Present

Mouth and tongue- moist

Skinfold turgur- n

Capillary refill-

Extremities-

Urine output- 4-5 times passed

	GARDE 4	GRADE 3	GRADE 2	GRADE 1
ATTITUDE	PRESENTED HIMSELF	IN A HURRY AND	IN A HURRY AND	COULD NOT

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	IN A CONFIDENT MANNER. TOOK IN DETAIL OVER AND CLEARED HIS DOUNBTS BY ASKING QUESTIONS AND TRIED TO UNDERSTAND THE FLOOR SITUATION. LISTENED TO RELATIVE CALMLY	TOOK OVER AND BECOME MORE ANXIOUS WITH SCENARIO BUT STILL TRIED TO APPROACH RELATIVE IN CONFIDENT MANNER. LISTENED TO RELATIVE HAPHAZARDLY.	TOOK OVER AND BECOME MORE ANXIOUS WITH SCENARIO AND APPROACHED REALTIVE WITH LOW CONFIDENCE. COULD NOT LISTEN TO RELATIVE.	PRESENTED HIMSELF IN A CONFIDENT MANNER AND BECAME MORE ANXIOUS AND UNBLE TO HANDLE FLOOR SITUATION. NOR LISTEN TO RELATIVE
COMMUNICATION	AFTER LISTENING TO RELATIVE CALMLY. EXPLAINED DIFFERENCE / CHANGE BETWEEN YESTERDAY'S CLINICAL CONDITION AND TODAY'S CLINICAL CONDITION. EXPLIANED COURSE OF ILLNESS I/V/O UNDERSTANDING STATE AND STAGE OF DISEASE. CLEARED ALL THEIR DOUBTS ASSURED THEM ABOUT TREATMENT.	EXPLAINED DIFFERENCE / CHANGE BETWEEN YESTERDAY'S CLINICAL CONDITION AND TODAY'S CLINICAL CONDITION. EXPLAINED COURSE OF ILLNESS I/V/O UNDERSTANDING STATE AND STAGE OF DISEASE. THOUGH EXPLAINED NICELY CLINICAL CONDITION COULD NOT HANLDE THEIR ANXIETY AND UNBLE TO CLEAR THEIR	COULD NOT HANLDE REALTIVE. NOR TRIED TO LISTEN NOR COMMUNICATED STATE AND STAGE OF THE DISEASE AND DIRECTLY WENT TO COSULTANT WITHOUT GETTING FLOOR SITUATION.(BECAUSE OF ANXIETY)	FAILED TO COMMUNICATE TO RELATIVE AND TO CONSULTANT.

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	EXPLAINED ALL THINGS IN DETAIL BUT IN CONCISE MANNER TO THE CONSULTANT	DOUBTS IN THE END EXPLAINED ALL THINGS IN PARTIAL MANNER WHILE COMMUNICATING WITH CONSULTANT.		

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1. Father/mother irritable as they are unable to judge the change in patient's condition. They feel there is no any change.
2. Anxious because a senior consultant is looking after all other patients except their patient.

(Demo parents have to act in anxious+2 and irritable manner)

- Q: why my child is still having same complaints.,
  A:

Condition	Previous	Today (with difference)
frequency of loose stool	7-8	4-5
Quantity	Profuse	Scanty
Vomiting	2-3	No any episode since after admition
Activity	Dullness	Improved +
Mental state	Irritable all the time Will all- doctors/strangers/ parents/ relatives etc.	Decreased Now only on approach of doctors and not with parents and relatives
Hydration status – skin turgor	Lost	Normal
Eyes	Sunken +	Normal

Here, to make a note whether examinee has covered all points or not. How he receive relative/parent and address their concern and communicate and assures them about clinical condition (treatment).

While talking with consultant they firstly should explain difference between clinical condition (improvement/ stand still or no improvement) compare to yesterday. They should also be able to explain in detail floor status.

OSCE 2019 FOR PAEDIATRIC JR EVALUATION: PAEDIATRIC DEPARTMENT

STATION - I: HISTORY TAKING & RECORDING (10 MINS)

PREPARATION OF STATION 1:

Name of the case	Viral acute gastroenteritis with grade II dehydration
Name of the Patient	Mr ABC
Age / Gender	14yr / Male/ Muslim
Education / Occupation	9th std
Preliminary Data & address	F – 37 years M – 35 years Address – Satpati
Presenting Situation	PATIENT IS HAVING Loose watery stool since 3 days, yellowish, profuse+2 , non-offensive, Sputtering+2, Painless+, Rumbling before stools Weakness+2, O-gradual, P-progressive, Frequency 7-8, Quantity-profuse and Vomiting is since yesterday, O-sudden, P-progressive F-3-4 times, Quantity-profuse, nausea before vomiting, Vomitus- ingesta watery sour, Offensive+2, <after eating and drinking+2, >after vomiting, Appetite- decreased Thirst- increased large quantity often for cold water+2 Irritability+2 Abdominal pain on and off since 1 month
Past Medical History	No H/o Similar Symptoms
Family History	GF- DM, HTN GM- DM
Demeanor / Body language / Appearance	Irritated due to complaints.
Objectives	At the end of Station I student should able to: 1. Identify the lacunae in given document and should be able to complete remaining data. 2. Elicit the evolutionary picture (ODP) of disease presentation 3. Shown efforts in eliciting the Causative factor & Negative history 4. Elicit the medicinal intervention taken for the current acute episode 5. Elicit the symptomatic expressions of acute gastroenteritis with emphasis on pain in abdomen, character of stool and vomitus, frequency of vomiting and stool, frequency of micturition, modalities of the sensations. 6. Elicit the changed mental and physical general expressions of child during the current acute episode 7. Elicit other complaints along with the acute presentation of acute gastro enteritis.

	8. Elicit the past history of similar episodes. 9. Able to observe the behavior 10. Able to document clinical, homoeopathic and negative history simultaneously while taking the Case
Flow of the conversation	**Nature of the complaints and the details / You are suffering from which complaints:** Mention about the complaints i.e. – I am having loose stools and vomiting **Since when you have loose stools?** Loose stools Since 3 days **What could be the cause of complaint?** Not any. **Have you eaten outside food or water 3 days back ?** No, last 5 days I am eating home food **How is the onset of loose stools?** On first two days I passed thrice loose stool. On third day the frequency was increased 7 – 8. **How much is the quantity of stools?** Profuse **What is consistency of stool?** Watery, loose **Colour of stools**: yellow **Odor:** Non offensive **Flatulence/ sputtering:** Stools comes out with flatus. **Modalities** : the urge comes to pass stool any time a day **Abdominal pain?** No pain but rumbling **Since when you have vomiting?** Vomiting since yesterday **What could be the cause of complaint?** Not any. **How is character of vomiting?** Vomitus contains all what has eaten or drunk and watery consistency. **Is there any smell to vomitus?** Yes. Sour smelling **What are the aggravating factors for the complaint or factors which increase and decreases complaint?** **Vomiting increases** after eating & drinking **When you feel better?** Feels better after vomiting. **Any changes in behavior?** I am feeling very angry on small issues since morning when I started for vomiting **What are other symptoms?** Not any. **Is your thirst altered? Or they may ask as – How is your thirst?** **Thirst:** LQSI, Is thirst for cold or warm water? Cold water. **What about appetite?** It is decreased.

OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT

	What treatment you have taken? No treatment taken **Past history:** Nothing specific **Behavior:** Irritable Apart from above said information they ask anything else say I don't know or I am unable to recollect or I haven't noticed.
Possible Diagnosis	Viral acute gastroenteritis
Method of observing the performance	Check list
Level Designated for	MD (HOM) final year student
Place in Academic Year	2018-19

OSCE 2019 FOR PAEDIATRIC JR EVALUATION: PAEDIATRIC DEPARTMENT

Grade marking during history taking: Station I

Name of the Applicant: ______________________________

The observations were framed as follows:

No	Activity-Marks	3	2	1	0
1	Preliminary Data	Asks all preliminary data – Name, Age Education, Religion	Asks partially – Name and Age asked	Incomplete data – Either Name or Age ask	Fails to ask any data
2	Overall History	Asked clinical as well as Individualistic	Asked Partially Clinical & Homoeopathic History (LSM) + Causation	Asked Partially Clinical & Homoeopathic History (LSM) - Causation	Missed ODP, Sensation, Modality, Causation
3	ODP: Time	Is able to elicit accurately the onset, duration and the course of illness – Frequency (progress)	Elicits the onset, duration but not the course	Elicits either the onset, duration or the course of the illness	--
5	Sensations	Able to elicit all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting with the intensities.	Able to elicit and all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting but misses all the intensities	Able to elicit only nature of stools and vomiting but misses intensities and colour, quantity	Only Eliciting the complaints ie. Vomiting and Loose stools
6	Modalities-AF	Is able to elicit the AF with options	Ask for AF without any options	---	Didn't ask for Causation
7	Aggravation	Is able to elicit	Is able to elicit	---	Didn't ask for

		vomiting and stool the < modalities with intensity with various options	vomiting and stool the < modalities missed the intensity and various options		the aggravation modalities
8	Amelioration	Is able to elicit vomiting and stool the > modalities with intensity with various options	Is able to elicit vomiting and stool the > modalities missed the intensity and various options	---	Didn't ask for the ameliorating modalities
9	Concomitants	Asked for Mental and Physical generals	Asked for either Mental or Physical generals	---	Didn't ask concomitants
10	Past history	Is able to elicit P/H/O of similar complaints	Asks the P/H/O but does not elicit the similar complaints	---	Does not ask
11	Associated Symptoms	Asked for the Associated complaints	--	--	Didn't ask
12	Document evaluation	Asked more than 5 lacunaes	Asked 3-4 lacunaes	Asked 1-2 lacunaes	Didn't ask

Document evaluation points:

1.	STOOL- CHARACTER	Sputtering+2, Painless+, Weakness+2,
2.	STOOL MODALITY	Rumbling before stools
3.	ODP OF STOOLS	O-gradual, P-progressive, Frequency 7-8
4.	VOMITING MODALITY	nausea before vomiting, <after eating and drinking+2, >after vomiting,
5.	VOMITUS CHARACTER	Vomitus- ingesta watery sour, Offensive+2
6.	GENERAL	Appetite- decreased Thirst- increased large quantity often for cold water+2 Irritability+2
7.	No any other complaint	-
8.	Medication	No any
9.	Family history	Fa mo
10.		

OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT

STATION I:
HISTORY TAKING & RECORDING

SCENARIO:

Your junior team member has taken following data. Go through data and evaluate the document and take final action.

Name of the Patient	Mr ABC
Age / Gender	14yr / Male/ Muslim
Education / Occupation	9th std
Preliminary Data & address	F – 37 years M – 35 years Address – Satpati
Presenting Situation	PATIENT IS HAVING Loose watery stool since 3 days, yellowish, profuse+2 , non-offensive, Vomiting is since yesterday, O-sudden, P-progressive F-3-4 times, Quantity-profuse Abdominal pain on and off since 1 month
Past Medical History	No H/o Similar Symptoms
Family History	GF- DM, HTN GM- DM
Demeanor / Body language / Appearance	Irritated due to complaints.

DURATION OF INTERVIEW & RECORDING:
10 mins

TASKS:

OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT

Considering the child of 14 years, a Homoeopathic physician should -

- Able to elicit the clinical expressions of acute complaints
- Able to elicit the individualistic expressions during acute complaints
- Able to arrive at clinical diagnosis
- Able to formulate the prescribing totality.
- Able to record the taken history in given recording sheets.

Grading marking for recording the history:

No	Activity-Marks	3	2	1	0
1	Preliminary Data	Records all preliminary data - Name, Age Education, Religion	Records partially - Name and Age asked	Records Incomplete data - Either Name or Age ask	Fails to Records any data
2	Overall History	Records clinical as well as Individualistic history	Records Partially Clinical & Homoeopathic History (LSM) + negative data about Causation	Records Partially Clinical & Homoeopathic History (LSM) - negative data about Causation	Only records chief complaint but didn't record its ODP, Sensation, Modality, Causation
3	ODP: Time	Is able to	Records the	Records either	Only records

		record accurately the onset, duration and the course of illness – Frequency (progress)	onset, duration but not the course	the onset, duration or the course of the illness	chief complaint but didn't record onset, duration or the course of the illness
5	Sensations	Able to record all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting with the intensities.	Able to record all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting but misses all the intensities	Able to record only nature of stools and vomiting but misses intensities and colour, quantity	Only records the complaints ie. Vomiting and Loose stools
6	Modalities-AF	Records negative data about absence of any ailments from	---	---	Didn't record ailments from
7	Aggravation	Records the < modalities of vomiting and stool with intensity	Records the < modalities of vomiting and stool but misses the intensity	---	Didn't record the aggravating modalities
8	Amelioration	Records the > modalities of vomiting and stool with intensity	Records the > modalities of vomiting and stool but misses the intensity	---	Didn't record the ameliorating modalities
9	Concomitants	Records Mental and Physical generals	Records either Mental or Physical generals	---	Didn't record concomitants

10	Past history	Records abscence P/H/O of similar complaints		---	Does not record
11	Associated Symptoms	Records absence of the Associated complaints	--	--	Didn't record

OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT

STATION- II: CLINICAL EXAMINATION – 10 MINS

OBJECTIVES OF THE STATION 2:

- To assess the interpersonal skills - greeting and explaining about the clinical examination
- To assess the clinical skills

Learning objectives:

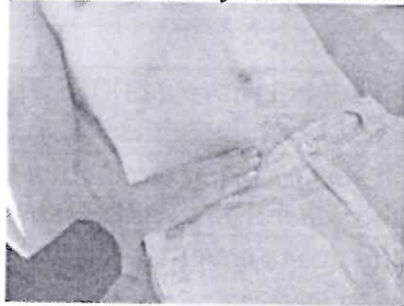
- To understand how well the student is able to explain the procedure about the clinical examination
- To understand whether the students are taking aseptic measures
- To understand how well the student is able to do clinical examination of abdomen, assess grades of dehydration.

