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National upgrade on Gynecological oncology, held  
on 29<sup>th</sup> May 2006 at G. Kuppaswamy Naidu  
Memorial Hospital, Coimbatore

For Private Circulation only

## National Board of Examination's CME programmes go high tech on 22<sup>nd</sup> July 2006

The first Interactive CME session for DNB candidates using Open Indira Gandhi National University satellite infrastructure was held on 22<sup>nd</sup> July 2006. The Board in collaboration with the School of Health Sciences, Indira Gandhi National Open University has planned five such sessions for August 2006 and gradually the frequency will be increased. These sessions will also be recorded and DVDs will be made available to accredited hospitals and DNB candidates. The transmission will be available at C-BAND (GD1-GD4), 4165 MHz, Horizontal Polarization, Transponder C-12 on INSAT 3C, Symbol Rate: 26,000 SPS, FEC: 1/2 and also at DTH (KU BAND) GD-1, NSS 6, Down link frequency: 12427.5 MHz, Symbol Rate: 21, 0937, Polarization horizontal, FEC: 3/4. All the National Board of Examinations' accredited hospitals may kindly ensure that all the DNB candidates attend these sessions. The Hospitals, which have not yet installed the reception equipments are requested to contact the Regional Director IGNOU in their respective states (city) and request him/her for making the necessary arrangements for reception of satellite transmission on the specified dates and time. The details are on the National Board of Examinations website: [www/natboard.nic.in](http://www/natboard.nic.in)



### Grading System for examination-should National Board of Examinations go for it?

Prof. A.K. Sood, Executive Director, National Board of Examinations, New Delhi

#### What is grading?

The word 'grade' is derived from the Latin word *gradus* where it means 'step'. Grading is a process wherein subjects may be classified on the basis of pre-defined standards. In educational context grading is essentially a method of communicating measurements of students' achievement. It involves the use of a set of symbols that ought to be clearly defined and uniformly understood by the students, teachers and all others concerned. The absence of either of these will defeat the very purpose of awarding grades. While developing the grading system it is of utmost significance that the meaning of each grading symbol be clearly spelt out. Having done so, it becomes obligatory on the part of each examiner to adhere to the specified system of grading. This would, however, in no way encroach upon the autonomy of the examiner to determine which grade to award to a particular student. A properly introduced grading system may not only provide for the comparison of students' performance, but also indicate the quality of performance with respect to amount of efforts put in and the amount of knowledge acquired at the end of the course.

#### What does grade convey?

There is no denying the fact that the basis upon which the judgement of awarding the grades is made, vary considerably from institution to institution and from examiner to examiner. There seems to be no common point of reference that makes it possible to compare grades awarded by different examiners and different institutions while using norm-referenced measure. At best the information that can be inferred from grades is that a particular student in a given time with a given teacher is either above average, average or below average, if three-point grade system is used in terms of academic achievement. However, the comparison of student's performance across institutions may be made with reference to a specific criterion by employing criterion-referenced measure. Thus, the grades may be used for conveying both the students' performance with reference to a specified criterion and also the relative positions of students with reference to their peer group.

#### Functions of grades

The award of grades may serve a variety of purposes. Firstly, it gives an account of the extent to which the instructional objectives have been realized by the learner. This information serves a very useful purpose not only for the learner and the teacher but also for the institutions. Secondly, award of grades provide for a permanent record of learner's growth and development that might

be helpful for institutions of higher learning for allocating seats and also for prospective employers. Thirdly, it may be very helpful for the University/Institution itself in making the kind of decisions pertaining to placement and promotions. Fourthly, award of grades may be helpful in reviewing transactional strategies and curricular appropriateness. Besides these, grades are also used in determining the Grade Point Average (GPA) for the purposes of awarding merit scholarships in a number of Universities/Institutions of higher learning.

#### Inaptness in grades

Teachers' evaluation can never be completely devoid of subjectivity, be it carried out in terms of marks or grades. The fact is that all methods of human assessment have problems but this should not deter efforts to minimize the errors of assessment. It is easy to identify imperfections in grading but it is difficult to propose a satisfactory alternative. Although grading is considered as one of the most significant aspects of teaching and learning for several reasons, it is not free from criticism. Those who criticize, argue that grading is complicated, it is value-laden, it has little research basis, it provides extrinsic but not intrinsic motivation. Another criticism is that grades are often awarded without employing both multiple criteria and multiple sources of information. Yet another criticism about grading is that when faulty, it can do more harm than good to both the students and the teachers.

