Assessment Tools
Fund
in the discipline "Intermediate Course of Therapy"

Level of higher education
SPECIALIST
Field of Study
560001 – KR clinical practice
(code and name of the training area)

Name
(name of the focus (profile) of the educational program)

Qualification
Physician (General Medicine)

2026

The assessment tool fund was reviewed and approved at the department meeting

Department of Therapy
name of the department

Protocol No. 1 of August 26, 2026

Head of Department of Therapy _____ Professor Sabirov I.S.
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1. LIST OF COMPETENCIES WITH INDICATION OF THE STAGES OF THEIR FORMATION IN THE PROCESS OF MASTERING THE DISCIPLINE

Competencies being developed	**Planned learning outcomes for the discipline, characterizing the stages of competence development**	**Types of assessment tools/ section code in this document**
PC-5: Capable of identifying the main pathological conditions, symptoms, disease syndromes, and nosological forms in patients in accordance with the International Statistical Classification of Diseases and Related Health Problems, 10th revision.	**<u>Know:</u>** 1. Methods of conducting research to identify the main pathological conditions, symptoms, disease syndromes, and nosological forms. 2. Specifics of identifying various types of pathological conditions, symptoms, disease syndromes, nosological forms in accordance with the ICD 10 revision. 3. The main syndromes of damage to organs and systems and their specificity in the differential diagnosis of various nosological forms in accordance with the ICD 10 revision.	**Block A** Questions for midterm assessment Questions for midterm assessment Test tasks Oral survey
	<u>Skills:</u> 1. To understand the obtained results of the study of the main nosological forms of diseases; 2. Analyze various types of pathological conditions, symptoms, disease syndromes, and nosological forms in accordance with the ICD. 3. To note the practical value in comparing specific pathological syndromes and disease symptoms.	**Block B** Situational tasks (cases) Written analysis of a clinical situation (Diagnosis, identification of syndromes)
	<u>Expertise:</u> 1. Skills in identifying the main pathological conditions, symptoms, and disease syndromes. 2. Methods of searching, identifying and systematizing the main	**Block C** Supervision of the patient's therapy (cases) Practical tasks Practical skills checklists (Diagnosis formulation) **Block D** Clinical analysis of patient cases Presentation of a clinical case

Competencies being developed	Planned learning outcomes for the discipline, characterizing the stages of competence development	Types of assessment tools/ section code in this document
	pathological conditions, symptoms of disease syndromes, nosological forms in accordance with the ICD X revision. 3. Skills of self-justification of the combination of various symptoms and syndromes into nosological forms in accordance with (ICD-10 revision).	
PC-14: Capable of maintaining medical records.	**<u>Know:</u>** 1. List and characteristics of accounting and reporting medical documentation in medical organizations of a therapeutic profile; 2. Regulatory documentation adopted in healthcare, as well as documentation for assessing the quality and effectiveness of medical organizations.	**Block A** Questions for midterm assessment Questions for midterm assessment Test tasks Oral survey (Preparation of cards, medical histories, appointments)
	<u>Skills:</u> 1. Conduct a medical and statistical analysis of health indicators of the assigned population; 2. Maintain medical records, including in electronic form.	**Block B** Situational tasks (cases) Written analysis of a clinical situation (Preparation of cards, medical histories, appointments)
	<u>Expertise:</u> 1. Skills and methods of maintaining accounting and reporting documentation of various types in medical institutions; 2. Skills in comparative analysis of medical documentation of various types in medical institutions.	**Block C** Practical tasks Skills checklists (Practical filling out of documentation, using templates and electronic medical documentation) **Block D** Clinical analysis of patient cases Presentation of a clinical case (Documentation analysis)

The planning sheet for discipline

Discipline **Intermediate Course of Therapy**
Field of study/specialization **General Medicine**
Course/semester **5**
Credit units (CU) **3**