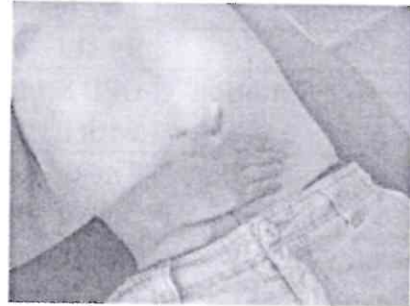
II. PREPARATION OF STATION 2:

Name of the case	VIRAL GASTROENTERITIS WITH GRADE 2 DEHYDRATION
Name of the Patient	Mr. ABC
Age / Gender	14 / Male
Education /	9th std
Presenting Situation	OPD Scenario. Patient is having LOOSE STOOLS AND VOMITING with irritability due to complaints
Clinical Examination	The doctor will perform the examination of Abdomen, grades of dehydration and general and Vitals examination.
Demeanor / Body language / Appearance	Slight irritability due to complaints.
Expected Activity:	1. Greet the patient 2. Relieve his irritability by telling what aspect of examination he or she is going to perform 3. General examination and vitals 4. Examination of Abdomen 5. Examine grades of dehydration
Flow of the conversation	Doctor will do before asking you anything: 1. Introducing herself / himself 2. Orienting about the necessary of examination 3. What examination he or she is planning to follow 4. Will wash the hands with aseptic lotion before and after the examination Doctor will do the following: 1. They will examine your eyes, nails, mouth and tongue, lymphnodes, and odema. Allow them to do so. 2. They will take your pulse, temperature using thermometer – Let them do so. They will keep thermometer in axilla – you will

allow them. If they ask you to put thermometer in mouth deny telling you will not put in mouth is there any alternative way to take the temperature

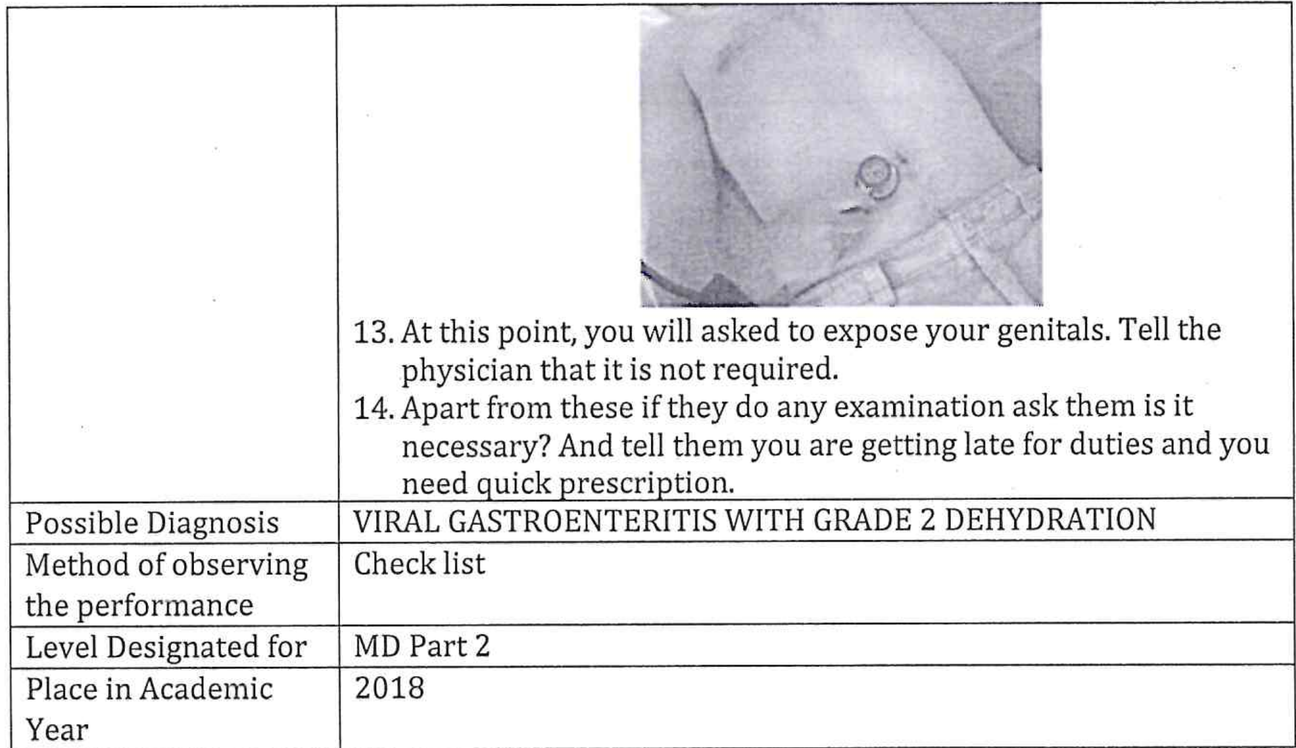
3. They will take your BP/RR.
4. They will open the mouth and will examine the throat with the help of torch. You are expected to open your mouth. No interaction needed.
5. They will see your tongue while opened mouth. Let them do it.
6. Now you will be asked to lie as flat as possible with your arms straight down and they will inspect your abdomen.
7. They will check skin turgor by pinching the skin over the abdomen allows them to do so.
8. They will also touch your extremities – Palm and Feet.
9. They will loosen the cloths around the abdomen to inspect.
10. They will now start palpation of your abdomen in various areas. First superficial and then deep with pressure. You will be asked if there is pain. <u>You will report no pain.</u> You will be asked to breathe heavily and will do so when asked.





11. They will place there middle finger of one hand and tap by the index finger on the placed middle finger. They will percuss all over the abdomen

12. They will put their stethoscope on your abdomen.

	 13. At this point, you will asked to expose your genitals. Tell the physician that it is not required. 14. Apart from these if they do any examination ask them is it necessary? And tell them you are getting late for duties and you need quick prescription.
Possible Diagnosis	VIRAL GASTROENTERITIS WITH GRADE 2 DEHYDRATION
Method of observing the performance	Check list
Level Designated for	MD Part 2
Place in Academic Year	2018

OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT

Station II: Clinical Examination:

Name of Applicant: ______________________________

Instructions to the observer for Grade marking during Clinical Examination

	Activity	A	B	C	D
1	Approach	Introduces self, asks for name of patient and states purpose of encounter	Introduces self and asks for name of patient	Introduces self	Doesn't introduced the self / directly started with examination
2	Interpersonal Skills	Made the patient feel comfortable by asking permission and telling about what aspect of examination will be done	Made the patient feel comfortable by orienting what aspect of examination will be done not taken the permission	--	Start examining without making patient feel comfortable
3	Order of Examination	General Examination → vitals → Systemic	Haphazardly did the examination but covered all the 3 examinations	Haphazardly did the examination but covered all the 2examinations	Only systemic examination
3	Order Systemic Examination	Followed the order Inspection → Palpation → Percussion → Auscultation	Followed the order but covered any 3 aspects	Did not Followed the order but covered all 4 aspects	Didn't follow the order less than 4 aspects touched. Followed the order but did only 2 aspects
3	Principles of Examination	Use of Hand sanitization before and after	Use of hand sanitization before examining	--	Not used hand sanitization

		examining patient	patient		
4	Examination skills – General A	Did all (7) relevant examination in organized way	Did few (5/7) relevant examination in organized way	Did few relevant examination – unorganized	Did it but in hurry &/ or did only 3 or less in any way
5	Examination skills – General B	Pulse, RR Temperature, BP	--	--	Missed any vitals
6	BP	Proper placement of instrument, proper tying of cuff, with proper placement of tubes, seeing systolic by palpation method,	Misses any 1 of the above step, and / or faulty techniques in 2 steps	Misses any 2 of the above step, and / or faulty techniques in 3 steps	Misses any 3 of the above step, and / or faulty techniques in all 4 steps
7	Temp	Use the thermometer wipe with cotton seen the mercury level – then ask permission then put proper way in axilla for 2 min. then record it	Use the thermometer without wiping but ensured the mercury level and then put the thermometer after asking patient for 2 min	Use the thermometer without wiping but ensured the mercury level and then put the thermometer without asking patient for 2 min	Not able to perform
8	Pulse	Palpate the radial artery Count pulse for 1 min	Palpate the radial artery Count pulse for 15 sec	--	Unable to perform
9	RR	Place hand on abdomen and count respiration	Place hand on abdomen and count respiration	Not placed hand on abdomen. Visual counting	Unable to perform

		(movement of abdomen) for full 1min.	(movement of abdomen) for 15-30 sec.	for 15-30 sec.	
10	Examination skills – Dehydration assessment	Checks skin turgor at abdomen, oedema extremities, eyes, mouth, lips tongue	Does all this in an unorganized way	--	Didn't do
11	Palpation	Palpated with the fingers all the four quadrants; superficial palpation with deep palpation	Palpated with the Palm all over the four quadrants – haphazard in superficial and deep palpation	--	Faulty technique or didn't palpate all the quadrants or did either superficial or deep palpation
12	Percussion	Correct technique used and percussed all the areas of abdomen	--	--	Wrong technique / not done
13	Auscultation	Warm the chest piece and placed in all the quadrant esp bowel sounds in 4 region	placed in all the quadrant esp bowel sounds in 4 region	--	Haphazardly placed the chest piece

OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT

Station 2 – Clinical Examination

III. INSTRUCTIONS TO THE STUDENTS

SCENARIO:

Doctor has already taken the History and documented properly in the format.

DURATION OF EXAMINATION WITH RECORDING:

10 min

TASKS:

- Follow the appropriate procedure while examining the patient
- Perform NECESSARY general examination and clinical examination

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Grading of the recording of Physical examination-

Sr. no	Activity	A	B	C	D
1.	Order of recording of Examinations done	General Examination → vitals → Systemic	Haphazardly recorded the examination but covered all 3 examinations	Haphazardly recorded the examination but covered only vital and systemic examinations	Recorded Only systemic examination
2.	Order recording of Systemic Examination	Followed the order Inspection → Palpation → Percussion → Auscultation	Followed the order but recorded any 3 aspects	Did not Followed the order but recorded all 4 aspects	Didn't Followed the order but recorded only 2 aspects
3.	BP	Records- Systolic/ diastolic, mm of Hg		Records- Systolic/ diastolic but no measurement units (mm of Hg)	Not mentioned
4.	Temp	Writes temp C/F and mentions axillary	Writes temp C/F	Only write units	Not mentioned
5.	Pulse	Writes all rate rhythm, volume parameters	Writes rate and rhythm only	Writes rate only	Not mentioned
6.	RR	Writes RR per minute, its characteristic and type	--	Writes RR per minute	Not mentioned
7.	Examination skills – Dehydration assessment	Records Mental status, thirst, heart rate, quality of pulse, breathing, eyes, tears, mouth and tongue, skinfold, capillary refill,	Records Mental status, thirst, eyes, tears, mouth and tongue, skinfold, extremities, urine output.	Records Mental status, thirst, eyes, tears, mouth and tongue, skinfold, urine output.	Not mentioned Or record these signs of dehydration - thirst, eyes, tears, mouth and tongue, skinfold

		extremities, urine output.			
8.	Palpation	Records as soft, non-tender, LSK		--	Not mentioned
9.	Percussion	Records as hepatic dullness with tympanic note all over abdomen	--	--	Not mentioned
10.	Auscultation	Records bowel sound present (+) or absent (-) in all quadrants sounds in number	Records as bowel sounds present (+) or absent (-) in all quadrants	--	Not mentioned

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PAEDIATRIC DEPARTMENT

STATION III:

ORIENTATION FOR HOMOEOPATHY

TASKS:
YOU HAVE TO ORIENT RELATIVE FOR HOMOEOPATHIC TREATMENT.

DURATION:
3 - 5 mins

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WHY SHOULD I TAKE HOMOEOPATHIC TREATMENT?

ANS:

1. NO SIDE EFFECT
2. SIMPLE AND EASY TO TAKE
3. SWEET IN TASTE
4. COST EFFCETIVE
5. BEST RESULTS

Grading for Communication with Patients Relatives:

	Grade 3	Grade 2	Grade 1	Grade 0
Attitude	Presented him in a confident manner. Listened to parent calmly. Tried to understand the parent's concern.	Tried to maintain confident approach. Was hasty while understanding parent's concern. Listened to parent calmly.	Was confused and didn't explain in a confident way Didn't Listened to parent calmly.	Didn't perform
REASONS GIVEN FOR HOMOEOPATHIC TRREATMENT	Covered 4 points	Covered 3 points	Covered 2 points	Covered only one points

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PAEDIATRIC DEPARTMENT

CASE

Chief complaints:

Location & Spread (Tissue, Organ, System)	Sensations and Pathology	Modalities A.F. < , >	Accompaniments
GIT stomach and Rectum since 3days O-gradual P-progressive F-7-8 Quantity-profuse	Loose watery stool, yellowish, profuse+2 , non offensive Sputtering+2 Painless+ Rumbling before stools Weakness+2		
Since yesterday O-sudden P-progressive F-3-4 times Quantity-profuse	Vomiting , nausea before vomiting Vomitus- ingesta watery sour Separate water from stool Offensive+2	<after eating and drinking+2 >after vomiting	Appetite- decreased Thirst- increased large quantity often for cold water+2 Irritability+2

Past History: NIL

Case actuality-

Physical Examination: General

General Appearance:

Pallor: +2 Icterus: Ab oedema: Ab Weight: 25kg Temp: 97.4*F Pulse 92/min

R.R.-24/min

Eye/Conjunctiva: Sunken tear+, Skin: mildly turgor lost, Tongue: dry Glands: not palpable

Physical Examination: Systemic:

R.S: clear AEBE

Per Abdomen: soft, NT ND, BS- hyper peristalsis, L0S0K0

CVS: S1S2+

CNS: conscious dull, sleepy

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Grade of Dehydration:

Symptom	
Mental status	Irritable +2
Thirst	Increased for large quantity small interval for cold water
Heart rate	116/min
Quality of pulses	-
Breathing	Normal
Eyes	Sunken
Tears	Present
Mouth and tongue	Dry
Skinfold	Mildly Turgor lost
Capillary refill	-
Extremities	No cold clammy limbs
Urine output	Decreased

Investigations:

CBC	Hb- 14.2	N	L	E	M	B
19/8/13	WBC- 8.800	55	41	2	2	0

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PAEDIATRIC DEPARTMENT

OSCE

IV. INSTRUCTIONS TO THE STUDENTS

SCENARIO:

Doctor has already taken the History considering clinical as well as Homoeopathic aspects. After the doctor has done clinical examination. The investigation are reported.

This is the standard history, examination finding and investigation for further processing

DURATION OF STATION:

10 minutes

TASKS:

write answers for the following questions:

- Arrive at clinical diagnosis with differential diagnosis
- Formulate the totality
- Give the final choice of remedy with differentiating closely coming remedies
- Suggest the posology with reasoning
- Formulate follow up criteria with frequency of monitoring
- Inform to Consultant.

- **Checklist for assessing the clinical diagnosis with differential diagnosis**

Grading of Diagnostic skills

A Grade: Mentions report as WNL and diagnosis as viral AGE with grade 2 dehydration with reason from history, clinical examination and investigation

B Grade: Mentions report as WNL and diagnosis as viral AGE with grade 2 dehydration without any reason

C Grade: Mentions report as WNL and diagnosis as viral AGE.