Besides, some argue that when one takes into account the vast amount of information concerning individual student, it appears to be quite unreasonable to condense it all into a single letter or number representing that student's progress and development. There are also some who question the value of grades. They often cite the evidence of low correlation between grades and subsequent success in life. Here one should not forget that learning is not the only requirement for success in life. Another reason may be attributed to the imperfection of measures of measures of achievement in learning. Yet, one more reason could be the difficulty of defining success in life and of measuring it precisely.

Despite all these limitation, grading remains the only feasible procedure for evaluating the students' potential realistically. Moreover, all arguments against it can be countered by laying adequate emphasis to improve the ways and means of awarding the grades so as to make them more reliable and valid.

#### Issue of pass and fail

Issue of pass and fail is a perennial problem which has bugged our society since the time it was introduced by the British in 1847. The same practice continued in our educational system even after Independence. In our present examination system 35% or 40% or 50% is the cut-off score which divides pass and fail. This demarcation of 35% or 40% or 50% is arbitrary and has no sound basis. It is difficult to really differentiate between two candidates, one getting 34 marks and another getting

35 marks when all know that the marks awarded by the examiners are not free from error of measurement. However, this arbitrary decision perpetuated by the Universities over the years has been accepted by the students and the society in the absence of any alternatives. Failing all students securing less than 35% or 40% or 50% is not a desirable practice. Since half of the student population is unable to scale the examination, it becomes rather a colossal wastage of human resources at the national level. It further creates stagnation in the system on the one hand and many other problems for parents and society on the other. Moreover, stigma of fail on the basis of single criterion is unjustifiable.

The marks obtained in an examination are considered as the yardstick of the quality of performance which is very sacrosanct for the people. Even the educated people have too much faith in marks despite knowing fully well that these are not much reliable and do not necessarily reflect the true measure of achievement. The faith depends on the assumption that the one who passes is capable and possesses all abilities and the one who fails is incapable and devoid of any ability whatsoever, which is not true. Thus the examination system creates two categories of students in terms of ability and promotes discrimination in the society.

Further, the marks awarded are affected by many factors such as unfair means, erratic marking, subjectivity of the examiner etc. It is not fair to label a student as "pass" or "fail" on the basis of such unreliable measures. What is desirable is that the performance displayed by the students may be classified in terms of ability ranges denoted by letter grades. The provision may, however, be made for the improvement of grades in case the students do not seem to be satisfied with their performance.

The stigma of 'fail' marks the career of students at different levels. At personal level they feel a loss of face which jeopardizes their self respect and dignity. At the social level their categorization as failures make them outcaste from the educated circle and at the psychological level they become tense and insecure for their future life. These aspects create a formidable impact on the psyche of the unsuccessful students.

In the present system it is only the student who suffers to blemish and others go scot-free. Not only this, a sizeable number of students suffers from traumatic experiences caused by the University results and indulges in indiscreet actions like suicide etc. The incidents of this kind occurred in the past decade have created an alarming situation for the society to think of some reforms in examination system which could be humane and student-friendly. Therefore, it is high time to get rid of pass/fail by way of introducing grading system as a viable alternative. The alternative so designed, however, provides for sufficient flexibility so that students get the option to improve upon their grades, should they so decide. The criticism that the abolition of pass/fail practice would lead to a chaotic as there would be no distinction between good

## NBE Executive Director Speaks

performers and poor performers, does not hold any good as the performances of students in grading system are graded into a number of categories which make them distinctly different from each other. Another criticism of the abolition of pass/fail is that it would lead to creation of a heterogeneous group, thus increasing the problems of the teachers. This problem can conveniently be tackled by resorting to differential treatment augmented by diagnostic testing. Yet another criticism of the abolition of pass/fail is the problem of accommodation of all students in higher classes. This problem may be overcome if the allocation of seats is made on the basis of the Grade Point Average (GPA) of the desired combination of subject areas.

