The Resident Hub™

Program Directors' Handbook

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AMERICAN ACADEMY
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Overview and Administration

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Program Calendar

Calendar

The program calendar is developed by the program director with the assistance of the residency coordinator and input from the chair, subspecialty chiefs, faculty, and chief resident(s). Minimal residency program requirements set by the Accreditation Council for Graduate Medical Education (ACGME) and Residency Review Committee (RRC) need to be incorporated into the calendar. See www.acgme.org for the most recent Ophthalmology Program Requirements. In creating the calendar, the program director establishes a comprehensive annual plan which can be adjusted on a monthly basis to allow for change while incorporating the recurring events of the academic year.

The office of the residency coordinator should maintain and update all call schedules, track the location of residents by rotation, and keep a calendar of events that may influence scheduling and attendance throughout the year (eg, the Academy Annual Meeting, ARVO meetings, Resident's Day, Resident Interviews, state society meetings, etc). All information and calendars must be disseminated to various clinics, telephone operators, and emergency rooms, and updated as changes occur. When dealing with important dates like resident selection interviews, consult all relevant calendars and the chairperson.

Most training programs now maintain academic calendars and call schedules through department Web sites. By going on line, all department members can easily review calendars to note deletions or conflicts. Several commercial software packages are available for program scheduling, including New Innovations, Residency Partner, WebEsprit, Blackboard, and WebCT.

Call

The faculty call schedule is determined on a yearly basis by either the program director and the residency coordinator, or the chairperson. Alternatively, subspecialty directors may construct call schedules that involve their respective faculty members and that provide specific coverage for emergency and especially trauma patients.

Typically, the residents' call schedule is developed at the beginning of the academic year for first year residents and toward the end of the year for residents approaching their second or third year. This process ensures equitable distribution of on-call responsibilities while taking into account

holidays, weekends, and special events. Incoming residents should receive a preliminary schedule which they can modify once they are familiar with the institution and their new duties. Thereafter, residents should be responsible for making their annual schedule, adjusting it, and providing it to the residency coordinator for distribution. Copies need to be provided to various departments along with the name of each attending of the day.

Assigning call responsibilities is the task of either the program director or the residents and chief residents. Be sure to analyze call frequencies to avoid violation of Residency Review Committee (RRC) standards, and be certain that backup and faculty coverage is available as necessary.

Leave

Medical schools and institutions have assigned vacation allotments. These can be modified by department, but each resident is entitled to a certain amount of time off. Modifications might include allowing a resident no more than one week off on any single rotation to avoid training deficiencies. Depending on the time of year and the residents' personal issues, leave time can be difficult to plan equitably. Some programs have residents "draw straws" to be fair, and they can trade weeks with one another afterward. Time off should be approved by the service affected by the resident's leave (including fellow residents), and then by the program director. The residency coordinator should keep careful track of leave time per resident as well as a posted vacation calendar.

Some programs provide residents funding and time off (which does not count toward vacation) to attend meetings if they have a presentation or poster accepted. This often encourages scholarly activity among residents. In addition, some programs provide senior residents extra time off for fellowship and job interviews.

Educational Program

Education Committee

The education committee evaluates didactics, the clinical and surgical curriculum, resident performance, and changes in the function of the residency program. By participating on the committee, faculty and current residents alike will benefit from the ongoing didactics and changing curriculum of a program. Larger programs often include individuals from each section in the department; however, key individuals from the faculty who have an interest in resident education should also be included. Smaller departments may instead make educational decisions during monthly department meetings that may include all faculty. In any circumstance, resident participation is required.

Teaching Methods

While resident education primarily revolves around clinical patient encounters, a diversity of teaching techniques is encouraged. These may include online learning modules as well as more standard classroom conferences that require good audiovisual resources. University-based Internet connectivity is important for current and future learning opportunities. Setting up

appropriate wet labs or providing resources for teaching microsurgical skills outside of the operating room itself is helpful and, in most instances, necessary.

Some universities offer pedagogy workshops for new faculty, and although programs can depend on their subspecialty faculty to provide the substrate for teaching, the *Basic and Clinical Science Course* (BCSC) from the Academy is an extremely effective educational template. The Academy also offers resources in written, video, and interactive formats for reviewing basic skills and ideas. Role modeling is an effective teaching method in the clinical setting, but allowing time to review cases is also important.

Didactics

An education committee provides input to help review current lecture series and update them as necessary. Make every effort to provide protected time for all of the residents to attend the review. Try to meet in the morning before clinical responsibilities begin or in the evenings when they are finished. Occasionally, special programs can be offered on weekends when clinical responsibilities are limited to on-call residents. Monitor the full didactic series by rotating the lectures every 1 to 2 years, so that every resident is able to hear each lecture at least once in a 3-year span. Be careful to review the content of the series to assure that a broad base of information is provided (consider using the BCSC as an outline). Subspecialty directors can help identify members of their service with particular expertise or interests, and assign topics to cover the important core topics—this can help avoid redundancy and gaps in the presented curriculum.

Education vs. Service

Faculty will often find it difficult to accommodate the requirements of both education and service; however, accreditation requires clear efforts to educate during clinical rotations. To improve educational experiences, residents should provide input on all rotations—in fact, the Accreditation Council of Graduate Medical Education (ACGME) desires their input. The following principles may be used to design the rotation template:

- Emphasize education rather than service.

- Prioritize the core curriculum and stratify the rotation time allotment. Core clinical rotations should be allotted appropriate time compared with lower-priority rotations.

- Minimize overlapping obligations to other services when assigned to a specific rotation.

- Eliminate noneducational activities (eg, preop history and physical exams).

- Match the resident level of training with the level of responsibility. Residents in early phases of training need more faculty supervision, while senior residents should practice more autonomously.

Resident Research

Given the varied availability of laboratory facilities and supportive faculty, each training program takes its own direction in educating resident physicians on various aspects of research. Despite the difficulty to balance clinical education and patient care, a program should provide residents enough time to inspire and initiate research projects.

Most programs encourage or require each resident to present at a meeting or publish in a major journal during their training. By offering the opportunity to travel to national meetings and supporting travel expenses, you can motivate residents to complete substantial research projects in addition to their clinical responsibilities.

Try to coordinate research opportunities with your subspecialty faculty (as mentors) and director of research for your department (if your department has one). Resourceful residents will even find time to do bench research. Monies can usually be garnered from grant support through the principal investigator or via departmental/university reserves earmarked for research projects; an application may be required. Agencies (AUPO, ASCRS, American College of Surgeons, ARVO, etc) may also provide awards to support clinical research.