D Grade: Diagnosis not mentioned

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- ## Checklist for assessing the totality:

SR. NO.	PARAMETERS	YES	NO
	Totality Formulation:		
1	All the characteristic expressions (symptoms) are considered in totality		
2	All the characteristic expressions are considered with gradation in formulating totality of symptoms		
3	Concomitant are taken in the totality		
4	Reportorial Approach (Name) mentioned		
5	Evaluation order is mentioned according to mentioned repertorial approach		

Totality Formation:	
Grade A:	Point number 5 + Yes score 3 out of 4
Grade B:	Point number 5 + Yes score 1 out of 4
Grade C:	Point number 5 not done + Yes score 2 out of 4
Grade D:	Point number 5 not done + Yes score 1 out of 4

Overall Assessment	**Grade A**	**Grade B**	**Grade C**	**Grade D**

- **Checklist for assessing the Remedy Selection:**

	Remedy Selection:		
1	Group of remedies mentioned		
2	Thermal, acute /chronic, evolution and location considered in coming to small group		
3	Character of the stools and vomiting , modalities and concomitant consider in final selection		
4	Final remedy prescribed with relevant reason		
5	Closely coming remedies differentiated		

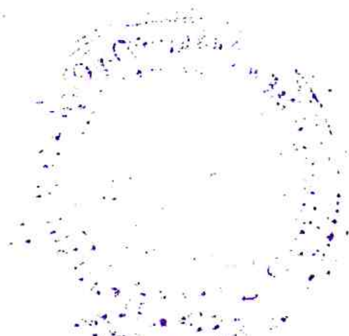
Remedy Selection	
Grade A:	Point Number 5+4 yes score 2 out of three
Grade B:	Point Number 5 + yes score 3 out of four
Grade C:	No Point number 5 but either 3 out of four
Grade D:	Point number 1, 2 & 3

Overall Assessment	**Grade A**	**Grade B**	**Grade C**	**Grade D**

**OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT**

- **Checklist for assessing the posology:**

GRADE	GRADE A	GRADE B	GRADE C	GRADE D
Criterias	SUSCEPTIBILITY, SENSITIVITY, SUPPRESSION, CORRESPONDENCE LEVEL, GENERAL VITALITY, MIASM MENTIONED WITH REASONS	SUSCEPTIBILITY, SENSITIVITY, SUPPRESSION, CORRESPONDENCE LEVEL, GENERAL VITALITY, MIASM MENTIONED	SUSCEPTIBILITY, SENSITIVITY, GENERAL VITALITY, MENTIONED WITH REASONS SUPPRESSION, MIASM CORRESPONDENCE LEVEL NOT MENTIONED	SUSCEPTIBILITY MENTIONED SENSITIVITY, SUPPRESSION, CORRESPONDENCE LEVEL, GENERAL VITALITY, MIASM NOT MENTIONED



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PAEDIATRIC DEPARTMENT

- **Checklist for assessing the follow up criteria with frequency of monitoring:**

GRADE	MARKS
Irritability	3
Weakness	3
Thirst	3
Stool-I-F	2
Stool-offensive and sputtering	2
Vomiting-I-F	2
Temperature	1
HR	1
RR	1
AG	1
Hydration status	2

MARKS TOTAL= 21

GRADE A- > or = 17

GRADE B- 10 to 17

GRADE C- BELOW 10

OSCE 2019 FOR PAEDIATRIC JR EVALUATION:
PAEDIATRIC DEPARTMENT

- **Checklist for assessing COMMUNICATION WITH CONSULTANT:**

	GARDE 3	GRADE 2	GRADE 1	GRADE 0
POINTS INFORMED	INFORMED DIAGNOSIS, TOTALITY, SIMILIMUM AND POSOLOGY WITH REASON	INFORMED DIAGNOSIS, TOTALITY, SIMILIMUM AND POSOLOGY WITHOUT REASON	INFORMED DIAGNOSIS, TOTALITY AND SIMILIMUM PARTIALLY WITHOUT REASON	DIRECTLY JUMPED TO SIMILIMUM ONLY

PAED JR OSCE

		manasi	sneha	priya	avisha
station 1	history taking	20	23	15	12
	history recording	25	21	7	15
2	examination recording				
3	Orienting pt for Hor	5	4	4	4
4	DIAGNOSIS	2	2	2	2
	TOTALITY	1	1	0	1
	REMEDY SELECTION	2	0	2	2
	POSOLOGY	1	1	0	1
	FOLLOW UP	1	1	0	0
	INFORMING CONSU	3	3	3	2

Dr. M. L .DHAWALE MEMORIAL HOMOEOPATHIC INSTITUTE, PALGHAR

Department of Psychiatry

PLAN OF OSCE FOR PSYCHIATRIC EVALUATION (middle batch) 2019

Station-I: Communication skill- 10mins

Sarita is a 25 years old social worker from Palghar having compliant of being tired always with multiple pain sites in body, weakness with no desire to go out of the house. Complaints have started since the 8 months. The complaints are occurring daily and started after she has received scolding from her boss in front of lot many crowd at work related to some patients. Since then she has become sad and often have thoughts that she is not worthy of anything.

Her family has reported that she has become inactive, doesn't wish to talk to anyone in family or at work. Her eagerness to go to work reduced since many months. Often get irritated when told for something or forced to go for work. But she remain aloof in her room all the time with poor self-care.

Husband and other family members in family are worried about her state as she hardly pay attention to 5 year old child too, and at times shared her wish to end all these by husband by any means.

Station- II: Documentation – 10 mins

Prepare LSMC based on the above supplied information and the conversation carried out with patient

Station-III: Analysis and Synthesis- 10 mins

Preparing the totality and possible repertorization

Station- IV: Examination: MSE and PE- 10mins, ordering investigations if any

Manya, a 32 years old record keeper, found to have taken often sick leaves. His supervisor reported that he is at times very slow at work and often complaint about many aches. According to the supervisor He is found to be smelling of alcohol at work place, and gets irritated often on small things. On supervisors information he often fights at home under influence of alcohol. At times he mumbles with himself at work or at home.

(I shall add the description of above scenario once that gets finalized for act)

Station- V – writing MSE and PE with investigation – 10mins

PSY 2019

DR. M. L. DHAWALE MEMORIAL
HOMOEOPATHIC INSTITUTE
Opp. S.T. Workshop, Palghar-Boisar Road, Palghar 401 404. • Tel : 02525-256932/33 • Fax : 02525-257019
(Recognized by the Central council of Homoeopathy, New Delhi and Maharashtra University of Health Sciences, Nashik)

Conversation with patient-

Dr.- Hello, myself Dr. ....

Pt. - Hmm... (Nodded head with no emotions on face)

Dr. – so, Sarita how old are you?

Pt. – 28 years

Dr. - What work do you do?

Pt. – social worker

Dr. – Very good, where do you work?

Pt. – Palghar

Dr. – Which company?

Pt. – Not in company but in hospital

Dr. – Which hospital exactly?

Pt. – MLDMHI, as a community social worker

Dr. – Very good, since how long do you work there?

Pt. – Since last 7 years

Dr. – How do you do at work?

Pt. – I do all my work very well and at time (with some irritation on face)

Dr. – That's very good, how is everything at work as of now?

Pt. – I'm not going to work since many months

Dr. – How many months?

Pt. – 8 months

Dr. – Ohh, but why aren't you going to work anymore?

Pt. – I don't know

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Dr. – There must be something right? Otherwise you being so well organized at work, I don't understand the reason of not going to work.

Pt. – I feel very tired and weak, so I don't go

Dr. – Since when are you feeling so much tired and weak, so that you can't go to work for 8 months?

Pt. - Since last 8 months, and it happens every day. I don't have any interest in going work, doing any household work.

Dr. – Hmm, what else?

Pt. – I get these bodyaches always, especially the headaches. Which also prevents me from doing any work

Dr. – Ok, what else?

Pt. – I don't know, I get these weird thoughts all the times.

Dr. – What kind of thoughts?

Pt.- That I am not worthy of anything

Dr. – Ok, what else thoughts do you get?

Pt. – I don't like to talk to anyone. Just wanted to be alone

Dr. – Why?

Pt. – Because I get irritated often very easily, at home. If my son is crying then, or my in-laws saying something or husband trying for something.

Dr.- Trying for something?

Pt.- Yes, for sexual relation, I don't like that too.

Dr. – Any other thoughts?

Pt.- Yes, as I feel I'm not worthy of anything, I can't face the world because all " Izzat" what I had is gone. I often get these suicidal thoughts, which I share with my husband.

Dr. – Ohh, since when all these problems started?

Pt. – I can say that when my supervisor has scolded me at work?

Dr. – Scolded you? Why would he/she did so?

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Pt. – I don't know doctor, months ago I have brought one patient for admission. But my other colleague who is my junior has not filled up all the necessary documents like consents, Rashan card details etc.

Dr. – Hmm, so what happened/

Pt. – My admin sir, called me in word and have scolded me in front of many patients and relatives.

Dr.- So, what happened to you?

Pt. – What happened? What will happen sir, "mere izzat ki to poori lag gayi na". he could have scolded me or told me about mistake somewhere else and in polite and professional manner.

Dr. – What exactly did you felt at that time?

Pt. – I was very angry, I have worked for so many years for them and on one single and small mistake they scolded me so badly (weeping). That too in front of people whom I visist day in and out and convince them about the wellness of hospital, bring them for admission and he has scolded me in front of them..... I was very angry, but I couldn't uttar a word. Mere izzat ki poori lag gayi. What is the point then to be here if you have lost the name you had.

Dr. – hmm

Pt. – I had a bad headache that day and since then get this headache often whenever I get this irritated thought.

Dr. – What kind of headache?

Pt. – Its very throbbing kind of sensation, which is there in whole body too.

Dr. – Hmm

Pt. – How one can live with such shame, I couldn't face my family members while coming to home.

Dr. – Yes, what had happened is very bad. How is your sleep?

Pt. – Many times I don't get sleep because of these thoughts, also my appetite is gone.

Dr. – Are you a known case of any illness?

Pt- no

Dr. – Any past illnesses?

Pt.- Had malaria many years ago

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Dr. – Any other physical or psychological illnesses in family?

Pt. – My grandmother had similar complaints I think so.

Dr. – Any medications have you taken till now

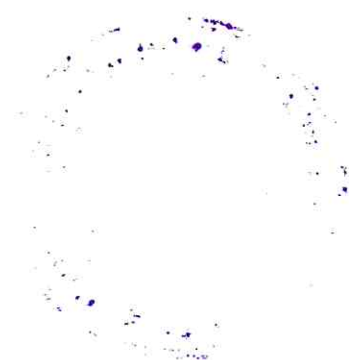
Pt. – Yes, some painkillers for these aches only.

Grade marking during History taking/ communication- Station 1

No	Activity-Marks	3	2	1	0
1	Approach	Introduces self, asks for name of patient and states purpose of encounter. Observes patient silently for one min.	Introduces self and asks for name of patient and observes	Introduces self-ask about patient history	Fails to introduce self and starts inquiry at hoc manner
2	Complaint	Is able to locate the seat of the disease as the mind, head and general body, with cognition and affect	Is able to locate the seat in the mind and head with affect only	Is able to locate the seat as mind or head	Is unable to locate the seat of the illness
3	Time	Is able to elicit accurately the duration and the course and evolution of illness With time correlation	Elicits the duration but not the course but does not zero down on the exact data	Elicits either the duration or the course of the illness	Is unable to elicit accurately either the duration or course
4	Sensations	Is able to elicit the nature of the pain and other sensations with qualities of thought	Is able to elicit the nature of the pains sensations	Is able to elicit type of the pain only	Is not able to elicit the details

5	Modalities-AF	Is able to elicit the AF accurately with emotions involved and eliciting the internal emotions responsible for same	Asks for AF but cannot zero down the cause i.e. being at external only	Asks for AF in a general way	Ignores
6	Aggravation	Is able to elicit all the < and modalities with intensity	Is able to elicit 2 modalities for	Is able to elicit 1 modality	Ignores
7	Amelioration	Is able to elicit all the > modalities with intensity	Is able to elicit the > modality but misses the intensity	Is able to elicit the > modality	Ignores
8	Concomitants				Writes anything
9	Mental health evaluation	Is able to elicit all the mental symptoms along with quality of life person living currently with deterioration of functioning	Is able to observe mental state but missies the functioning's	Is able to ask for mental symptoms for daily routine	Fails to observe or ask for mental symptoms or state.
9	Past history	Is able to elicit P/H/O	Asks the P/H/O but does not elicit the similar complaints	Asks the P/H/O	Does not ask
10	Completion	Is able to complete evolutionary history comfortably with some or more	Is able to complete evolutionary history comfortably	Is able to complete the history but not knowing	Is able to complete history with identificati

		information about the type of person patient was before the complaint started up and finishing off with closure comment of helping him out with some medicinal way and idea about the planning of future treatment	with some or more information about the type of person patient was before the complaint started up	the patient before attacks	on of symptoms only



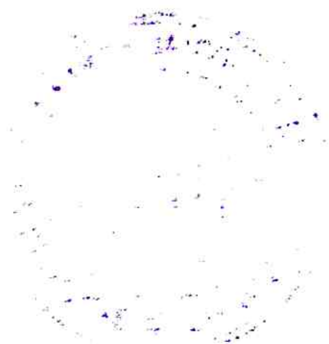
LSMC evaluation-

Area	0	1	2	3
Location	Unable to mention mind as prominent location, neither the duration and the frequency of symptoms	Able to elicit mind as the only location, also elicit either duration or the frequency of the illness	Able to identify the mind as location with various sub functions, elicit the duration of the illness but nit the course	Able to identify all the locations of mind, body and sub functions, also the duration and progress of the illness with its frequency
Sensation	Able to elicit only the pain, weakness along with the mood symptoms	Able to elicit the nature of pain, with weakness and thoughts	Able to elicit all the pain and its nature, along with the irritability and sadness, also the thoughts but misses all the intensities	Able to elicit and write down all the body sensations of weakness, lethargy, throbbing pain, suicidal ideations, all the intensities. With prominent thoughts of not being worthy of anything. Also identifies and write down the sleep, sexual and appetite dysfunctions.
Modality	Ignores the ailment factors	Identifies only one ailment factor	Identify all the ailment factors and all modalities but misses the intensities	Write down all the ailment factors and modalities with intensities.

Mental state examination –

Area	0	1	2	3
Appearance	Completely neglect it	Only writes down the age	Writes down the age and build up only	Writes down the age/sex, build up, facial configuration, sitting posture etc.
Behavior	Only mentions about being non co-operative	Mentions about being semi co-operative only	Mentions about being semi co-operative, irritability	Mentions about being semi co-operative, eye contact details, shouting behavior and complaining nature
Speech	Mentions only about the mumbling	Mentions about rate and the nature of speech	Mentions about the rate, mumblings, with occasional poor quality of speech	Mentions about the mumbling, rate, tone, content of speech, and it being relevant or irrelevant
Mood	Only suggest irritable mood	Only identifies anxious as mood	Identifies the anxious and irritable both as mood	Identifies and mentions nature of mood being anxious and irritable along with its explanations.
Affect	Doesn't mentions it	Marks as incongruent	Marks as only congruent	Write down the affect being congruent with its explanations

Thinking	No classification done about the productivity and content	Identifies the productivity as poor but content of being complaining	Identifies the productivity as poor, but content as complaining and anxious	Mentions about the good productivity of thoughts, with content of being anxious and irritable with boss and his physical health. Also identifies no delusions in it.
Perception	Writes no perceptual difficulties	Identifies no de-personalization.	Identifies no perceptual disturbances and no de personalization	Identifies no any perceptual difficulties but suggest the possibility of possible hallucinations at work suggested by supervisor.
Sensorium/memory	Only mentions of memory	Writes only about the orientations	Writes about the alertness and orientation and memory elicitation of being intact.	Writes about the good alertness and well orientation with time, and intact memory with good concentrations.
Insight	Could not elicited it	Write down only poor insight	Write down as grade 1	Write down as grade 1 with explanations
Judgment	Doesn't write anything	Writes only poor	Write down judgment about at personal level	Writes down about the judgment at both personal and social level being poor.



