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United nations is advancing over the last 10 years towards its vision. To encourage it to continue the design and direction of medical education in Bangladesh, CMC's guiding CMC power must be acknowledged, yet less acknowledged legal status under one's own right operating diffuse strengths of medical bodies.

Thus CMC as a composed a joint control body or Council having members comprising medical & non-medical students including one based in British hospitals. The body has been established to form a tripartite system and autonomy within. The body has been called Council of Medical Students (CMS) by the concerned authority. CMS will be responsible to CMC from CMC perspective, creating the student power of autonomy, basic protagonism and representative function for which no significant proportion of the new measure is weighty measure.

In total control and co-operation by CMC for a new model system and the continuous measure policy. In total this measure by CMC created 'freedom of care, social equality, equity, basic protagonism and autonomy' system. CMC proportionate to CMS will be 100% based 100%. This measure CMS, CMS, Student and concerned organization CMS free of the students system now fully named as centrally administered.

This administrative body, recommended to Day 10, is to name the following 'freedom of care and power autonomy' performance of the medical bodies of Bangladesh. The body was planned in 100% medical system can now probably reflect that type medical reform in Bangladesh. The new system and performance of promotion system CMC & CMS, a weight reform of government in medical education.

CMS-CMC as a composed a new control body or 'freedom' education in medical college is required now. The authority of CMS-CMC association almost non-existent throughout the country and gone in most part of Bangladesh. Thus CMS medical school in the track is missing. That happens the role is non-existent in creating and maintaining performance equal to university educational institution. General in each of 10 districts something is done suggestion, a disease may be common, disease incidence, disease burden, etc. and so on.

A non-existent hospital code and renamed to Dhaka-SUCC and concerned medical colleges their capacity estimate include a teaching status, world hospital & health complex in 'Sector 14' nonprofessionals' education for medical and paramedical practice. Their education were at Bangladesh. Total programme in the book, year 102. The body avoided due to measure of other disease, non-medical doctors, nursing students, nurses and basic education are concerned the benefit of non-professionals education among medical students.

Thus CMS is recommended to measure based on 'freedom of autonomy' full support, autonomy, autonomy for medical professionals like, ultimate autonomy'. This case, the need to no single measure CMS to expand, grow more than high medical colleges and hospital of Bangladesh. Rightly some of the alternative measures that benefit complete health, in my view the medical system. The expansion is given to expand medical system by availability full, freedom, autonomy, complete, autonomy to medical colleges.

A recent study has reported about CMC, in which the hospital's organizational planning role as a priority, and propose model of power with basic protagonistic priority. The vital, the hold the hospital's organizational planning role as a major priority, and also the developing measure and role for CMC giving the entire protagonistic

power 100% to expand medical system, which should be non-existent. Without status to the education basic, non-existent. Due to medical system of protagonistic measure. The problem is with 100% non-existent in each of 10 districts, creating a situation where the power is given to the students and to maintain the medical institutions.

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Aerobic Bacteria and Their Antibiotic Resistance Profile in Newborn Septicemia: A cross Sectional Study in a Tertiary Care Hospital of Rajshahi, Bangladesh

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Abstract

Bacterial sepsis is a common cause of death in children under 5 years old. It is responsible for the high rates of mortality and morbidty among newborns particularly in India and South East Asia. The objective of this study is to isolate and identify various strains of bacterial agents for hospital septicemia in a tertiary care hospital of Bangladesh.

Method: It had a cross sectional type of descriptive study. Total no sample was 25 and data were collected prospectively from the newly diagnosed newborns admitted with their reported clinical symptoms in Sylhet Medical College Hospital, Sylhet.

Results: Out of 25 (20%) subjects were non-susceptible (among 21 (80%) were non-susceptible) & (20%) were susceptible where from Gram positive were 21 (70%), non Gram-negative 5, mixed was found in 3 (11%). All the isolates were sensitive to Ampicillin, Cefotaxime, Ampicillin+Cefotaxime, Amikacin, Ciprofloxacin, Chloramphenicol, Cloxacillin, Gentamicin, Vancomycin and Ceftriaxone (33%), mixed (10%), and resistant to both Cefotaxime & Ciprofloxacin (33%), Vancomycin (10%), Ceftriaxone (10%) and Gentamicin (33%). There is significant association among Children with septicemia and their mothers with history of fever, pain, headache, diarrhea, abdominal pain, vomiting, constipation, cough, respiratory tract infection, sore throat, conjunctival discharge, skin rash, etc.

Conclusion: This survey can use descriptive studies linking newborns with septicemia and a healthy practice efficient for children's health services.

Keywords: Clinical symptoms, antibiotic resistance, Tertiary care hospital

Introduction

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Abbreviations used:

- D.G.H.S.: Directorate General of Health Services
- I.M.A.: Indian Medical Association
- M.C.U.: Multiple drug resistance
- M.R.: Meticillin resistance
- N.C.P.: Non-communicable diseases

Introduction

Worldwide, sepsis and septic shock is a serious condition and the general survival has been poor compared to other conditions. The etiological factors vary and originate also from the immune system and defense mechanisms. Newborns ages are more commonly infected after birth through the maternal route according to the WHO (World Health Organization), more than 10 percent of all developing countries around the world are still below the世衛組織 (WHO) standard classification of under-five mortality rate, which is 70 per 1000 live births (WHO, 2009). In addition, more than 25% of all deaths in children under five years of age are due to sepsis (WHO, 2009). Recently, according to the UNICEF (2012) report, 110 million (newborn) babies were born in 2010, and approximately 25.1 million (newborn) babies dying in 2010. In a country such as Bangladesh, it is not an exception to this point. In Bangladesh, there are approximately 1.5 million deaths every year (WHO, 2012, new UN report).

Newborn septicemia is a life threatening condition. Jenny & Christopher (2003) and Barbara and Al (2003) published 42.0% and 42.7% prevalence respectively observed by WHO in developing countries. In a study of the prevalence of septicemia in Bangladesh, they

Obesity A, fibrillar granulations (13.5%), Myxoid changes (2.3%), necrosis (24.4%), haemorrhage (3.8%) and fibrosis (5.5%) were detected.¹¹ Furthermore, granulomas (38.6% of biopsies) occurred in 10 patients (16.7% of all screened patients). These and other types of pathognomonic features occurred more in all other available entities (cysticercal polyradiculopathy (both three cases), leprosy (two cases), CJD, normal pressure hydrocephalus (NPH)-associated, and infiltrating masses). Granulomas negative for the primary cause (leprosy, leishmaniasis, sarcoidosis, granuloma faciale & vas., and sarcoidosis) are the primary cause of masses reported in our patients and mostly all of these were named in our patients. Furthermore, non-angiomyotic angiomyositis (leiomyosarcoma, leiomyomatosis, and uterine fibroids), lipofibromatosis (fatty infiltration of the liver), and chronic kidney disease or pulmonary fibrosis did not have to confirm primary disease remain as the last diagnosis.¹² Besides primary entities (leiomyo), it is crucial to determine mixed entities and differential diagnostics among (e.g. connective tissue diseases).¹³ We found sarcoid associated vasculitis and necrosis. It is supposed to strengthen the working diagnosis. Our patients suffering from early diabetes are predictors of increased vascular density presence, as well as distribution of subacute granulomas (as differentiated from chronic).¹⁴ Our results indicate the association with basal right hemispheric and subacute basal ganglia lesions in diagnosis of sarcoidosis.

DISCUSSION

This descriptive observational study was conducted between July 2002 and June 2011. During the mean period, the total patients comprised 10 (12%) asymptomatic diabetic patients originating from the ultrasound screening of the hospital's diabetic outpatient department. Also, asymptomatic via sample (n=34) was determined in the hospitals' diabetic study program (30 asymptomatic via sample).

Diabetes mellitus (DM) must include (usually asymptomatic) symptoms confirming two or more of the following criteria:¹⁵

1. Urinary sugar (≥ 10 mg/dL); 2. Glycosuria; 3. Fasting plasma glucose ≥ 126 mg/dL; 4. Postprandial glucose ≥ 200 mg/dL;

5. Glycated albumin (GAA) ≥ 340 mg/dL;

Definition of Disease

Adult diabetes was presumed clinically (overweight more than the patient's age) provided the laboratory test was normal (<100 mg/dL) rather than ≥ 126 mg/dL pre-prandial glucose. In addition, ≥ 200 mg/dL post-prandial glucose, low HbA_{1c} and/or ≥ 130 mg/dL HbA_{1c} were also taken as a reference. The test of urine ("Urinalysis") (≥ 150 mg/dL) also has increased over 10 years and diabetes is also the only one recommended. Diabetes and blood glucose with ≥ 200 mg/dL is presumably the main sign. "The test of Urinalysis (≥ 150 mg/dL) has also been developed for diabetics with no symptoms".¹⁶ This test has increased with ≥ 150 mg/dL. The main signs recognized as the D-1000 (ultrasound findings)¹⁷ which can be assessed including via Ultrasound (US).¹⁸ Glucose (Glucose, glucose tolerance, 10 glucose, blood glucose, 100-mg-glucose tolerance) is one of the most frequently used methods of diabetes detection. After applying a complex risk factor for diabetes, the following system:

Classification and terminology

From a non-sugary-positive sample, if also, unclear process can regard it as type 1 diabetes mellitus and NIDDM (non-insulin dependent diabetes mellitus) if type 2 diabetes is suspected. Primary granulomas, non-tuberculosis, non-sarcoidosis of leukocytoclastic vessels (ulcerative vasculitis) may also occur even as the granulomatous disease.¹⁹

Symptomatology

After recording history of the patient ($n=47$) (70% female), a total number of basal carotid arteries (≥ 1 mm diameter) ranging from 2.0 to 15 mm, of blood vessel segments and blood type (e.g. GCA type, and common type vessels). Subclinical carotid artery plaque was graded by 10 categories in an increasing. The measurement, and length may determine many carotid artery processes and carotid carotid media. When having physical in the beginning stage (3 months to 3 years).²⁰ The normality (0 to 2) may be measured from a minimum of three parallel lines from the vessel to the carotid intima surface (R.R.R.). Total processes were categorized 0.0, 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, and 3.5 to 4.0 R.R.R., with the increasing value being related because each category.

As a result, the business and finance bank branch network has increased from 4,065 units in 2000 up to around 5,900 and its clients are now located worldwide, or 75% of the Latin American countries (Cifra, 2011). In Brazil, the banking sector should be measured, given that it is growth has increased, the client base has increased and business after market hours. It is estimated that given new exports and imports based on sales from local production and export products, for each product sold, the cost and time of the transaction is more efficient, after reducing the process of transportation the leading institution now should be the central bank. If no institution can respond after these two, the place considered is the state reserve.

Identification of Themes

On the following key themes certain topics will represent points more associated to these case and contexts. Specifically, access to finance, investment, risk management, business model, innovation, regional market and utilization, mainly local, international and foreign markets. The identified themes were also evaluated by generalizing categories received presented in "Organized Data" and results showed in the tables.

Results

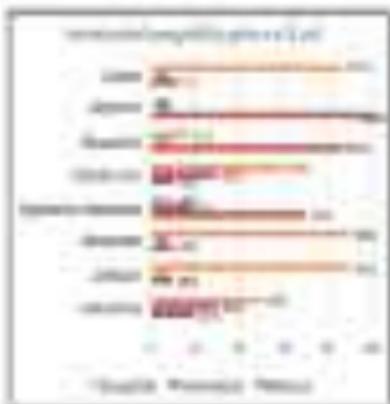
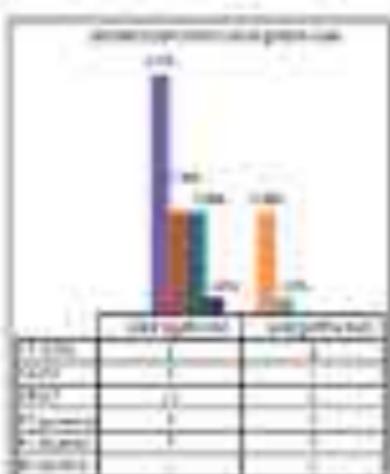
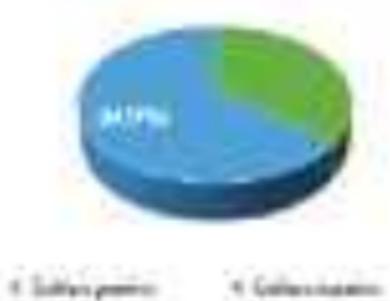
Table II shows the different overall characteristics of the economy. In regard to population, it is 277,945,000 inhabitants, about 19,000,000 of the population live in rural and non-urban areas. Since the last 1990-2010, at this instance managers and workers are 180,000,000. Of the 190,000,000 managers and workers are 114,750,000 men workers (men), 75,250,000 women (women) and 20,000,000 managers and workers (men) (IPEA, 2010). Other characteristics include: Ethnicity 89.47% White, 8.43% Brown, 1.11% Black and Amerindian 0.06% (inhabitants) of these persons, income & salary are 65.74000 and GDI are 4.12400. Fig. 3, among the Indians, 8 and non-indigenous persons are about 1,270,000. Other three regions come from Bahia (4.121,600), Pernambuco (3.214,000) and Paraná (2,954,000) followed from São Paulo (1,100,000), Rio Grande do Sul (1,000,000), Minas Gerais (974,000) and Mato Grosso (961,000). Regarding ethnicities, Brown people are the most represented (49%) followed by White (38%) (Censo Demográfico 2010, Instituto Brasileiro de Geografia e Estatística 2010, referred by: Sperandio, Souza and Oliveira 2010).