An annual research conference held toward the end of the academic year can serve as an important showcase for resident efforts and stimulate collegial interchange among residents and faculty. The faculty may chose to recognize the best research project and present a monetary prize to further encourage residents if they feel it is appropriate. Programs that require only one project over the 3-year period should designate milestones to avoid last minute submissions. For example, during the first year, residents identify a preceptor and topic, during the second year they conduct research, and during the third year they submit for publication and present at a research conference.

Resident Teaching Skills

Programs should have a formal method for developing resident teaching skills as well as an experiential component.One example of a formal learning method is an online curriculum, *Strategies in Clinical Teaching,* at wichita.kumc.edu/strategies/index.html. Modules included Precepting Microskills, Observation and Feedback, and The Ten-Minute Talk. Each module is followed by a post-test. Residents are required to complete each post-test and submit the results to the program director. The office of Graduate Medical Education may require that these modules be completed prior to a contract request being sent to the GME office in February for the upcoming academic year.

Some approaches to experiential education include resident-led sessions on surgical skills in the spring of each year, junior-senior teams in the OR to transition surgical responsibilities, and senior-proctored wet labs for juniors. Resident-directed OKAP review sessions twice a week and case management presentation sessions give additional opportunities for residents to lead teaching discussions with faculty oversight.

Faculty workshops are also important to help staff continually develop teaching skills and to help monitor the success of ongoing programs. Some universities have education centers or departments that provide generic teaching skills, and many of the larger medical specialties, including internal medicine and several surgical specialties, have courses and materials that they are generally willing to share. For example, *The Chief Resident as Manager* (University of Utah) provides residents some guidance in developing teaching skills, preparing slides, and delivering lectures. Chief Resident seminars are occasionally held locally for all specialties or nationally for Ophthalmology Chief Residents. Grand Rounds presentations, both within the institution and in fluorescein clubs and local ophthalmology societies, afford good opportunities for residents to participate and hone their presentation skills. To further teach these various skills, the Academy offers sessions at the Annual Meeting in the Technology Pavilion and occasionally in Skills Transfer courses. The AUPO may in the future also provide a workshop for this purpose.

Transition to Fellowships and Practice

In the past, residents had a wide range of opportunities to enter subspecialty fellowships and private practice. But modern times have altered the job market and require a more sophisticated approach to finding a position. Individuals in the department, especially the program director, should assist and advise on fellowship options and practice opportunities; the future success of each resident reflects back on the institution of training. By assigning faculty members to serve as mentors from the beginning of the first year, the program director helps build close relationships between residents and their particular attendings who can serve as advisors throughout residency.

While academic faculty have historically had limited experience in practice management, modern academic faculty know far more about private practice than their predecessors did. Residents and fellows should be encouraged to have regular interaction with community physicians (ie, clinical faculty) with whom they can discuss private practice issues. This interaction facilitates a milieu for healthy marketing, expands the horizons of trainees, and improves departmental town-gown relationships. Networking with physicians statewide, industry sales reps, and alumni creates a steady flow of job opportunities for graduates. The Academy, ASCRS, pharmaceutical companies, various subspecialty societies, and local ophthalmic associations also offer job seekers and potential employers opportunities to interact.

Over the years, graduating residents have been assisted by a variety of practice management programs offered by consulting firms and sponsored by some of the larger pharmaceutical companies. These programs are usually repeated every year or so, and if not provided locally, they are often paid for by unrestricted grants from companies. If your institution has a law school, outreach programs may provide residents with legal support for their contracts. Local attorneys or other consultants who specialize in physician practice management are often happy to lecture and discuss legal issues as part of their community outreach activities. The Academy, the American Society of Cataract and Refractive Surgery (ASCRS), and the American Society of Retinal Specialists (ASRS) also offer programs that teach about these issues at annual meetings, during teleconferences, and in a variety of home study forms. Continually encourage residents to take part in these offerings even though such programs don't always appear relevant to a resident's immediate plans.

Administration

Duty Hours

The program must ensure that learning objectives are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education has priority in the allotment of the residents' time and energy. Faculty and residents are collectively responsible for the safety and welfare of patients, and duty hour assignments should reflect this. More information on resident duty hours is available through the ACGME Web site at www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf.

Supervision of Residents

Many problems in education, patient-care quality, and institutional risk management can be alleviated by adequate supervision, especially in the city, county, and VA systems. Have schedules available from the coordinator's office to indicate which faculty are to be present and when. Keep track of attendance for promotion (or admonition) portfolios.

All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents should be provided with rapid, reliable systems for communication with supervising faculty.

Faculty schedules should be structured to provide residents with continuous supervision and consultation.

Faculty and residents should be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

Duty Hours Requirements

Duty hours are defined as all time spent in clinical and academic activities related to the residency program. This time includes patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, in-house call activities, and scheduled academic activities such as conferences. Duty hours do not include reading or preparation time spent away from the duty site.

Duty hours must be limited to 80 hours per week, averaged over a 4-week period, inclusive of all in-house call activities.

Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities (including on-call duty), averaged over a 4-week period. One day is defined as a continuous 24-hour period free from all clinical, education, and administrative activities.

Adequate time for rest and personal activities must be provided. This time consists of a 10-hour period between all daily duty periods and after in-house call.

On-Call Activities

Call must not occur more frequently than every third night, averaged over a 4-week period.

Continuous on-site duty must not exceed 24 continuous hours. Residents may be permitted to remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care, as defined in Specialty and Subspecialty Program Requirements.

No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.

At-home call (pager call) is defined as call taken from outside the assigned institution.

- The frequency of at-home call is not subject to the every-third-night limitation. However, at-home call will not be so frequent as to preclude rest and reasonable personal time. Residents taking at-home call will be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

- When residents are called into the hospital from home, the hours spent in house are counted toward the 80-hour limit.

- The program director and the faculty must monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and fatigue.

Moonlighting

Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, as provided in the Institutional Requirements.

Internal moonlighting, ie, moonlighting that occurs within the residency program, the sponsoring institution, or the sponsor's primary clinical site(s), must be counted toward the 80-hour weekly limit on duty hours.

Oversight

Duty hours must be monitored, and programs have developed multiple methods for tracking resident duty hours. Programs may elect to have residents clock in and out to precisely calculate the number of hours each resident works. While this method may be accurate, it is time consuming; it is a good tool to use only by programs whose residents are approaching 80 hours of work per week. Other programs elect to have residents keep time cards for one week out of a

specific time period. This method gives the program director a sample of hours worked. Some programs may instead elect to survey the residents periodically. See sample "Resident Duty Hours Survey."