Title of module according to WPD	Type of control	Forms of control	Minimal credit points	Maximal credit points	Week of control
Module 1					
Module 1. Pulmonology	Formative assessment	Activity, attendance, prescriptions, patient's case history /clinical case solving, SIW	5	8	5
	Midterm examination	Control work №1 (2 theoretical questions, 1 clinical case, 1 analysis, 2 prescriptions)	8	15	
Module 2					
Module 2. Cardiology	Formative assessment	Activity, attendance, prescriptions, patient's case history /clinical case solving, SIW	5	8	8
	Midterm examination	Control work №2 (2 theoretical questions, 1 clinical case, 1 ECG, 2 prescriptions)	8	15	
Module 3					
Module 3. Cardiology	Formative assessment	Activity, attendance, prescriptions, patient's case history /clinical case solving, SIW	5	8	16
	Midterm examination	Control work №3 (2 theoretical questions, 1 clinical case, 1 ECG, 2 prescriptions)	9	16	
Total			40	70	
Midpoint assessment (tests)			20	30	16
Summative assessment			60	100	

Note:
1. 0.5 points are withdrawn for every missed lecture and/or practical session.
2. 0,5 points are added for active participation in the practical session.

The planning sheet of discipline

Discipline **Intermediate Course of Therapy**
Field of study/specialization **General Medicine**
Course/semester **6**
Credit units (CU) **4**

Title of module according to WPD	Type of control	Forms of control	Minimal credit points	Maximal credit points	Week of control
Module 4					
Module 4. Rheumatology	Formative assessment	Activity, attendance, prescriptions, patient's case history /clinical case solving, SIW	3	5	26
	Midterm examination	Control work №4 (2 theoretical questions, 1 clinical case, 1 ECG, 2 recipes)	7	12	
Module 5					
Module 5. Rheumatology	Formative assessment	Activity, attendance, prescriptions, patient's case history /clinical case solving, SIW	3	5	30
	Midterm examination	Control work №5 (2 theoretical questions, 1 clinical case, 1 ECG, 2 recipes)	7	12	
Module 6					
Module 6. Gastroenterology	Formative assessment	Activity, attendance, prescriptions, patient's case history /clinical case solving, SIW	3	5	35
	Midterm examination	Control work №6 (2 theoretical questions, 1 clinical case, 1 ECG, 2 recipes)	7	13	
Module 7					
Module 7. Nephrology. Hematology.	Formative assessment	Activity, attendance, prescriptions, patient's case history /clinical case solving, SIW	3	5	41
	Midterm examination	Control work №7 (2 theoretical questions, 1 clinical case, 1 ECG, 2 recipes)	7	13	
Total			40	70	
Midpoint assessment (exam – interview on questions: 2 theoretical questions, situational case, ECG)			20	30	42
Summative assessment			60	100	

Note:

1. 0.5 points are withdrawn for every missed lecture and/or practical session.

2. 0,5 points are added for active participation in the practical session.

3. TYPICAL TESTS AND OTHER MATERIALS REQUIRED FOR ASSESSING THE PLANNED LEARNING OUTCOMES IN A DISCIPLINE/PRACTICE (ASSESSMENT TOOLS)

Block A

A. 1 Test tasks

1. WHAT IS THE MOST COMMON SIDE EFFECT OF INHALATION

CORTICOSTEROIDS?

A) candidiasis of the oral cavity and throat

B) osteoporosis

C) hypercortisolism

D) arterial hypertension

2. WHICH OF THE DIRECT ANTICOAGULANTS DOES NOT REQUIRE SYSTEM CONTROL

BLOOD CLOTTING?

A) rivaroxaban

B) heparin

C) warfarin

D) bivalirudin

3. WHICH OF THE LISTED DRUGS CAN BE USED IN

WARFARIN OVERDOSE?

A) vitamin K

B) sulodexide

C) protamine

D) calcium chloride

4. WHICH OF THE GENETICALLY MODIFIED BIOLOGICAL DRUGS

USED IN SEVERE RHEUMATOID ARTHRITIS AND INEFFICIENCY

METHOTREXATE?