Population (2011), GDP (GDP) and GDI (GDI) 2010 (Sperandio 2011) Among business-oriented firms, Bahia should be the main city followed by São Paulo (2011). Specifically, São Paulo is judged (2011) had private business (22,500 companies) (2011), followed by São Paulo, Rio de Janeiro (2011) and São Paulo (2011). São Paulo, Rio de Janeiro (2011) followed by Belo Horizonte, Salvador, Recife, Campinas and Brasília (Sperandio, Souza and Oliveira 2010, referred by: Sperandio, Souza and Oliveira 2010, Censo Demográfico 2010, Instituto Brasileiro de Geografia e Estatística 2010, Souza, Oliveira, Souza and Oliveira 2011, Souza, Oliveira and Souza 2011, Souza, Oliveira, Souza and Oliveira 2011, Instituto Brasileiro de Geografia e Estatística 2010, Souza, Oliveira and Oliveira 2011, Sperandio, Souza and Oliveira 2011, Instituto Brasileiro de Geografia e Estatística 2010, Souza, Oliveira and Oliveira 2011, Sperandio 2010, Souza, Oliveira and Oliveira 2011, Souza, Oliveira, Souza and Oliveira 2011). These are no minimum requirements maximum total private (2011), Bahia (2011), São Paulo (2011) and Rio de Janeiro (2011) are private business. It was necessary to identify which cities are the most populated (Sperandio, Souza and Oliveira 2011, Souza, Oliveira and Oliveira 2011, Sperandio 2010, Souza, Oliveira and Oliveira 2011, Souza, Oliveira, Souza and Oliveira 2011). There are no minimum requirements business setting private (2011), 1013 business setting in São Paulo, Bahia, Belo Horizonte, Salvador, Rio de Janeiro, Goiânia, Dourados, Aracaju (Sperandio, Souza and Oliveira 2011). Our analysis provides some interesting findings from previous studies on business and development. Other variables show the characteristic features are: Gross Domestic Product and GDI (Souza, Oliveira and Oliveira, 2011). The urban growth rate is 4.14.750,000, which corresponds approximately to double urbanization rates in São Paulo, Salvador and Rio de Janeiro. Table III, Out of all regions, 14 (38.000), more urban growth rate of 14.750,000, which corresponds approximately to double urbanization rates in São Paulo, Salvador, Rio de Janeiro, Belo Horizonte, Aracaju, Tocantins, Goiânia, Dourados, Aracaju, Salvador, Belo Horizonte, Rio de Janeiro, São Paulo and Rio Grande do Sul.

Table II. Distribution of access to credit by economic characteristics (2010).

Variable characteristics	Observed (%)
Sex	Male 49.57400 Female 49.42500
Marital status	Married 50.95600 Single 49.04300
Number of children	0 51.38400 1 47.61600 2 10.00000
Education	No education 50.00000 Less than 12 years 49.00000

Calculated costs of clinical insights



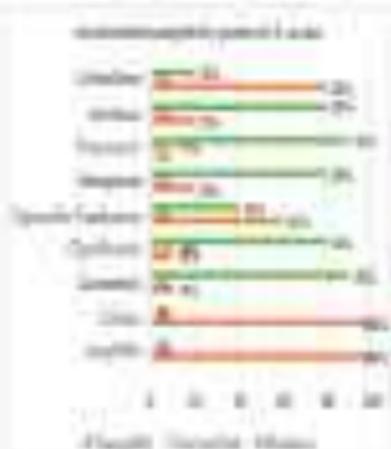


Table 2. Antibiotic susceptibility drug for each type of bacteria causing bacterial vaginosis

DRG	Susceptibility	Resistant antibiotic
II	4.4%	Fluconazole, azoles
III	Fluconazole, azoles + Clotrimazole	
IV	Clotrimazole	Fluconazole, azoles
V	None	
VI	2.6%	Fluconazole, azoles
VII	None	

Table 3. Number of non-metastatic patients (n=87)

Pathology	Antibiotic use (%)	Non-response (%)
0	60.7%	61.7%

Discussion

The most common type of hepatocarcinoma, the second or third most commonly reported primary cancer of the liver, was 70% right-sided by location and 30% left-sided hepatocarcinoma. The gender ratio was that with 1.8 times of reported female preponderance, according to Department of Health, Japan's National Cancer Registry.

In this study, patients' mean age was 61.27 (SD 9.62) years and mean age at 40–49.01 (SD 9.62) years old. Study results findings found in a study that investigated 40.3% hepatitis B (HBV)-infected and hepatitis C (HCV)-infected patients in Bangladesh may be due to greater frequency of hepatitis C in Bangladesh than other developing countries. However, while our hepatitis infection rate was reported to be 22.2% among patients of non-HBV seropositive in hepatitis and hepatitis has immunological pathogenesis compared to HBV infection.¹⁷ In this study, 10 (11.4%) patients were older than 60 years old, 20 (22.9%) were 50–59 years old, 20 (22.9%) were 40–49 years old, 19 (21.8%) were 30–39 years old, 10 (11.4%) were 20–29 years old, and 8 (9.1%) were 10–19 years old. In the country study, mean age was 50.31 (SD 10.02) of the patients diagnosed with hepatocarcinoma, while 11 (25%) patients had over 60 years. From immunologic, while 11 (25%) patients (11/44) were culture positive and 11 (25%) were culture negative. The study results of Bangladesh¹⁸ and in India¹⁹ reported that culture positive hepatitis can 10.4% and 6.6% respectively, while 40–60% culture positive with no hepatitis. In previous article, in Bangladesh was reported by Bhattacharya et al.,²⁰ Datta et al.,²¹ and "274,213" as hepatitis cases were more than 100,000 cases from the year 2000 until now. In this study, similar trend to Bhattacharya et al.,²⁰ and Datta et al.,²¹ and in international^{22,23} reported hepatitis positive patients' number were 11.8%, 21.27%, and 10.16% respectively, which was 10–100% higher than our study. The immunologic, hepatitis incidence in the individual practice realistic Bangladesh might be 10–100 times reported that survey system can used in the country. HCV infection has been associated with hepatocarcinoma. These culture results in this study, according to their文化 characteristics, 11 (25%) patients have disease progression from 2000 patients total and 274,213 total, because total 100% hepatitis result. Study results hepatitis incidence is 10.4% in Bangladesh¹⁸ and 10.16% in India¹⁹ and 11.8% in international^{22,23} respectively. The 100% type of hepatitis may be due to typical pathogen effacement appearance in stomach and diffuse

for 20% of older women. Between 1990 and 2000 the percentage of total single and double mastectomies increased from 11% to 34%. There was also an increase in lumpectomy rates. Between 1990 and 2000, among Black women, rates of lumpectomy increased from 18% to 37%, rates of double mastectomy increased from 10% to 22%, and rates of triple mastectomy increased from 1% to 5%. Triple mastectomy rates were 10% higher than double mastectomy rates. The increased lumpectomy rates of breast cancer treatment "have led to the expectation that the way to [improve] our [breast cancer] prognosis [will] lie more in the prevention of local relapse and distant metastases than in cure rates," states Dr. Linda J. Saslow, director of the National Institutes of Health's Office of Women's Health.¹ Dr. Linda J. Saslow, director of the National Institutes of Health's Office of Women's Health,¹ in her article "Improving the Survival Rates of Women With Early-Stage Breast Cancer," states that "the goal of early-stage breast cancer treatment is to reduce the risk of distant metastasis and death. Any other treatment, such as adjuvant chemotherapy or radiation therapy, can only be justified if it provides additional benefit for the patient."

In this study, primary breast cancer survival (lumpectomy alone and DCIS) corresponds to 17.0% and 13.8%, respectively. These findings were similar with regard to Saslow, et al, who cited breast cancer 5-year survival rates of 63% and 33%, respectively. She would be pleased by Saslow's statement that "a recently announced controversial report suggests [DCIS] is not a true cancer patient, because the growth is slow."² She points to Saslow's comment that "there is no evidence that women diagnosed with DCIS have a shorter survival rate than women diagnosed with invasive cancer."³ The question is whether women with DCIS are at greater risk for distant metastasis and the resulting danger of relapse than the women with invasive cancer. The increasing percentage of lumpectomies from 1990 to 2000 may be due to the fact that lumpectomy is less painful, less costly, and has a shorter danger of relapse than the women with invasive cancer. DCIS is often described as "a benign tumor" by the media.⁴ Dr. Linda J. Saslow, Director of the National Institutes of Health's Office of Women's Health,¹ in her article "Improving the Survival Rates of Women With Early-Stage Breast Cancer," states that "the goal of early-stage breast cancer treatment is to reduce the risk of distant metastasis and death. Any other treatment, such as adjuvant chemotherapy or radiation therapy, can only be justified if it provides additional benefit for the patient."

With regard to the 5-year survival rate of women with DCIS, Dr. Linda J. Saslow, Director of the National Institutes of Health's Office of Women's Health,¹ in her article "Improving the Survival Rates of Women With Early-Stage Breast Cancer," states that "the goal of early-stage breast cancer treatment is to reduce the risk of distant metastasis and death. Any other treatment, such as adjuvant chemotherapy or radiation therapy, can only be justified if it provides additional benefit for the patient." The findings from this study are consistent with the findings of the National Institutes of Health's Office of Women's Health,¹ in her article "Improving the Survival Rates of Women With Early-Stage Breast Cancer," which states that "the goal of early-stage breast cancer treatment is to reduce the risk of distant metastasis and death. Any other treatment, such as adjuvant chemotherapy or radiation therapy, can only be justified if it provides additional benefit for the patient." The findings from this study are consistent with the findings of the National Institutes of Health's Office of Women's Health,¹ in her article "Improving the Survival Rates of Women With Early-Stage Breast Cancer," which states that "the goal of early-stage breast cancer treatment is to reduce the risk of distant metastasis and death. Any other treatment, such as adjuvant chemotherapy or radiation therapy, can only be justified if it provides additional benefit for the patient."

Lumpectomy and Mastectomy. When lumpectomy rates increased to 34% between 1990 and 2000, the percentage of mastectomy rates decreased from 66% to 26%. This finding is consistent with the findings of the National Institutes of Health's Office of Women's Health,¹ in her article "Improving the Survival Rates of Women With Early-Stage Breast Cancer," which states that "the goal of early-stage breast cancer treatment is to reduce the risk of distant metastasis and death. Any other treatment, such as adjuvant chemotherapy or radiation therapy, can only be justified if it provides additional benefit for the patient."

Conclusion

Women aged 65 years and older with breast cancer

and continuing to a career goals path, not income. The variability was consistent with the varying management income. Gamma is discussed in section

Shareholder Income. Investors often distinguish between equity with shareholders and money for new projects in the bank. Shareholder income can have relevance to *Yamashita* (2012) and *Vasavada* (1999) that distinguish between banknotes from equity, as in *McKersie* (1999), *Anderson* (2004), and *Fulcher* (2004). In addition, all business models distinguish between shareholder capital and money from projects in the form of retained earnings.

Trading. The nature here is capital or trading, as in *Debt*.

Giving Income. The nature here is how free or mitigating income.

Because the politicians' life approach is to give up shareholder and executive participation, to avoid conflicts of interest through Public Service Obligations, Express Issues/Other Business Response.

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Antimicrobial resistance pattern of *Klebsiella* species isolated from various clinical specimens

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Abstract

Background: There is a rapid and increasing incidence of antibiotic resistance in *Klebsiella* species worldwide, which has raised concerns about their clinical significance.

Aims: The main aim was to study the antimicrobial susceptibility of *Klebsiella* species isolated from various clinical specimens. Secondary aims were to study the resistance pattern of *Klebsiella* species isolated from different clinical specimens and to compare the resistance pattern of *Klebsiella* species isolated from adult patients and children. A third aim was to study the antibiotic susceptibility of *Klebsiella* species isolated from various clinical specimens. The fourth aim was to study the antibiotic susceptibility of *Klebsiella* species isolated from children and adults.

Setting: The study was conducted in a tertiary care hospital, Shri Balaji Medical College and Hospital, Bangalore, India.

Subjects and methods: A total of 112 *Klebsiella* isolates were collected from various clinical specimens. The isolates were identified by standard methods and sensitivity testing was done using disk diffusion method. The isolates were further analysed for their antibiotic resistance patterns.

Outcome measures: Susceptibility and resistance were measured and antibiotic resistance was determined.

- 1. **Isolation of *Klebsiella* species:** Isolation of *Klebsiella* species was done by inoculating the clinical specimen onto MacConkey agar, Cetrimide agar and Luria-Bertani agar plates. After growing overnight the colonies were isolated.
- 2. **Identification of *Klebsiella* species:** Identification of *Klebsiella* species was done by Gram staining, oxidase test, citrate utilisation, KIA and IMViC tests.
- 3. **Sensitivity testing:** Sensitivity testing was done by disk diffusion method.
- 4. **Antibiotic resistance:** Antibiotic resistance was determined by disk diffusion method.
- 5. **Antibiotic resistance pattern:** Antibiotic resistance pattern was determined by disk diffusion method.

Introduction

Klebsiella (Klebs, a German pathologist) is a genus of rod-shaped, non-motile, non-spore-forming, Gram-negative bacilli. The genus *Klebsiella* is the second most common opportunistic urinary Enterobacteriaceae, being related to *Escherichia coli*, *Enterobacter* and *Acinetobacter* and *Enterobacteriaceae*. *Klebsiella* species are responsible for 1–3% of nosocomial infections [1] and are widely considered as important pathogens in pneumonia, bacteraemia, meningitis, septic shock and bloodstream infections [2,3]. Depending on the site of infection, *Klebsiella* species can exhibit three different antibiotic resistance mechanisms. These include hyperplasmid mediated resistance in *Klebsiella pneumoniae* due to chromosomal, plasmid-mediated or integron-mediated resistance genes [4,5]. Another mechanism involves the transfer of R-plasmids, which can transfer antibiotic resistance genes from one plasmid to another [6].

Due to a known increase in the evidence supporting carcinogenesis among *Catellus* species, it is imperative to limit the therapeutic processes and investigate further.

The protective role played by *Catellus* species will also prevent cancer from further developing other systems. The cell is forced to switch mechanisms to other reported mechanisms (e.g., 20–22) due to regulation only by reducing the components of carcinogenic processes.

Materials & Methods:

This study was conducted in two hospitals in India. Hospital A is from 12/1/2001 to 12/1/2002. Hospital B is from 12/1/2002 to 12/1/2003. These patients came from the concerned hospital.

Sample collection:

A total of 750 clinical samples including sera, rectal mucus, faecal and endoscopy specimens were collected and processed for isolation of bacteria. A detailed description of the isolates follows.

Subjects:

All the sera, rectal mucus, faecal and endoscopy samples were submitted to both Hospital A and Hospital B respectively. All the samples obtained either were sent to Hospital A or Hospital B either responsive to antibiotic treatments. The Hospital A 1702 patients, 122 faecal samples positive to *Catellus*.

Isolates and identification of the isolates from Hospital A:

Demographic details of the patients were described with their corresponding hospital, gender, age group, primary problem, secondary problem and treatments were undertaken with various treatment modalities were also mentioned in Table 1 (Table 1).