If a resident exceeds 24 continuous hours plus 6 additional hours, the program director should be notified and the resident should be dismissed and excused from all clinical and educational responsibilities.

If call responsibilities become exceptionally cumbersome and generate excessive fatigue, the program director should be notified and the call schedules changed as necessary.

Resident's File

The residency coordinator is responsible for maintaining the resident's file. Most programs are uniform about what is included: application materials for residency, all letters of recommendation and evaluation, exam scores, GME-related materials (such as immunization records), licensure, and hospital credentialing/privileging lists (mostly for post-residency). This file is confidential and should be accessible by only the program director, coordinator, department chair, and resident. Some institutions, however, permit any faculty to access the resident's file.

Arrangement with Clinical Facilities

Medical schools and training programs are required to establish relationships with facilities where training occurs. The deans, department chairs, and chief executive officers of the various institutions should have written documents (which need to be available during the accreditation process) arranged and updated to maintain the relationships.

There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. The PLA should:

- Identify the faculty who will assume both educational and supervisory responsibilities for residents;

- Specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

- Specify the duration and content of the educational experience; and,

- State the policies and procedures that will govern resident education during the assignment.

The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS)

Safety and Security

Although safety and security are not always major considerations, check that each facility has adequate security criteria and appropriate personnel available to work with residents, especially late at night or alongside volatile patients.

Benefits

Depending on each institution's fiscal responsibility to its program, a benefit package is to be included. Your office of GME should provide benefits information in the general handbook for residents at your institution. Health coverage is commonly offered, but malpractice, licensure, and some insurance coverage are also often included.

Finances

As the health care economy endures rapid change, always remember the tenuous nature of funding for residency training programs. Each department should keep a regular and ongoing dialogue with hospital and GME leadership about the availability of current positions, as well as projected positions based on funding. Please recognize that most training programs are funded through the Centers for Medicare & Medicaid Services (CMS) funds, and that allocated monies for ophthalmology positions in these programs may cover up to only the PGY-4 year. Residents who have trained partially or completely in other specialties and exceed this postgraduate year level will not be compensated, and institutional or medical school leadership may require the department to cover any additional expense. You should ask your office of GME about "add-on" training time for residents who may graduate "late" due to extended leave.

In all instances, there are no guarantees as to funding or its potential effects on existing trainees. The CMS has carefully defined a fellow as someone in additional training at a "certified/accredited" fellowship program, and no ophthalmology fellowships are currently accredited or certified by the American Board of Medical Specialties (ABMS). Although the AUPO Fellowship Compliance Committee (FCC) is working to establish a standardized certification process for ophthalmology fellowship programs, ophthalmology fellows cannot be included in your residency GME count.

The Program Director

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Career Development

The role of the program director in ophthalmology residency training programs has evolved over the past ten years, and the main factor driving the evolution has been the Accreditation Council for Graduate Medical Education (ACGME) Outcomes Project: a multiyear transition from a process-driven approach toward an outcomes-based approach. Central to this transition is the enumeration of the 6 general competencies that now provide the framework for the curriculum and evaluation of residents. As a result of the Outcomes Project, the program director is expected to be an excellent educator, administrator, clinician, surgeon, researcher and scholar. To address the new ACGME requirements, program directors must develop expertise in adult education principles, curriculum design, and evaluation techniques. It is safe to say, however, that the majority of program directors have had little formal training in these areas.

In light of the changes, program directors face numerous challenges, and chief among them is time pressure. Continued and increasing financial pressure on departments forces most program directors to spend significant time in clinical activities to generate revenues. Lack of prior training and experience in administrating formal education adds stress and inefficiency to an already busy schedule. And these issues are in addition to the daily requirements of dealing with often unpredictable and varying resident needs.

Although these challenges will vary from department to department, an essential first step is to pursue a close working relationship with the department chair. While the program director often knows the critical issues facing the residency program, the chair can often address time and financial concerns. Frequent and open communication between the chair and program director aids in maintaining a common purpose and direction among faculty and residents. Likewise, obtaining faculty buy-in regarding the new educational requirements is paramount. Unfortunately, all of the previously mentioned pressures apply to most faculty members, so a concerted effort must be made to educate them about their pivotal role in resident education and evaluation. In the best scenario, the department has an incentive plan that rewards faculty members for their educational involvement.

On a positive note, these changes also present opportunities for program directors. Consider publishing on the effort your program expends to meet the ACGME general competency requirements. As the role of the program director evolves, there are increasing opportunities to make educational research part of their career development path. Certainly as program directors share their experiences in this evolving process, the better able they will be to improve the education of their residents.

Resources

Given the ACGME requirements regarding the general competencies, program directors face an immediate challenge to obtain the requisite expertise in education and evaluation principles. The best place to start is the ACGME Web site, www.acgme.org, which has a great deal of essential information, including the Program Requirements for Ophthalmology, the Program Director's Virtual Handbook, and the Toolbox for evaluations and instruction. Other specialties have established educational Web sites for their program directors; two of these are www.surgicaleducation.com and www.im.org/APDIM. Other resources include the Association of American Medical College (AAMC) site, www.aamc.org, and the American Medical Association (AMA) site, www.ama-assn.org.

Resources at the local level should also be consulted. Many institutions have faculty members with expertise in graduate medical education who are available to assist in teaching techniques, curriculum design, and evaluation techniques. The Graduate Medical Education Committee (GMEC) at your institution should be a clearinghouse for these types of resources, and it should be actively involved in making expert faculty available to individual departments.

Job Description*

Background

The most critical features of the program director position are those required by the Resident Review Committee (RRC). The RRC expects the program director to be an effective administrator, educator, and research coordinator, and these abilities will be evaluated at each site visit. The program director takes on numerous other tasks, roles, and responsibilities that vary from program to program.

In describing the role of the program director, the Program Requirements make a general statement that sets the tone for the specific expectations: the program director and faculty are responsible for the general administration of the program and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for the program director and faculty are essential to maintaining such an environment. The length of appointment for the program director should provide for continuity of leadership; the program director should have a term of at least 3 years.