A) infliximab

B) cyclophosphamide

C) bosentan

D) abciximab

5. THE MOST SELECTIVE COX-2 INHIBITOR IS:

A) celecoxib

B) nimesulide

C) meloxicam

D) piroxicam

A.2 Questions for midterm assessment

Definition, etiology, pathogenesis, pathomorphology, diagnostic criteria, classification, laboratory and instrumental diagnostics, diagnostic criteria, treatment principles. Prognosis, prevention: community-acquired pneumonia, bronchiectasis. COPD, chronic obstructive bronchitis. Bronchial asthma, asthma attack. The concept of chronic pulmonary heart disease. Atherosclerosis, dyslipidemia, coronary heart disease. Angina pectoris, coronary heart disease. Acute myocardial infarction. Complications of acute myocardial infarction. Primary circulatory arrest. Hypertension, hypertension crises. Symptomatic arterial hypertension. Infectious myocarditis - concept. Congenital heart defects. Heart failure. Acute rheumatic fever. Mitral valve defects. Aortic valve defects. Infective endocarditis. Rheumatoid arthritis. Systemic lupus erythematosus - concept. Gout, osteoarthritis. Chronic gastritis. Chronic acalculous cholecystitis. Biliary dyskinesia. Chronic hepatitis. Liver cirrhosis. Gastric ulcer, duodenal ulcer. Acute glomerulonephritis. Chronic glomerulonephritis. Chronic pyelonephritis. Iron, B12, and folate deficiency anemia.

Block B.1

Clinical Case No. 1
A 45-year-old woman consulted a doctor complaining of a feeling of abdominal fullness occurring 40-50 minutes after eating, along with nausea. She has suffered from chronic gastritis for about 20 years, with exacerbations occurring once or twice a year. She takes proton pump inhibitors and antacids. She has not received eradication therapy. The current exacerbation occurred within the last 2 weeks due to a dietary irregularity, and occasionally took Almagel. On examination, the woman's condition is satisfactory. Height is 166 cm, weight is 64 kg. The skin is clear and of normal color. Breathing is vesicular, without wheezing. Heart sounds are clear, and the rhythm is regular. Heart rate is 70 beats per minute, blood pressure is 120/70 mmHg. The abdomen is soft, with tenderness in the epigastrium and pyloroduodenal zone. There are no symptoms of cholecystitis. The liver is normal. There is no dysuria. The tapping (Pasternatsky) sign in the lumbar region is negative. Stool is observed once daily, without pathology. Fibrogastroscopy: the esophagus is freely patent, the mucosa is unchanged. The cardia is completely closed. The gastric mucosa is hyperemic, with areas of atrophy in the antrum, the folds are smoothed out, and well-straightened with air. The pylorus is patent. The mucosa of the duodenal bulb is unchanged. A biopsy was taken from the antrum of the stomach: the rapid urease test is positive. Histological examination of the biopsy: the gastric mucosa is atrophic and has chronic polymorphic cell infiltration.

Questions:

1. What is the most likely diagnosis?

2. Justify your diagnosis.

3. Make a plan for further examination of the patient.

4. Prescribe treatment to the patient and justify it.

Clinical case #2
A 62-year-old patient visited his family doctor at the clinic complaining of weakness, fatigue, dizziness, and tingling in his fingers. According to the patient, the symptoms had been worsening over the past few months.
On examination, pale skin, glossitis, and decreased vibration sensitivity in the legs are noted. Complete blood count: erythrocytes - 2.9 × 1012 /l, hemoglobin - 90 g/l, MCH - 28 pg, MCV - 100 fl, leukocytes - 4.9 × 109 /l, basophils - 0%, eosinophils - 1%, segmented neutrophils - 73%, lymphocytes - 18%, monocytes - 8%, platelets - 192 × 109 /l, ESR - 25 mm/hour.
Questions:
1. Suggest the most likely diagnosis.

2. Justify your diagnosis.
3. Develop and justify a plan for additional examination of the patient.
4. Prescribe treatment and justify your answer.