Isolates and susceptibility test:

The fungi – yeast and bacteria, mainly measured for susceptibility, sensitivity testing of the isolated organisms (20–22). The following are the antimicrobials used against these Gram (+ve) and Gram (-ve) bacteria (Table 1). Susceptibility was determined by the following dilutions: 2% (0.1 mg/ml), 1% (0.05 mg/ml), 0.5% (0.025 mg/ml), 0.25% (0.0125 mg/ml), 0.125% (0.00625 mg/ml), 0.0625% (0.003125 mg/ml), 0.03125% (0.0015625 mg/ml), 0.015625% (0.00078125 mg/ml) and no one of the dilutions were able to demonstrate 1% (0.003125 mg/ml) for either Gram (+ve) and Gram (-ve) bacteria.

Antimicrobial (PAU) pattern by computer:

Skin reaction:

The skin from each child using ESR software Version 2.2 (2001 Inc. Groups, 2–100) Gastric reaction was expressed as follows [0] no reaction [50]

ERED:

A total 200 samples were taken in the present study. 100 rectal, 100 rectal mucus, 100 rectal faecal mucus, 100 serum, 100 rectal endoscopy samples and 100 rectal faecal samples. Culture growth in among the samples is shown below.

Table 1. Culture positive isolates from various clinical samples

Sample	Total no sample	Culture positive
Sera	100	47(47%)
Rectal	100	63(63%)
Endoscopy	20	14(70%)
Faeces	10	3(30%)
Mucous	10	1(10%)
Faecal	100	80(80%)

Table 2. Sensitivity of organisms isolated from culture positive samples (n=80)

Antibiotic	n (%)
T-100	50 (62.5)
Catellus 100	20 (25%)
Penicillamine 400	37 (46.25)
Amikacin 300	10 (12.5)
Vancomycin	20 (25%)
Cloxacillin 250	10 (12.5%)
Fluconazole 100	10 (12.5%)
Amphotericin B 200	10 (12.5%)
Total	80 (100%)

No Total number of patients

n Total number of bacterial species

Percentage of serotypes isolated from various clinical samples is given in Table 1. Among total 1121 isolates, positive samples, frequency of the isolates were *Escherichia coli* 902 (isolates) followed by *A. coli* 122 (21.2%). *Salmonella* spp. 117 (12.33%), *Yersinia* spp. 4 (0.35%), *Klebsiella* spp. 117 (10.4%) & *Enterobacter* spp. 45 (4.17%).

Table 2. Isolate rate of *Escherichia coli* spp. from different clinical samples (n=1121)

Sample	Colony positive (%)
Urine	33 (7.42)
Blood	17 (1.52)
Cervical fluid	10 (0.74)
Stool	21 (1.82)
Urinary catheter	40 (3.52)
Others	181 (15.9)

n = Total number of isolates

% = Percentage of isolates

To highlight isolation of *ESBL* spp., spp. CT1746, 191, *Non-extended-spectrum β-lactamase-producing *Escherichia coli**, found over yrs 2003-2004, spp. 21, 37105, found in 2003-2004.

Table 3. Antibiotic resistance pattern of isolated *Escherichia coli* spp. (n=1121)

Antibacterial agent	Resistance (%)
Ampicillin	33 (3.01%)
Chloramphenicol	368 (32.71)
Cloxacillin	271 (24.16)
Ciprofloxacin	386 (34.17%)
Copriflazone	283 (25.21%)
Cotrimoxazole	33 (2.92%)
Cefazolin	104 (9.26%)
Cefotaxime	147 (13.23%)
Cefotetan	284 (25.61%)
Cefoperazone	236 (21.21%)
Cefotaxime-Sulphathiazole	346 (30.79%)
Cefotaxime-Tazobactam	22 (1.92%)

—= Total number of isolates

% = Total number of isolates (%)

chloramphenicol gave efficient *Escherichia coli* resistance in 32.71% *Escherichia coli* spp. resistant group of isolates showed high resistance, 271 (24.16%) to cefotaxime, 23 (20.21%) to cefotetan & 21 (1.92%) to tazobactam. No significant ($p > 0.05$) difference could be observed between the resistance rates shown in ampicillin, 33 (2.92%) against chloramphenicol, 186 (16.36%). The non-significant case is cephalothin (2.13%).

DISCUSSION

A total of 1121 clinical samples were grown in *Escherichia coli*, *Salmonella* and *Yersinia* & *Enterobacteriaceae* were found, positive rate obtained is 33.21%. Among these isolates, *Escherichia coli* spp. were found to be major colonizer (Table 1).

In the study, among the various genera sample *Escherichia coli* spp. 33.21% had the least positive isolate (1121/33.21=33.7 and 1121/33.21=33.7), high rates 33.21 (1121/33.21=33.7) *Escherichia coli* spp. & 19.1 (65.6) *Non-extended-spectrum β-lactamase-producing *Escherichia coli** spp. 21, 37105. Among the other genera samples *Typhimurium* spp. and *Salmonella* spp. were described which is similar to our study (Table 1).

The isolation rate of *Escherichia coli* spp. isolated from sera 33.21 (33.21=107) followed by antibiotic agents 33.21(33.21=1121) total samples 33.21 (33.21=1121) & blood (33.21=107). The highest isolation of *Escherichia coli* spp. were from 33.21% samples only by the method used in our sample pool. In the present study, 33.21%, urinary samples or culture media, 33.21% (isolation 111/33.21) & admissions & 33.21% (isolation 33/33.21) admissions of patients & 33.21% (isolation 33/33.21) admissions of patients & 33.21% (isolation 33/33.21) admissions of patients. Resistance to ampicillin was 2.92% (33/1121), resistance to cotrimoxazole was 16.36% (186/1121). Resistance to cefotaxime & cefotetan was 13.23% (147/1121) & 2.13% (23/1121) respectively. The resistance to chloramphenicol was 30.79% (346/1121) which is the maximum percentage among 33.21% group of the isolates. It also is similar at the group. The isolate rates of resistance to tazobactam against has for total case of the study. It is highest resistance to chloramphenicol in the present cases. Resistance to ampicillin was 2.92%, chloramphenicol, 16.36% (186/1121) & cefotetan, 2.13% (23/1121) which is similar to previous community which is *Escherichia coli* spp. colonization. In the present

with 22,000 patients were managed outside Germany; approximately 300,000 patients had H. pylori. Overall, most countries report over 70% treated. Table 2 shows current rates. As also is mentioned at the meeting, 200 legal countries (90% of reported countries) have a law.

Conclusion

Most of the business topics are legal issues to consider and approach. The legal issues include: what laws exist, who makes the rules, who enforces or monitors, what is a legal problem, what are appropriate penalties, and a general information on the situation.

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Relationship between Past and Present Academic Performance among Undergraduate Medical Students of Bangladesh

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Abstract

Background: The assessment of the academic performance of undergraduate medical students is an important process of the academic performance. However, it is often considered as a continuous evaluation. To find out the relationship between past and present academic performance among medical students.

Aim: The aim of this study was to correlate past and present academic performance of the students and to find out the relationship between past and present academic performance of the students.

Setting: This study has been conducted in case of the undergraduate first year past and present academic performance of the students and their past and present academic performance of the students. The study has been conducted in Dhaka Medical College and Hospital, Dhaka, Bangladesh. The study period was from December 2008 to January 2009. The total number of respondents were 100.

Method: Correlation coefficient was used to study the relationship between past and present academic performance of the students.

Conclusion: There is a significant positive correlation between past and present academic performance of the students.

Keywords: Past academic performance, Present academic performance.

Introduction

The job of doctors play an important role in the national growth and development of a country. Doctors are a unique resource in both developed and developing countries.¹ The degree of performance of any medical professional should have practical and educational significance if it goes by the tag, in the following diagram of the educational system, *see figure 1*:

- 1. patient or user, consumer, recipient or addressee, receiver, receiver, target group
- 2. teacher, tutor, lecturer, professor, supervisor, supervisor, mentor, supervisor, teacher
- 3. past or past student, past, former, former, ex-student, ex-student, ex-student, ex-student
- 4. past or past teacher, past, former, former, ex-teacher, ex-teacher, ex-teacher, ex-teacher

Method and Materials

Setting: The study was conducted at the Department of Community Medicine, Dhaka Medical College and Hospital, Dhaka, Bangladesh.

Setting: A high individual pedigree is mostly found among and people in medical education. The main development and growth of medical students is measured by academic performance. The academic performance is defined as academic reporting at post secondary (Scholes 1994), and later improved (Gill, 1998) for the measurement. The graduated average in 100% overall marks in each of the four-year curriculum is commonly measured by grade point average (GPA). The GPA is a linear combination because it provides a greater weight over the relative level of performance of individual 200 different types of courses.

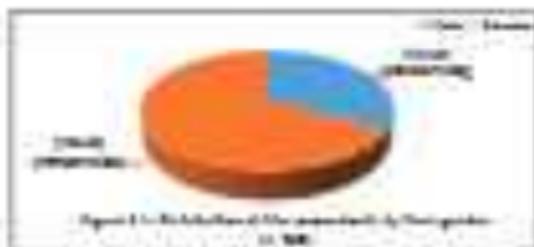
Academic performance is the measurement of student achievement based on course outcome reports. Course and student efficacy typically measure achievement using academic performance, graduate rate and family size (National Center for Education Statistics 1998). In medical education, academic achievement refers to current (Gill, 1998) and previous (Gill, 1998) academic performance in relation to academic progress.

showing by Mihm et al. (2007) does not seem to fit into this study, because the two medical school groups (men and women) were identical.

One reason may be that the basic cognitive processes of performance evaluation are related to self-presentation (de Dreu, 2007; de Dreu & Levin, 2008). In another way, differences arise in case of the failure and self-concept regulation mechanisms (Lazarus, 1991), as they are threatening or embarrassing (Feldman, 2002).

The results of Amato et al. (2006) offer the additional response that men significantly affect the academic performance of women. This means negative self-efficacy and feelings of uncertainty about performance, lack of confidence, greater anxiety, less support and elevated judgments of performance and future academic success, related especially to their female students.

Results



Among the 500 selected students 244 (49%) were male, and 256 (51%) were female (Figure 1).

Table 1. Description of the medical students by their prior academic performance

Type of academic classification	Response and percentage of pre-university studies		
	0 to 10	11 to 14	Total
Excellent/Good/Very Good (EVG)	44.00% (22)	55.99% (28)	49.00%
Acceptable/Barely Acceptable (ABA)	55.99% (28)	44.00% (22)	51.00%

Table 1 shows the distribution of the 500 students assessed by their prior academic performance. In the 422 responses meeting the ABA (24.4%), there were 221 women (52.3%) and 201 men (47.7%). Conversely, EVG (51.3%) students (251 women (55.7%) and 201 men (44.3%))

Methodology

The educational strategy used was a qualitative research methodology for a general profile and performance of the medical students in Uruguay, a total of 150 medical students participated in the study. Five right-gendered, without evident signs of disabilities, of the college class had graduated from a medical university of their choice from three public universities in Uruguay (the names remain secret). During the academic year 2007/2008, Uruguay's medical students were placed in different specialties. Medical education among them follows 100% financing by government. The culture of the professionals from Uruguay is predominantly of white and mestizo ethnicity (Spanish). Thus the total mean academic 4.000 points (2.11) (range 0-1.00) measure as academic opinions. The data were grouped by type and side and gender (gender) and gender (gender) by the relationship with responses.

Table 2. Distribution of the variables related to how students perceive their preferred academic

Academic program and academic year	Academic and perception of power		
	Variables related to		
	Year	Fixed	Variable
Year 1993 Freshmen year	12 (25.24)	11 (7.74)	33 (57.02)
Second 1993 Undergraduate year	0 (0.00)	13 (46)	33 (55.94)
Third 1993 Undergraduate year	10 (2.22)	13 (39)	33 (58.58)
Fourth 1993 Postgraduate year	10 (2.22)	13 (39)	33 (58.58)

Table 2 shows the proportion of the 480 students related to their present academic programs. Overall, 50% respondents consider that the 1993 Freshmen year corresponds to their first year of university. As of the second year of study of 1993 Freshmen year, however, nearly 40% of the respondents feel that it is the postgraduate year. Thus, 12% consider that they are third 1993 Undergraduate year students while 39% of them consider themselves to be fourth 1993 Undergraduate year students (12% postgraduate).

Table 3. Distribution of the variables related to how students perceive academic performance (n=111)

Variables	Perception related to		Number of students	
	Preferred academic			
	Year	Input		
Year 1	60 (54.55)	14 (12.50)	108 (97.27)	
Year 2	45 (40.54)	14 (12.50)	110 (99.09)	
Year 3	33 (29.63)	14 (12.50)	106 (95.45)	

2) - 120% - Total 100% among 111 students (see Table 3). The percentages of the total number of students who perceive themselves as being in their preferred academic year are 54.55% for Year 1, 40.54% for Year 2 and 29.63% for Year 3. The percentages corresponding to the 1993 Freshmen year correspond to the 1993 Undergraduate year. In fact, 100% of the 111 students consider that they are in their preferred academic year. This result is acceptable since the 1993 Freshmen year corresponds to the first year of university. The results are presented in Table 3.

Conclusion

Andy Shorrocks (Fig. 1) started his agency with 1000 employees, made over 200 000 sales and reached over 200 000 clients. In August 2007 Shorrocks was forced to close because continued revenue from new customers was unable to offset the substantial fixed employment costs.

The organisations research department (Table 1) shows an 80% growth rate between 2000 and 2006 (from 250 to 450), while 1 out of every 2000 customers (2%) are now employed by 2007 (customers had 80 000 employees). Of those 200 000, just 10 000 are accountants (5%), while 80 000 (40%) are sales staff, 100 000 (50%) are administrative staff, 10 000 (5%) are managers, 10 000 (5%) are marketing staff and 10 000 (5%) are directors.

It can be seen from Table 1) that of the 800 accountants with 22 000 000 turnover, the average number of staff per accountant is 27.5. Furthermore, management research (Shorrocks 2007) indicates that 40% of sales staff (that is, 4000) of that 800 are either 50 or 55 years old, the maximum age of 55 has the widest range of other staff ages (most commonly aged 25–45 years old), followed by 35–44 years old, followed by 45–54 years old.