Qualifications of the Program Director

There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

The program director should be a member of the medical staff of the sponsoring or integrated institution. The institution must ensure that the program director is given sufficient authority, financial support, and facilities by the governing body of the sponsoring institution to permit him or her to organize and supervise the following activities of the training program:

- Resident selection and evaluation

- Resident instruction

- Patient management

- Research

- Initiation of recommendations for staff recruitment

The program director should have:

- Requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee

- Current certification in the specialty by the American Board of Ophthalmology or specialty qualifications that are acceptable to the Review Committee

- Current medical licensure and appropriate medical staff appointment

Responsibilities of the Program Director

The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

- Oversee and ensure the quality of didactic and clinical education in all sites that participate in the program.

- Approve a local director at each participating site who is accountable for resident education.

- Approve the selection of program faculty as appropriate.

- Evaluate program faculty and approve the continued participation of program faculty based on evaluation.

- Monitor resident supervision at all participating sites.

- Prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete.

- Provide each resident with documented semiannual evaluation of performance with feedback.

- Ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution.

- Provide verification of residency education for all residents, including those who leave the program prior to completion.

- Implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and to that end must:

  - Distribute these policies and procedures to the residents and faculty.

  - Monitor resident duty hours according to sponsoring institutional policies with a frequency sufficient to ensure compliance with ACGME requirements.

  - Adjust schedules as necessary to mitigate excessive service demands and fatigue.

  - If applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and fatigue.

- Monitor the need for and ensure the provision of backup support systems when patient care responsibilities are unusually difficult or prolonged.

- Comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation, and promotion of residents; disciplinary action; and supervision of residents.

- Be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures.

- Obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

  - Applications for ACGME accreditation of new programs

  - Changes in resident complement

  - Major changes in program structure or length of training

  - Progress reports requested by the Review Committee

  - Responses to all proposed adverse actions

  - Requests for increases or any change to resident duty hours

  - Voluntary withdrawals of ACGME-accredited programs

  - Requests for appeal of an adverse action

  - Appeal presentations to a Board of Appeal or the ACGME

  - Proposals to ACGME for approval of innovative educational approaches

- Obtain DIO review and cosignature on all program information forms as well as any correspondence or document submitted to the ACGME that addresses program citations or request for changes in the program that would have significant impact, including financial, on the program or institution.

- Ensure that all residents have equivalent educational experiences.

- Seek approval from the Review Committee for a required rotation of 6 months or more to any site other than the primary teaching site.

- Seek approval from the Review Committee for any change in resident complement, either the total number or the number at any level. If the change in resident complement results from an extension of a single resident's training and is not greater than 6 months, only prior notification of the Review Committee is required.

- Prepare explicit written descriptions of the lines of responsibility for the care of a patient and make these clear to all members of teaching teams. Residents must be provided with rapid, reliable systems for communication with and appropriate involvement of supervisory physicians in a manner appropriate for both quality patient care and educational programs.

- Ensure that residents are educated in basic and clinical sciences through a structured and regularly scheduled series of conferences and lectures. This series should include a minimum of 360 hours during the 36-month training program, at least 200 hours of which are intramural. In addition, a minimum of 6 hours per month should be devoted to case presentation conferences (eg, Grand Rounds, Continuous Quality Improvement) attended by several faculty and a majority of residents. The program director or designee is responsible for documenting residents' attendance at conferences.

- Ensure the residents are entering their operative cases into the resident case log system.

- Verify the surgical experiences of each resident, including the number of cases in each category where the resident has served as the primary surgeon or the assistant surgeon. This documentation must be provided to the Review Committee on its program information forms; individual resident logs must be available at the time of the site visit.

* Adapted, with permission, from the *Program Requirements for Ophthalmology,* © 2005 ACGME, www.acgme.org.

Curriculum

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While the heart of any ophthalmology residency program is its people, the backbone of a successful residency program is its formal education curriculum. As the Accreditation Council for Graduate Medical Education (ACGME) states in the Program Requirements for Residency Education in Ophthalmology (www.acgme.org), the program director is responsible for developing and implementing the academic and clinical program of resident education by:

- Preparing and implementing a written statement outlining the educational goals of the program with respect to the knowledge, skills, and other attributes of residents for each major assignment and each level of the program

- Preparing and implementing a comprehensive, well-organized, effective curriculum, both academic and clinical, which includes the presentation of core specialty knowledge supplemented by the addition of current information

- Providing residents with direct experience in progressive responsibility for patient management

Each of these responsibilities presents a challenge for a residency program director, particularly someone with additional commitments to patient care, research, and education. The goal of this section is to help residency program directors fulfill these responsibilities and enhance the quality and effectiveness of their residency programs. The section first reviews general principles of adult learning and describes an organizational approach to developing an ophthalmology residency curriculum. This approach is also applicable in the creation of the individual teaching component in the curriculum. This section then reviews examples of program goals and specific educational activity goals, highlights features of an effective ophthalmology residency program curriculum, and outlines characteristics of a meaningful patient care experience.

General Principles and Guidelines

In developing the academic and clinical curriculum for an ophthalmology residency program, a program director should consider the fundamental principles of learning, as well as general guidelines for developing an educational program or activity. Understanding and utilizing these principles and guidelines will improve the quality of the educational experience for both the teacher and the learner.

Principles of Learning

Learning is active. Learning is most effective when residents share responsibility for their own learning, ie, the resident actively participates by setting personal learning objectives. Motivation is probably the most powerful determinant of whether or not learning occurs: we must be motivated to learn! The teacher's role is to create the environment and conditions that encourage motivation and learning in their residents.

Learning is purposeful and problem-centered. Ophthalmology residents are eager to acquire practical information required to solve real problems. Learning is easier to accomplish and more likely to be retained when it is done for a purpose. There is a strong need for clear goals and learning objectives, and the learning objectives need to be realistic and achievable.

Learning requires feedback on performance. Feedback may be extrinsic (faculty evaluations, examination scores, etc.) or intrinsic (self-evaluation); ophthalmology residents often have keen insight into their relative strengths and weaknesses. Positive reinforcement of good behavior helps to promote its continuance; constructive feedback provides opportunities for improvement and may prevent errors from becoming habitual.

Learning occurs in a supportive learning environment. A supportive learning environment encompasses a variety of factors: an enthusiastic teacher who is available and approachable; an opportunity for residents to ask questions without fear of humiliation and judgment; and adequate time and resources to complete the learning task. The learning experience flourishes in a setting of mutual trust and respect between the teacher and learner.