Clinical Case No. 3
A 45-year-old woman consulted a doctor complaining of a feeling of abdominal fullness occurring 40-50 minutes after eating, along with nausea. She has suffered from chronic gastritis for about 20 years, with exacerbations occurring once or twice a year. She takes proton pump inhibitors and antacids. She has not received eradication therapy. The current exacerbation occurred within the last 2 weeks due to a dietary irregularity, and occasionally took Almagel. On examination, the woman's condition is satisfactory. Height is 166 cm, weight is 64 kg. The skin is clear and of normal color. Breathing is vesicular, without wheezing. Heart sounds are clear, and the rhythm is regular. Heart rate is 70 beats per minute, blood pressure is 120/70 mmHg. The abdomen is soft, with tenderness in the epigastrium and pyloroduodenal zone. There are no symptoms of cholecystitis. The liver is normal. There is no dysuria. The tapping (Pasternatsky) sign in the lumbar region is negative. Stool is once daily, without pathology. Fibrogastroscopy: the esophagus is freely patent, the mucosa is unchanged. The cardia is completely closed. The gastric mucosa is hyperemic, there are areas of atrophy in the antrum, the folds are smoothed out, well straightened with air. The pylorus is patent. The mucosa of the duodenal bulb is unchanged.
Questions:
1. What is the most likely diagnosis?
2. Justify your diagnosis.
3. Make a plan for further examination of the patient.
4. Prescribe treatment to the patient and justify it.

Block C

Individual creative assignments

Topics of abstracts of independent work in the form of presentations :

1. Propaedeutics for respiratory diseases.

2. Functional research methods in pulmonology (spirometry, peak flowmetry).

3. The mechanism of development of bronchial obstruction in COPD.

4. Principles of antibacterial therapy for community-acquired pneumonia.

5.Treatment of bronchial asthma by mountain climate.

6.Pathophysiology of PAH. Pathogenesis of pulmonary heart disease. Euler-Liljestrand phenomenon.
7.ECG interpretation protocol.

8. The role of risk factors for coronary heart disease. Coronary heart disease.

9. AMI, course options, clinical presentation depending on the development of complications.

10. AMI as an emergency condition.

11. Indications and contraindications for stress tests in coronary heart disease. 12. Diagnostic search in hypertension.

13. Target organ damage in hypertension.

14. Pathogenesis of hypertension (Page's mosaic theory).

15. Principles of examination of a patient with joint diseases.

16. Immunological mechanisms of development of RA and SLE.

17. Principles of GIBP in the treatment of RA, SLE.

18. Features of examination of patients with diseases of the digestive system.

19. The importance of gastroscopy, indications, contraindications.

20. Methods for diagnosing HP infection.

21. Principles of eradication therapy of HP infection.

22. Laboratory and instrumental diagnostic methods for liver diseases. 23. Markers of chronic viral infection in hepatitis and liver cirrhosis. 24. Modern antiviral therapy for chronic hepatitis and liver cirrhosis. 25. Laboratory diagnostics of kidney diseases.

26. Scheme of hematopoiesis.

27. The role of iron, vitamin B12, folic acid.

Block D

List of questions and tasks for midterm assessment (test):

7th semester

Definition, etiology, pathogenesis, pathomorphology, diagnostic criteria, classification, laboratory and instrumental diagnostics, diagnostic criteria, treatment principles. Prognosis, prevention. Community-acquired pneumonia. Bronchiectasis. Chronic obstructive bronchitis. Bronchial asthma, asthma attack. The concept of chronic pulmonary heart disease. Atherosclerosis, dyslipidemia. Coronary heart disease. Angina pectoris. Acute myocardial infarction. Complications of acute myocardial infarction. Primary circulatory arrest. Hypertension, hypertension crises. Symptomatic arterial hypertension. Infectious myocarditis. Congenital heart defects. Heart failure. Acute rheumatic fever. Mitral valve defects. Aortic valve defects.

VIII semester

Infective endocarditis. Rheumatoid arthritis. Systemic lupus erythematosus. Gout, osteoarthritis. Chronic gastritis. Chronic acalculous cholecystitis. Biliary dyskinesia. Chronic hepatitis. Liver cirrhosis. Gastric ulcer, duodenal ulcer. Acute glomerulonephritis. Chronic glomerulonephritis. Chronic pyelonephritis. Iron, B12, folate deficiency anemia.

Questions to check your level of KNOWLEDGE **:**

1. Etiology, pathogenesis, clinical presentation of the main diseases with various nosological forms, methods of management and treatment of patients in outpatient and day hospital settings;
2. Methods and means of collecting and analyzing patient complaints, data from his anamnesis, indications and contraindications for additional clinical and paraclinical research methods;
3. The need to collect and analyze patient complaints and his anamnesis data;
4. Etiopathogenesis, clinical picture and diagnosis of major diseases;
5. Indications and contraindications for the selection of additional clinical and paraclinical research methods;
6. Indications and contraindications for additional clinical and paraclinical research methods.
7. Research methods for identifying the main pathological conditions, symptoms, disease syndromes, and nosological forms.
8. The specifics of identifying various types of pathological conditions, symptoms, disease syndromes, and nosological forms in accordance with the ICD-10 revision.