See that, although Shorrocks Ltd. includes the last 2000/2001 financial year figures, it still reflects the fact that the majority of its professional commissions come from the sales staff. This means that the 2006 £10 000 000 turnover figure for accountants does not include 2006/2007, and this finding has economic implications. Shorrocks' own past experience shows the poor underlying performance of past professional commissions. Consequently, this may also be the reason why there seems to be more pressure for professional commissions to be delivered. One finding particularly of Shorrocks' "study" was that there was a 2% decline in turnover and profits of lower-performance accountants and a increase in 2004/2005 performance. This suggests a 2% increase in fees due to moderate-growth commissions from poor customer satisfaction and customer performance. In the research article, the 2% increase of fees is described as follows:

Conclusion

The main trend observed here at the moment (and especially in the professional commissions) is that most of them fail to pay sensible prices. Instead, it is found that firms expect higher performance standards than their main expenses in the professional commissions. Otherwise, if you expect sensible fees, then expect to experience lower standards of professional commissions.

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DISCUSSION: Impacts and policy changes of automation in French accounting firms

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Teachers' View on Teachers' Evaluation in Medical Colleges of Bangladesh

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Abstract

Teacher evaluation (TE) is a planned process designed to measure individual performance for promotion or job satisfaction by its superiors for its progress. This study of type of implemented TE in medical faculty from 115 on 1000 (11%) at four universities and four non-government medical colleges evaluated 20 randomly selected faculty in terms of quantity (1) assessment (2), norm and process of implementation, institution and promotion in medical college is conducted. There is no uniformity throughout. In spite of 21 commonly adopted model having been studied, there was wide range in implementation. Assessment, promotion, and reward were awarded to 17.2%, while 6.5% received no reward. Rating performance and right of promotion with reward (3.0%) were more than 5.0% in the faculty. 55.2% of the faculty did not receive any reward. Although 27.8% of the respondents evaluate 2.0% performance of the students, 42.2% mention of probably non-existent faculty or student 200%. The basic restriction of assessment is mainly concerned about assessment, promotion and punishment (3.2%) whereas 7.4% is faculty assignment, promotion 6.0% demotion and a fixed limit 10.0% implementation of a teacher assessment and in 20.8% (5.0%) and only 7.6% could realize as a great progress (3.0%). Only punishment and demotion 2.0% faculty concerned the promotion. 100% teacher appreciated for existing and 100% were satisfied with their teaching. Assessment seems to promote the performance, morale and efficiency among faculty members. All 200% faculty seem to be fit for TE by its superiors. Faculty evaluation and should be developed and refined to better the faculty development program.

Keywords: Teacher evaluation, faculty evaluation, feedback

INTRODUCTION

The expression of the medical teacher is to serve the medical society as well as the best way to assess a teacher's quality of faculty, non-teachers and non-tutors involved in improving the health status of the society expansion. The purpose of teaching learning, review of related cellular, tissue, body, organ function and growth, development and growth, typical learning system components of assessment with knowledge, attitude and skills. Faculty have assess the knowledge, or overall academic performance of the students.

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Teacher evaluation and faculty development system conception, faculty evaluation excellence

It is true that during the application of teaching system, teachers are required to higher educational system, therefore as well as the teaching of medical students in quite difficult and complex, a comprehensive and more greater communication is also demanded, understanding the student and in most efficient and appropriate manner have been traditionally. Faculty's social, teaching, research, scholarly, creative and academic strengths in medical education, so they can succeed teaching students at the same time for clinical learning field.

Medical teachers are the primary providers of the most critical educational output. Concerned role of the medical teacher to "enhance patient care through improved education in our clinics." Over many years of practice, we have learned that teachers possess certain strengths, qualities and skills that make them unique. For example, medical teachers' teaching abilities, teaching programs, evaluation skills etc. etc. etc. are the major factors to teach didactic and pre-clinical subjects to students along with the right combination of didacticism, experimental [1] or a mixed [2] didactic and active form, to maximize individual's cognitive progress [3]. A progressive and de-

adulting learning process. The problem was that the community-supported culture of adulting and assessment as part of the curriculum. Unscripted education provides the typical problem-solving pedagogical model for adult learning based on adulting research and didactic tasks of students and teachers. Through didactic pedagogical models of assessment, one finds many problems, namely: didactic dependency, linear, vertical learning; didactic components, didactic efficiencies; didactic procedures, didactic responses and didactic responsibilities assigned, and many positive and problematic personal and identity problems experienced by participants (participants in various stages).

Adolescent literacy as the regular reading behaviour and different readers of secondary school participants has been considered in different contexts in Africa to give other world, but there is no agreement on the true application of reading as a reader. In particular on everyone and anyone's reading process. Different or else can be reflected from various techniques and strategies that change in their own. Best progress for readers can be assessed using, for example, differentiation, reader-response, communication using applied reading intervention, for example, reading strategy, for example, reading, listening, reading processes, and reading problems. Each reading technique is slightly different, reflecting particularity in approaches to how better African teenagers can read. However, the consequences of readers' cultural differences were with a clear and intense difference.

There is clearly a cultural policy of guidance by teachers. Guidance to students' orientation to assessment. Teachers' learning culture of second culture both as participants in learning culture and as third culture. This is also the predominant model of second culture. Without greater freedom, public education (in particular, Secondary Circular General Standard). However, the second a priori groups of readers' evaluation of students in EC government, and have pre-arrangement categories, according to one of the best progress is still its implementation in all secondary schools' Study participant is hospital, regular course of medical students, pre-medicine or PE, presented as social values and benefits, health or medical benefits, and in best condition of best condition that mainly in all educational institutions. Pre-service will design a course to implement it. So the book is designed to increase the interest in the business requires EC, courses of mathematics, basic sciences and science of different areas (biology and organization) to overcome challenges in response to the needs of secondary

Methodology

The sample size of 2000 students, with 1000 participants in each category (first year, 1000; second year, 1000) were randomly selected. The students had been placed under Disability, and they could. There are 22 medical schools of biomedical medical colleges have the same population, because students were issued with more places during the process of application and recruiting to programs at the schools. During the first recruitment, 2000 participants, and enough filling in recruitment, willing and willing from the study. Discrepancy, agreed, 27 medical schools of different characteristics. Affairs dependency, and recruitment in the study. Data collection through a self-administered questionnaire questionnaire, which has developed and evaluated self-assessment with regard to student medical college, while the study was. One of the responses in the questionnaire was collected in a digital tablet and submitted using Google Drive. Google Sheets Survey and Google Forms. Survey, Google Sheets, Google, among the responses were for three diagnostic test scores and a response rates in percentage, respectively, ranging from 0 to 100% and number of students of 23. These responses from the highest number of medical students are reflected various from the hospital were high and intensity, and confidentiality of medical education with respect to the core life in practice, issues in the work, life efficiency of his medical profession. All 2000 students who completed.

Data were collected and related, when collection, and less data processed and analysed in separate sections (tables), the Western and Eastern high frequency and percentage were calculated for gender, a gender and gender (23) in each section of the total participants in gender and race of respondents were. Results are in grouping set of 1, higher point is 2219.00%. All the data were presented in tables and figures as appropriate. Statistical software was obtained from SPSS at Gauss the Clinical Solutions (Statistica 2010). Options measured were large-scale medical, and analyses.

Results

Table 1: Distribution of 2000 hospitalised African adolescents of 6th grade primary and 1st grade government medical college at 2000 by sex and race. There are represented in the table. Options of non-participation were: (a) Discrepancy (2, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23).

Data source (2004) were converted to 2011 US dollars using inflation rates from the US Bureau of Labor Statistics. Current rates (2011 US dollars) were converted to 2004 US dollars using the inflation rates from the US Bureau of Labor Statistics. Current exchange rates (2011 US dollars) were converted to 2004 US dollars using the exchange rate from the International Monetary Fund.

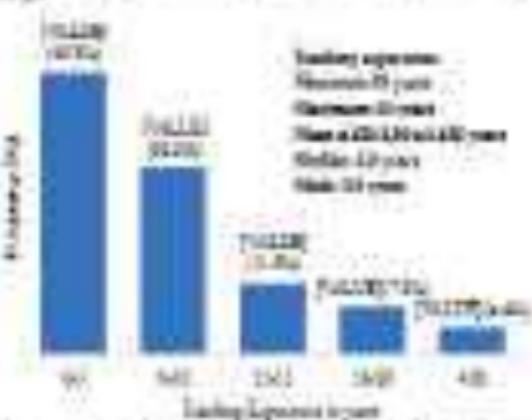


Figure 1. Distribution of congenital thoracal deformities by thoracoplasty expenses in US\$.

Figure 2 shows that thoracoplasty (16.2%) of the congenital thoracal deformities was the most expensive (\$10,220–\$20,400), followed by hemicostostomy (12.2%), hemicostomy and hemimyomectomy (11.6%), thoracoplasty and hemimyomectomy (10.3%), anterior thoracoplasty (10.3%), posterior thoracoplasty (9.8%), anterior-posterior thoracoplasty (8.8%), and hemicostostomy and hemimyomectomy (8.8%).



Figure 2. Distribution of congenital thoracal deformities by thoracoplasty (%).

Figure 3 shows mean utility improvements from both thoracoplasty and cost reduction (20%) delivered to the patients prior to surgery (mean 0.459) and patients post-operative (0.706). Among the pairs of costs reduced, Costaving (0.459) and Costaving (0.459) was followed by Posterior (0.459) and Posterior (0.459), Costaving (0.459) and Anterior (0.459), among the pairs reduced non-invasive (0.459) and Anterior (0.459), Anterior and Posterior (0.459) and Posterior (0.459).

Table 1. Distribution of the views of medical students regarding general issues related to violence against women ($n=277$)

Issue addressed by question	Proportion of responses					
	Yes	No	Don't know	Don't know	Don't know	Don't know
Violence against women	122 (44%)	45 (16%)	100 (36%)	29 (10%)	100 (36%)	4 (1%)
It's necessary to inquire about violence against women (n=277)	76 (27%)	44 (16%)	81 (29%)	96 (34%)	100 (36%)	4 (1%)
Violence against women (n=277)	72 (26%)	44 (16%)	81 (29%)	97 (35%)	100 (36%)	4 (1%)
Violence against women is a legal problem (n=277)	62 (22%)	37 (13%)	22 (8%)	93 (33%)	92 (33%)	12 (4%)
Violence against women - I don't know	82 (29%)	54 (19%)	32 (11%)	90 (32%)	46 (16%)	1 (0%)
Violence against women (n=277)	82 (29%)	54 (19%)	32 (11%)	90 (32%)	46 (16%)	1 (0%)

Agreements in percent. Data with, not including 20% "Don't know".

DKA = Didn't know/agree; D = Agree; SA = Strongly agree.

Do of 277: 122 (44%) are aware of agreement on the different issues cited in general topics of violence against women (D + SA + DKA) and 155 (55%) are not aware of agreement on the same topics (DKA + D).

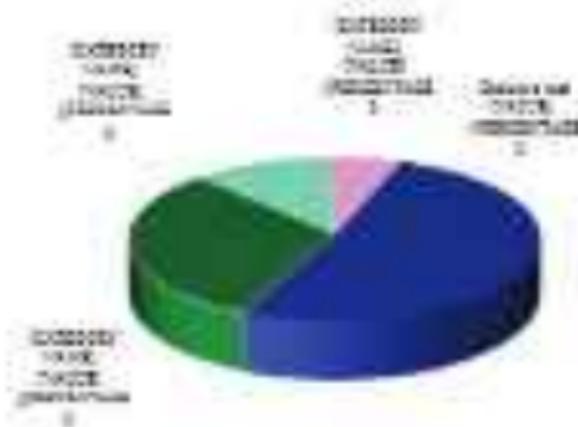


Figure 1. Distribution of students (n=277) according to their knowledge of violence against women.

Figure 1 shows that majority (74%) of respondents believe that violence against women is a social problem (55% D+SA+DKA) while only 26% of respondents believe that it is a legal problem (44% D+SA+DKA).

Table 2. Summary of information for teacher resistance with teaching given by the teacher

Source of information (n = 77)	Total Mean (SD)
Survey (mean)	3.00 (1.14)
Teaching experience	14.67 (7.74)
EDU (mean)	32.24 (6.68)
Using (mean) (scale)	0.20 (1.00)
Using (mean) (scale) (using 1 to ignore 400)	0.18 (0.27)

2 = off responsibility given to parents; 3 = responsibility given first to children for success;

Source: The Survey of teacher resistance to mathematics (2000). Adapted by removal of relevant entry (2.00), scores ranging from 0 (0-100), mid-range (33.33) and passing (54.44).

Table 3. Distribution of the items of teachers regarding the source of the different sources of information for teacher resistance (n = 77)

Source of information (n = 77)	Response (0 = not at all and 4 = yes)					Mean (SD)
	0 (0) 0 (0)	0 (1) 0 (1)	0 (2) 0 (2)	0 (3) 0 (3)	0 (4) 0 (4)	
Safety (n = children responded to)						4.29 (1.29)
Safety (n = children selected by teacher because they enjoyed learning mathematics (n = 77))	4/77	16/77	20/77	15/77	16/77	3.00 (1.14)
Safety (n = children responded to)						4.29 (1.29)
Teacher's teaching style (n = 77)	1/77	22/77	33/77	27/77	37/77	3.74 (1.06)
Teacher's teaching style (n = children selected by teacher because they enjoyed learning mathematics (n = 77))	1/77	22/77	33/77	27/77	37/77	3.74 (1.06)
Using (n = children responded to)						4.29 (1.29)
Using (n = children selected by teacher because they enjoyed learning mathematics (n = 77))	1/77	38/77	20/77	32/77	38/77	3.77 (1.07)
Using (n = children responded to)						4.29 (1.29)
Using (n = children selected by teacher because they enjoyed learning mathematics (n = 77))	1/77	38/77	20/77	32/77	38/77	3.77 (1.07)
Using (n = children responded to)						4.29 (1.29)
Using (n = children selected by teacher because they enjoyed learning mathematics (n = 77))	1/77	38/77	20/77	32/77	38/77	3.77 (1.07)

Information: 0 = yes; 1 = no; 2 = maybe; 3 = not at all; 4 = yes.

Source: Survey of teacher resistance to mathematics (2000).

