**MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF ZIMBABWE**

****

**SENIOR REGISTRAR LOGBOOK**

**FOR**

**CARDIOTHORACIC, VASCULAR, CARDIAC (PAEDS), THORACIC, CARDIOVASCULAR AND CARDIAC SURGERY**

Promoting the health of the population of Zimbabwe through guiding the medical and dental professions

 **GENERIC FORMAT FOR PRE-REGISTRATION SENIOR REGISTRAR IN CARDIOTHORACIC, VASCULAR, CARDIAC (PAEDS), THORACIC, CARDIOVASCULAR AND CARDIAC SURGERY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Attributes**  | **Strengths** | **Areas Of Improvement** | **Score**  |
| 1. **Presentation**

 **Personal/physical appearance**  |  |  |  |
| 1. **Communication**

Patient, relatives and any other interested parties.Effective verbal skills. Present ideas and information concisely. Inspires confidence in colleagues. Keeps others well informed etc • Interpersonal relations Work colleagues and superiors |  |  |  |
| 1. **Management**

Planning and OrganizationSets goals and priorities. Plans ahead and utilizes resources effectively. Ability to meet deadlines and monitor tasks.  |  |  |  |
| 1. **Judgement**

Considers pros and cons before making decisions. Considers risks. Considers impact of decisions and seeks advice. |  |  |  |
| 1. **Leadership**

Effectively manages situations and implements changes when required. Motivates, coordinates, guides and develops subordinates through actions and attitudes. |  |  |  |
| 1. **Ethics**

Observance of both the patient’s and the doctor’s rights. Considers the ethical impact of decisions. Demonstrates actions and attitudes of integrity. |  |  |  |
| 1. **Reliability**

Can achieve goals without supervision. Dependable and trustworthy. |  |  |  |
| 1. **Quality of Work**

Achieves high quality of work that meets requirements of the job**.** |  |  |  |
| 1. **Quantity of Work**

Achieves or exceeds the standard amount of work expected on the job. |  |  |  |
| 1. **Initiative**

**A self starter. Provides solutions to problems.** |  |  |  |
| 1. **Cooperation**

Willingness to work with others as a team member |  |  |  |
| 1. **Assessment by other disciplines**

Professional conduct, reliability and quality of work. |  |  |  |
| 1. **Participation in clinical audit, clinical governance and Continuous Professional Development**
 |  |  |  |
| 1. **Teaching**

Junior medical and dental staff. Nurses and other health professionals. |  |  |  |
| 1. **Research**

**Participation in ongoing research.** |  |  |  |
| 1. **Others**
 |  |  |  |

Score 1 – 5 : 1 is the worst score and 5 is the best score. Meet candidate quarterly and discuss strengths and areas of improvement. Consolidate with rating from other departments for overall

This logbook is divided into two sections

Section A

Generic topics covered in this section do apply to all the above specialties and for the basis for any specialties, hence knowledge or completion of Section A is mandatory for completion of Section B.

Section B

Specialty Section \_ This Section deal specifically with performing adequate procedures in the relevant Specialist with the sole aim of producing an independent and competent Specialist.

1. **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Period of Clinical Assessment**
3. **Period of Training**

**From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Teaching Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Names of Surgeon in Unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Number of Weeks Absent \_\_\_\_\_\_\_\_\_\_\_ Reasons \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Research Required Satisfied YES /NO**
3. **Name of Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **Signature of Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**
5. **Signature of Senior Registrar \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

**Section A**

1. **THORACO CARDIAC**
2. **General Knowledge of all possible thoracic incisions**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Emergencies**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Investigations**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**PAEDIATRIC EMERGENCIES**

1. **Foreign Bodies (Oesophageal and bronchial) :**  at least 10 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Blunt Chest Trauma :** at least 10 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Penetrating Chest Trauma :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **RTA :** at least 10 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**CHEST X RAY (AP AND LATERAL)**

1. **Pleural Effusion :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Foreign Body :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Rib Fractures:** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Haemothorax :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Pneumothorax :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Blunt Chest Trauma**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Frail Chest :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Tension Pnuemothorax**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

*Note: At Least 2 weeks of attachment with a Radiologist who will be Supervisor*

1. **VASCULAR**
2. **Penetrating Trauma With Vascular Injury :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Non Traumatic Vascular Emergencies :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Aorta And All Periplueral Arteries :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Veins :** at least 5 patients

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Name of Patient**  | **Hospital Number** | **Diagnosis** | **Mode of Treatment**  | **No of days in Hospital** | **Outcome**  | **Supervisor’s Signature**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Note: The Registrar is expected to do at least 20 patients in various areas of his specialty. 10 of which he should be the lead Surgeon with his supervisor as assistant and 10 of which he is an assistant. All cases to be separated as in Section A. these are to be submitted to the Medical and Dental Practitioners Council of Zimbabwe which will in turn do a randomized check or should they which to check all cases before registration.

Please note no separate written report of recommendation is required from the Supervisor. The comments on a case by case basis should be used by the MDPCZ for Specialist Registration.

**Overall assessment by Chairperson Department of Surgery or Designate**

Registrable ……………………………………………………………………

Non Registrable………………………………………………………………

**Recommendation by Surgical Society of Zimbabwe**

Registrable ……………………………………………………………………

Non Registrable………………………………………………………………