9. The main syndromes of damage to organs and systems and their specificity in the differential diagnosis of various nosological forms in accordance with the ICD X revision.
10. Etiology, pathogenesis, clinical picture of diseases.
11. The main types and methods of treatment of patients with various nosological forms.
12. Main directions and problems in the management of patients with various diseases.
13. List and characteristics of accounting and reporting medical documentation in medical organizations of a therapeutic profile;
14. Regulatory documentation adopted in healthcare, as well as documentation for assessing the quality and effectiveness of medical organizations.

Questions to check the level of training **SKILLS AND EXPERTISE:**

1. To compare different types and methods of treatment of patients with different nosological forms, to develop a treatment plan for diseases;

2. Manage and treat patients in outpatient and day hospital settings;

3. Monitor the effectiveness and safety of the prescribed treatment at all stages of its implementation.

4. Skills in analyzing various types of treatment for patients with various nosological forms;

5. Skills in managing and treating patients with various diseases in outpatient and day hospital settings.

6. Collect and analyze patient complaints and medical history data.

7. Prescribe laboratory, instrumental, pathological and other studies in order to recognize the condition or establish the presence or absence of a disease.

8. Conduct a survey, collect complaints and anamnesis from the patient;

9. Create a pedigree model for families with hereditary diseases;

10. Conduct a clinical status assessment;

11. Determine indications and contraindications for the selection of additional clinical and paraclinical research methods;

12. Use methods and means of medical examination and diagnostic measures.

13. Skills in collecting and analyzing patient complaints, data from his anamnesis, interpreting the results of the most common methods of functional diagnostics used for the heart and blood vessels, lungs, kidneys, liver and other organs and systems;

14. skills in drawing up a medical history, skills in prescribing the necessary laboratory and instrumental examination methods in order to recognize the condition or establish the presence or absence of a disease;

15. Skills in examining patients and carrying out necessary diagnostic measures;

16. Skills in constructing a clinical diagnosis.

17. Understand the obtained results of the study of the main nosological forms of diseases;

18. Analyze various types of pathological conditions, symptoms, disease syndromes, and nosological forms in accordance with the ICD.

19. Note the practical value in comparing specific pathological syndromes and disease symptoms.

20 Skills in identifying the main pathological conditions, symptoms, and disease syndromes.

21. Methods of searching, identifying and systematizing the main pathological conditions, symptoms of disease syndromes, nosological forms in accordance with the ICD 10 revision.

22. Skills of self-justification of the combination of various symptoms and syndromes into nosological forms in accordance with (ICD-10 revision).

23. Conduct a medical and statistical analysis of health indicators of the assigned population;

24. Maintain medical records, including in electronic form.

25. Skills and methods of maintaining accounting and reporting documentation of various types in medical institutions;

26. Skills in comparative analysis of medical documentation of various types in medical institutions.

4. METHODOLOGICAL MATERIALS DETERMINING THE PROCEDURES FOR ASSESSING KNOWLEDGE, ABILITIES, SKILLS AND (OR) WORK EXPERIENCE CHARACTERIZING THE STAGES OF COMPETENCY DEVELOPMENT

DESCRIPTION OF INDICATORS AND CRITERIA FOR ASSESSING COMPETENCIES, DESCRIPTION OF ASSESSMENT SCALES

Test (assessment of the "knowledge" level) In the course " Faculty Therapy ," the assessment of the "knowledge" level (theoretical aspects) is carried out using tests as a means of consolidating knowledge. As a result, all students in the group are actively involved in the work, and everyone participating receives a grade. The survey covers all topics of the course using tests.