Station- IV: Examination: MSE and PE- 10mins, ordering investigations if any

Manya, a 32 years old record keeper, found to have taken often sick leaves. His supervisor reported that he is at times very slow at work and often complains about many aches. According to the supervisor, he is found to be smelling of alcohol at work place and gets irritated often on small things. On supervisor's information, he often fights at home under influence of alcohol. At times he mumbles to himself at work or at home.

Mr. Kishor shall act like-

Kishor has to be semi-cooperative. He should maintain eye to eye contact initially but shall avoid completely during and after sharing of alcohol habit. He should mumble at times, especially before giving his name or his personal details. He should get irritated and respond with some shouting while asked about alcoholism and his personal information like family, his fights in family. Instead he shall complain about boss and his bossy nature which stressed him out at times. He shall frequently try to divert the examiner with trying to get their attention related to his cramps in legs and body ache which he experiences and worried about them a lot. Completely deny the role of alcoholism for his absences from work or any other thing. Shall frequently ask physicians to check him if he has anything troublesome, but deny alcoholism at the same time.

Sr.no	Name of resident	Station 1: communication (30)	Station 2: documentation (13)	Station 3: Analysis & synthesis (06)	Station 4: skills (30)	Station 5: Analysis & Judgement (15)	Station 6: Examination & investigations (06)	Total (100)
1	Dr. Bharatraj	9	6	3	17	11	5	51
2	Dr. Karishma	8	8	2	7	6	3	34
3	Dr. Tanveer	22	11	4	16	10	1	64

Sr No.	NAME OF STUDENT	Station 1- clinical history: 27	statio 2- clinical examination: 27	staion 3- investigation order & D/D:6	station 4-supportive emergency measure : 3	station 5- communation with staf & colleague-12	station 6- communication to consultant & over to colleague & orientation of HOM-5	80
1	Sanjana	17	16	4	1	3	3	44
2	Rishikesh	9	11	half	2	1.5	2	26
3	Ashwin	18	14	1	1	2.5	1	37.5
4	Deepali B	10	19	2.5	2	2	3	38.5
1	Rutuja	13	14	1.5	1	2	1	32.5
6	Avisha	12	12	2	1	2.5	2	30.5
7	Rashi	6	13	half	1	0	1	21.5
8	R.K	6	12	2	0	1.5	3	24.5
9	Sumit	23	18	2.5	2	2	2	49.5
10	Suchita	20	11	1.5	1	2.5	2	38

OSCE 2018 FOR PAEDIATRIC JR EVALUATION: PAEDIATRIC DEPARTMENT

STATION - I: HISTORY TAKING & RECORDING (10 MINS)

PREPARATION OF STATION 1:

Name of the case	Viral acute gastroenteritis with grade II dehydration
Name of the Patient	Mr ABC
Age / Gender	14yr / Male/ Muslim
Education / Occupation	9th std
Preliminary Data & address	F – 37 years M – 35 years Address – Satpati
Presenting Situation	PATIENT IS HAVING Loose watery stool, yellowish, profuse+2 , non-offensive, Sputtering+2, Painless+, Rumbling before stools Weakness+2, O-gradual, P-progressive, Frequency 7-8, Quantity-profuse and Vomiting- Vomiting , nausea before vomiting, Vomitus- ingesta watery sour, Separate water from stool, Offensive+2, <after eating and drinking+2, >after vomiting, Appetite- decreased Thirst- increased large quantity often for cold water+2 Irritability+2 Vomiting is since yesterday, O-sudden, P-progressive F-3-4 times, Quantity-profuse Abdominal pain on and off since 1 month
Medication	No any
Past Medical History	No H/o Similar Symptoms
Family History	Fa – healthy M – healthy GF- DM, HTN GM- DM
Demeanor / Body language / Appearance	Irritated due to complaints.
Objectives	At the end of Station I student should able to: 1. Elicit the evolutionary picture (ODP) of disease presentation 2. Shown efforts in eliciting the Causative factor & Negative history 3. Elicit the medicinal intervention taken for the current acute episode 4. Elicit the symptomatic expressions of acute gastroenteritis with emphasis on pain in abdomen, character of stool and vomitus, frequency of vomiting and stool, frequency of micturition, modalities of the sensations. 5. Elicit the changed mental and physical general expressions of child during the current acute episode

<table>
<tr><td></td><td>6. Elicit other complaints along with the acute presentation of acute gastro enteritis.
7. Elicit the past history of similar episodes.
8. Able to observe the behavior
9. Able to document clinical, homoeopathic and negative history simultaneously while taking the Case</td></tr>
<tr><td>Flow of the conversation</td><td>Nature of the complaints and the details / You are suffering from which complaints:
Mention about the complaints i.e. – I am having loose stools and vomiting
Since when you have loose stools?
Loose stools Since 3 days
What could be the cause of complaint? Not any.
Have you eaten outside food or water 3 days back ?
No, last 5 days I am eating home food

How is the onset of loose stools?
On first two days I passed thrice loose stool. On third day the frequency was increased 7 – 8.
How much is the quantity of stools? Profuse
What is consistency of stool? Watery, loose
Colour of stools: yellow
Odor: Non offensive
Flatulence/ sputtering: Stools comes out with flatus.
Modalities : the urge comes to pass stool any time a day
Abdominal pain? No pain but rumbling

Since when you have vomiting? Vomiting since yesterday
What could be the cause of complaint? Not any.
How is character of vomiting?
Vomitus contains all what has eaten or drunk and watery consistency.
Is there any smell to vomitus? Yes. Sour smelling
What are the aggravating factors for the complaint or factors which increase and decreases complaint?
Vomiting increases after eating & drinking
When you feel better? Feels better after vomiting.
Any changes in behavior? I am feeling very angry on small issues since morning when I started for vomiting
What are other symptoms? Not any.

Is your thirst altered? Or they may ask as – How is your thirst?
Thirst: LQSI,
Is thirst for cold or warm water? Cold water.</td></tr>
</table>

OSCE 2018 FOR PAEDIATRIC JR EVALUATION:
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	What about appetite? It is decreased. **What treatment you have taken?** No treatment taken **Past history:** Nothing specific **Behavior:** Irritable Apart from above said information they ask anything else say I don't know or I am unable to recollect or I haven't noticed.
Possible Diagnosis	Viral acute gastroenteritis
Method of observing the performance	Check list
Level Designated for	MD (HOM) final year student
Place in Academic Year	2018-19

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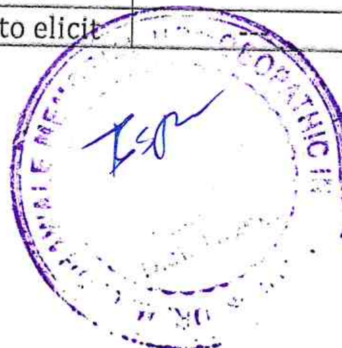
Grade marking during history taking: Station I

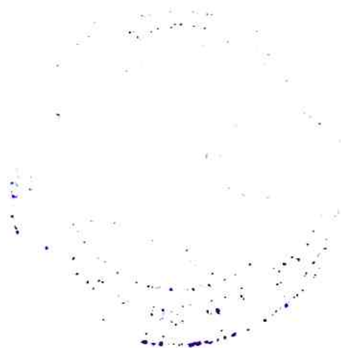
Name of the Applicant: ______________________________

The observations were framed as follows:

No	Activity-Marks	3	2	1	0
1	Preliminary Data	Asks all preliminary data – Name, Age Education, Religion	Asks partially – Name and Age asked	Incomplete data – Either Name or Age ask	Fails to ask any data
2	Overall History	Asked clinical as well as Individualistic	Asked Partially Clinical & Homoeopathic History (LSM) + Causation	Asked Partially Clinical & Homoeopathic History (LSM) - Causation	Missed ODP, Sensation, Modality, Causation
3	ODP: Time	Is able to elicit accurately the onset, duration and the course of illness – Frequency (progress)	Elicits the onset, duration but not the course	Elicits either the onset, duration or the course of the illness	--
5	Sensations	Able to elicit all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting with the intensities.	Able to elicit and all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting but misses all the intensities	Able to elicit only nature of stools and vomiting but misses intensities and colour, quantity	Only Eliciting the complaints ie. Vomiting and Loose stools
6	Modalities-AF	Is able to elicit the AF with options	Ask for AF without any options	---	Didn't ask for Causation
7	Aggravation	Is able to elicit	Is able to elicit		Didn't ask for



		vomiting and stool the < modalities with intensity with various options	vomiting and stool the < modalities missed the intensity and various options		the aggravation modalities
8	Amelioration	Is able to elicit vomiting and stool the > modalities with intensity with various options	Is able to elicit vomiting and stool the > modalities missed the intensity and various options	---	Didn't ask for the ameliorating modalities
9	Concomitant s	Asked for Mental and Physical generals	Asked for either Mental or Physical generals	---	Didn't ask concomitants
10	Past history	Is able to elicit P/H/O of similar complaints	Asks the P/H/O but does not elicit the similar complaints	---	Does not ask
11	Associated Symptoms	Asked for the Associated complaints	--	--	Didn't ask



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STATION I:

HISTORY TAKING & RECORDING

SCENARIO:

Master. ABC has visited the clinic for his medicine. Mst. ABC is 14 years old male. He is suffering from acute complaint since 3 days. He wants Homoeopathic treatment which can relieve him complaints.

DURATION OF INTERVIEW & RECORDING:

10 mins

TASKS:

Considering the child of 14 years, a Homoeopathic physician should -

- Able to elicit the clinical expressions of acute complaints
- Able to elicit the individualistic expressions during acute complaints
- Able to arrive at clinical diagnosis
- Able to formulate the prescribing totality.
- Able to record the taken history in given recording sheets.

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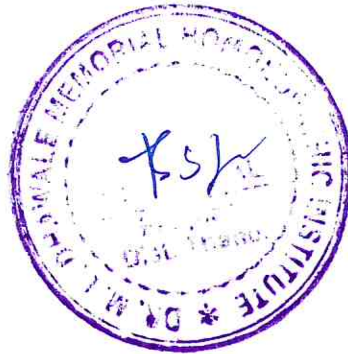
PAEDIATRIC DEPARTMENT

Grading marking for recording the history:

No	Activity-Marks	3	2	1	0
1	Preliminary Data	Records all preliminary data – Name, Age Education, Religion	Records partially – Name and Age asked	Records Incomplete data – Either Name or Age ask	Fails to Records any data
2	Overall History	Records clinical as well as Individualistic history	Records Partially Clinical & Homoeopathic History (LSM) + negative data about Causation	Records Partially Clinical & Homoeopathic History (LSM) - negative data about Causation	Only records chief complaint but didn't record its ODP, Sensation, Modality, Causation
3	ODP: Time	Is able to record accurately the onset, duration and the course of illness – Frequency (progress)	Records the onset, duration but not the course	Records either the onset, duration or the course of the illness	Only records chief complaint but didn't record onset, duration or the course of the illness
5	Sensations	Able to record all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting with the intensities.	Able to record all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting but misses all the intensities	Able to record only nature of stools and vomiting but misses intensities and colour, quantity	Only records the complaints ie. Vomiting and Loose stools
6	Modalities-AF	Records negative data	---	---	Didn't record ailments from

		about absence of any ailments from			
7	Aggravation	Records the < modalities of vomiting and stool with intensity	Records the < modalities of vomiting and stool but misses the intensity	---	Didn't record the aggravating modalities
8	Amelioration	Records the > modalities of vomiting and stool with intensity	Records the > modalities of vomiting and stool but misses the intensity	---	Didn't record the ameliorating modalities
9	Concomitant s	Records Mental and Physical generals	Records either Mental or Physical generals	---	Didn't record concomitants
10	Past history	Records abscence P/H/O of similar complaints		---	Does not record
11	Associated Symptoms	Records absence of the Associated complaints	--	--	Didn't record



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STATION- II: CLINICAL EXAMINATION – 10 MINS

OBJECTIVES OF THE STATION 2:

- To assess the interpersonal skills – greeting and explaining about the clinical examination
- To assess the clinical skills

Learning objectives:

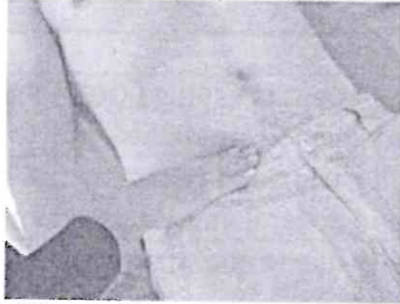
- To understand how well the student is able to explain the procedure about the clinical examination
- To understand whether the students are taking aseptic measures
- To understand how well the student is able to do clinical examination of abdomen, assess grades of dehydration.

II. PREPARATION OF STATION 2:

Name of the case	VIRAL GASTROENTERITIS WITH GRADE 2 DEHYDRATION
Name of the Patient	Mr. ABC
Age / Gender	14 / Male
Education /	9th std
Presenting Situation	OPD Scenario. Patient is having LOOSE STOOLS AND VOMITING with irritability due to complaints
Clinical Examination	The doctor will perform the examination of Abdomen, grades of dehydration and general and Vitals examination.
Demeanor / Body language / Appearance	Slight irritability due to complaints.
Expected Activity:	1. Greet the patient 2. Relieve his irritability by telling what aspect of examination he or she is going to perform 3. General examination and vitals 4. Examination of Abdomen 5. Examine grades of dehydration
Flow of the conversation	Doctor will do before asking you anything: 1. Introducing herself / himself 2. Orienting about the necessary of examination 3. What examination he or she is planning to follow 4. Will wash the hands with aseptic lotion before and after the examination Doctor will do the following: 1. They will examine your eyes, nails, mouth and tongue, lymphnodes, and odema. Allow them to do so. 2. They will take your pulse, temperature using thermometer – Let them do so. They will keep thermometer in axilla – you will

allow them. If they ask you to put thermometer in mouth deny telling you will not put in mouth is there any alternative way to take the temperature

3. They will take your BP/RR.
4. They will open the mouth and will examine the throat with the help of torch. You are expected to open your mouth. No interaction needed.
5. They will see your tongue while opened mouth. Let them do it.
6. Now you will be asked to lie as flat as possible with your arms straight down and they will inspect your abdomen.
7. They will check skin turgor by pinching the skin over the abdomen allows them to do so.
8. They will also touch your extremities – Palm and Feet.
9. They will loosen the cloths around the abdomen to inspect.
10. They will now start palpation of your abdomen in various areas. First superficial and then deep with pressure. You will be asked if there is pain. You will report no pain. You will be asked to breathe heavily and will do so when asked.