Developing an Educational Program

Conduct a needs assessment. What do you want to teach and why? The needs assessment makes the teaching session more efficient by reducing the redundancy of teaching things that are already known and maintaining focus on the most important aspects of a particular topic. Needs assessments can be accomplished through surveys and questionnaires, course evaluations, and other methods.

Develop learning objectives. What do you expect your residents to be able to do after completing the educational activity? Learning objectives provide focus and direction to both the teacher and the learner and should address vital aspects of knowledge, skills, and attitude. Be cautious of learning objectives that are too broad in scope, too numerous for the educational time allotted, or not achievable or observable.

Develop teaching materials and methods. Different learning objectives require different teaching methods. Lectures are the most common teaching method because they are efficient for the teacher, but consider other methods such as problem-based learning, case-based discussions, small group discussions, and self-learning packages.

Teach. Remember the principles of adult learning and incorporate them into the teaching session. Adults learn best when learning is active and problem-centered. Involve the learner in the development of the learning objectives and choice of teaching methods. Be available and approachable, and provide relevant and timely feedback.

Evaluate teaching effectiveness. Evaluation is conducted to measure the performance of the learners, the effectiveness of teachers, and the overall quality of the program. The results of the evaluations provide the opportunity for continuous quality improvement of the educational activity. Methods for evaluation include surveys and questionnaires, self assessment, written examinations, and other activities.

Putting the Principles to Work

How can the program director use these principles and guidelines to enhance the effectiveness of the teaching and learning experience? Developing a supportive learning environment is essential: residents and teachers must be enthusiastic and committed to building a program based on trust and mutual respect. The learning experience, in patient care and educational conferences, should be active and emphasize practical, problem-centered learning. And there needs to be a commitment on the part of the residents and faculty to engage in constructive feedback to improve individual and program performance.

In terms of the guidelines, consider the following example based on organizational structure to develop a specific educational activity. The Association of University Professors of Ophthalmology (AUPO) Policy Statement on Medical Student Education proposes that all primary care physicians be able to detect strabismus and abnormal eye movements.[1] Using this goal to define the needs assessment, how can you construct an educational activity that would promote learning for medical students (note the target audience)?

The first task is to develop learning objectives. What do you expect the students to be able to do after completing the educational activity? After completing the session, a student should be able to:

- Diagram the position of the extraocular muscles

- List the innervation and function of the third, fourth, and sixth cranial nerves

- Perform an ocular motility exam in a normal individual

- Distinguish esotropia and exotropia using a penlight

- Diagnose third, fourth, and sixth cranial nerve palsies

- Differentiate a pupil sparing from a pupil involving third nerve palsy

These learning objectives are "SMART": specific, measurable, achievable, relevant/results-oriented, and targeted to the specific audience.[2] It is reasonable to expect medical students to achieve these learning objectives provided they participate in the appropriate educational

experience.[3] For this reason, you should develop teaching methods that promote active, problem-centered learning. A variety of methods could be employed:

- Lecture to discuss the anatomy and function of the extraocular muscles and cranial nerves three, four, and six

- Small group demonstration and performance of the motility and pen light examinations

- Videotape and photographic demonstrations of normal and abnormal eye movements

- Case-based learning to differentiate third, fourth, and six cranial nerve palsies

Finally, we need to conduct an evaluation to ensure that the students have achieved the learning objectives and that the educational program is effective in design and function. A brief written examination could be administered to assess the student's knowledge and clinical reasoning skills. Students could be directly observed performing the motility and penlight examinations. Participation in case-based learning could facilitate assessment of a student's knowledge and preparation, ability to communicate effectively, and interactions in a group setting. In terms of teacher and program performance, students could complete a questionnaire to assess teacher and program effectiveness.

Educational Goals

The ophthalmology residency program director is responsible for preparing and implementing a written statement outlining the educational goals of the program with respect to the knowledge, skills, and other attributes of residents in each major assignment and level of the program. The ACGME Outcome Project has had a significant impact on ophthalmology residency training and provides the general framework to develop the overall residency program goals, as well as the goals for specific educational activities and clinical rotations.[4] As stated in the ACGME Outcome Project, the residency program must ensure that its residents obtain competency in the core areas to the level expected of a new practitioner (www.acgme.org/outcome). Toward this end, programs must provide educational experiences as needed in order for their residents to demonstrate:

- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

- Medical knowledge about established and evolving biomedical, clinical, and cognate (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

- Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

- Interpersonal and communication skills that result in effective information exchange and

teaming with patients, their families, and other health professionals

- Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

- Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, and the ability to effectively call on system resources to provide care that is of optimal value

Specific Rotation/Educational Activity Goals

In addition to general residency program goals, residency program directors and faculty are required to implement goals for specific educational activities and clinical rotations. This provides the opportunity to identify specific areas in terms of knowledge, skills, and attitudes that residents must master during their residency training. Look at 3 examples of specific educational activity goals for common ophthalmology residency program experiences: a single didactic session, an educational series, and a clinical rotation. For each of these examples, ask yourself the SMART questions: Are the learning objectives specific? Measurable? Achievable? Relevant? Targeted? Also, consider the best possible teaching method for each and how you would evaluate whether or not the resident achieved the learning objective.

Didactic Conference. Following a didactic conference on anterior uveitis, the ophthalmology resident should be able to:

- Classify uveitis based on the primary location of the ocular inflammation

- Identify the common symptoms and signs of anterior uveitis

- List the most common systemic associations of anterior uveitis in children and adults

- Discuss the significance of HLA-B27 and HLA-B27 associated anterior uveitis

- Conduct an appropriate laboratory work up of a patient with recurrent anterior uveitis Initiate an appropriate management strategy including follow up considerations

- Identify the long-term complications of anterior uveitis and anterior uveitis treatment

Educational Series. The surgical skills workshop, a yearlong educational series for ophthalmology residents, is designed to promote learning of the indications, complications, and operative techniques for common ophthalmic surgeries. After completing the educational series, residents should be able to:

- Identify the most common ophthalmic surgeries performed in an ophthalmology residency program

- Describe the most common indications for a particular ophthalmic procedure

- Recognize the most common complications of a given ophthalmic surgery

- Develop a logical, step-by-step approach to perform common ophthalmic surgeries

- Obtain an informed consent from a patient scheduled to undergo cataract surgery

Clinical Rotation. After completing the retina rotation, the first-year ophthalmology resident should be able to:

- Obtain a comprehensive history from a patient with a retinal problem

- Perform a complete eye examination including indirect ophthalmoscopy, fundus contact lens biomicroscopy, and scleral depression

- Recognize features of diabetic retinopathy (including clinically significant macular edema and proliferative diabetic retinopathy) and age-related macular degeneration (including the exudative complications of the disease)

- Perform an accurate retinal drawing

- Interpret normal and abnormal fluorescein angiograms using appropriate terminology

- Formulate differential diagnosis for common retinal diseases.