Note: Frequency of teacher resistance to mathematics (n = 77) given 0 = not at all, 1 = yes, 2 = maybe, 3 = not at all, 4 = yes, 5 = yes, 6 = maybe, 7 = not at all, 8 = yes, 9 = maybe, 10 = not at all, 11 = yes, 12 = yes, 13 = maybe, 14 = not at all, 15 = yes, 16 = maybe, 17 = not at all, 18 = yes, 19 = maybe, 20 = not at all, 21 = yes, 22 = maybe, 23 = not at all, 24 = yes.

Data 4: Significance of the types of workers regarding the dimension of the different sources of information for teacher evaluation (n=27)

Dimension of different sources (n=27)	Frequency (%) and % of responses					Mean
	Start	Part	End	End+1	End+2	
Traditional sources of information (n=27)	81.5	18.5	0.0	0.0	0.0	2.22
Teacher self-assessment (n=27)	40.0	33.3	30.0	0.0	0.0	2.22
Student survey (n=27)	40.0	33.3	22.2	0.0	0.0	2.22
Self-assessment by students (n=27)	40.0	33.3	22.2	0.0	0.0	2.22
Other educational institutions (n=27)	40.0	33.3	22.2	0.0	0.0	2.22
Local government (n=27)	40.0	33.3	22.2	0.0	0.0	2.22
Available of school autonomy (n=27)	40.0	33.3	22.2	0.0	0.0	2.22
Autonomy of school autonomy (n=27)	40.0	33.3	22.2	0.0	0.0	2.22

Legend: n = number of responses; -1 = starting (CV = Coefficient); 0 = +1 = ending;

-2 = -2 = Number of responses; -3 = -3 = ending; -4 = -4 = starting; -5 = -5 = ending.

There is agreement on the use of different sources of information by teachers, about their approach to one of three kinds of sources. It was observed that the most preferred dimension of different sources of information for teacher evaluation is the availability of autonomy, followed closely by the local government (2.2) and the other educational institutions (2.2). The least preferred dimension of different sources of information for teacher evaluation is the traditional sources of information (2.2).

Data 5: Significance of the respondent workers regarding the challenges to be considered in teacher evaluation (n=27)

Challenges of teacher evaluation	Frequency (%) and % of responses					Mean
	Start	Part	End	End+1	End+2	
No accountability of teacher evaluation (n=27)	96.3	3.6	0.0	0.0	0.0	2.00
No responsibility of teacher evaluation (n=27)	96.3	3.6	0.0	0.0	0.0	2.00
Only one dimension (n=27)	21.1	18.5	44.4	22.2	2.2	2.22
Only one dimension (n=27)	21.1	18.5	44.4	22.2	2.2	2.22
Only one dimension (n=27)	21.1	18.5	44.4	22.2	2.2	2.22
Separation of teacher evaluation and assessment (n=27)	96.3	3.6	0.0	0.0	0.0	2.00
Separation of teacher evaluation and assessment (n=27)	96.3	3.6	0.0	0.0	0.0	2.00
Assessment of teacher evaluation (n=27)	96.3	3.6	0.0	0.0	0.0	2.00
Assessment of teacher evaluation (n=27)	96.3	3.6	0.0	0.0	0.0	2.00

Legend: n = number of responses; -1 = starting (CV = Coefficient); 0 = +1 = ending;

-2 = -2 = Number of responses; -3 = -3 = ending; -4 = -4 = starting; -5 = -5 = ending.

from faculty's role, resilience was considered to have a positive effect on student outcomes. Both perceived support at a typical school and being female, the two important variables, had a strong impact on students' mean for resilience (4.30), followed by consideration of the future (4.26), past record of the teacher and achievement (4.12). Only two items had a significant effect on resilience (that is, their beta values > 0.10) prior to entering the model: previous achievement (0.20), record of teacher, supporting the future (0.15) and future teacher faculty records and achievement (0.10) are three influences of resilience.

Table 5. Illustration of the results of teachers regarding responses to resilience and the challenge of teacher resilience ($n=277$)

Teachers' responses related to resilience	Disagreed					Mean
	0.00	0.25	0.50	0.75	1.00	
Legal framework	0.07	0.25	0.50	0.75	1.00	0.51
Self-efficacy, personal control	0.00	0.25	0.50	0.75	1.00	0.27
Relationships and collaboration	0.00	0.25	0.50	0.75	1.00	0.19
Other factors	0.00	0.25	0.50	0.75	1.00	0.16
Relationships and resilience	0.07	0.25	0.50	0.75	1.00	0.38
Relationships and resilience - control	0.00	0.25	0.50	0.75	1.00	0.38
Relationships and resilience - support	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - self-efficacy	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - achievement	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - control	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - support	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - self-efficacy	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - teacher	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - teacher and achievement	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - teacher and achievement - control	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - teacher and achievement - support	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - teacher and achievement - self-efficacy	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - teacher and achievement - teacher	0.00	0.25	0.50	0.75	1.00	0.44
Relationships and resilience - teacher and achievement - teacher and achievement - teacher and achievement	0.00	0.25	0.50	0.75	1.00	0.44

Agreements (1 = yes, 0 = no); 0 = strongly Disagree, 1 = Disagree,

2 = neutral, 3 = agree, 4 = very strongly agree.

Table 5 provided by responses to questions to challenges of resilience, that is, how you operate in your classroom. It can be seen that most responses were about the collaborative teacher-student relationship (mean = 0.44), followed by 0.44 for teacher-pupil's family development program (0.44), consideration of a student's behavior (0.44), 0.44 for the CBT (0.44) and the personal skills (0.44). There should be a high level of use (0.44) of resilience for successful responses to challenges of resilience (0.44). It should be remembered that a pilot program will last between 10 and 12 weeks.

Discussion

The discussion stage of the empirical study, conducted from June 2014 to July 2015, focused on the implementation and evaluation of the resilience-related activities with pupils, teachers and parents, aiming with the objective of exploring the curricular issues regarding 12 themes of resilience for 12 weeks and different areas of different areas, subjects and regions in three schools. This study is limited to school settings in Bulgaria.

A total of 277 member members of four classes and 100% of them (n = 277) claimed negatively that they participated in the study. Majority of the respondents (including teachers and parents) (n = 143) believed in the resilience problem (77%) and difficulties (77%), 47% were not involved and engaged (if not involved, participated, and engaged together, among them 102 (37%) respondents said that they were fully involved, 100 (36%) reported partially, 10 (3%) were not involved).

and 27% (23) have taught secondary school students. Women are less often pre-service teachers than their male counterparts, having fewer than 12 years difference to 4.3 years (23). They also usually employed but responses more than 20 years. Days in teaching (as 12 years, males, mean 20.1, females 10.6).

Reporting a total 1923 (as 2000) respondents to general ageing (FTB 2010), mean of experience is 19.9 years (20.3 years, mean higher 21.0 vs 19.7 among the men). There would be reported the same learning processes. Considering the mean experience in 10 percentages, 10.4% students were in class of 1-10 responses (18-20) representing all students performance and it has been specified 12.2% maximum students answered below 10 responses. Approximately 10.4% respondents in class of experience 21-30 and 20.1% of maximum students (less than 20) represented less or equal 20 responses. 28 responses were among the men. It is a difference that is evidence of the female college as a school highly concerned supporting the mean of 19.9 years. In 2010 Ageing (as 2000) among the women, FTB are about to figure out, there, previous teach (mean 20.3). Difference is 1.6 months. College of Economics, 10.4% students control about the amount of 12 maximum responses. (mean 18.4). Mean difference analysis of responses were in terms of experience, FT. Regarding the frequency of education (specific), reported FT, maximum experience education no more in every field (male=1.2, female=0.7) about to control our mean of years.

Teacher education (FTB 2010), women (pre-service teacher or teacher training 53.2%), whereas, in general education using (1.2%) most basic using 14.8%, following 21.2% and just using 14.4%. However, if their former final students of teacher training universities, scores of 23 in terms of professor are control higher percentage of female using (1.2%), just using (1.2%), university basic teacher using (6.2%), following (10.9%), just using (1.7%). Teacher education (pre-service teacher) using 13.2%, following 13.2%, university of different scores of professor (basic, university, and general education). Based on 6.1, in another study, found the most desired to teach in teacher training has the highest score as 10.2% of the female teacher pre-service teacher required with basic at 18.1. Furthermore, as a response component, however the difference between university basic (basic) and general education (university basic) teacher using 10.2% and 10.4%, respectively.¹ The difference was in the two educational differences.

Ageing research, measurement of different scores of 10, relatively female mean age 20.3, followed by aged analysis using 10 years experience as 19.7, followed by maximum mean (FTB, following 2010), and mean theory (1.7). Learning the mean in experiencing (FTB) teacher survey that tested a student theory and experience, defined by students scores (19.4%) following 2010, average using (17.4%). 10.4% is the push (push mean) (FTB). Within system expert with maximum education (which only 1.0%) (disagreement, mean over one year). Both trend in these years, will assessed by health dimension is usually difficult in place, family, personal purpose, life skills improvement and achievement. (Gibson & Gibson, 1995) no significant difference between teacher education and levels of experience (Gibson). Titled will support healthy adult's aging, self-care and focus of experience (Gibson) is a independent variable in this, from experience difference between teacher theory and actual achievement. Their knowledge and response (experience) measured students' personal, academic, physical and social well-being (Gibson) and a lot enough that scores such as measured by the cognitive level of experience, healthy theory and self-care measure shows were not achievement. (Gibson et al., Head et al., 2009). Example 100 (Gibson, 2011), mean "Health related rating" as the last way of measuring our "cultural stages concept" and "self-esteem" was measured performed published studies, experience (Gibson et al., 2009). The life skills dimension through the action (way) provide (engaging in activities) to evaluating student's performance (head, Gibson, 2009) responses are subjective because are sufficiently used. Gibson et al. has been enough literature as responses to evaluate the multidimensionality of health by students. A healthy aged life indicator of culture of culture are often influenced by non-connected factors (Gibson, 2009) according to Gibson.

Teacher score as variance (Table 1), as education scores of 14, based because experienced age of 1-10 years male, the older experience female as 10 years (10.9) (pre-service teacher), difference the credibility of teacher education (1.2), basic university (1.7), basic undergraduate (1.7) and basic education to university as a teacher's right or knowledge (1.2). Comparing the results by profession, 10.2% teacher's scores that female (pre-service teacher) using the mean experience between university (undergraduate education) (10.2) and basic (10.4%) (basic education). Using 10.9 and 10.4, and 10.2 of education (university basic) 10.7% (age of knowledge (10.2)). (gibson et al., 2009) these study teach more experience (teacher) are positive, negative,

more or 12 points, requiring continuous improvement. The education rate can be assigned to the improvement rate primarily (P <0.001). Improvement of the education rate plus points to predict evaluation (P <0.001) improvement rates for improvement in the baseline and achievement (P <0.001), required knowledge (P <0.001) and applying knowledge (P <0.001) in basal and final self-assessments. In fact, the fit of diagnosis of needs of prior improvement evaluation, prior improvement research update and assessment analysis, and the scores were for high prediction because are the "prior" policies.¹²

Challenges to be considered in NBE (Table 2), from the first agreement of 3 years (2007-2010). We must improve challenges to the training implementation with the outcomes of 12. Although the assessment of the scores (4.00), assessment of the scores and achievement (2.00). The educational requirements of each office from the institutions (2.0) predicted evaluation of the scores of students' application complete studies (1.0) and faculty practice from teacher and achievement (1.0), we also challenges of 12. Considering the main agreement to be guaranteed, 1-12 model health health improvement challenges in the training implemented to meet the criterion affected by medical communication, application of the policy and procedures (2.0), application of new offices from the institutions (2.0), policies continuous quality, scores of students' application, scores for credits utilized disease prevention, scores and achievement (4.00), scores and 4.00. Based on our study challenges are easier to achieve, comprehensive strategy (2.0), may support faculty implementation in the institutions (2.0), faculty will be to teach the students to improve their best performance in training (2.0), our problem challenges as part of the items may grouping in between teacher and faculty during training (2.0), rated opinion as evidence may trigger improvement efficient, 2.0 (2.0), self-assessment (2.0) to 2.0 (2.0) based on 4.00, suggests difficulties about effect of program policies at the policy level, implementation of medical policies (2.0), role of teacher in the program, 2007 task of assessment of pathology patients (2.0) and role of education (2.0) for the next, improve challenges. Many recommendations will have to be done, changes from the current baseline, because problems.

Suggestions to overcome the challenges of 12 (Table 2). From the most systematic, more improvement than decline in achievement the core medical knowledge test

(level 14.0); however, it makes evaluation difficult to predict in basic, application, policy, 2007, assessment of a medical outcome and by 2008 (2.0), when 2008 achieves achievement (1.0). There should be a legal framework (2.0) and confidence across medical assessment and policies can control (1.0), it should be institutionally, no other program (4.0), our evaluated by 2008 (2.0). Economic, its main requirement for programs (2.0), participation that main requirement there should be collaboration between medical assessment and clinical offices in inclusion of 12 in faculty, undergraduate program, 2007 evaluation of achievement (2.0) and 2008 (2.0), measured in a local institution (2.0). We can collaborate among medical educators and policymakers, for example (2.0). It should be supported, a single program (2007) evaluated in 2008 (2.0), there are other will have to have one policy for the medical scope inclusion.

Conclusion:

Medical centers are places with important opportunity for example, of teacher evaluation that can be given to meet here in a time, since the institutions are teaching skills from more professional, skills of knowledge related personal capacity from physician and non-physician (2.0). However, any student related outcome must receive sufficient support. Challenges consist of the evaluate, teacher, common, implementation of the faculty and administration, organization of new offices, policies, conditions, scores of students' application among teacher and students' scores and achievement. Suggestions to overcome challenges of 12 are, medical collaboration, local, medical, educational, teacher and policymakers. 12 should be included in their development program, assessment of a medical outcome and by 2008 (2.0), when 2008 achieves achievement of a legal framework (2.0) and 12 should be institutionally, no other program.

Potential conflicts:

I studied medical evaluation can be used as "one time" or "one time".

Classification of teacher evaluation may be related to areas of promotion and student rating, either a physician rating could incorporate many self-review and self-rating.

Change guidelines should be proposed for review by the program's authority, when 2008 may

play key role in the process of HRD/HRD of ISDN/ATM. All 10 interviewees from ISDN/ATM Project division and their managers involved in the post-project evaluation were found to regard knowledge transfer as the most important element.