### Suggested Grading system for National Board of Examinations

- Each question in the answer script is awarded letter grade according to the level of performance judged by the Evaluator.
- The Board may follow 'Letter Grading System' on a five-point scale (A, B, C, D, E); 'A' being the highest and 'E' being the lowest (unsatisfactory grade which means the candidate will have to repeat his/her test, at present this level is 50%). The cut off values to these grades may be as follows:

| Letter grade | Equivalent grade point | Point grade range | Percentage equivalence | Qualitative value |
|--------------|------------------------|-------------------|------------------------|-------------------|
| A            | 5                      | 4.50 & above      | 80% & above            | Excellent         |
| B            | 4                      | 3.50 to 4.49      | 60% to 79.9%           | Very good         |
| C            | 3                      | 2.50 to 3.49      | 50% to 59.9%           | Good              |
| D            | 2                      | 1.50 to 2.49      | 40% to 49.9%           | Satisfactory      |
| E            | 1                      | 0 to 1.49         | Below 40%              | Unsatisfactory    |

- Answer to each question may be gone through carefully into its minute details and its strengths and weaknesses may be marked to facilitate its overview. The level of performance may then be judged in terms of Goods, Very good, Excellent etc.
- Having decided the level of performance in qualitative terms, corresponding Grade, be then marked against answer to a question. Answer to each question, therefore, will have separate Grades such as 'A', 'B', 'C' or 'E'.
- These Grades may have to be combined into an Overall Grade for the question paper/course i.e. 'A' or 'C' or 'E' as the case may be.
- In order to arrive at an Overall Grade for individual paper, the following methods may be suggested:-
  - If all the questions in the question paper have the same Weightage in terms of marks or percentage, then Overall Grade points may be worked out as follows:

| Q. No. | Weightage for each question | Letter grade awarded | Equivalent points grade | Overall grade           |
|--------|-----------------------------|----------------------|-------------------------|-------------------------|
| Q.1    | 10 Marks                    | A                    | 5                       | 5+2+4 = 11              |
| Q.2    | 10 Marks                    | D                    | 2                       | ----- = ---- = 3.66 = B |
| Q.3    | 10 Marks                    | B                    | 4                       | 3 = 3                   |

- If all the questions have different weightages in terms of marks or percentage. Qualitative Grade point/overall Grades in a course may be arrived at with the help of grade points and Weightage/percentage put together:

| Q. No. | Weightage for each question | Letter grade awarded | Qualitative points | Qualitative points & overall grade |
|--------|-----------------------------|----------------------|--------------------|------------------------------------|
| Q.1    | 20                          | C                    | 3x4=12             | 12+12+8+24 = 56                    |
| Q.2    | 20                          | C                    | 3x4=12             | ----- = ---- = 2.8 = C             |
| Q.3    | 20                          | D                    | 2x4=8              | 4+4+4+8 = 20                       |
| Q.4    | 40                          | C                    | 3x8=24             |                                    |

(Here 5 marks / percentage constitutes one unit. In the above example, 4 units of 5 marks are involved.)

In question No. 1, 2 & 3; and 8 units of 5 marks in question No. 4

- The sub-part of a question is to be graded separately, i.e. the grade for one question (including parts therein) is to be awarded as one point. It is left open to the convenience of the Evaluator to adopt any scheme for keeping track of the performance in sub-parts.

## Collaboration between NBE & IGNOU

### Skill Training Process in Medical Programmes of IGNOU

Dr. T.K. Jena, Reader  
School of Health Sciences, Indira Gandhi  
National Open University, New Delhi

Indira Gandhi National Open University (IGNOU) offers post Graduate Diploma in various medical specialities. The theory material is developed in a self instructional style and the practical training is provided through contact sessions conducted

in tertiary and secondary health institutions through a three-tier hands-on-training model which not only provides flexibility in pace and place of learning but also ensures that after completion of the training process, a student can actually practice the skills with confidence in his own work environment. In addition, this three-tier system has integrated the pedagogy of skill learning and has ensured that the benefit of both group learning and one-to-one learning is given to the students.

#### The Model

The model describes the implementation of practical component in three steps at three levels. First, the tertiary level infrastructure (Medical College) where the academicians could be involved as counselors to impart the second step of learning process. Second, the involvement of secondary level of health infrastructure (District Hospital) where the subject specialists could help the students in repeatedly performing the skills and thus guide them in practicing the skill that are taught in tertiary level. Thirdly, the primary level health setup, where the student is performing his job. This could also be a clinic/health set up run by the student himself where the student tries to practice the learned skills without any supervision. In IGNOU parlance, these three levels are called as programme study centre (PSC), Skill Development Centre (SDC) and Work Place (WP) respectively. For administrative purpose, the programme study centers are linked up with the Regional Centres (RCs) which are a part of the IGNOU establishments.