- Discuss treatment indications and options for common retinal problems including diabetic retinopathy and age-related macular degeneration

- Critically review the primary literature for a specific retinal problem and provide a brief overview to a faculty member and medical student

Curriculum Development

The ophthalmology residency program director is charged with preparing and implementing a comprehensive, well-organized, effective curriculum that includes the presentation of core specialty knowledge supplemented by the addition of current information. The formal education curriculum should include a basic and clinical science conference series emphasizing core ophthalmology knowledge, as well as a variety of additional conferences such as a continuous quality improvement conference, resident case presentations, fluorescein angiography conference, a surgical skills workshop, and a journal club. In addition, grand rounds and visiting professor rounds contribute greatly to the quality of the resident education experience.

On its Web site, www.icoph.org/ed/resgui.html, The International Council of Ophthalmology provides extensive guidelines that the program director may reference when creating an ophthalmic curriculum that is suited to a particular program and its resources.

Basic and Clinical Science Series

The basic and clinical science series serves as the core curriculum of many ophthalmology residency programs. This series may be scheduled regularly every morning, Monday through Friday, throughout the academic year or grouped together on a single day once a week. Each specialty service is responsible for 1 to 2 conference sessions per month; educational methods include lectures, small group discussions, and case presentations. Conferences cover a broad range of topics including ophthalmic pathology, optics, cornea/external diseases, glaucoma, neuro-ophthalmology, pediatric ophthalmology, oculoplastic and orbital diseases, retina, intraocular inflammation and uveitis, and ophthalmic fundamentals. Residents are expected to read all of the Basic and Clinical Science Course manuals published by the Academy; these manuals provide the core specialty information for residents to build their knowledge base.

Residency programs may elect to provide their conference series on a daily basis or concentrate their educational program in weekly sessions. Though it is important for residency programs to develop their own core basic and clinical science education curriculum, there are opportunities for residencies to participate in extramural programs and review courses to supplement their internal offerings.

Continuous Quality Improvement Conference

Continuous quality improvement conferences improve the quality of patient care through open discussion of clinical and surgical topics. These conferences center on surgical cases and complications. The use of videotape examples focuses the learners' attention and encourages reaction and response. Interaction improves the quality of the group discussion and increases the likelihood that learning occurs by all members of the group.

Resident Case Presentations

The purpose of resident case presentations is twofold: to increase knowledge throughout the department by discussing both common and unusual case presentations in all ophthalmology specialty areas; and to promote the role of residents as teachers. Regardless of the topic, all faculty members are strongly encouraged to attend, promoting a rich, multifaceted discussion.

Fluorescein Angiography Conference

The fluorescein angiography conference may be held 1 to 4 times per month and supplements the core basic and clinical science series. This conference provides the opportunity for in-depth discussion of retinal diseases with an emphasis on the diagnostic and therapeutic role of fluorescein angiography and other ancillary studies, including optical coherence tomography, electrophysiologic studies, and ultrasonography. Cases may be presented as unknowns or can be assigned to residents in advance to allow for a more thoughtful, purposeful discussion during the conference (again promoting the role of resident or fellow as teacher).

Surgical Skills Workshop

The surgical skills workshop is an effective teaching method to promote discussion on the indications, complications, and operative techniques for common ophthalmic surgeries. The residents and a faculty moderator discuss a common ophthalmic surgery and prepare a list of indications and complications for that procedure. Then, they develop a step-by-step algorithm to facilitate resident understanding and performance of the surgery. Surgery simulation models, if available, allow the residents to apply their knowledge and practice skills under "real" conditions and the supervision of a faculty member. Feedback, both verbal and physical, to guide the resident can be given immediately.

Journal Club

Journal club is a longstanding tradition in graduate medical education. Journal club provides the opportunity for the faculty and residents to critically review ophthalmic publications. The club generally meets monthly and involves discussion of 3 to 6 articles per session. Although the majority of articles are recently published, journal club may include the review of classic journal articles that serve as a basis for current understanding and clinical practice.

Clinical Education

The quality of an ophthalmology residency program ultimately depends on its ability to provide residents with direct patient care experiences in an environment of appropriate faculty role modeling and supervision. The faculty must have a broad range of general and subspecialty expertise and must demonstrate a strong commitment to the education mission through their patient care, education, and research activities. The Program Requirements for Residency Education in Ophthalmology states the requirement thus: "The volume and variety of clinical ophthalmological problems in children and adults must be sufficient to afford each resident a graduated supervised experience with the entire spectrum of ophthalmic diseases so that the resident may develop diagnostic, therapeutic, and manual skills and judgment as to their appropriate use."

The clinical education program should include ample opportunities for outpatient experiences, surgical experiences, and inpatient consultation services. The outpatient experience should consist of a variety of general and specialty rotations that ensure residents obtain expertise in a broad range of ophthalmic diseases; resident education should also include discussion of the ethical and socioeconomic aspects of eye care. The surgical experience must be designed to ensure residents assist and perform sufficient surgery to become competent ophthalmic surgeons. Specifically, the Program Requirements for Residency Education in Ophthalmology advises: "Each resident must have major technical and patient care responsibilities in the surgery (including laser surgery) of cataract, strabismus, cornea, glaucoma, retina/vitreous, oculoplastic, and trauma to provide an adequate base for a comprehensive ophthalmic practice." Finally, residents should be actively involved in inpatient consultative services not only to provide necessary eye care but also to learn the importance of the ophthalmologist's role in the overall health care delivery system.

The residents gain increasing responsibility for patient care in both the clinical and surgical arenas according to their experience and skill level. Some programs prefer to introduce junior residents to the operating room early in their training to facilitate their development from assistant to primary surgeon; however, the bulk of the residents' intraocular surgical experience still occurs in the final year of training.