11. They will place there middle finger of one hand and tap by the index finger on the placed middle finger. They will percuss all over the abdomen

12. They will put their stethoscope on your abdomen.

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	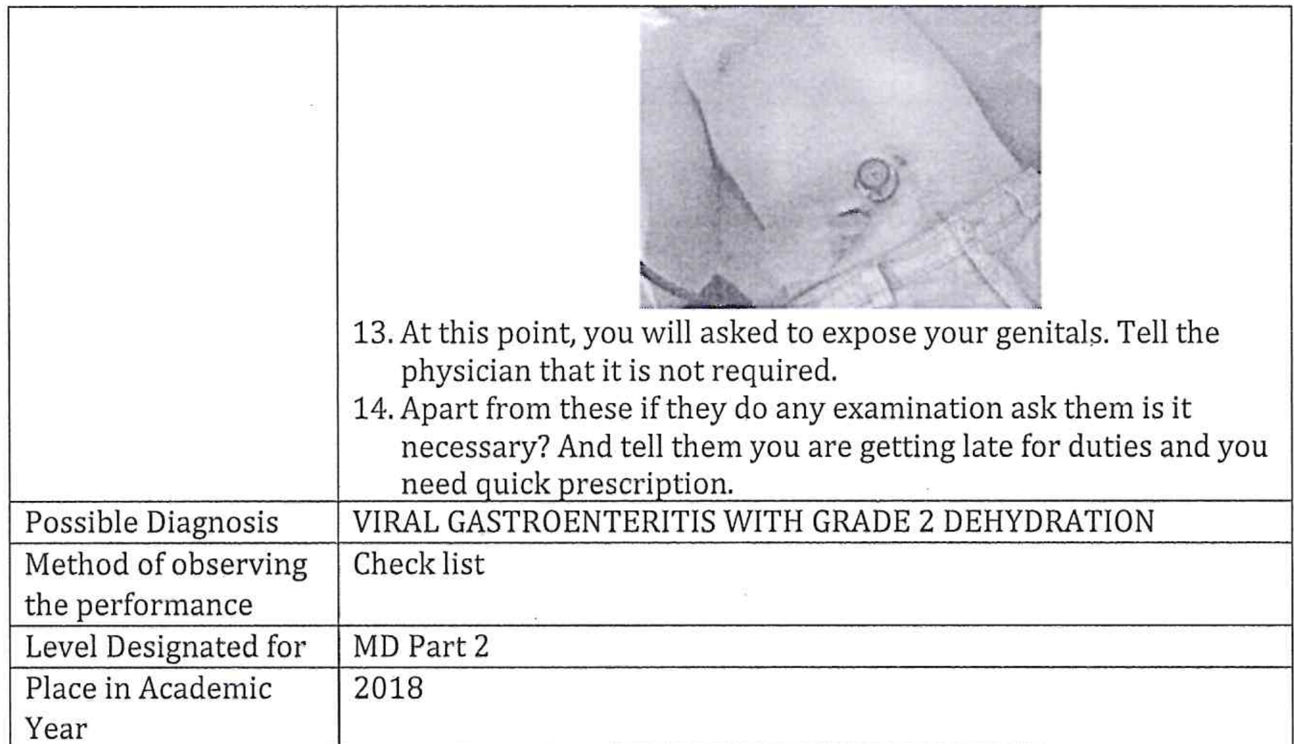 13. At this point, you will asked to expose your genitals. Tell the physician that it is not required. 14. Apart from these if they do any examination ask them is it necessary? And tell them you are getting late for duties and you need quick prescription.
Possible Diagnosis	VIRAL GASTROENTERITIS WITH GRADE 2 DEHYDRATION
Method of observing the performance	Check list
Level Designated for	MD Part 2
Place in Academic Year	2018

OSCE 2018 FOR PAEDIATRIC JR EVALUATION: PAEDIATRIC DEPARTMENT

Station II: Clinical Examination:

Name of Applicant: ______________________________

Instructions to the observer for Grade marking during Clinical Examination

	Activity	A	B	C	D
1	Approach	Introduces self, asks for name of patient and states purpose of encounter	Introduces self and asks for name of patient	Introduces self	Doesn't introduced the self / directly started with examination
2	Interpersonal Skills	Made the patient feel comfortable by asking permission and telling about what aspect of examination will be done	Made the patient feel comfortable by orienting what aspect of examination will be done not taken the permission	--	Start examining without making patient feel comfortable
3	Order of Examination	General Examination → vitals → Systemic	Haphazardly did the examination but covered all the 3 examinations	Haphazardly did the examination but covered all the 2examinations	Only systemic examination
3	Order Systemic Examination	Followed the order Inspection → Palpation → Percussion → Auscultation	Followed the order but covered any 3 aspects	Did not Followed the order but covered all 4 aspects	Didn't follow the order less than 4 aspects touched. Followed the order but did only 2 aspects
3	Principles of Examination	Use of Hand sanitization before and after	Use of hand sanitization before examining	--	Not used hand sanitization

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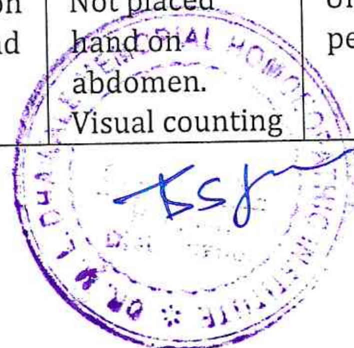
		examining patient	patient		
4	Examination skills – General A	Did all (7) relevant examination in organized way	Did few (5/7) relevant examination in organized way	Did few relevant examination – unorganized	Did it but in hurry &/ or did only 3 or less in any way
5	Examination skills – General B	Pulse, RR Temperature, BP	--	--	Missed any vitals
6	BP	Proper placement of instrument, proper tying of cuff, with proper placement of tubes, seeing systolic by palpation method,	Misses any 1 of the above step, and / or faulty techniques in 2 steps	Misses any 2 of the above step, and / or faulty techniques in 3 steps	Misses any 3 of the above step, and / or faulty techniques in all 4 steps
7	Temp	Use the thermometer wipe with cotton seen the mercury level – then ask permission then put proper way in axilla for 2 min. then record it	Use the thermometer without wiping but ensured the mercury level and then put the thermometer after asking patient for 2 min	Use the thermometer without wiping but ensured the mercury level and then put the thermometer without asking patient for 2 min	Not able to perform
8	Pulse	Palpate the radial artery Count pulse for 1 min	Palpate the radial artery Count pulse for 15 sec	--	Unable to perform
9	RR	Place hand on abdomen and count respiration	Place hand on abdomen and count respiration	Not placed hand on abdomen. Visual counting	Unable to perform



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		(movement of abdomen) for full 1min.	(movement of abdomen) for 15-30 sec.	for 15-30 sec.	
10	Examination skills – Dehydration assessment	Checks skin turgor at abdomen, oedema extremities, eyes, mouth, lips tongue	Does all this in an unorganized way	--	Didn't do
11	Palpation	Palpated with the fingers all the four quadrants; superficial palpation with deep palpation	Palpated with the Palm all over the four quadrants – haphazard in superficial and deep palpation	--	Faulty technique or didn't palpate all the quadrants or did either superficial or deep palpation
12	Percussion	Correct technique used and percussed all the areas of abdomen	--	--	Wrong technique / not done
13	Auscultation	Warm the chest piece and placed in all the quadrant esp bowel sounds in 4 region	placed in all the quadrant esp bowel sounds in 4 region	--	Haphazardly placed the chest piece

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Station 2 – Clinical Examination

III. INSTRUCTIONS TO THE STUDENTS

SCENARIO:

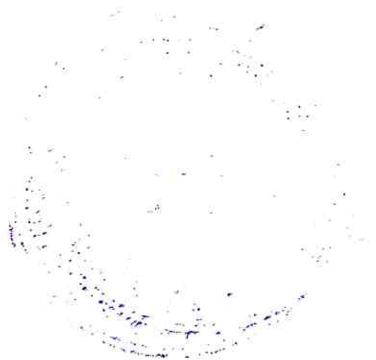
Doctor has already taken the History and documented properly in the format.

DURATION OF EXAMINATION WITH RECORDING:

10 min

TASKS:

- Follow the appropriate procedure while examining the patient
- Perform NECESSARY general examination and clinical examination



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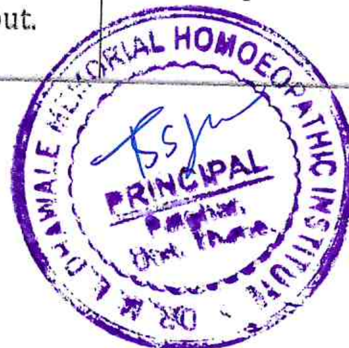
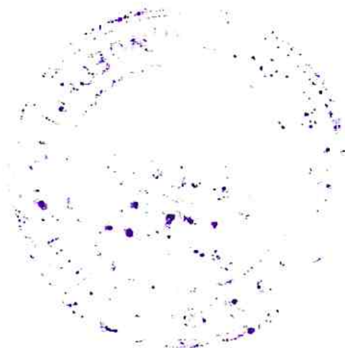
Grading of the recording of Physical examination-

Sr. no	Activity	A	B	C	D
1.	Order of recording of Examinations done	General Examination → vitals → Systemic	Haphazardly recorded the examination but covered all 3 examinations	Haphazardly recorded the examination but covered only vital and systemic examinations	Recorded Only systemic examination
2.	Order recording of Systemic Examination	Followed the order Inspection → Palpation → Percussion → Auscultation	Followed the order but recorded any 3 aspects	Did not Followed the order but recorded all 4 aspects	Didn't Followed the order but recorded only 2 aspects
3.	BP	Records- Systolic/ diastolic, mm of Hg		Records- Systolic/ diastolic but no measurement units (mm of Hg)	Not mentioned
4.	Temp	Writes temp C/F and mentions axillary	Writes temp C/F	Only write units	Not mentioned
5.	Pulse	Writes all rate rhythm, volume parameters	Writes rate and rhythm only	Writes rate only	Not mentioned
6.	RR	Writes RR per minute, its characteristic and type	--	Writes RR per minute	Not mentioned
7.	Examination skills – Dehydration assessment	Records Mental status, thirst, heart rate, quality of pulse, breathing, eyes, tears, mouth and tongue, skinfold, capillary refill,	Records Mental status, thirst, eyes, tears, mouth and tongue, skinfold, extremities, urine output.	Records Mental status, thirst, eyes, tears, mouth and tongue, skinfold, urine output.	Not mentioned Or record these signs of dehydration - thirst, eyes, tears, mouth and tongue, skinfold



		extremities, urine output.			
8.	Palpation	Records as soft, non-tender, LSK		--	Not mentioned
9.	Percussion	Records as hepatic dullness with tympanic note all over abdomen	--	--	Not mentioned
10.	Auscultation	Records bowel sound present (+) or absent (-) in all quadrants sounds in number	Records as bowel sounds present (+) or absent (-) in all quadrants	--	Not mentioned



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CASE

Chief complaints:

Location & Spread (Tissue, Organ, System)	Sensations and Pathology	Modalities A.F. < , >	Accompaniments
GIT stomach and Rectum since 3days O-gradual P-progressive F-7-8 Quantity-profuse	Loose watery stool, yellowish, profuse+2 , non offensive Sputtering+2 Painless+ Rumbling before stools Weakness+2		
Since yesterday O-sudden P-progressive F-3-4 times Quantity-profuse	Vomiting , nausea before vomiting Vomitus- ingesta watery sour Separate water from stool Offensive+2	<after eating and drinking+2 >after vomiting	Appetite- decreased Thirst- increased large quantity often for cold water+2 Irritability+2

Past History: NIL

Case actuality-

Physical Examination: General

General Appearance:

Pallor: +2 Icterus: Ab oedema: Ab Weight: 25kg Temp: 97.4*F Pulse 92/min R.R.-24/min

Eye/Conjunctiva: Sunken tear+, Skin: mildly turgor lost, Tongue: dry Glands: not palpable

Physical Examination: Systemic:

R.S: clear AEBE

Per Abdomen: soft, NT ND, BS- hyper peristalsis, L0S0K0

CVS: S1S2+

CNS: conscious dull, sleepy

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Grade of Dehydration:

Symptom	
Mental status	Irritable +2
Thirst	Increased for large quantity small interval for cold water
Heart rate	116/min
Quality of pulses	-
Breathing	Normal
Eyes	Sunken
Tears	Present
Mouth and tongue	Dry
Skinfold	Mildly Turgor lost
Capillary refill	-
Extremities	No cold clammy limbs
Urine output	Decreased

Investigations:

CBC 19/8/13	Hb- 14.2	N	L	E	M	B
	WBC- 8.800	55	41	2	2	0

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OSCE

III. INSTRUCTIONS TO THE STUDENTS

SCENARIO:

Doctor has already taken the History considering clinical as well as Homoeopathic aspects. After the doctor has done clinical examination. The investigation are reported.

This is the standard history, examination finding and investigation for further processing

DURATION OF STATION:

10 minutes

TASKS:

write answers for the following questions:

- Arrive at clinical diagnosis with differential diagnosis
- Formulate the totality
- Give the final choice of remedy with differentiating closely coming remedies
- Suggest the posology with reasoning
- Formulate follow up criteria with frequency of monitoring

- **Checklist for assessing the clinical diagnosis with differential diagnosis**

Grading of Diagnostic skills

A Grade: Mentions report as WNL and diagnosis as viral AGE with grade 2 dehydration with reason from history, clinical examination and investigation

B Grade: Mentions report as WNL and diagnosis as viral AGE with grade 2 dehydration without any reason

C Grade: Mentions report as WNL and diagnosis as viral AGE.