The PSC becomes the nucleus of programme implementation process. The Programme In-charge (PIC) is stationed at the PSC. He/she is normally a permanent faculty of the medical colleges with additional responsibilities of being the PIC. He will primarily be monitoring the learning process of all students enrolled in his institution with the help of other counselors. The students will be required to come here to attend the contact sessions in theory and practical. The end assessment examination would also be held here. Every student has an opinion to select his nearest SDC. The number of SDCs is not fixed. There could be as many SDCs as the number of students. SDC is selected as per the guidelines where students are allowed to practice the skills under supervision.

At work place, the students will practice the skills

## Collaboration between NBE & IGNOU

without supervision so that enough number of patients are examined by them before appearing in the term-end examination for certification.



Fig.1. Implementation Model

### Implementation Process of Practical Component

Every course has a practical component. The skills that the students need to learn under each course are listed in their programme guide. The skill training is divided into three parts i.e. training at PSC, training at SDC and training at Work place. The students have to maintain record for each case as mentioned in their practical manual. For all the three places, the time division against each skill is also mentioned in the practical manual. At the PSC, students are demonstrated each skill. To ensure that they have understood the steps involved in each of the skills demonstrated, they should also practice the skills on at least one of the sample cases. If they get opportunity, they are allowed to practice the same skill on more number of patients at PSC. However, if they do not get more chances, they practice the same procedure at their allotted SDC. At the SDC, the students practice all the skills taught to them at the PSC. To guide them, there are counsellors at SDC. Depending upon the programme students have to perform the activities himself under the supervision of the counselor. Guidelines are given to ensure that the minimum of patients/activities are practiced at SDC. Similarly, a student has to do un-supervised activities at the work place. These activities are recorded in the logbook.

### Log Book Maintenance

The students are supplied with logbooks. This helps to ensure that the skill training is implemented in a standardized manner throughout the country. The logbooks are countersigned by the counselors of medical college/SDC so that the learning defects of the students are identified in time and reinforcement of training could be provided. The programmes where logbooks are not supplied, major headings/formats for recording the activities/case records is provided in the practical manuals. Students are required to write down the details of procedures. They have to maintain record for all the cases they perform at SDC and the work Place. In some programmes, logbooks carry a weightage of 10% marks in the final evaluation. This further enhances the regularity of maintenance of logbooks by students.

### Teleconference

In the teleconferencing sessions, subject experts are invited to deal on various subject areas as marked for that session. While dealing with the theory component, principles/concepts dealt in different units are highlighted and the questions arose by the students are replied with the help of examples so that they could link them to practical activities. In the practical component, important clinical examination procedures are dealt with and attempts are made to deal with rare patients and where possible, show them live or get video clips. Discussions are also generated with the help of models or with the video clips of five to ten minutes on certain procedures. Attempts are also made to make model case presentation, case discussion and simulate clinical rounds/ seminars. Most of the presentations follow the format of panel discussion or lecture demonstrations. Attempts are made to link the practical spells with the teleconference dates wherever feasible. This increases the participation of students. Some of the teleconference sessions are also recorded so that students missing important sessions could go through these cassettes.

### Evaluation of Students

Students undergo evaluation both in theory and practical component. In theory, the internal assessment is done through tutor marked assignments having weightage of 25 to 30%. In term-end examination, the weightage is 70%. In practical examination, the internal assessment varies from 30 to 50%. It is essential to pass in the internal component so as to become eligible for term-end examination. The term-end examination includes long case, short case, spots and viva-voce. 50% of the examiners are external examiners. This helps to maintain standard of the examination process. The framing of the examination questions, checking of the answer sheets are done by a panel of examiners of respective specialities. Thus, at all levels of evaluation of a student professional quality is given prime importance.

### Monitoring

To ensure proper implementation of the programme monitoring is done at three levels. Feedback from the peripheral setups (Skill development centres) are collected by the regional consultant who in turn send bi-monthly reports to programme coordinator. Feedback at state level is taken in the Regional Health Sciences

Advisory Committee (RHSAC) meeting held one to twice a year. At the school level, feedback is collected directly from the students and counselors through proforma that are incorporated in the programme guide. Time to time feedback is also collected in structured proforma from the Programme In-charge, Regional consultant, Regional centres. In addition, feedback is also collected in every 4-5 years while revising and updating the programmes. The regional health sciences advisory committee (RHSAC) is formed in every state which has the members from state health departments, Medical college having the PSC, Regional centre of IGNOU and the School of Health Sciences. As all the persons involved in the programme implementation meet together, the hurdles in implementation process are identified and the remedial measures are taken. This committee thus helps to streamline the implementation of practical component at all levels.