Conclusion

Ophthalmology residency program directors have significant responsibilities in developing the academic and clinical programs for resident education, and with these responsibilities comes great opportunity. Program directors can improve the quality of ophthalmology resident education by incorporating the principles of adult learning and the organizational guidelines in their curriculum planning and implementation. Developing program and specific educational activity goals based on the ACGME Outcome Project's core competencies ensures that the next generation of ophthalmologists has the essential knowledge, skills, and attitudes to serve their patients. Establishing a curriculum grounded in the ophthalmic fundamentals and supplemented with emerging knowledge enables residents to learn and practice ophthalmology effectively in the present, and to develop lifelong learning skills that ensure future growth. By creating a comprehensive patient care experience, based on a balance of medical and surgical training, general and specialty experiences, and education and service responsibilities, the program director ensures that ophthalmology residents develop the skills needed to provide high quality and compassionate care.

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Core Competencies

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Defining Core Competencies

There are 6 areas in which a resident must demonstrate competency: patient care, both clinical and surgical; medical knowledge; professionalism; practice-based learning and improvement; interpersonal and communication skills; and systems-based practice. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

1. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

2. Medical knowledge about established and evolving biomedical, clinical, and cognate (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

3. Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

4. Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals

5. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

6. Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

A full version of the competencies provides more detailed definitions and is available through the Accreditation Council for Graduate Medical Education (ACGME) at www.acgme.org/outcome/comp/compFull.asp.

Applying Core Competencies

The core competencies should be included in the objectives of the overall residency program and in the specific objectives of individual rotations. They should be specifically addressed in the formal didactic teaching program. Many of these objectives will also be addressed in teaching

rounds, clinical case conferences, journal review sessions, and through individual discussions amongst faculty members and residents in the clinic and operating room.

A growing number of medical centers have developed online courses that cover many of the topics that are pertinent to all residents, such as professionalism, communication, and practice-based learning. It is helpful to contact colleagues at other institutions to get ideas for how to structure these courses or to share course materials. Refer also to the "Other Resources" segment at the end of this section.

Evaluation Process

The teaching of the core competencies and performance of residents in each area is driven by the evaluation process. Areas that are not included in the evaluation process are more likely to be neglected by both the faculty and the residents. The best assessment will be obtained by utilizing multiple evaluation tools for each area. Sample evaluation tools and recommendations for their use are listed.

Specific Evaluation Tools

Each core competency should be evaluated using evaluation tools specific to that area. As required by the ACGME and RRC, more than one evaluation tool should be used for each competency area. While a comprehensive tool like the Global Ratings evaluation, www.acgme.org/acWebsite/RRC_240/240_resEval.asp, can be used to rate progress in multiple areas, various combinations of the following tools are recommended:

Patient Care
 Clinical
 1. Global Ratings
 2. Record Review and Chart Stimulated Recall
 3. 360-degree Evaluations – technicians, ER doctors, patients, fellow residents
 Surgical
 1. Global Ratings and Surgical Videos – surgical skills assessment form
 2. 360-degreee Evaluations – OR nurses, technicians
 3. Surgical Log
 4. Checklist

Medical Knowledge
 1. Chart Stimulated Recall
 2. Oral Exams
 3. Written Exams
 4. Global Ratings

Professionalism
 1. Patient Survey
 2. 360-degree Evaluations
 3. Global Ratings

Practice-based Learning and Improvement
   1. Record Review and Chart Stimulated Recall
   2. Oral Exams
   3. 360-degree Evaluations
   4. Global Ratings
   5. Quality Improvement Project with Evaluation

Interpersonal and Communication Skills
   1. 360-degree Evaluations
   2. Patient Surveys
   3. Global Ratings

Systems-based Practice
   1. 360-degree Evaluations
   2. Patient Surveys
   3. Global Ratings
   4. Chart Stimulated Recall

A summative discussion of resident performance with the program director or other faculty member must be conducted at least twice a year to meet requirements set by the ACGME. Refer to the forms posted at www.acgme.org/acWebsite/RRC_240/240_resEval.asp for more information.

Choosing Evaluation Tools

In developing a complete evaluation protocol, the program director must choose evaluation tools that match the needs and resources of the program and provide valid assessments. For a breakdown of sample evaluation tools and their appropriate use, refer to www.acgme.org/Outcome/assess/ToolTable.pdf. The following aspects should be considered (see www.acgme.org/outcome/assess/keyConsider.asp for more information):

Validity. The evaluation tool chosen for each competency should provide a valid assessment. The ACGME Web site offers a matrix of known evaluation tools that may be useful for each core competency; visit www.acgme.org/Outcome/assess/ToolTable.pdf. The tools are ranked for their desirability for assessing each area.

Quantification. Evaluation tools are most useful if they can provide a numerical score for each area. This score will be essential for monitoring resident performance over time and for assessing the effect of changes in curriculum or teaching approaches on resident performance.

Faculty and administrative time commitment. In developing a comprehensive assessment program, the program director must consider the amount of faculty and administrative time required for particular evaluation tools.

Cost. The resources and support needed to administer some of the suggested evaluation tools may be prohibitive for many programs.

Sample Evaluation System

To effectively and efficiently administer an evaluation system, the program should maintain a timetable and records based on the evaluation tools that the program selects. See sample "Progress Summary."

Also, by asking residents to maintain a portfolio of activity, achievement, and goal fulfillment, residents can monitor progress in each competency area and provide the program director with a detailed overview of their progress. The resident portfolio can be used continually to evaluate practice-based and systems-based learning and improvement, and is recommended by the ACGME as an effective records and assessment system. An efficient system may use 3 or 4 tools in various ways to assess all the core competencies; an example of such a system follows:

Global Ratings – Quarterly
> All core competencies

360-degree Evaluations – Semi-annually
> Patient care
> Practice-based learning and improvement
> Interpersonal and communication skills
> Professionalism
> Systems-based practice

Patient Surveys – Semi-annually
> Interpersonal and communications skills
> Professionalism
> Systems-based practice

Record review and chart stimulated recall – Quarterly
> Patient care (clinical)
> Practice-based learning and improvement
> Systems-based practice

Oral exam – Quarterly
> Medical knowledge
> Practice-based learning and improvement

Written exam (OKAP) – Annually
> Medical knowledge

Portfolio – Continuous (Reviewed at each evaluation session)
> Practice-based learning and improvement
> Systems-based practice

Other Resources

As new tools and methods for resident evaluation evolve, several ophthalmology residency programs and advocacy groups are sharing their work, especially online. The ACGME Web site houses a considerable amount of information helpful in creating and adapting your own tools to evaluate achievement in the core competencies, and some of the more pioneering programs have contributed content there and on their own respective university sites.

Samples

The ACGME offers (but does not endorse) examples of specific approaches that may be used to assess the general competencies; also included is information regarding the technical and practical characteristics of each approach, www.acgme.org/outcome/assess/compList.asp.