D Grade: Diagnosis not mentioned

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- ## Checklist for assessing the totality:

SR. NO.	PARAMETERS	YES	NO
	Totality Formulation:		
1	All the characteristic expressions (symptoms) are considered in totality		
2	All the characteristic expressions are considered with gradation in formulating totality of symptoms		
3	Concomitant are taken in the totality		
4	Reportorial Approach (Name) mentioned		
5	Evaluation order is mentioned according to mentioned repertorial approach		

Totality Formation:	
Grade A:	Point number 5 + Yes score 3 out of 4
Grade B:	Point number 5 + Yes score 1 out of 4
Grade C:	Point number 5 not done + Yes score 2 out of 4
Grade D:	Point number 5 not done + Yes score 1 out of 4

Overall Assessment	**Grade A**	**Grade B**	**Grade C**	**Grade D**

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- **Checklist for assessing the Remedy Selection:**

	Remedy Selection:		
1	Group of remedies mentioned		
2	Thermal, acute /chronic, evolution and location considered in coming to small group		
3	Character of the stools and vomiting , modalities and concomitant consider in final selection		
4	Final remedy prescribed with relevant reason		
5	Closely coming remedies differentiated		

Remedy Selection	
Grade A:	Point Number 5+4 yes score 2 out of three
Grade B:	Point Number 5 + yes score 3 out of four
Grade C:	No Point number 5 but either 3 out of four
Grade D:	Point number 1, 2 & 3

Overall Assessment	Grade A	Grade B	Grade C	Grade D

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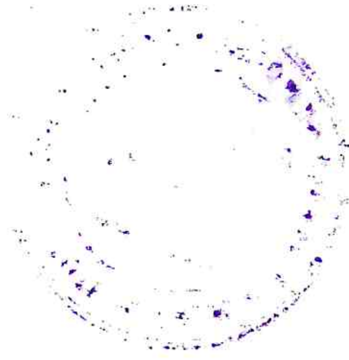
- **Checklist for assessing the posology:**

GRADE	GRADE A	GRADE B	GRADE C	GRADE D
Criterias	SUSCEPTIBILITY, SENSITIVITY, SUPPRESSION, CORRESPONDENCE LEVEL, GENERAL VITALITY, MIASM MENTIONED WITH REASONS	SUSCEPTIBILITY, SENSITIVITY, SUPPRESSION, CORRESPONDENCE LEVEL, GENERAL VITALITY, MIASM MENTIONED	SUSCEPTIBILITY, SENSITIVITY, GENERAL VITALITY, MENTIONED WITH REASONS SUPPRESSION, MIASM CORRESPONDENCE LEVEL NOT MENTIONED	SUSCEPTIBILITY MENTIONED SENSITIVITY, SUPPRESSION, CORRESPONDENCE LEVEL, GENERAL VITALITY, MIASM NOT MENTIONED



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- **Checklist for assessing the follow up criteria with frequency of monitoring:**

GRADE	MARKS
Irritability	3
Weakness	3
Thirst	3
Stool-I-F	2
Stool-offensive and sputtering	2
Vomiting-I-F	2
Temperature	1
HR	1
RR	1
AG	1
Hydration status	2

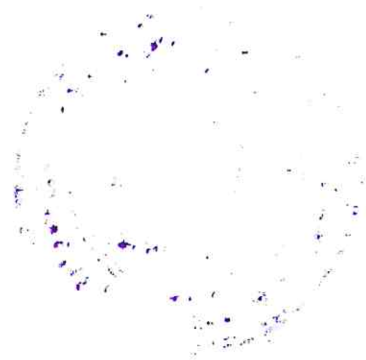
MARKS TOTAL= 21

GRADE A- > or = 17

GRADE B- 10 to 17

GRADE C- BELOW 10

Ars	Chin	Colch	Crot-t	Nuph	Sulph	Verat	Bry	Camph	Podo	Thuj
5	7	6	6	6	6	6	6	6	6	5
6	4	4	4	4	4	4	3	3	3	3
1	3	3	2			2	3	3	2	2
1	2		2	1						2
1	1	1	1	1	1	1	1	1	3	
2			1		1	1			1	
1		1		3	3		2			
2	1	1		1	1	2		2		2



SCR Correction: Mini Feedback Format with Checklist

Name of Student: Dr.	Months / Years of Training:
Corrected By: Dr.	Consultant / Reader/ Lecturer /MO/ Supervisor
Case Correction done for the student: 1st time / Occasionally / Regularly	
Date of Submission:	Date of Correction:

Checklist (Please mark tick ✓ wherever applicable)

PD / PR / IP	History Available: Yes / No	Done/ Not Done
Data	Partial / Complete	Identified
Interpretation	Partial / Complete	Logical : Yes / No Integrated: Yes/No
Action	Partial / Complete	Appropriate: Yes/ No
Suggestions:		

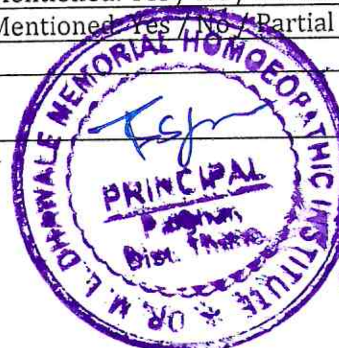
CASE RECORDING		
Preliminary Information	Partial /Complete	Important info: Missed / Recorded
Chief Complaints: LSMC & Associated Complaints	All columns filled: Yes/No	Classification: Accurate/ Error
Grading: Done/No/ Inconsistent	All complaints noted: Yes/No	Cause Identified: Yes / No
	Evolution: Yes /No	Negative History: Yes / No
Physical Generals	Overall <50%, 50-75%,>75%	Grading: Done / No/ Inconsistent
Physical Reactions	All reactions: Yes / No /Partial	Effect Mentioned: Yes / No / Partial
Diet and Daily Routine: Yes/ No	**Relevant Investigation**: Yes/ No	**Physical Examination:** General: Yes / No Systematic: Yes/ No
Past History: Yes/ No	**Family History:** Yes / No	**Diagnosis:** Yes / No
Suggestions:		

Life space: Just Description of event / Proper Correlation/Psychosomatic and Psychodynamic Correlation/ Grammatically Accurate
Suggestions:

Life Space Table:	Significant events identified: Yes / No	Duration mentioned: Yes / No

Life space description: Adequate / Partial / Excessive / grossly incomplete / Mixed with Char. Expressions
Chara. Expressions: Properly identified / Missed out important / grossly inadequate / inconsistent
A/F and Modalities: Properly identified / Missed out important / grossly inadequate / wrong
Attributes: Properly identified / Missed out important / grossly inadequate / wrong / too general
Interpretation: Used psychological theories / Miasm accurate / Not done/ Partial
Suggestion:

Mental State:	Page23: recorded: Yes / No	Adequate / Incomplete	Connections: Yes / No
IPR	Significant relationships evaluated: Yes / No	Effect on patient recorded: Yes / No	
Emotion:	Overall <50%, 50-75%,>75%	Grading: Yes / No	Connections: Yes / No
Intellectual:	Overall <50%, 50-75%,>75%	Grading: Yes / No	Connections: Yes / No
Performance	Properly evaluated: Yes / No / Partial	Blocks identified: Yes / No /Partial	
Reactions	Emotional: Yes / No / Partial	Effect Mentioned: Yes / No / Partial	
	Intellectual: Yes / No / Partial	Effect Mentioned: Yes / No / Partial	
	Life situation: Yes / No / Partial	Effect Mentioned: Yes / No / Partial	
PSPD:	Attempted / Factual / Fair / Good / Used theories		
Suggestions:			



SCR Correction: Mini Feedback Format with Checklist

S-S-F-T: Attempted: Yes / No	Form: Proper / Partial / Missed out important	Function: Proper / Partial / Missed out important
Structure: Proper / Partial / Missed out important	Time: Recorded: Yes / No	Evolutionary connections: Yes/No/Inaccurate
Clinico-path connections: Yes/No/Inaccurate	Miasm – Accurate interpretation: Yes / No	Error in:
Suggestions:		

Symptom Classification: Yes / No		Error in:
Diagnostic Net: Yes / No	Overall <50%, 50-75%,>75%	Error in:
EHT: Yes / No	Correlation: Yes /No /Partial	Error in:
Conceptual Image: All data transferred: Yes / No	Correct Classification: Overall <50%, 50-75%,>75%	Miasmatic Classification:Overall <50%, 50-75%,>75%
Suggestions:		

Essential Evolutionary Totality	Essential Data: Overall <50%, 50-75%,>75%	Correlation with Axis: Yes / No / Partial
Disposition: In tune with LST and MS: Yes / No / Grossly different	Essential Connections: Yes / No	Error in:
Repertorial Totality & PDF	Correct approach: Yes / No	Totality as per Approach: Yes/ No
Totalities and MM differentiation	Chronic Totality Proper: Yes / No /Partial / Grossly inadequate	MM Differentiation: Yes / No /Partial / Grossly inadequate
	Acute Totality Proper: Yes / No /Partial / Grossly inadequate	Intercurrent Totality Proper: Yes / No /Partial / Grossly inadequate
Suggestions:		

Planning & Programming	Parameters identified with Reasons: Yes / No / Partial	Accurate Potency and Repetition: Yes / No / Partial
TPD – TPR	Attempted: Yes / No / Partial	Overall <50%, 50-75%,>75%
General Management – Diet / Ancillary measures / education & orientation		Overall <50%, 50-75%,>75%
Follow Up Criteria:	Properly written: Yes / No	
Suggestions:		

SCR Evaluation Summary

Areas	Issues	Recommendation
SCR Conceptual Understanding		
SCR Practice		

Overall Suggestions:

Kindly Submit/resubmit new/current SCR by date: ____/____/____

FINAL OSCE MARKS	AMINA	CHETAN	MEHVISH	DEVYANI	APARNA	SHUBHAM
STATION 1- OBSERVER	21	24	18	13	18	27
STATION 1- RECORDING	12	21	11	15	13	21
STATION 2 - OBSERVER	30	32	24	31	20	16
STATION 2 - RECORDING	21	18	15	20	15	11
STATION 3 - RECORDING	8	7	5	12	4	6
	92	102	73	91	70	81

STUDENT	MARKS
DR. CHETAN	102
DR. AMINA	92
DR. DEVYANI	91
DR. SHUBHAM	81
DR. NATASHA	80
DR. MEHVISH	73
DR. APARNA	71

NATASHA

14
17
23
15
11
80

PLAN OF OSCE 2018 FOR PAEDIATRIC JR EVALUATION

Station-I: HISTORY TAKING- 10mins

Preliminary data-

Name: Ayush. Harinarayan. Jha

Date:18/8/13

Age: 9yr

Sex: M

Address: Dhodi pada Boisar.

Chief complaints-

Location & Spread (Tissue, Organ, System)	Sensations and Pathology	Modalities A.F. < , >	Accompaniments
GIT stomach and Rectum since 3days O-gradual P-progressive F-7-8 Quantity-profuse	Loose watery stool, yellowish, profuse+2 , non offensive Sputtering+2 Painless+ Rumbling before stools Weakness+2		

Since yesterday O-sudden P-progressive F-3-4 times Quantity-profuse	Vomiting , nausea before vomiting Vomitus- ingesta watery sour Separate water from stool Offensive+2	<after eating and drinking+2 >after vomiting	Appetite- decreased Thirst- increased large quantity often for cold water+2 Irritability+2
Abdomen since 1 month	Pain on and off		

Past History: NIL

Family History: NIL

STATION 1: HISTORY TAKING

SCENARIO:

Mr A is 9 years old male. He is suffering from acute complaint. He wants Homoeopathic treatment which can relieve him complaints.

DURATION OF INTERVIEW:

10 mins

TASKS:

So being a Homoeopathic physician, you should do

- Take clinical and homoeopathic history which will allow you to come to clinical diagnosis as well as prescribing totality.
- Take Homoeopathic History which can help you to arrive at remedy through differentiation.
- Document all the data in LSMC format

LSMC evaluation-

Area	0	1	2	3
Location	Unable to mention location, neither the duration and the frequency of symptoms	Able to identify location, also elicit either duration or the frequency of the illness	Able to identify the location with various sub functions, elicit the duration of the illness but not the course	Able to identify all the locations onset, the duration and progress of the illness with its frequency with quantity
Sensation	Not Able to elicit the nature of stools and vomiting its intensities and colour, quantity	Able to elicit only nature of stools and vomiting but misses intensities and colour, quantity	Able to elicit and write down all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting but misses all the intensities	Able to elicit and write down all the body sensations of weakness, colour quantity of stools, painlessness, With prominent sensation of rumbling before stools, nature and quantity of vomiting with the intensities.
Modality	Ignores the modalities	Identifies only one modalities	Identify all the modalities but misses the intensities	Write down all the modalities with intensities.

STATION- II: CLINICAL EXAMINATION – 10 MINS

Physical Examination: General

General Appearance:

Pallor :+2 Icterus: Ab oedema: Ab Weight: 15kg Temp: 97.4*F Pulse 92/min

R.R.24/min

Eye/Conjunctiva:Sunken tear+ Skin:midly turgor lost Tongue: dry Glands: not palpable

Physical Examination: Systemic:

R.S: clear AEBE

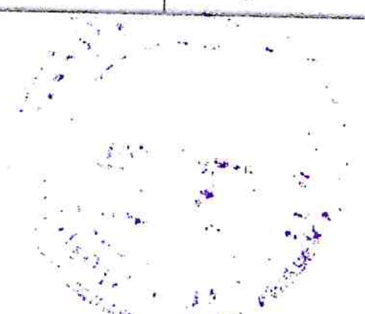
Per Abdomen: soft, NT ND, BS- hyperperistalsis, L0S0K0

CVS: S1S2+

CNS: conscious dull, sleepy

Grade of Dehydration:

Symptom	
Mental status	Irritable +2
Thirst	Increased for large quantity small interval for cold water
Heart rate	116/min
Quality of pulses	-
Breathing	Normal
Eyes	Sunken
Tears	Present
Mouth and tongue	Dry
Skinfold	Mildly Tourgor lost
Capillary refill	-
Extremities	No cold clammy limbs



Urine output	Decreased

CONCLUSION- Grade II dehydration

Instructions to the observer for Grade marking during Clinical Examination

	Activity	A	B	C	D
1	Approach	Introduces self, asks for name of patient and states purpose of encounter	Introduces self and asks for name of patient	Introduces self	No preliminaries
2	Interpersonal Skills	Made the patient feel comfortable by asking permission and telling about what aspect of examination will be done	Made the patient feel comfortable by orienting what aspect of examination will be done	Made the patient feel comfortable by asking permission for examination	Start examining without making patient feel comfortable
3	Principles of Examination	Use of Hand sanitization before and after examining patient	Use of hand sanitization before examining patient	--	Not used hand sanitization
4	Examination skills – General A	Did all (7) relevant examination in organized way	Did few (5/7) relevant examination in organized way	Did few relevant examination – unorganized	Did it but in hurry &/ or did only 3 or less in any way
5	Examination skills – General B	Mouth, Pulse, Eye, Nails, BP, RR Temperature,	Does 5/8 in a proper way	Does 3/8 in a proper way	Couldn't perform any examination
6	BP	Proper placement of instrument,	Misses any 1 of the above step, and / or faulty	Misses any 2 of the above step, and / or faulty	Misses any 3 of the above step, and / or

		proper tying of cuff, with proper placement of tubes, seeing systolic by palpation method,	techniques in 2 steps	techniques in 3 steps	faulty techniques in all 4 steps
7	Temp	Use the thermometer wipe with cotton seen the mercury level – then ask permission then put proper way in axilla for 2 min. then record it	Use the thermometer without wiping but ensured the mercury level and then put the thermometer after asking patient for 2 min	Use the thermometer without wiping but ensured the mercury level and then put the thermometer without asking patient for 2 min	Not able to perform
8	Pulse	Palpate the radial artery Count pulse for 1 min	Palpate the radial artery Count pulse for 15 sec	--	Unable to perform
9	RR	Place hand on abdomen and count respiration (movement of abdomen) for full 1min.	Place hand on abdomen and count respiration (movement of abdomen) for 15-30 sec.	Not placed hand on abdomen. Visual counting for 15-30 sec.	Unable to perform
10	Examination skills - Systemic Abdomen	- Does I/Pa/Pe/A in an organized way – all quadrants. - Palpates liver, spleen properly - Bimanual palpation of Kidney, renal thump, exam of	Does all this in an unorganized way	Does exam of abdomen in an organized way but leaves out - Bimanual palpation of Kidney, renal thump, exam of UB & Leaves out	Leaves out examination of liver and spleen and exam as in previous column

		UB - Indicates need to examine external genitalia		indication to examine external genitalia	

Grading of Documentation skills of clinical examination

Grade	General	BP	Temp	Pulse	RR	Abdomen	Grades of dehydration
A:	Documents all 7 parameters	Systolic/ diastolic, mm of Hg	Writes temp C/F and mentions oral	Writes all 4 parameters	Writes RR per minute and its characteristic	Writes under 4 steps all relevant findings including imp negative findings and including all steps	All criterias written
B	Documents 5/ 7 parameters	Incomplete	Writes temp C/F	Writes rate and rhythm only	Writes RR per minute	Misses out 1 or 2 areas but not related to examination of liver/ spleen and kidneys	Written 5-6 criteria
C	Not mentioned						

Station 2 – Clinical Examination

III. INSTRUCTIONS TO THE STUDENTS

SCENARIO:

Doctor has already taken the History and documented properly in the format.