The Regional Consultant is usually a retired medical person having a personal rapport at state level. This helps to promote the health programmes in states and win the confidence of professional colleagues as well the state Governments. Health being a state subject the regional consultant's personal efforts makes significant impact on popularizing the programmes. The regional consultant by physical supervision to SDCs in the state ensures proper hands on training at peripheral level.

### NBE Journal

**N**BE has started a journal to enable the sharing of technical materials and experiences of various accredited institutions in the area of post graduate medical education and training. It would be appreciated if you could kindly contribute in the journal in any of the following areas:

- 👉 Scientific articles (Title, name of authors, summary 250-300 words, key words, introduction, methodology, results, discussion, references (Vancouver), tables (one on each page))
- 👉 Letter to the editor (from DNB students and teachers)
- 👉 Review articles related to post-graduate medical education and training
- 👉 Book reviews
- 👉 Guest editorial on issues related to medical education and training
- 👉 NBE institutions review (brief write up on your institutions and how innovative post graduate medical education training is being followed in your institute)
- 👉 Interesting clinical cases (brief with photo etc.)
- 👉 Any other issue related to medical education

Kindly send these in hard copy & also on floppy by mail or through email address: nbefellow@yahoo.com

## NBE Teachers Speak

### Suggestions for DNB Training for Fellowship Students & DNB Students

Dr. Arvind Sangamnekar, Director  
Dwarika Sangamnekar Medical Foundation, Pune

#### Profile and Format of Teaching and Training Programme

The Post-Graduate teaching should be more of learning than the traditional teaching and training. The students has to learn many things from the Patients, Doctors from other Staff, Nurses, etc. to improve the clinical, surgical and diagnostic skills. The students should be motivated for self-learning than only to listening to dry didactic lectures.

#### Combined Pooled Education Programme

In a particular town or nearby, if three or more Accredited Institutions exists, part of the teaching programme should be a combined joint programme of all such Accredited Institutions. This combined pooled education programme will be more useful mainly for Basic Sciences, Communication Skill, and Language improvement, Animal Laboratory etc.

#### Fellowship Students on Teaching Faculty

The Fellowship student has already passed his undergraduate / post-graduate examinations in a particular sociality and has acquired the degree. The Fellowship students should be involved in the teaching programme. He should contribute for the teaching and training of DNB students and other medical and para-medical personnel in the accredited Institutions. This will improve the teaching ability and communication skill of the Fellowship student and he will also be able to assess his own knowledge and expression power.

#### Duration of Fellowship Course

At present, the duration of Fellowship of National Board is for a period of two year. The super-speciality work designated for Fellowship is always restricted and limited. Therefore, at a time only one student should be posted for Fellowship. This will help to get major share of clinical work to the student and the student will be more clinically updated. After the completion of the course of first student, the next student should be posted. The crowd in the fellowship programme will hamper in acquiring clinical skills

#### Documentation

There should be a prescribed and uniform documentation procedure, especially in relation to Log Book, Clinical Notes, Examinations, Thesis etc. This will help the regimentation of the work and will give good clinical exercise to the DNB / Fellowship student.

#### Topics for Thesis

National Board should inform the various topics accepted for thesis to all the Accredited Institutions.

This will avoid the duplication of the topics as well as repetition of the same topics and copying of the thesis. This will give the avenue for the new and challenging subjects for thesis, research and academic work.

#### Monitoring Periodic Performance

There should be prescribed formats of monitoring the periodical performance of the DNB / Fellowship students. This should include attendance, aptitude, motivation in the work, academic performance, surgical skills, self-confidence, personality development etc. This will help for the march of the student towards excellence.

#### Animal Laboratory

Training in the Laboratory is very useful for developing further skills for Fellowship Programme. The students should be asked to work in the Animal Laboratory to get the experience. Animal Laboratories are available only in the few institutions like University, Zoology Deptt., Pharmaceutical Lab and not even in medical colleges.

#### Communication Skills

The students pursuing Post-Graduate Course has to deal with patients of various types and various socio-economic strata, as well as with the fellow Doctors, Health Administrators, Teachers etc. Many of the students lack in communication skills, especially, the communication in English Language. Special efforts should be taken to improve the communication skills and to acquire command over the language. Lack of communication skill, many a times, reflects in oral and practical examinations and also in actual medical practice in future life and therefore, the importance of communication skills.