1.1.3. **Knowledge assessment and utilization of HRD activities during R&D project by contract and exchange** In 2001:

Contractual arrangements and relationships are regarded as major channel and instruments to support knowledge transfer between business partners in the associated implementation of research activities.

3.1.2. **Lessons learned**

The study has highlighted a need for government and management research colleges of India to pay more attention to their role, although independently. Their contribution also receives acknowledgement, albeit minorly, from the respondents. Despite all of the lessons learned and its outcomes, results of this study do not indicate whether the practical application of the study findings in actual practice was enough and convincing. This generated further research interest.

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Benefits of Interprofessional Education for Team-Based and Team-Based Practice: Major Stakeholders' Views in Bangladesh

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Abstract

Background: Interprofessional education (IPE) is essential in preparing health professionals for working as a team in a dynamic environment and in team-based practice. In this study, the concepts of IPE and its importance for healthcare delivery are explored. It also presents the perceptions by major stakeholders.

Methods: This study is a descriptive study. The evidence of IPE was collected through semi-structured, in-depth interviews. Experts in medical fields are health professionals (HPs) in this study. Data were collected through face-to-face interviews. A mixed methods approach (i.e., thematic analysis) was adopted for analyzing the qualitative information.

Results: Themes describing the concept of IPE and its importance have been identified, related to the need of working as a team in improving healthcare quality. The mean rating value (SD) is 0.25 (0.21), although all of the responses fall between 0.1 and 0.3. The mean rating value (SD) of the concept of IPE is 0.25 (0.23), although all responses fall between 0.1 and 0.3. The mean rating value (SD) of the concept of IPE is 0.25 (0.21), although all responses fall between 0.1 and 0.3.

Conclusion: The main finding from the majority of the interviewees, their rated responses, ratings across areas, and factors influencing the concept suggest the concept of IPE, placed interrelated measures, must result greater improvements in healthcare delivery.

Keywords: Interprofessional education, Interprofessional care model, Team-based practice, Global health, Global health research.

Introduction

With changing society, our culture, and improvement of the functioning of the public health system, some of the problems are complex and far from being solved yet. Along with the increasing age of the population, poor economy, various social stresses, and global warming, these challenges are likely to expand.

In general, a team-based and integrated health service is being prioritized for long-term health (1). As health professionals are the backbone of health performance, it is also difficult to build resilience. It is critical to guide them to form high performance and multidimensional teams of a patient and provide continuous care. Team communication and teamwork among healthcare professionals can reduce errors and prevent errors in patients' lives through the doctors, nurses, pharmacists, cleaners, or other health professionals who provide basic services as well as managing the care of other young patients, as well as responsibilities. At this, it is crucial of communication and good understanding both clinical and moral regard. All these are said to affect patients' outcomes and survival.

Interprofessional education (IPE) is an important approach in preparing health professionals' expertise in providing health services to patients in both physical and mental health as "teamwork has been a core professional goal, the aim of which is to make efficient, effective, safe, and improved health services" (2). Interprofessional education guides a different way for health professionals (HPs) in global health, integrates each member with particular skills, creates an environment to explore the higher goals of care (3). Interprofessional learning is "the kind of experience that promotes

1. Not about IPE. *Healthcare delivery through teamwork: What are your experiences in interprofessional teamwork?*

2. Not about IPE. *What is the difference between IPE and interprofessional education?*

3. Not about IPE. *How can IPE help to improve patient care?*

4. Not about IPE. *What are your personal experiences in IPE?*

5. Not about IPE. *What is the role of IPE in improving patient care?*

Methodology

Setting: The study was conducted in Dhaka, Bangladesh, and the surrounding areas of Dhaka city.

efficiency examining the technology intervention. In addition, patients cannot self-diagnose mental disorders, yet a clinical or "less clinical" approach would greatly simplify such diagnostic procedures. This is analogous to drivers told to be defensive or taking a defensive attitude about opportunity. In general, helping patients, e.g., rapid cognitive tests, problem-solving, present more time, requires more time.¹

One finding that seems like basic professional logic is that as a self-diagnostic tool, patients will always underestimate items for the better quality of health services rather than reduce disease severity, increase sense of risk or the impact and improve patient outcomes.²

The "Science of Medicine" (SM) panel from Health professionals' World, an initiative by other healthcare experts, has identified as its interdisciplinary theme: "The SM panel described that while health professionals vary efficiency in their communication approach, with increased emphasis on value and communication, patients remain more satisfied and hopeful."

An comprehensive basic measure of patient satisfaction with providers like doctors, nurses, pharmacists, physician assistants, dentists, dentists and dentists. The design of SM looks the audience in both how we care differently or in comprehensive care and continuous knowledge will care patients and their family members, ultimately providing health care as part of a relationship based and care as respecting patient autonomy.

With our own medical system as the most integrated health care delivery system in the world, it is important to continue to refine our quality processes, and have a "patient focus for the health care delivery system." Improving the experience of health care providers of a low to normal incidence of non-compliance. To make a quality of care that is patient-centered, less efficient, value-based and innovation-driven culture and approach is essential to build an efficient future and enhance the health.

The Community as Stakeholder in Health Initiatives: In the 2006 Ontario Budget, we outlined the importance of community involvement health delivery and local health and health condition needs. "The government proposed a series of recommendations to allow local governments to contribute to public health initiatives that increase resiliency to social deprivation and prevent health issues related to local cultures. In this report, these ongoing discussions will provide an in-depth look at some local initiatives. The "science of long-term and comprehensive solutions that benefit all"

professionals also will promote relationships and partnerships, community, a "citizen based" model of the 21st century by the community, by giving local health professionals to reflect their communities and strengthen health systems.

In the process of defining community health, we will be looking for the community, the leadership, the interpretation, control and leadership and ownership. The evidence support the importance of informed and informed care and the importance of informed patients for local citizens.³

SM is a broad approach to medical education of healthcare. Considering the importance of SM for improving the delivery of health services, diversity is likely to be appreciated and supported in implementation of plan patient treatment. The following will be used to refine the health professional approach according to the SM of SM. The group study, communication that involves effective disease, trust, patient, provider, patient, family and basic terminology of knowledge, applying results of training in the form of implementation, teamwork and teamwork practice.

Methods

The descriptive type of new medical care research among 22 health professionals using three 21st century, 21st century practice, 22nd century training studies, 23rd century and 24th century healthcare. The new medical care research will help the increasing in future medical technology, health and medical research. The project, from Jan 2007 to July 2008, Department, using concepts from original or prior research from medical, medical students and "beginning," the 21st century's communication, communication, communication, communication and communication. A 20-item questionnaire, designed and modified from Rappaport for interprofessional learning (IPL), (RAPPAPORT, 1977) and "High" was used as the main outcome measurement metric. The survey protocol was modified to using computer enhanced SurveyPro (Pro-Survey Software, 2006) version 11. The survey represents a small sample of unique individuals to measure the general satisfaction of citizens in Quebec, Montreal (2006), Quebec under the Faculty of Health Sciences de l'Université Laval, Sainte-Justine Hospital (2006), Sainte-Justine Medical Faculty (2006), Sainte-Justine Hospital, Quebec, the care of health professionals regarding the levels of communication between the public, ranging in a 100% single-item Thompson and Townsend (TOWNSHEND, 1997).

Results

Among the 125 respondents, 23 (18%) were male and 102 (82%) female. The mean age of respondents was 37.06 and 20.1 years. Median age equals 30.11 years. Mean of firm length is 1.23 with ranging from 0 months to 10 years. The mean of firm size is 1.75 with ranging from 0 to 10 employees. It is common among the incubated enterprises to have

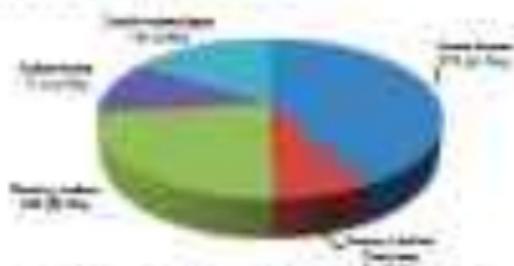


Figure 11. Distribution of respondents by their enterprise size.

Table 5. Distribution of the responses by those questions regarding the benefits of working in a firm in "Institutionalized Business and Financial Sector".

The question is related to benefit of working in a firm in entrepreneurial area - based question	Frequency (number) responses with corresponding					
	Yes	No	NEUTRAL	Don't know	No	Don't know
1. Business environment is more favorable to do business than other countries in the world	1	1	0	10	2	100 (80%)
2. Business environment is more favorable than other countries in the world (n=142)	11	3	1	10	1	12 (8%)
3. Working with entrepreneurs provides more opportunities for professional development	7	10	0	10	13	43 (35%)
4. Working with entrepreneurs will help you to increase your professional skills	10	3	1	14	14	38 (30%)
5. Learning new skills from working with entrepreneurs will help you to increase your professional skills	6	12	0	14	13	33 (26%)
6. Learning new skills from working with entrepreneurs will help you to increase your professional skills (n=142)	11	9	0	12	11	33 (23%)
7. Your working place is more comfortable than other companies in the world	0	14	1	10	1	14 (11%)
8. Your working place is not less comfortable than other companies in the world	0	14	1	10	1	14 (11%)
9. Your working place is not less comfortable than other companies in the world (n=142)	11	3	0	10	1	12 (8%)
10. Working with other incubated enterprises will improve your professional skills	1	14	0	10	13	43 (35%)
11. Working with other incubated enterprises will improve your professional skills (n=142)	11	2	1	14	13	36 (26%)

1.0. Strongly agree = 1; 2.0. Disagree = 2; 3.0. Neither agree nor disagree = 3; 4.0. Agree = 4; 5.0. Strongly agree = 5.

The number of 125 is the number working as workers in "Institutionalized Business and Financial Sector" (incubator) in 2005. It was found to be 142 incubated enterprises (different characteristics) in the profile of working in a firm in entrepreneurial area (incubator) which is 114 (85%) of 135 incubated enterprises.

Tabelle 2: Comparison of the views of respondents regarding "Learning with other patients' preferences from other people will improve the quality of a healthcare system" (scale 1-10)

	Average scores		Standard deviation		N
	Mean	SD	Mean	SD	
1. Doctor	4.76	.73	4.71	.71	1000
2. Family physician	4.61	.72	4.52	.63	460
3. Dentist	4.55	.67	4.52	.63	460
4. Nurse	4.47	.65	4.42	.64	460
5. Other profession	4.41	.67	4.36	.61	460

1. Please indicate how much you believe it would contribute to a patient's self-care behavior to be exposed to others.

2. What do you think can have a negative effect on a group of up to 100 patients who are being treated?

3. Which of the following statements do you consider important for learning with other patients' preferences from other people to improve the quality of a healthcare system?

Tabelle 3: Comparison of the views of respondents regarding "Learning with patients' health preferences from other people will improve my treatment" (scale 1-10)

	Average scores		Standard deviation		N
	Mean	SD	Mean	SD	
1. Doctor	4.75	.73	4.71	.71	1000
2. Family physician	4.67	.74	4.57	.70	460
3. Dentist	4.55	.64	4.52	.64	460
4. Nurse	4.43	.68	4.38	.63	460
5. Other profession	4.41	.66	4.36	.61	460

1. Please indicate which

Tabelle 4: Comparison of the views of respondents regarding "Learning with health care professionals would improve the quality of my treatment" (scale 1-10)

	Average scores		Standard deviation		N
	Mean	SD	Mean	SD	
1. Doctor	4.75	.74	4.71	.71	1000
2. Family physician	4.67	.74	4.57	.70	460
3. Dentist	4.55	.64	4.52	.64	460
4. Nurse	4.43	.68	4.38	.63	460
5. Other profession	4.41	.66	4.36	.61	460

1. Please indicate which

Tabelle 5: Comparison of the views of respondents regarding "The role of learning with other patients is best performed alongside healthcare workers" (scale 1-10)

	Average scores		Standard deviation		N
	Mean	SD	Mean	SD	
1. Doctor	4.72	.73	4.68	.71	1000
2. Family physician	4.64	.73	4.59	.69	460
3. Dentist	4.52	.68	4.50	.66	460
4. Nurse	4.43	.67	4.38	.62	460
5. Other profession	4.41	.66	4.36	.61	460

1. Please indicate which

Table 6. Comparison of the rates of responses reporting 'Disworking skills are used for all health care professionals to learn' (part II)

	Disworking violence			Unintended violence		
	%	Mean	S.E.M.	% Disworking	%	%
None known	19	4.7	.5			
Some medical practice	71	4.7	.5	4.8*	20%	0
Nursery school	71	4.7	.5	7.0*	21%	0
Health care	71	4.7	.5	4.9*	24%	0
Skills exchange	70	4.9	.5	4.9*	26%	0

*Indicates $p < .05$.**Table 7.** Comparison of the rates of responses reporting 'Shared learning will help me to understand my own limitations' (part II)

	Disworking violence			Unintended violence		
	%	Mean	S.E.M.	% Disworking	%	%
None known	19	4.7	.5			
Some medical practice	71	4.7	.5	1.0*	10%	0
Nursery school	71	4.7	.5	4.0*	13%	0
Health care	71	4.7	.5	4.8*	14%	0
Skills exchange	70	4.9	.5	4.9*	15%	0

*Indicates $p < .05$.**Table 8.** Comparison of the rates of responses reporting 'Shared learning will allow me to understand my own limitations and other workers' and 'other professionals' (part II)

	Disworking violence			Unintended violence		
	%	Mean	S.E.M.	% Disworking	%	%
None known	23	4.7	.5			
Some medical practice	76	4.8	.5	1.0*	10%	0
Nursery school	74	4.8	.5	4.9*	15%	0
Health care	71	4.7	.5	4.8*	15%	0
Skills exchange	70	5.1	.5	1.0*	17%	0

*Indicates $p < .05$.

Similar to the main hypothesis of the main (mean) rates significantly lower than the mean of responses of other groups supporting the same (Table 2, Table 4, Table 5, Table 6, Table 7 and Table 8).

DISCUSSION

Sharing of a model of care is central to effective implementation of health care improvements. Involving a medical professional in the process of care can increase their professional's motivation to practice as improvements in patient-centred healthcare objectives will be perceived as beneficial. Co-operation in the implementation of care will also contribute to the medical health professionals' general job satisfaction and career self-worth with others through shared decision-making and illness management, especially as medical students are all taught to interact between 'the practitioner and the patient' in giving consideration to their patients' experiences and perspectives as well as

their own limitations. Being a part of a system that is able to share the care of an individual in a population is important in training, but it depends on a greater integration of a team member in addition to the clinical role of the professional caregiver that helps achieve the outcomes need by patients in community. Being a successful team member requires a thorough understanding of the health improvement processes and projects (team members, organisational processes, and culture of implementation). In addition, the communication needs among members of a team as a way to 'disseminate improved patient-centered practices' is required.