DURATION OF INTERVIEW:

5 min

TASKS:

Perform the needful clinical examination:

- Use aseptic precautions
- Introduce yourself
- Explain about the examination which you are going to perform on patient
- Perform clinical examination which is necessary for the complaint

Station-III: INVESTIGATION OF THE CASE

Investigations:

CBC	Hb- 14.2	N	L	E	M	B
19/8/13	WBC- 8.800	55	41	2	2	0

OSCE

III. INSTRUCTIONS TO THE STUDENTS

SCENARIO:
Doctor has already taken the History considering clinical as well as Homoeopathic aspects. After the doctor has done clinical examination. Doctor had advised the relevant investigation which further will help for diagnosis

DURATION OF station:
5 minutes

TASKS:

Mention on the ruled paper:

- Interpretation of Investigations which are in front of view
- Write if the count of all component of Report given is normal or not with STANDARD normal ranges of each`
- Please submit the paper at the end of exam

Grading of Diagnostic skills
A Grade: Mentions normal ranges of all components of report with mentions report as WNL
B Grade: Mentions normal ranges of 2-3 components of report and mentions report as WNL
C Grade: Only mentions report as WNL

Station- IV: Analysis and Synthesis- 10 mins

[Preparing the totality and possible Repertorization {keep bells diarrhea on table] and give your final remedy with differentiation of close coming remedy.]

- **<u>Totality according to Bell's diarrhea repertory</u>**

Stool loose watery yellow, profuse+2

Stool offensive and sputtering+2

Stool<after eating and drinking+2

Irritable+2

Thirst increased for large quantity often for cold water+2

Vomiting sour ingesta+

Weakness+2

- **<u>Reportorial results:</u>**

Remedy Name	Ars	Bry	Calc	Sulph	Verat	Crot-t	Apis
Totality	8	7	6	6	6	6	5
Symptom Covered	5	3	4	4	4	3	4
[SP] [Diarrhoea]Character of the stools:Watery :Yellow:	1		2			2	2
[SP] [Diarrhoea]Character of the stools:Expulsion :Sputtering, spattering all over the vessel:							
[SP] [Diarrhoea]Aggravations:Eating:After (see also after meals):	2		1	1	1	3	1
[SP] [Diarrhoea]Aggravations:Drinking after:	2			1	1	1	
[SP] [Diarrhoea]Concomitants (Mind and mood):Irritability ill humour:	1	3	1	3			
[SP] [Diarrhoea]Concomitants (Appetite):Thirst:Drinking large quantities:					2		
[SP] [Diarrhoea]Concomitants (Nausea and vomiting):Vomiting:Sour:		1	2				1
[SP] [Diarrhoea]Concomitants (General symptoms):Exhaustion (prostration):	2	3		1	2		1

- **<u>Eliminating method:</u>**

Remedy Name	Ars	Chin	Colch	Crot-t	Nuph	Sulph	Verat	Bry	Camph	Podo	Thuj
Totality	8	7	6	6	6	6	6	6	6	6	6
Symptom Covered	6	4	4	4	4	4	4	3	3	3	3
[SP] [Diarrhoea]Character of the stools:Copious:	1	3	3	2			2	3	3	2	2
[SP] [Diarrhoea]Character of the stools:Watery :Yellow:	1	2		2	1						2
[SP] [Diarrhoea]Character of the stools:Painless:	1	1	1	1	1	1	1	1	1	3	
[SP] [Diarrhoea]Aggravations:Drinking after:	2			1		1	1			1	
[SP] [Diarrhoea]Concomitants (Appetite):Thirst:Intense:											
[SP] [Diarrhoea]Concomitants (Mind and mood):Irritability ill humour:	1		1		3	3		2			
[SP] [Diarrhoea]Concomitants (General symptoms):Exhaustion (prostration):	2	1	1		1	1	2		2		2

- **<u>Totality of symptoms according to Kent's repertory:</u>**

- Irritable+2
- Weakness+2

- Thirst increased for large quantity often for cold water+2
- Stool<after eating and drinking+2
- Stool offensive and sputtering+2
- Stool loose watery yellow, profuse+2
- Vomiting sour ingesta+

- **<u>Reportorial result:</u>**

Remedy Name	Nat-s	Chin	Calc	Phos	Ars	Bry	Ph-ac	Cham
Totality	17	16	15	15	14	14	14	13
Symptom Covered	7	6	6	6	6	6	6	6
[KT] [Mind]Irritability (see anger):	2	2	3	3	2	3	3	3
[KT] [Stomach]Thirst:Large quantities:Often,for:						3		
[KT] [Stomach]Desires:Cold drinks:	3	3	2	3	3	3	2	3
[KT] [Generalities]Weakness,enervation (see lassitude,weariness):	3	3	3	3	3	2	3	2
[KT] [Rectum]Diarrhoea:Eating:After:	2	3	2	2	3	2	2	2
[KT] [Rectum]Diarrhoea:Drinking water:Immediately,after:								
[KT] [Stool]Sputtering:	3							
[KT] [Stool]Watery:Yellow:	2	2	2	1	1		2	1
[KT] [Stomach]Vomiting:Sour:	2	3	3	3	2	1	2	2

Differential Materia Medica

Podophylum	Arsenic album
Diarrhea painless watery profuse Diarrhea offensive Thirst for large quantity for cold water at short interval Diarrhea immediately after eating and drinking with prostration	Diarrhea with weakness and irritability Thirst for small quantity small interval Aggravation after and drinking.

- **<u>Final selection with Reason:</u>**

<u>Podophylum:</u> Diarrhea painless watery profuse

Diarrhea offensive

Thirst for large quantity for cold water at short interval

Diarrhea immediately after eating and drinking with prostration

III. INSTRUCTIONS TO THE STUDENTS

DURATION OF STUDENT:
10 min

TASKS:

Mention on the ruled paper:

1. Formulate the acute reportorial totality after classifying and evaluating the symptom
2. Take appropriate reportorial approach and come to group of remedies
3. Now do differentiation of remedies stepwise and mention final remedy by differentiating closely coming remedies

Gradation for Station 4:

Checklist for assessing the totality and remedy:

SR. NO.	PARAMETERS	YES	NO
	Totality Formulation:		
1	All the characteristic expressions (symptoms) are considered in totality		
2	All the characteristic expressions are considered with gradation in formulating totality of symptoms		
3	Concomitant are taken in the totality		
4	Reportorial Approach (Name) mentioned		
5	Evaluation order is mentioned according to mentioned repertorial approach		
	Remedy Selection:		

1	Group of remedies mentioned		
2	Thermal, acute /chronic, evolution and location considered in coming to small group		
3	Character of the pain , modalities and concomitant consider in final selection		
4	Final remedy prescribed with relevant reason		
5	Closely coming remedies differentiated		

4.

Totality Formation:	
Grade A:	Point number 5 + Yes score 3 out of 4
Grade B:	Point number 5 + Yes score 1 out of 4
Grade C:	Point number 5 not done + Yes score 2 out of 4
Grade D:	Point number 5 not done + Yes score 1 out of 4
Remedy Selection	
Grade A:	Point Number 5+4 yes score 2 out of three
Grade B:	Point Number 5 + yes score 3 out of four
Grade C:	No Point number 5 but either 3 out of four
Grade D:	Point number 1, 2 & 3

5.

Overall Assessment	**Grade A**	**Grade B**	**Grade C**	**Grade D**

Dr. M. L. DHAWALE MEMORIAL HOMOEOPATHIC INSTITUTE, PALGHAR

Department of Psychiatry

ASSIGNMENT 3

STRUCTURING THE OSCE STATIONS, 2018

BACKGROUND

A batch of 6 Homoeopathic undergraduate students from part II MD (Hom) students who are posted as residents at the Palghar teaching hospital for a period of 2 yrs and in their departmental IPD for at least 6 months. They are trained in history taking and clinical skills, documentation and homoeopathic prescribing procedures necessary for psychiatric cases. Especially they were exposed to competency based education in alcohol use and abused related topics. In the IPD, they frequently encounter cases referred from medicine department to manage acute Alcohol withdrawal where patients are not cooperative. I have planned OSCE stations keeping in mind above need to test their skills, attitude and knowledge related to subject of assessment and management of acute alcohol use disorder (AUD). They have to go through the OSCE examination procedure. This will cover the knowledge, skills & attitude of the students in acute alcohol withdrawal including general physical examination clinical and homeopathic & ancillary prescribing skills.

This assignment will be elaborated as follows:

I- Objectives of the OSCE
II- Preparation of the Station
III- Instructions to the candidates
IV- Gradation obtained
V- Experience of validation of the stations

I - OBJECTIVES

1. Evaluating the history taking skills of the part II students in the subject of psychiatry in topic of Alcohol Use Disorder (AUD). PG student has undergone a 2 month course on acquiring competency in specific area of care during their Residency of last 2yrs. History taking, physical examination and diagnostic and therapeutic thinking will be assessed.

2. Evaluating the ability of the student to document the information received during history taking on a prescribed format

3. Utilizing the information to construct a totality leaving to Homoeopathic prescription.

These factors will be tested through 3 stations-2 activity stations (one history taking and one examination) and one information processing station - question station

Material : standard patient with attendant

II - PREPARATION OF STATION 1: (observing patient, History taking with help of wife)

Name of the case	Acute alcohol gastritis after binge drinking in chronic alcoholic.
Name of the Patient	Mr. Bevda Ghetoch
Age / Gender	35 / Male
Education / Occupation	Working as peon in government office
Presenting Situation	Homeopathic Hospital IPD Scenario. In anukampa ward devoted to psychiatry patient. Patient is referred by casualty medical officer having severe vomiting, pain in epigastrium. The patient is our old patient who reported irregularly for his chronic alcoholism, last reported six months back. Patient had recent history of binge drinking, non-cooperative, and restless with pain & withdrawal? , exhausted but can't rest and talks irrelevantly. Wants to go home all the time. Accompanied by wife who is exhausted with his habits and anxious about his current state. She is the one who has all basic information of patient's history.
Symptoms	Observation, he is restless with pain in epigastrium rubs hand and pressing that area. Tries to sleep but suddenly gets up with discomfort and becomes restless. When asked any question looks anxiously at wife and says he is going to die in-between talks irrelevant things. Anxious wife reports on inquiry Complaints of severe burning pain in epigastrium post marriage party, unquenchable thirst for cold water but vomits as soon as he drinks, followed by retching. Appetite reduced. Sleepless since last night. Vomiting is acrid & sour in smell and relieves his pain for a while, followed by severe exhaustion, trembling of hand. The complaints have started 2 days ago after binge drinking in marriage party. Next morning, had sudden attack of acute epigastric pain with burning and vomiting cannot take food vomits as soon as he eats and now talks irrelevantly. (he)/ You visited your family physician who gave some medicines and syrup antacid with which the acute pain was better for a while but his health did not improve and mental health deteriorated since last night with sleeplessness.

	You (he) cannot drink water though you are thirsty for cold water. You are restless with pain look exhausted with trembling. wish to move out of bed but feels tired. You are unable to sleep at all as lying down increases the restlessness. You report on inquiry history of similar frequent episodes of binge drinking and followed by vomiting and restlessness. You are talking of death and will not survive this episode. Will die like his father. You see him and talk to him.
Medication	Allopathic medicines (You (he) cannot remember the medicine names)but was antacid .
Past Medical History	There has been history of similar complaints of irrelevant talk followed by convulsion. been treated with allopathic medication with little relief and was finally helped at hospital with homeopathy (record is not available).
Family History	Father Alcoholic (died young) Brother – Alcoholic
Demeanor / Body language / Appearance	Anxious due to complaints. Restless talks of death talks irrelevantly, talks as if talking to dead father. Sour smell around you.
Objectives (What the SP / wife (attendant) should elicit from the trainee)	1. Causative factor for this current acute state of pain 2. Evolutionary symptomatology 3. Onset and Progress of acute episode of epigastric pain / nausea / acidic vomiting. 4. Frequency of past episodes with its severity. 5. Current state of mental health including sleeplessness. 6. Clinical expressions to diagnose the acute alcoholic gastritis Individualized expressions – A/F recent history of alcohol, type of pain – area of xiphisternum pain and heart burn. 7. Concomitant unquenchable thirst for cold water, exhaustion Anxiety about health /death. Tongue white coating. 8. Mental concomitant Anxiety about the progress of disease, irrelevant talks of death and talked with dead people.
Flow of the conversation	a. IF ASKed to attendant RESPOND TO INTRODUCTION: Name /address /your relationship with patient / if they introduce acknowledge that **b. Nature of the complaints and the details / You are suffering from which complaints:** Mention about the complaints i.e. Show as epigastric area and says pain, starts talking – irrelevant says he is going to die. restless Wife volunteers he is having burning pain in epigastrium. Started

	vomiting not slept whole night and he is restless talking of his death. **c. How did they start? Since patient non cooperative (question to wife)** It started 2 days back after marriage party where he drank and drank alcohol with friends and next day morning i.e. yesterday developed pain and vomiting . **d. How have they progressed?** Initially it was only pain and vomiting , we gave him allopathic medicine slept now very restless talks of death and irrelevant matter whole night he was grumbling and moaning. **e. What are the aggravating factors for the complaint or factors which increase and decreases complaint?** He might have consumed spicy and oily food during marriage along with alcohol,. **f. What are the relieving factors for the complaint or increase and decreases complaint of pain and vomiting ?** he feels better by cold water he asks for it very frequently thirsty all the time but vomits immediately **g. Is his thirst altered? Or they may ask as – How is his usual thirst?** My thirst has increased for cold water and like to take sips of water as has fear of vomiting. **h. What about appetite?** It's reduced **i. What treatment you have taken** He has taken allopathic treatment – syrup and tablets for pain & vomiting. But his complaints didn't improve much rather is sleepless and talks irrelevant things. **j. Nature of sleeplessness? and since when?** Since last night, he is very restless and talks. He is weak and exhausted. **k. What does he talk in sleep?** He talks of death all the time says he sees his father who passed away long back. He wants to get up but is weak.