#### Students and Discipline

The Accredited Institutions should have the power to supervise, assess and monitor the progress in all aspects of DNB / Fellowship students. There should be some power imparted to the Institutions to punish the students, if any in-disciplinary behavior as well as gross negligence in the clinical work is observed. This power should be in the form of canceling the term or asking some extra day to work etc. The details of format of punishment can be decided after dialogue and discussion across the table. Basically, the punishment is not for harassing the student, but for streamlining the student for better performance.

#### Weightage to Research and Other Academic Work

Some weightage should be given to the DNB / Fellowship students who have presented the papers in the conferences, published the papers in the journals and has done some research work. This will enable the DNB / Fellowship students to participate more and more in the clinical, academic and research work and more and more scientific and research work will evolve. The weightage should also be

given to the students who have participated and have shown excellence in extra-curricular activities like sports, cultural events, community health programme etc.

#### Fee Structure

The academic involvement of accredited Institution for DNB candidates are increasing every year. The expenditure on instruments and modern equipments, consultants, infrastructures has also been increasing every year. The NBE has allowed to charge Rs.50,000/- per year as training charges which may not be inadequate. In view of this, the fee structure for the Post-Graduate students of DNB/ Fellowship in Accredited Institutions should be reviewed. The income from the fees collected should be utilized only for the academic development including teaching and training programmes. This will be useful in the long run for the benefit of the students only.

#### National Board of Examinations gold medals

National Board of Examinations offers following gold medal to the meritorious DNB candidates:

- Dr. H S Wasir Gold Medal for Cardiology
- Dr. H L Trivedi Gold Medal for Nephrology
- Dr. S K Sama Gold Medal for Gastroenterology
- Dr. C S Sadasivam Gold Medal for Cardio thoracic Surgery
- Dr H S Bhat Gold Medal for Genito Urinary Surgery
- Dr R.K Gandhi Gold Medal for Paediatric Surgery
- Dr. B.R. Santhanakrishanan Gold Medal for Pediatrics
- Dr Sam G P Moses Gold Medal for General Medicine
- Dr Satyapal Agarwal Gold Medal for Radio Therapy
- Dr. Arcot Gajaraj Gold Medal for Radio-Diagnosis
- Dr. B Ramamurthi Gold Medal for General Surgery
- Dr. K Bhaskar Rao Gold Medal for Obstetrics and Gynaecology
- Dr G Venkataswamy Gold Medal for Ophthalmology
- Dr S. Kameswaran Gold Medal for Otorhinolaryngology
- Dr Balu Sankaran Gold Medal for Orthopaedic Surgery
- Dr. M. Santosham Gold Medal for Respiratory Medicine
- Dr. Sarda Menon Gold Medal for Psychiatry

## NBE Accredited Hospitals

### Maharaja Agrasen Hospital- providing quality services to the masses



Prof. M.S. Gupta  
Chief executive officer  
Maharaja Agrasen Hospital  
Punjabi Bagh, New Delhi

**M**aharaja Agrasen Hospital, Punjabi Bagh, New Delhi is a 336 bedded centrally air-conditioned and fully computerized superspeciality Hospital offering advanced Medical facilities and equipped with latest state-of-the-art Medical Equipments. Maharaja Agrasen Hospital has been so named because Maharaja Agrasen was a noble king of Agroha (Haryana) in whose heart, the welfare of his subject was the super most. In his kingdom, Education and Medical Facilities were free to every body irrespective of caste, religion, race, sex, etc. The hospital had a humble beginning with 65 beds on 15<sup>th</sup> August, 1991, and within a short span of one decade, developed into a renowned tertiary care institution which caters not only to the health care requirements of Delhi, but also to the adjoining states particularly Haryana, Rajasthan, Punjab and Uttar Pradesh. Maharaja Agrasen Hospital, Punjabi Bagh offers DNB courses in the specialities of Family Medicine, Medicine, Surgery Obstetrics and gynecology and Paediatrics

Maharaja Agrasen Hospital is an ISO 9001:2000 certified hospital now. It guarantees hospitals' services in terms of quality. The Hospital is providing high quality Services to the community. It has Casualty Services, Medicine Unit, Blood Bank, Laboratory, Imaging Section, IVF, In Vitro Fertilization (IVF), ICU, OT, Surgery, Labour Room, Nursery Complex, Neonatal Nursery And ICU, Paediatric ICU, Comprehensive Cardiac Care Centre, Dialysis Unit and Library facilities.