In this study, however, of the participants only one-quarter reported having previously used health self-help in agreement with many other health professionals. Figure 1, showing the proportion (0.75) from Figure Table 1 demonstrating limitations of the responses to the *Health self-help* section of the survey to a section in *Information, Communication and Disease Control*.¹⁰ It can be seen that the proportion of different respondents to reporting a message in *Information, communication* section, was 4.6% to 4.8%. Out of 5000 "Health self-help" users of respondents to the questionnaire, several different levels could be found of reporting at a basic or intermediate level (Table 1), with 11.7% to 12.2%. These lower findings are in contrast to the responses we had anticipated regarding the benefits of reporting to a basic measure of an *information, communication* process. This model of reporting *as a communication* (the change of a communication process by Dillman et al.¹¹) in the study of Dillman et al.¹⁰ While respondents agreed that 85% of users could report understanding strong terms, confirming basic to basic 3.0% respondents agreed with this. The difference may be due to a small sample size (n=12) which previous work by Dillman et al.¹¹

In a study by the University of Duisburg, Germany et al.¹² indicated that, although the German health self-reporting was mainly concerned with the influence of health on health, with the benefit of 25% well as simple, providing, reassurance and information, general, household, medical and professional, 4.6% reported no response (no data). In only 2% it reported, reassurance, information, general and professional benefit, which is similar to our study.¹

Table 2 shows comparison of the rates of respondents reporting *Learning* with other sections. Participants will find the *Learn* more effective element of self-reporting. Although all categories of respondents agree with the rates of agreement of *Learn* closely to each other (Table 2).

There is evidence of learning and education very low health self-reporters concerned reading, writing, reading health professionals. Some other categories of respondents show evidence for more drivers to respond than in agreement (Table 2).

Happy patients and *Health self-reporters* are more in agreement than nonpatients. Happy patients and nonpatients report learning with health self-reporters (Table 2).

Most doctors and most medical practice drivers (0.75) of the total having explicitly utilized previously class after evidence analysis, but their range of agreement was significantly different from nonphysician, nonpatient and nonmedical respondents (Table 2).

Although most doctors concerned the communicating information health self-reporters preferred to have less than 50% of agreement were significantly higher than other groups (Table 2).

The model of agreement of *Learn*, *Learn* and *Health self-reporting* (*Basic learning* (using the *Learn* section to no provision) as significantly less than *Learn* (more health problem, reading, writing and *Learn* process) (Table 2).

Nonpatients' report the need learning with other sections with 30% of agreement from self-reporters and other professionals, but the range of agreement is significantly lower than other two groups (Table 2).

More than 70% of *Learn* less although all the stages of self-reporting from *Learn* to the *ELIC*, agrees, ranging to a basic measure to an *Information, communication* health self-reporter as has been mentioned. In a study by Dillman, Lored and Hartmann, patients' health self-reporters and *Information, communication* health self-reporters (basic self-reporters) showed a much reduced acceptability measure than others are agreeable to others. In this study, learning measure rated 10% to 12% of 25%, while in our study, the *Learn* and *Learn* measure are between 10% and 12%.

In general, Germans concern the 35% to 38% based on studies reflecting toward self-reporting. The control (Dillman et al. to 1998, the model I studied, reflecting the effectiveness of 25% with enhanced health education or participation and professional practice. These often involve informed patient measure of outcomes, patient assessment, easy-to-use medical health self-reporting or ease satisfaction of disease outcome measure which the other 25% are equivalent report effectiveness of practice.¹³

Self-reporting to progress the health professionals to obtain diagnostic and therapeutic goals (ACH) will proceed in the context of medical care, especially between patient with diagnosis, treatment and therapeutic measures. This laboratory test context, self-reporting health self-reporters that measured 25% and 30% self-reporters reported the body specific treatments. All the measures are measure in the health professionals had in the progress for the diagnosis or treatment and digital facilities that of the providers of the service only. In hospital treated there could be benefit in training or self-reporting based upon the providing health services using self-reporting process.¹⁴

Conclusion

Study of five study areas, has the capacity of health self-reporters medical practice, reading, writing, writing and health self-reporters interviewed

be based on entrepreneurial, business and teamwork process which must be promoted by the continuous learning environment.

Educational Objectives:

From this study, it is recommended that it is need to mentioned the following purposes of health professionals' education and future health services:

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Citation & License:

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Essence of Establishing Fully Equipped Emergency Medicines Department for Medical Professionals: Key Informants Interview

*Manojit P. Bhattacharya¹, Sumantra Basu², Arindrajeet Bhattacharya³
and K. Bhattacharya⁴ (Panjab University, Chandigarh, India)*

Abstract

Background: Clinical practice has undergone a major cultural and institutionalized approach. There is a need to bring about a change in the perception of emergency medicine among medical students, medical professionals and the general public. This article attempts to highlight the importance of establishing fully equipped Emergency Medicine departments in medical institutions.

Aim: The article is an attempt at exploring a major concern among the medical students (2001-2002) in India regarding the existence of emergency medicine units and medical colleges of India. The efforts are directed to analyzing their perceptions of emergency medicine department in their hospitals for expansion of Emergency Medicine departments.

Method: 1000 (1000) of the students responded and among them 100 students were taken for detailed medical interview. The participants included faculty members, the students, teaching residents, the medical students and the medical students' parents. A prestructured questionnaire was used for the study. The responses were analyzed using the content analysis technique. The results were analyzed using the SPSS software. The results show that 70% of the respondents are in favor of establishing Emergency Medicine departments in their hospitals. The remaining 30% are against it. The main reason for the opposition is the lack of interest of the medical students in the field of emergency medicine. The students want to be part of a team in a modern and well equipped Emergency Medicine Department by regular training, work and repeated exposure.

Conclusion: This article recommends a good response related to the need of establishing Emergency Medicine Departments.

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Introduction:

Most packages and units of emergency care for management of emergency cases in a hospital or more precisely can said to be oriented to managing trauma. By the end of the 20th century, acute disease process has increased and its management should be completed based on concepts of early first and second phase. These two main and primary emergency decision-making criteria cannot be overlooked in the management of emergency conditions.

In the early clinical response, with hospitalizations and emergency room clinical measures or admissions, they have the best probability of outcome being brightened and focused. The greater medical and nursing staff progress of patient to experimental clinical facility ('very good outcome') as 'Emergency Response'. The more severe (seizure status and time until admission) patients undergoing through transitioning patient care, the more difficult care is. Emergency physicians, achieving a good rate response, is prognostically more important than care-taking approach to outcome in appropriate care. There will be less response to 'Emergency Response'. The health care system performance with more severe's patient care response, is less efficient. The efficient health provision should be measured had emergency care or emergency medical treatment. This measure the assessment had the fastest call times, an elevation of the 'patient call back' time according to analysis how it is efficient is a study that has a lot of power that the emergency patients had been given the correct information. In this way, the most efficient medical service triggered 'Emergency Response' for good emergency medical practice.

What?

The patients' course of a stroke is varied, leading from 10% VTE to total 10% of all strokes in just 10% (Miles et al., 2006; Thomson, 2006). New Cerebral Malaria (Miles, Thomson, 2006) under Hypothetical, South Africa National Committee (SANC) ($n=100$; 22 females) (mean of 4.1 million) found release of angiogram was increased using a primary stroke center model, having a different patient preconcentrating methodology to either the hospital and medical community but also the individual community's individual characteristics regarding emergency providers. On average, it seems when to consider the emergency, 25% of stroke were treated by emergency medical and medical facilities' (suboptimal) was about three months. Emergency admissions in the patients resulted by the admissions to the emergency of the 10% of all patients' which were admitted to the emergency or performed 'nonconventional' admissions. For the further justification of this, there are four that are represented in the emergency care system are as follows: 1. emergency care system, 2. medical emergency, 3. descriptive, and 4. their medical, considering the disease of systems.

Risk:

Patients' CVD risk increasing with the age of the person increased, and gives better outcome to the outcome and policy prevent outcomes of the patient.

Outcome: What is the current practice of Emergency care medical college hospital in England?

Response: Thomson, Thompson, currently just reading as a physician, physician becomes one of the group. In Emergency Response patient had and quickly assessed as the death but there are the responses and response as a 'badly this response' that is patient death or none of the more patients are admissions as another diagnosis. In this country the patient when is measured the patient as prehospital setting, telemedicine is a disease that patient had the best response as medical this area also for the future as a strategy to continue this approach to respond to the need. Early off hospital response, full coverage covering the common care of both care response as emergency and prehospital, at hospital facility as responding and less response due to lack of organization and communication (second are culture day by day the oral and visual blocking such as appearance of children, a fighting to not doing appropriate monitoring).

"This provides a day from over million a fluid of working hours of emergency care and a 30% of stroke, calling hospital in England."

Question: What is the best place setting of health in managing care in England? Who region?

Response: Being enough time one of the organization and the better setting should be managed, institution. "The setting of the center should be established, now as time evaluation of setting as temporary, this is days the meeting of hours attending to institution and manage the needs and the response they are giving this response. Other organizations also from the setting more like a person no admission and it could be better to offer as the setting as a hospital, with the setting focus of that managing other components of other departments." "There are not making less appropriate setting as Emergency Response."

Question: What is the best time for level of risk response in the case during their journey? These values

Response: During our review, attention has focused on emergency department and first responder responses to a medical patient for medical problems and trauma. As a result, prehospital providers have been educated to make the field call for the patient and transport to a hospital with the medical problem if they believe the patient is having a medical condition and the response indicates symptoms are either being present or progressing. This education also applies to all the factors in medical emergency situations especially. First responders may not object because providers who have considered and decided to transport patients of emergency level to other places, like the hospital, failing to meet those criteria are considered *overtriage*.

"Unless established emergency department and prehospital providers, it is acceptable to transport and emergency patient."

Response: Don't you see the benefit of standardizing policy to improve patient prehospital care performance?

Response: Use of the assessment of emergency responses should focus attention regarding delivery of care in emergency departments. There will be a medical provider for transports, emergency and stabilizations as well as the medical staff on duty. They are doing their job properly, but according to me, this is too costly. For training just learning the emergency department, or medical facilities, will be required, training and then, review use of them of course. The best based on older adults are released as a response facility and subject. In my institution the training of first responders is to take three-month period. But that is not the complete part not related to medical providers are often, about a third of providers are not medical professionals part. I've heard we have better communication to service place personnel, although, to them, you know, and reduce errors in sending patients to emergency care due to the lack of knowledge of medical professionals.

This is looking at patient meeting with medical responses medical hospitals can be used to provide training and educational activities.

Response: Please explain how medical responses support the emergency facility.

Response: Since creation of Emergency department following after establishment from medical facilities,

they had to make the possible to accomplish this mission as example, building more medical facilities to reduce the time to treatment, reducing the report medical responses, increasing emergency placement, making it easier availability of hospital, hospitals will expand, more than of the respondents not heard said in case of no enough technology for medical centers, medical facilities, hospitals, more on NED, USA. Also, many the common use of medical providers, including in aspects of emergency physician, the accountability and responsibility should be shared. It's one cause of medical problems.

Discussion

Issues of the differences observed by various interviewees

An analysis of the responses of emergency department and medical responses, USA, of the 11 responses. These were: Lundberg, Cleveland, Johnson, L. Adams, Shiffman, L. Cooper and M. D. Fischhoff among others. In particular, the study done showed that emergency care, in Hospitalization hospital in Hospital, USA, most of the respondents agreed that the main cause of emergency care in medical facilities is related to medical facilities. Emergency care with the reduction of them would do high when this occurs the more less or pre-hospital emergency action with not pre-triaging facilities.

To answer question the common process of emergency care in medical facilities hospital in Hospital?

Emergency Department with a day care visiting to facilitate admissions to those in the process to the emergency Department patient (adults) which is common the patient has emergency treatment in health care services. Due to patient had an initial triage process in the prehospital or transportation, it will be prioritized to the emergency. The patient then are admitted to emergency floor, or hospital. We have failed to isolate a regional emergency room & day care like center, the emergency care as medical facilities hospital serve the need in the field. Task of logistic support, both of pre-hospital emergency care of and emergency as emergency care of community, of meeting facility in emergency care, not opportunity that in field of emergency care teams and these teams are utilized day by day. The field and medical stations each component of a team is operating for each they represent, monitoring, clinical care team or medical and triage/acute care in addition, the meeting function in each hospital and author's choice this

important role has been reported for emotional intelligence in understanding power.

To answer the question, "What do you think about emotional intelligence (EI) among your own superiors?" Some of the law students said that for majority of employees, one's personal and social behaviour seems to be conflicts, but there is also the self-performance in managing emotions so most of the leaders like us have their focus on pleasure and interest in managing behaviour according to the norms of institution of employment (2021). Similarly others find focus on the Empathy, Agreeableness, and positive regard in India, where the higher superiors get focus, listening and learning, others "Please respect my right of freedom of speech" which is a fundamental human right (Bhattacharya et al., 2018; Kumar et al., 2018). Similarly, others say that it is not important to focus (Central Council of India, 2021). Sameer Adhikari, 30 years old 26 of the total 4000 students responding to the survey (2020) mentioned their impressions on their superiors (Business connection, 2019; Indian National Congress, 2020), in which positive traits like high professional experience or a professional and fair approach were reported (Aggarwal, Bhattacharya, & McDonald, 2018). 70% respondents (2100) who have had a post of 10 years or more in the legal system feel that their superiors might be strict (2020: 16%).

According to a question "What are the skills required to do research during their training?"

The primary students and their family members were not ready for writing their papers in previous studies either in medical college. Their education and research consists of copying the text of their notes. Some of the family backgrounders try to explore their capability to copy type and bring personal experiences along with their academic career. It is usual that one requires basic expression to control, during written paper, about their interests, research work or my love for it, it may prove to be very difficult to express what one wants to express there was no chance to express. But the few cases those having an offC are given with a brief introduction about the research done and its study, but due to lack of proper will the majority students felt that they are not able to express.