	l. If observes well will ask ... since when he is trembling ? he is trembling since early morning **m. Whether you have had past history of the same complaint?** Yes. He had weakness trembling and was hospitalized with convulsion, then we brought him here he was better but once again restarted drinking. Apart from above said information they ask anything else say I don't know or I am unable to recollect or I haven't noticed.
Possible Diagnosis	Acute alcoholic gastritis with 1st. -→2nd.stage of withdrawal symptoms
Method of observing the performance	Check list
Level Designated for	Senior PG 3rd. year residents
Place in Academic Year	MD part II Sr. student

Grade marking during History taking

No	Activity-Marks	3	2	1	0
1	Approach	Introduces self, asks for name of patient and states purpose of encounter. Observes patient silently for one min. and relates to attendant asking how are you related to her ?	Introduces self and asks for name of patient and observes relates to attendant without asking for relationship	Introduces self ask to attendant about patient history	Fails to introduce self and starts inquiry ad hoc manner
2	Complaint	Is able to locate the seat of the disease as the alcohol induced Gastritis, mind & nerves alcohol withdrawal beginning of 2nd stage	Is able to locate the seat in the Stomach and gastritis due to alcohol	Is able to locate the seat as upper GI tract	Is unable to locate the seat of the illness
3	Time	Is able to elicit	Elicits the	Elicits either	Is unable to

		accurately the duration and the course and evolution of illness in holistic manner. With time correlation	duration but not the course but does not zero down on the exact data	the duration or the course of the illness	elicit accurately either the duration or course
4	Sensations	Is able to elicit the nature of the pains and vomiting with the characteristic expression of pain/ discharge .	Is able to elicit the nature of the pains and vomiting	Is able to elicit either the pains or vomiting	Is not able to elicit the details
5	Modalities-AF	Is able to elicit the AF accurately with modalities of pain vomiting.	Asks for AF but cannot zero down the cause	Asks for AF in a general way	Ignores
6	Aggravation	Is able to elicit all the < modalities with intensity	Is able to elicit 2 modalities for	Is able to elicit 1 modality	Ignores
7	Amelioration	Is able to elicit all the > modalities with intensity	Is able to elicit the > modality but misses the intensity	Is able to elicit the > modality	Ignores
8	Concomitants	Is able to elicit the exact nature of the thirst with characteristics, general of weakness trembling and sleeplessness ,	Is able to ask the concomitants but cannot get the characteristics	Is not able to spot the concomitants though asks	Ignores the concomitan ts
9	Mental health evaluation	Could observe changes in mental plan with characteristic expression of talk , contains and speech.trembling of limbs Correlate it with evolving 2nd, stage of alcohol withdrawal	Is able to observe mental state but missies characteristics of talk and its contains	Is able to ask for mental symptoms but missies on observations	Fails to observe or ask for mental symptoms or state.

9	Past history	Is able to elicit P/H/O of similar complaints with ODP and comparison	Asks the P/H/O but does not elicit the similar complaints	Asks the P/H/O	Does not ask
10	Completion	Is able to complete evolutionary history comfortably	Is able to complete 75%	Is able to complete 50%	Is able to complete 25%

III – INSTRUCTIONS TO THE CANDIDATES

STATION 1: HISTORY TAKING

SCENARIO:

Mr. bevda ghetoch is 35 years old male working as peon in government office. His wife 30 yr old female house wife. He is suffering from acute abdominal complaint with vomiting and weakness. Last night complaints worsened and developed sleeplessness and irrelevant talk. He is brought to hospital by wife wants to treat his acute and re start Homoeopathic treatment which can relieve his complaints.

DURATION OF INTERVIEW:

10 mins

II- Preparation station no 2: Give them transaction and ask for writing in LSMC column & arrive at provisional clinical diagnosis as well order investigation .

Objective:

1. Evaluating the ability of the student for recording the information in alcohol screening form & Location-sensation-modality and concomitant format from transactional study
2. Ability to arrive at provisional diagnosis & order investigation to arrive at comprehensive diagnosis

Material supplied

1. Transactional record of standard patient & doctor interaction
2. On Examination findings
3.

O/E General sclera muddy, BP 140/90 CNS : NAD Abdomen Epigastric Tenderness (No guarding), Liver / Spleen NAD

Provisional Diagnosis: 1.Alcoholic Gastritis? D/D Pancreatitis, Hypokalemia,
2. Alcohol Withdrawal Stage 2

Summary of transaction between Patient & Doctor

Patient is referred by casualty medical officer having severe vomiting, pain in epigastrium. The patient is our old patient who reported irregularly for his chronic alcoholism, last reported six months back. Patient had recent history of binge drinking, non-cooperative, and restless with pain & withdrawal? , exhausted but can't rest and talks irrelevantly. He is unable to sleep at all as lying down increases the restlessness, he is mentally restless & Wants to go home all the time. and says he is going to die due to this ailment & going to his father who passed away similarly(talks to him).

The complaints have started 2 days ago after binge drinking in marriage party. Next morning, had sudden attack of acute epigastric pain with burning and vomiting cannot take food vomits as soon as he eats and now talks irrelevantly. He has unquenchable thirst for cold water but vomits as soon as he drinks, followed by retching. Appetite reduced, sleepless since last night. Vomiting is acrid & sour in smell and relieves his pain for a while, followed by severe exhaustion, trembling of hand.

So far family physician who gave some medicines and syrup antacid with which the acute pain was better for a while but his health did not improve and mental health deteriorated since last night with sleeplessness. History of similar frequent episodes of binge drinking and followed by vomiting and restlessness and hospitalization.

Family history father died of IHD (alcoholic)

Investigations: supposed to order for arriving at final diagnosis.

- CBC , ESR S. Lipase , S. Amylase, LFT, S. Electrolytes,
- Urine routine
- USG Abdomen

Grade marking & Evaluation

No	Activity-Marks	3	2	1	0
1	Completion and documented in alcohol screening paper	Is able to complete history comfortably and documented in screening paper	Is able to complete the history	Is able to complete 75%	Is able to complete 50%
2.	Completion and documented in LSMC	Is able to complete history comfortably and documented in LSMC	Is able to complete the history	Is able to complete 75%	Is able to complete 50%

3.	Could arrive at provisional diagnosis	Could arrive Provisional diagnosis of mind & body with clear-cut stage of withdrawal & order investigation precisely	Could arrive partial Provisional diagnosis of mind or body Withdrawal Stage could not conclude	Provisional diagnosis vague not clear	Could not arrive at provisional diagnosis

III – INSTRUCTIONS TO THE CANDIDATES

STATION 2: data recording, organizing , arriving at provisional diagnosis & ordering investigation

Scenario: Doctor has already taken the History considering clinical as well as Homoeopathic aspects. Transactional record of history will be shared with them

Task

1) write LSMC on Four column sheet
2) Arrive at provisional diagnosis and order investigations

Duration 15 min;

III - PREPARATION OF STATION 3:

- Ability of arriving at a comprehensive diagnosis to assess the ability to differentiate common and characteristics
- To assess the knowledge of value of symptom and do evaluation of symptom
- To assess the ability to take appropriate approach and formulating the repertorial totality
- To assess the knowledge of differentiating the remedies and formulating the prescribing totality

Material supplied :

1. Standard LSMC format & generals of the case including some observations
2. Investigation reports

Location	Sensation	Modality	Concomitant
GIT Since 2days Epigastrium	Severe vomiting, Severe burning pain+2 Rubbing and pressing the area Restlessness due to pain+2 Vomiting with retching: Vomiting is acrid & sour in smell followed by	A/F Recent history of binge drinking (Chronic alcoholic) >Vomiting + <Imm. After eating or drinking+2	Thirst: unquenchable for cold water+2 Weakness++ : trembling of hands Mentals: Irrelevant talking: looks fearful : When asked any question looks anxiously at wife and says he is going to die , in-between talk's irrelevant things Talking of death and feel

	severe exhaustion, trembling of hand. App: reduced Look of the patient: Exhausted with trembling		he will not survive this episode. Will die like his father. Sees him and talks to him.

Evaluation patient:

General: weakness, trembling of hands

Mental: Irrelevant talking: looks fearful: When asked any question looks anxiously at wife and says he is going to die, in-between talks irrelevant things, Talking of death and feel he will not survive this episode. Will die like his father. Sees him and talks to him.

Investigations:

Electrolytes :Na+ = 150, K+ = 3.2, Cl- = 94 CBC: Hb: 11 gm%, rbc: 3.9 mill./mm3, wbc total : 3000 ,N/L/E/M/B : 60/1/20/1/0, normochromic macrocytic, platelet: adequate .amylase: 200 U/L, lipase : 70 U/L, bilirubin: total- 1.8 direct- 0.9 indirect- 0.9, SGOT :80, SGPT: 70

USG abdomen: NAD

Checklist for assessing the totality and remedy:

SR. NO.	PARAMETERS	Score	YES	NO
	Clinical diagnosis			
1.	All points of evolutionary history taken in consideration & correlated with report & examination findings			
2.	Mental status examination and neurological findings are correlated and arrived at stage of alcohol withdrawal			
	Totality Formulation:			
1	All the characteristic expressions (symptoms) are considered in totality	1		
2	All the characteristic expressions are considered with gradation in formulating totality of symptoms	2		
3	Mental & physical Concomitant are taken in the totality	3		
4	Repertorial Approach (Name) mentioned	4		
5	Evaluation order is mentioned according to mentioned reportorial approach	5		
	Remedy Selection:			
1	Group of remedies mentioned	1		
2	Thermal, acute /chronic, evolution and location considered in	2		

	coming to small group			
3	Character of the pain, modalities and concomitants considered in final selection	3		
4	Final remedy prescribed with relevant reason	4		
5	Closely coming remedies differentiated	5		

SCENARIO: Check the investigation reports / General observational data.

Task:

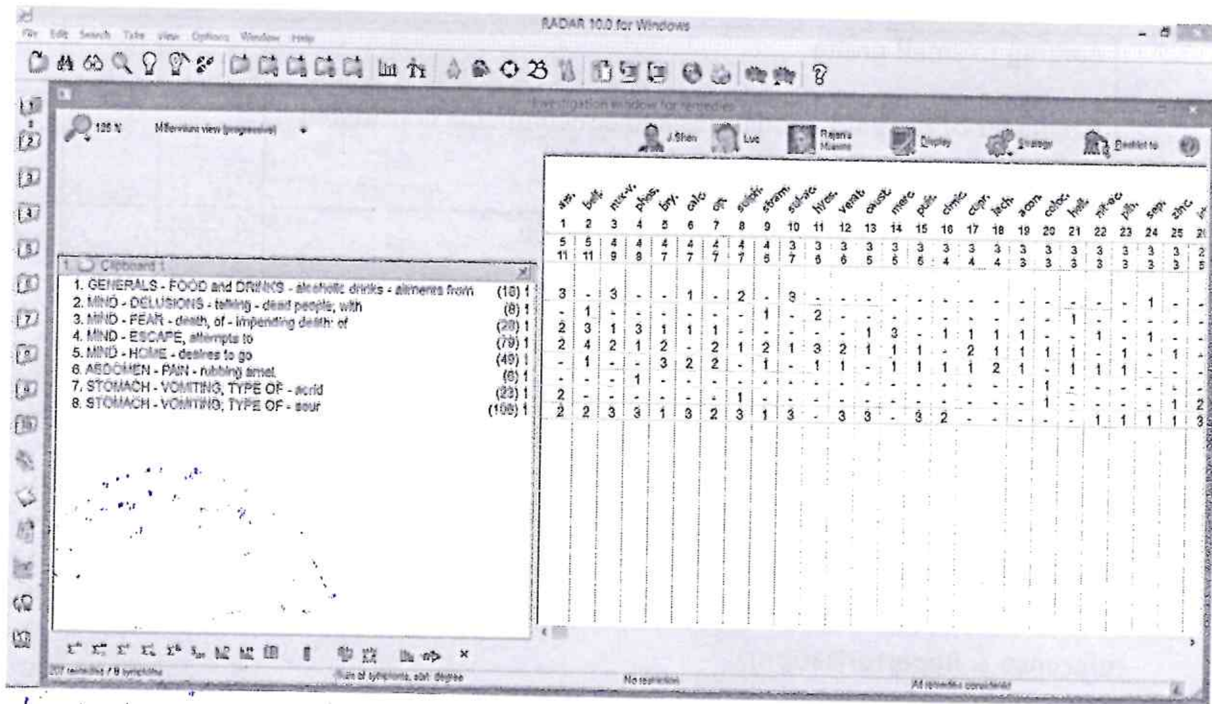
1) Arrive at comprehensive diagnosis with help of history/ examination and reports
2) Identify characteristic & Arrive at totality
3) Take suitable approach and Come to remedy (computer/ books will be available for reference & Repertorisation).
4) TPD / TPR (homeopathic & ancillary treatment)

Duration 20 min

Standard for evaluation

Totality:

1. A/F Binge drinking
2. Hallucination: talking to dead father
3. Fear of death: feels death is imminent
4. Desire to escape and go home
5. Thirst: unquenchable for cold water
6. Exhaustion < vomiting+2
7. Pain in epigastrium >Rubbing+2
8. Vomiting is acrid & sour in smell



TPD TPR

Date	No.	Problem Definition	Resolution Process and techniques	Resolution End point	Precautions and Dangers
	1.	Alcoholic Gastritis: Post alcoholic binge with hypokalaemia. Severe Epigastric Pain Severe Vomiting with retching	-Rehydration -Electrolyte replacement -Diet: Nil by mouth till Vomiting stops- Liquids- solids -Ars alb 200 frequent doses	-Stopping of vomiting, epigatric pain -Appetite and thirst normalization -reduction of irrelevant talking -Vital stability	-Hypervolemia -Perforation/ ulceration -Mallory Weis -?Rupture of Oesophageal Varices
	2.	Alcohol Withdrawal Stage 2	-Restraining of the patient -Primary IPD care: maintainence of hygiene, hydration status- administration of Vitamins etc. Remedy: acute homoeopathic remedy as indicated in frequent repetition	Severity and duration of stages of withdrawal minimized	-GTC -Choking hazard -Danger to attendants and self: as patient is disoriented and possibly violent
	3.	Chronic Alcoholism	Chronic Remedy in infrequent repetition with rehabilitation (Inclusive of visits to AA and counselling)	Sobriety	Relapse along with complications of alcoholism : liver cirrhosis, oesophageal varices etc.

IV. Self-evaluation and assessment: format will be given (10 marks)

Duration 10 min

V. End Instruction: Write about your exam experience and send report on email tonight: guidelines will be given