The Department of medicine at Maharaja Agrasen Hospital constitutes the largest department of the hospital and it caters to the maximum number of patients both in Outpatient & Indoor department. We plan to start shortly speciality clinics like Diabetes, Thyroid and Obesity, Hematology and Geriatrics. The department has 3 units and each unit consists of two Sr. Consultants and one Jr. Consultants. Jr. Consultants who are atleast 5 year post MD are physically available in the hospital round the clock and all patients admitted through Casualty/OPD get immediate attention of consultant on duty.

The surgery department of the hospital has the specialities of Urology, Plastic Surgery and Reconstructive Surgery, Pediatric Surgery, Cardio Thoracic Vascular Energy and Minimal Access Surgery. The department started Laproscopic surgery in 1995. All the consultants have attained the necessary training and expertise in adopting the Laproscopic training and expertise in adopting the Laproscopic technique to various surgical procedures in the abdomen. The academic activities of the department are reinforced as it imparts training to students, even

from overseas. The team of surgeons forms a well-knit team for the training. The department regularly conducts monthly meetings and conferences. The department has improved by leaps and bounds over the years and Laproscopic surgery has become a gold standard in gall bladder surgery. The OTs of the hospital have full fledged laproscopic sets and Three Chip cameras, Harmonic Scalpel set, Choleoscope set, Pneumatic Tourniquet etc. The hospital has 5 fully equipped operation theatres. The OT has a Siemens 3 D C-Arm, Philips & Meditronics image intensifiers. Latest high tech laproscopic sets, Harmonic dissectors, staplers, Video-endoscopic instruments etc.

The Imaging section has Avanto 1.5 Tesla MRI with 18RF Channels, TIM for Whole body screening, MR Spectroscopy, MR Angiography and CSF flow studies; MD 6CT (MULTISLICE) Scanner with pressure injector, CT Fluoroscopy for CT guided FNAC, CT Angiography, 3DCT; Ultrasound Machine – 3D and 4D Color Doppler of Siemens. Toshiba-Core Vision, Portable Toshiba-



Ma with image intensifier, 500 MA and Mobile Siemens X-Ray Unit; Bone Densitometer, Memmography.

The laboratory is fully equipped and computerized with facility of Histopathology, Cytology, Microbiology, Serology, Haematology and Biochemistry equipped with ELISA Reader (AVL-USA), Blood Gas Analyser (AVL-USA and Modular Eschweiler), Autoanalyser (Hitachi-Japan), Electrolyte analyzer (AVL-USA), fully Automatic Cell Counter (ACT Diff. (Wipro) and HMX – 5 Part Cell Counter – Wipro), Auto Immunoassay (AIA 600 – Japan and Alfa Prime – Lilac), Coagulometer (Stago – France), Microtome (Shandon – UK), Auto Tissue Processor, BACTEC Rapid Blood Culture (B.D.), Bactec Rapid TB Culture (B.D.), Nephelometer (Turbox), Diastat – Hb ATC Machine (Bio – Ead), Hb. Chromatography – Variet Express (Bio-Red), Mini API Automated System, Sperm Quality Analyser SQA II C-P (EMS-Marked by Ranbaxy), Urine Chemistry Analyzers-(a) Urilux (b) Diascreen-50.

The library of the hospital is equipped with all the standard Medical Books and Journals (Indian and Foreign Titles) with latest editions. Library facilities are available for DNB students & consultants for 12 hrs. Library has separate Internet terminal, IGNOU S a t e l l i t e Connection, Journal scanning, Downloading, Photoscanning & Xorex facilities also. Library easy access is available as per DDC schedule.



## Important Events During the Period- April to Sept 06

### CME Programmes in Surgery & Medicine

**C**ME programme for DNB candidates in surgery was held at Safdurjag Hospital New Delhi from 7<sup>th</sup> to 9<sup>th</sup> April 2006 and the CME programme for DNB candidates in the speciality of Medicine was held at Batra Hospital New Delhi on 15<sup>th</sup> -16<sup>th</sup> April 2006.



### Workshop at Guwahati & Shillong

**T**he Board in its continuing endeavour to reach out to the Northeast part of the country organised a one day Workshop on 14th July, 2006 for orientation of DNB teachers and examination and to enhance their skills in various teaching and assessment method. During this one day exercise, various representatives from NBE accredited institutions as well as Govt. Hospitals participated. A one day sensitisation Workshop was also organised on 15th July, 2006 at Shillong. This exercise was aimed at creating awareness about NBE Programmes and various activities undertaken by the board to reach out and create opportunities for Postgraduate Medical Education in the non-formal sector. Both of these programmes were highly acclaimed and applauded by the participants.