SURVEY RATING SCALE (current monitoring)

No.	**Name of the indicator**	**Mark (in %)**
1	Knowledge of the basic processes of the subject being studied, depth and completeness of disclosure of the issue.	0-20
2	Knowledge of specialized terminology and its use when answering.	0-30
3	Ability to explain the essence of processes, draw conclusions and generalizations, give reasoned answers.	0-30
4	Logicality and consistency of the answer, skill answer the questions asked, express your opinion on the issue under discussion.	0-20
	Total points	**Total points**

ABSTRACT GRADING SCALE (midterm control)

No.	**Name of the indicator**	**Mark (in %)**
	Form	
1	Text according to the diagram	0-10
2	A logical and clear transition from one part to another, and also inside parts	0-10
	Content	
1	Relevance of the topic	0-10
2	Relevance of topic content	0-10
3	Depth of material processing	0-10
4	Availability of conclusions that are relevant to the topic and content main part	0-10
	Design	
1	Title page with heading	0-5
2	The text of the abstract is written in accordance with the methodological instructions	0-5
3	Correctness and completeness of use of literature	0-5
	Defense of the abstract	
1	Literacy of presentation and terminology of the material	0-10
2	Quality of communication and answers to questions during defense abstract	0-10
3	Compliance with regulations	0-5
	Total points	**Total points**

PRESENTATION RATING SCALE (current monitoring)

No.	**Name of the indicator**	**Mark (in %)**
	Form	
1	Text according to the diagram	0-10

2	A logical and clear transition from one part to another, and also inside parts	0-10
	Content	
1	Relevance to the topic	0-10
2	The presence of the main theme in the water part and its appeal introductory part to the reader	0-10
3	Development of the theme in the main part (disclosure of the main provisions through a system of arguments supported by facts and examples)	0-10
4	Availability of conclusions that are relevant to the topic and content main part	0-10
	Presentation	
1	Title page with heading	0-5
2	Slide design and use of additional effects (slide changes, sound, graphics)	0-5
3	The text of the presentation is written briefly, well and the ideas formed are clearly presented and structured	0-5
4	The slides are presented in a logical sequence.	0-5
5	The slides are printed in the form of notes.	0-5
	Report	
1	Correctness and precision of speech during defense	0-5
2	Breadth of Horizons (Answers and Questions)	0-5
3	Compliance with regulations	0-5
	Total points	**Total points**

GRADING SCALE FOR TESTS (MODULES) (Results of the midterm exam)

1. Attached are two (2) theoretical questions, one (1) clinical case, one (1) ECG and two (2) recipes.

Evaluation of theoretical questions:

Theoretical question No. 1 – 0–4 points.

Theoretical question No. 2 – 0–4 points.

1 clinical case – 0–3 points.

1 ECG – 0–2 points.

1 recipe – 0–0.5 points.

1 analysis – 0–0.5 points.

In addition to the CR, it is necessary to provide one medical history of the supervised patient - 2 points.

The minimum number of points for the CR is 7 points.

The maximum number of points for providing a CD is 12 (13) points.

ASSESSMENT SCALE FOR THEORETICAL QUESTIONS (Boundary Control)

85–100% (4 points) – complete, consistent, literate, and logical answers; demonstration of the student's knowledge of the completed program and information from additional literature; reproduction of the educational material with the required degree of accuracy.

75–84% (3 points) – presence of minor errors, confidently corrected by the student after additional and leading questions; demonstration by the student of the knowledge acquired in the completed program, and clear presentation of the educational material.

60–74% (2 points) – presence of minor errors in the answer not corrected by the student; demonstration by the student of insufficient knowledge of the completed program; and unstructured presentation of the educational material.

less than 60% (0 points) – lack of knowledge of the section materials; gross errors are made in the answers.

CLINICAL CASE RATING SCALE (Midterm Exam Result)

1. One clinical case is attached.

2. The task is accompanied by questions.

3. For correct and complete formulation of the diagnosis (according to modern classifications) – 20% (0.5 points).

4. For a completed examination plan and a complete list of expected examination results – 40%.

5. For a completed treatment plan, including medication (indicating the dosage of drugs) and non-drug treatment methods – 40% (1 point).