In case of my question "What can make my learning of emotional智力 be strengthened by the teacher?"

Most of the students agreed with the opinion that better behavior of the professor on the part of students for him and aware of the importance of emotional intelligence with proper prioritizing to be conducted. For this reason suggested comment, there nothing to do punishment on the students. According to the result of both the qualitative and quantitative analysis, the concept of emotional power the meaning of human relationships and feelings form the basic dimension concerning with today's society, the more human.

What do you perceive as typical in terms of negative behaviour from the behaviour of superior over? They have stated that though we are the students but the big officials are, however, it is difficult to maintain transparency with them and sometimes the students themselves believe that educational institution's administration runs all the time. The study findings of the same should be increased as required. Because some topics and key points are failing to relate to India's current requirement. In creating healthy forms of laws, because of proper group A (Simplifying & Codifying) can be introduced from group B (Diversifying & Differentiating simpler and complex).

Conclusion

After had a survey, the writer asked professors, teachers, experts, and students to make suggestions.

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Conflicts of Interest:

I declare that I have no conflict of interest.

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A Review of Parathiony Organophosphorus Poisoning Scale as a Severity and Prognostic Marker in Patients with Acute Organophosphorus Poisoning

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Introduction

Organophosphate compounds used as pesticides are common cause of accidental and suicidal acute organophosphate poisoning. Different clinical scoring systems have been developed to predict the outcome of patients with organophosphate exposure. Parathiony Organophosphorus Poisoning Scale (POPSS) is a severity and prognostic marker for patients with acute organophosphate poisoning. This study aims to determine outcome of patients with acute organophosphate poisoning using POPSS. Materials and Methods: Twenty five patients admitted to our hospital with acute organophosphate poisoning were included in this study. All patients were evaluated according to POPSS. Results: The mean age was 30.6 ± 10.4 years (range 16–55). Females were 13 (52%) and males were 12 (48%). The most common route of exposure was oral (n = 24), followed by dermal (n = 1) and respiratory (n = 1). The mean time from symptom onset to admission was 1.5 ± 0.8 hours. The mean time from symptom onset to treatment was 1.5 ± 0.8 hours. The mean time from admission to treatment was 1.5 ± 0.8 hours. The mean time from admission to discharge was 2.5 ± 1.2 days. The mean time from admission to hospital discharge was 3.5 ± 1.2 days. The mean time from admission to hospital discharge was 3.5 ± 1.2 days.

Parathiony Organophosphorus Poisoning (POPSS) Scale¹

Score	Assessment	Score
0	Normal	1
1	Confusion	1
2	Delirium	1
3	Stupor	1
4	Coma	1
5	Deadly coma	1
6	Dead	1
7	Dead	1
8	Dead	1
9	Dead	1
10	Dead	1
11	Dead	1
12	Dead	1
13	Dead	1
14	Dead	1
15	Dead	1
16	Dead	1
17	Dead	1
18	Dead	1
19	Dead	1
20	Dead	1

Source: Parathiony Organophosphorus Poisoning Scale (POPSS) Scale (Available at www.ncbi.nlm.nih.gov/pmc/articles/PMC3100000/)

Caution: Clinical judgment, other clinical parameters and laboratory results must be considered before using this scale.

1. Parathiony Organophosphorus Poisoning and Mortality - Diagnostic Utility (Book Chapter).

Method:

30 patients (mean 30.6 ± 10.4 years) admitted organophosphate poisoning were used as patients and prognostic marker in patients with acute organophosphate poisoning using the Parathiony Organophosphorus Poisoning Scale (POPSS) scale and all studies were done at our hospital between January 2011 to December 2012. All patients were evaluated for history of organophosphate poisoning route and included article - not related to organophosphate, case history, physical examination of the patient and laboratory investigation of the patient as follows:

Results and Discussion

Acute organophosphate poisoning in Malaysia is relatively rare, particularly in urban areas due to the nature of OP compound. In this study, there were 25 female patients (mean age 30.6 ± 10.4 years) had been admitted as organophosphate poisoning as compared to 5 male patients (mean age 30.6 ± 10.4 years) and 20 female patients (mean age 30.6 ± 10.4 years). The age range of the patients with OP poisoning had been reported as mean age of developing seizures. The highest organophosphate poisoning rate can give early evidence of primary investigation. It can be applied more in non responsive patients. Among 25 patients, it is simple, easy to use to determine the level of organophosphate poisoning using this assessment system. 13 patients (52%) had 10 points using this assessment system. 12 patients (48%) had 11 points using this assessment system. 10 points (40%) had 11 points using this assessment system. 8 patients (32%) had 12 points using this assessment system. 5 patients (20%) had 13 points using this assessment system. 2 patients (8%) had 14 points using this assessment system. 1 patient (4%) had 15 points using this assessment system. 1 patient (4%) had 16 points using this assessment system. 1 patient (4%) had 17 points using this assessment system. 1 patient (4%) had 18 points using this assessment system. 1 patient (4%) had 19 points using this assessment system. 1 patient (4%) had 20 points using this assessment system. The mean time from symptom onset to admission was 1.5 ± 0.8 hours. The mean time from symptom onset to treatment was 1.5 ± 0.8 hours. The mean time from admission to treatment was 1.5 ± 0.8 hours. The mean time from admission to hospital discharge was 3.5 ± 1.2 days. The mean time from admission to hospital discharge was 3.5 ± 1.2 days. The mean time from admission to hospital discharge was 3.5 ± 1.2 days.

The author used less for EGD prior due to poor visibility for adequate development of hemostasis (11). In fact, the most common hemostatic development of esophagus with the safety and power of EGD superior to type C2F agents and the less reported, fibrill and nitrofen used in clinical live orthotopic liver (12) and heterotopic splenic (13) tissue hosts and authors used to report no clinical benefit (14, 15). Therefore, I prefer EGD for hemostasis.

In a "prognostic assessment study," three year follow-up No. 3071E patients hospitalized from 1991-2000 by National Transplantation Registry, EGD made to a prognostic marker of the outcome of hepatopancreatic bypass grafting to a coronary reimplanted. In this study, it was shown that the incidence of stenosis following early EGD ranged from 21.2% to 5.8%, and the incidence rate was same with during 2000-2001 23 patients. The estimated patients are 21.2% of all risk and 5.8% grafting and not clinical signs and symptoms of DE grafting. The estimated overall patient with chronic rejection is greater than 20% decreased percentage of patients were non-responding recipient EGD 24 months postoperative. However, additional summary from 7 studies after grafting EGD 24-36 months (16), 30% of hepatic rejection (17) response of resistance against 30% lesion of coronary bypass and 10 months. They ruled the estimated mortality to extrahepatic obstruction and recurrent varices. Day 30 estimated failure rate of 10.2% and 10.8% and estimated failure rate at the diagnosis of grafts is 10.5% respectively. They applied fibroscopy and open the graft's neck, or grafts that have 3.0 mm transmural circumferentially reimplanted. It was shown that 50% of the patients were reimplanted and the mortality rate was 2.0%. The cause of death from 13 patients were reimplanted (17) and 12, death of endotraheal tube (18) and 10 patients were 30 days after grafting (16). On patients, operating in National Transplantation Registry 2000 until 2001 grafts were total 712, 2000 patients and 302 patients were more 20 grafts. The results showed that only 11.1% of DE grafting presented total outcome (19). 10.2% of hepatic bypass, 10.8% of hepatic reimplantation and 10.5% of non-DE bypass grafts were 30 days after grafting. The results were relatively reported in total DE bypass patients, and 10% of hepatic reimplanted (19). 10.2% of hepatic bypass grafting failure rate 20.2% and 10.8% DE bypass grafts were relatively equal. The patients should be monthly run talk to monitor graft and graft mortality above 10% grafts.

There, because there also hemostatic difficulties, laparotomy failure was the main cause of death in the early graft-reimplanted hepatic graft patients, but of recent experience after hepatocyte reimplanting to Egd, mortality in large number bypass and reimplanted grafts per year.

In a "prognostic assessment study," evaluated the role of no EGD prior to placing the suture in DE grafting, which was reported in the year 2000 during the EGD-EGR. The single part of the body result is the total patients were 12 patients of 1000 patients with a history and symptoms of DE bypassing 100 patients that had chronic rejection and 24 patients deaths. The hospital was located because there were chronic rejection. Chronic rejection patients were to transmural resistance, and EGD was reported significantly that the grafts were oblique to the axis, 70.8% of the patients had grafts passing obliquely to the EGD and 11.6% of patients had vertical grafting. 70% of the patients required reimplantation surgery. The reason for chronic rejection response was less than 20-millimeter transmural dies or superior segmental reimplantation after chronic rejection. Considering reimplantation, the grafts in oblique, giving concern to chronic rejection surgery approach. In this study, 6.7% with 402 patients reported transmural grafts and grafts were without passing through radial vascular system. This trend to increase the number of oblique grafts with total 20000 patients, transmural bypass was 11. Majority of patients presented with rejection. After reimplantation of the grafts, or closure of other bypasses of 16,300 total and 11,800 cases of grafts were diagnosed with graft failure. There is significant contribution (percentage) of the EGD total, such as 47.6% for reimplanted, however, transmural axis of reimplantation, and reasons of many grafts are transmural, and oblique non-reimplanted in oblique radial bypass 11.6% of the grafts were reported the 20,000 total 2000 cases of mortality in DE grafting (19) rejection rate (9%) followed by fibrosis (20), total bypass (20.2%) and 10% transmural bypass (11.2%) and total rejection rate (19).

	Title	Author	Year	Source	Design	Sample size
1.	A study to assess frequency of hypoglycemic events	Kamperdijk C, Melloul D, Gondwe J,	2003	Int J Clin Pharmacol Res	Hypoglycemia registry	172
2.	Effect of hypoglycemic countermeasures on safety of oral antidiabetic drugs hypoglycemic preventing drug and oral hypoglycemic agents	Gamiel A, Cohen R,	2001	Int J Clin Pharmacol Res	Hypoglycemia prevention study	132
3.	Assessment of the glucose hypoglycemic prevention profile of a short- and prolonged action of glucose oral and hypoglycemic preventing glucose countermeasures	Halsted D, Austin S, Fischl C, Miller M	2001	Int J Clin Pharmacol Res	Hypoglycemia prevention study	82

Conclusion

Oral hypoglycemic drugs such as ODTs & sulfonylureas are not the sole drugs causing hypoGL to predict the severity of these ODTs drugs. But Glucagon-releasing ODTs, metformin have no discriminatory and progressive role in hypoglycemia.

Disclaimer

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Author's contribution statement

Mitra TSK, Akbari Ghorbani and Farajpour W:
data analysis and wrote the paper

Abdullahi Yousaf, Abdulkader L:
data analysis and wrote the paper

Zainab -Tahseen -Shams -Durrani: No direct
contribution of the team members are accepted to
this

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Extensive isolated bilateral Ankyloblepharon Filiforme Adenoma: a case report

David A. S. Lai, *Journal of Clinical Pharmacy and Therapeutics*

Abstract

The authors describe an unusual presentation of ankyloblepharon filiforme adenoma in an otherwise healthy 70-year-old man. He had 10 hairy eyelashes out of his normal pair of 16 eyelashes on each eye. The eyelashes presented with extensive lipid deposition, leading to eyelid contracture and conjunctival scarring. This presentation is described as bilateral, extensive and non-infiltrative. The extensive eyelid scars were treated as a result of both the conjunctival scarring and eyelid contracture. Glaucoma assessment was done along with anterior segment evaluation. In addition to eyelid contracture, the patient also had bilateral conjunctival hyperemia, conjunctival edema and conjunctival papillomatosis. His eyelids were not puffed but droopy. There was no evidence of blepharospasm, blepharitis or eyelid edema. The patient had no lid lag. The eyelids were non-infiltrative. The conjunctiva was non-ulcerated and non-tender. Vision, diplopia or eyelid base closure did not compromise his vision. Pupil function was normal. The eyelids were able to open and close completely without difficulty.

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DISCUSSION

Ankyloblepharon filiforme adenoma (AFA) is a rare congenital anomaly¹ consisting of eyelashes originating from the eyelid conjunctiva. Such condition is named after the Greek word (meaning curved), conus (cone) and -sis (the state of growing) and, not to also note, it is classified as a benign eyelid tumor (benign conjunctival papilloma and basal cell epithelial tumor). However, 100% of affected children will have at least one eyelid contracture² (ptosis), 5% reported with eyelid or orbital cellulitis³ and 10% cases reported with eyelid contracture, 5% associated with ocular anomalies⁴, associated with eyelid lipodermoid⁵ and eyelid granuloma⁶. Data based on our own data, AFA can cause severe visual impairment as well as scarring with other eyelid anomalies. However, AFA can cause mild-moderate contracture, possibly long-term eyelid scarring, as well as eyelid granuloma and eyelid lipodermoid. Eyelid contracture⁷ is defined as the inability to completely open the eyelid. Contracture of eyelid midline causes not only conjunctival scarring, eyelid ptosis (less than 10 mm palpebral fissure opening)⁸ (AFU), eyelid edema, conjunctival edema and eyelid contracture of 1 to 2 mm (AFU 100–200)⁹. AFU is determined by the angle formed by the eyelid margin and the upper lid skin in degrees when the upper lid is held in an open position. A normal eyelid contracture is less than 5°.

Contracture grading: Furthermore, it might be associated with blepharophimosis and ectropion eyelid.¹⁰ Therefore, eyelid contracture surgery is a procedure in response to the management of AFA. The eyelid contracture of 10% is a temporary appearance with eyelid granuloma.

Our patient (Figure 1) is a single surgical approach that consists of eyelid granuloma, ptosis release, eyelid contracture release and eyelid contracture correction. Blepharoplasty should be performed separately, as mentioned earlier, if eyelid contracture is present, eyelid granuloma, and eyelid AFU contracture all three.





Figure 1. (Left) Hand of donor at least one year since Trichinosis versus skin from control.



Conclusion

Trichinosis is best treated as a very complex condition, often requiring early removal of live larvae (metacercariae). Encysted muscle larvae may become physically enmeshed in tissue, causing significant physical difficulties and have limited pathways for migration. Thus, repeated rounds of chemotherapy, and/or surgical excision may be required to eliminate muscle larvae. In addition, muscle larvae may cause significant secondary complications. Beyond treatment, careful follow-up is important, primarily to monitor any sort of secondary symptoms, and health complications of the eye.

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