## Important Events During the Period- April to Sept 06

### Workshops on research methods for DNB candidates and consultants

NBE has been holding workshops for the National Board of Examinations faculty members/consultants of various Accredited hospitals/ institutions running DNB training programmes. During interactions with them it was felt that many consultants/ faculty members need to be given exposure to research methods, so that they are able to provide better guidance to DNB candidates in their thesis work. In that context National Board of Examinations had conducted a pilot workshop at Maulana Azad Medical College, New Delhi from 20<sup>th</sup> July to 22<sup>nd</sup> July 2006. Based on this feed back more workshops will be conducted for Consultants and for DNB candidates in near future and the material will also be available on the National Board of Examinations website.



### Consultative meeting with the National Board of Examinations institutions offering post doctoral fellowship programmes

Consultative meeting with the National Board of Examinations institutions offering post doctoral fellowship programmes was held on 17<sup>th</sup> August 2006 at India International Centre, New Delhi. Various issues related to the entry, training curriculum and exit examination and other issues related to fellowship programmes was discussed with the experts.



### Expert group meeting for post doctoral fellowship programmes

The Expert group meeting for post doctoral fellowship programmes was held on 18<sup>th</sup> August 2006 at National Board of Examinations Ansari Nagar office, New Delhi. The representatives from various institutions made a presentation on infrastructure and facilities in their hospitals for running various post doctoral fellowship programmes.



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## Important Events During the Period- April to Sept 06

### DNB (Rural Surgery) launched by NBE

The concept of rural surgery has evolved in India over the past decade based on the ground reality of surgical practice of surgeons practicing outside high-tech institutions in our country. The 'limited resources surgery' is fast gaining acceptance as a speciality to meet the needs of five billion out of the total of six billion population across the world. In India, 400 million people have no access to basic surgical care,



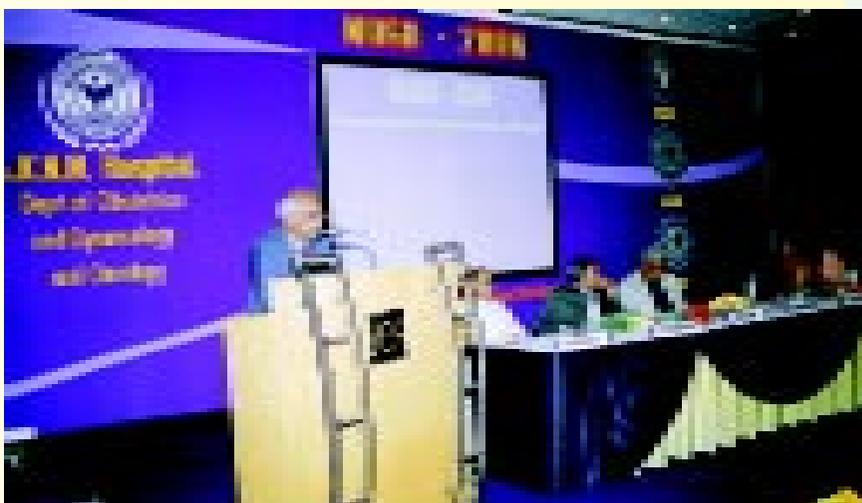
termed by the WHO as 'essential surgical care'. The aim of this course would be to provide basic and emergency and life saving surgical care to rural population of our country. They can form the back bone of health care delivery system and can play a vital role in fulfilling the Rural Health Mission announced by the Government of

India. National Board of Examinations has launched DNB (Rural Surgery) on pilot basis in six centres. Based on the feedback the programme will be launched in a big way.

Dr. Meena Cherian, from WHO Geneva, visited National Board of Examinations on 23rd August 2006 and discussed the feasibility of launching short term courses on emergency and essential surgical care.



### National upgrade on Gynecological oncology, held on 29<sup>th</sup> May 2006 at G. Kuppuswamy Naidu Memorial Hospital, Coimbatore



### Special placement in hospitals for the DNB candidates who fail repeatedly

As a part of the student support services for DNB candidates, the Board has identified certain hospitals in major cities, where candidates can be placed as observer for participation in academic activities. The candidates who wish to utilize these facilities should send their request addressed to the Executive Director, National Board of Examinations.

### Key points in case presentations

For the benefit of the DNB candidates undergoing training in major clinical specialties, the key discussion points for common clinical cases (related to history, clinical examination, investigations and management etc) are available on National Board of Examinations webs site.

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