6. The final score is determined as the sum of the percentages earned.

7. The accumulated amount of interest is converted into points (grade).

Assessment points	Evaluation criteria and %	Evaluation criteria and %	Evaluation criteria and %
Formulation of a preliminary diagnosis	Completeness (according to modern classifications) - 20%	Incomplete completion - 10%	Misdiagnosis - 0%
Survey plan	Full list of expected survey results - 40%	Partial list - 20%	Absent - 0%

Treatment plan	A complete treatment plan, including medication (with indication of drug doses) and non-drug treatment - 40%	Incomplete treatment plan - 20%	Absent - 0%

When evaluating clinical cases:

85–100% (3 points) – "Excellent" grade

70–84% (2 points) – "Good" rating

60–69% (1 point) – "Satisfactory" grade

0–59% (0 points) – "Unsatisfactory" grade

ECG RATING SCALE (interim examination)

1. The availability of a complete ECG transcript according to the protocols is assessed.

Degrees of evaluation	ECG Evaluation Criteria and %
Sinus or non-sinus rhythm	Specified - 10% Incorrect 0%
Is the rhythm regular or irregular?	Specified - 10% Incorrect 0%
Heart rate per minute	Specified - 60% Incorrect - 0%
Electrical axis of the heart	Specified - 60% Incorrect - 0%
Conclusion: PAH / PAH / LVH / RVH	Specified - 60% Incomplete answer - 30% Everything is wrong - 0% Specified - 60% Incomplete answer - 30% Everything is wrong - 0%

Conclusion: PAH + LVH	Specified - 60% Incomplete answer - 30% Everything is wrong - 0
Either LAG or LVH is indicated	Specified - 60% Incomplete answer - 30% Everything is wrong - 0

When assessing the ECG:

85–100% (2 points) – "Excellent" grade

70–84% (1 point) – "Good" rating

60–69% (0.5 points) – "Satisfactory" grade

0–59% (0 points) – "Unsatisfactory" grade.

RECIPES RATING SCALE (Result of the intermediate control)

1. Attached are 2 prescriptions for writing out.

2. Prescriptions are taken into account if they are correctly completed with dosages and signatures indicated.

3. For each correctly completed prescription with indication of doses and signatures – 0.5 points.

4. For an incorrectly filled out recipe – 0 points.

When writing prescriptions:

85–100% (0.5 points) – "Excellent" grade

70–84% (0.4 points) – "Good" rating

60–69% (0.3 points) – "Satisfactory" grade

0–59% (0 points) – "Unsatisfactory" grade.

LABORATORY RESEARCH ASSESSMENT SCALE (midterm exam)

A complete interpretation of laboratory studies is assessed.

When interpreting laboratory tests:

85–100% (0.5 points) – "Excellent" rating – with a full interpretation of the research: which changes are noted and in what diseases or conditions they occur.

70–84% (0.4 points) – "Good" rating – with incomplete interpretation of the tests. For example, not All diseases (conditions) in which these changes occur are indicated.

60–69% (0.3 points) – "satisfactory" rating – when indicating inappropriate or distorted interpretation of test results, for example, with what changes, with what

diseases or conditions they arise.

0–59% (0 points) – “unsatisfactory” – the analysis was interpreted incorrectly.

ANAMNESIS ASSESSMENT SCALE

1. The anamnesis is assessed in accordance with the patient being supervised.

2. The anamnesis must be prepared in accordance with the presented medical history diagram.

3. Availability of passport data, ability to collect complaints, anamnesis, objective examination of the patient (including palpation, percussion, auscultation) taking into account the preliminary diagnosis, as well as the examination plan, examination results with their interpretation, clinical diagnosis and its justification, etiology and pathogenesis of the disease, as well as an indication of non-drug and drug treatment methods, a diary, and a discharge summary.

Practical skills assessment level:

85–100% (2 points) – the medical history is written completely according to the provided outline. 70–84% (1 point) – the medical history is written approximately according to the provided outline, but there are some inaccuracies that the student fully understands. Minor inaccuracies may be introduced.

60–69% (0.5 points) – the anamnesis is compiled according to the presented scheme, but there are significant errors, for example: the formulated clinical diagnosis is not substantiated, the examination plan does not include all possible research methods, or a general treatment regimen for the disease is prescribed, and not an individual one for the patient.

0–59% (0 points) – the medical history is not compiled according to the presented scheme; there is no justification for the clinical diagnosis. The examination plan does not include all possible diagnostic methods. The treatment plan is not appropriate for the disease.