Latest Developments

RSVP (Recognize Success Via imPlementation), hosted by the ACGME, is a showcase for works-in-progress. The projects included here are examples of activities and approaches that may be used to teach and assess the general competencies. Specific to ophthalmology residencies are the sections discussing the Journal Club, the On Call Assessment Tool (OCAT), and the Ophthalmic Clinical Evaluation Exercise (OCEX). See samples "OCAT Tool," "OCEX Tool," and OCEX Rubric, www.acgme.org/outcome/implement/rsvp.asp.

Methods and Implementation

The Toolbox of Assessment Methods provides a brief description of 13 assessment methods and references to articles where more complete and in-depth information about each method can be found: www.acgme.org/Outcome/assess/Toolbox.pdf.

Competency Education for Program Directors

The University of Iowa Department of Ophthalmology Task Force offers their latest documentation, methodology, presentations, and assessment tools: webeye.ophth.uiowa.edu/eyeforum/compindex.htm.

Evaluations

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Evaluation of Residents

Levels of Competence

As it is impossible to establish uniform goals across all residency programs, individual programs should formalize goals that both residents and faculty can use as the basis for evaluations during and at the end of every rotation. Ideally, informal resident evaluations should be done halfway through the rotation so that inadequate progress can be corrected prior to the formal evaluation at the end.

Some methods for evaluating resident level of competence include:

- Written examinations

- OKAP exams

- Rotation evaluations or global performance rating

- Direct observation of resident surgery and patient examinations

- Objective structured clinical examinations: www.acgme.org/acWebsite/RRC_240/240_compAssessment.asp

- Review of videotaped resident surgery

- Review of resident surgical logs

- The 360-degree evaluation, which takes into account faculty assessment and critique from peers, nurses, and staff.

The Ophthalmology RRC has developed a list of core assessment methods that can be found at www.acgme.org/acWebsite/RRC_240/240_compAssessment.asp. The core assessment methods include: Global Rating, OKAP examination, 360-degree evaluations including self-assessment, fellow residents and professional associates, patient surveys, portfolios, procedural skills assessment, and surgical case logs.

Each faculty uses specific methods for assessing the resident's progress, and these methods may draw from written examinations, oral examinations, patient examinations, as well as subjective input. To reduce psychometric bias, faculty should make objective assessments and avoid being too generic (eg, using vague ratings like "excellent," "good," and "bad"). Whenever possible, evaluations should be tied to the core competencies. Two global rating forms, with a series of

ratings in different subcategories and a 1 to 9 rating scale, have been created by the American Board of Ophthalmology (ABO) and Association of University Professors of Ophthalmology (AUPO). They are available in electronic form for downloading at www.acgme.org/acWebsite/RRC_240/240_resEval.asp; program directors can modify the form for their individual program's use.

OKAP Exams

The Academy has made it clear that the Ophthalmic Knowledge Assessment Program (OKAP) exam is not to be used to determine whether to promote or certify a resident. Instead, the exam should be an external marker of a resident's knowledge base, and it may help support a decision for admonition or remediation. The education committee may also use the exam to gauge the effectiveness of a curriculum and to isolate aberrations. Some programs have established home study courses run by the residents (with input from fellows and faculty) that are based on the template of the *Basic Clinical Science Course* series.

Cycles of Evaluation

Evaluation cycles vary by program and are usually determined by the time span of a given rotation. A faculty member (rotation preceptor) should meet with the resident midrotation to discuss any areas that may need improvement before the end of the rotation. Programs should have formal written evaluations for each resident after every rotation. A summative discussion of resident performance with the program director or other faculty member must be conducted at least twice a year to meet requirements set by the Accreditation Council for Graduate Medical Education (ACGME), but it can be done more often if a program deems it useful. Both the program director and the resident must sign the evaluation. Refer to the forms posted at www.acgme.org/acWebsite/RRC_240/240_resEval.asp for more information.

Criteria for Advancement

The program director, with the advice of department faculty, determines whether to promote a resident to the next program year and the whether a resident has satisfactorily completed the program.

For promotion from PGY-2 to PGY-3, a resident must have demonstrated:
1. Acceptable progress in all competencies Ability to supervise medical students
2. Some independent ability to evaluate and manage patients
3. Successful completion of USMLE, Step 3

For promotion from PGY-3 to PGY-4, a resident must have demonstrated:
1. Acceptable progress in all competencies
2. Ability to supervise and teach medical students and PGY-2 residents
3. Ability to act with increasing independence

For graduation from the program the resident must have demonstrated:
1. Competence in all competencies

2. Ability to act independently
3. Adequate surgical experience and competence in all surgical areas.

Remediation of Deficiencies

Although remediation is determined on a case-by-case basis, it should follow due process when identifying a resident's deficiency or aberration. Plans to remediate should be carefully defined and the results documented. The program director and the resident should select an objective faculty mentor removed from the other evaluation processes who can assist with the remedial work. Be sure to indicate time frames for successful completion of the process, and have it correlate with critical junctures in the training calendar, eg, the end of the residency year, to ensure promotion or certification. Remediation of academic deficiencies can be assessed by performance on an OKAP exam, in-service exam, or oral exam given by selected faculty, or by completion of additional reading assignments. Note, however, that OKAP performance is not meant to be used as the sole criterion for promotion.

Certification

Certification of residency training is elaborated in the "Green Book" of Graduate Medical Education (GME) and can be requested online through the American Medical Association at www.ama-assn.org. Certification is defined as the successful mastery of content (the program complies with ACGME requirements) in a given period (36 months minimum). In most cases, this is a routine process; however, a resident may complete 36 months of training and not yet meet content requirements, as can be determined by due process. This individual may not sit for the ABO written qualifying or oral board examinations. Such a resident would require additional training at a center where the requirements are satisfied and certification verified. Again, make sure to carefully document the reasons behind the decision not to certify and discuss the issue with your office of GME.

Credentialing

In providing credentials to graduates of the program, the program director regularly approves requests for privileges (typically for procedures used in fellowship training or future employment). To avoid confusion and conflict, the program director should explain to trainees what the credentialing process entails. The program director has access to a resident's surgical log through the ACGME Web site at www.acgme.org/ads/default.asp. Many institutions and facilities require documentation for privileging of special procedures, including laser. Suggest that your trainees not request privileges to perform a procedure they have never done or have done only rarely (eg, lateral orbitotomy), particularly if they do not expect to perform that procedure in the hospital for which they are requesting privileges. A number of programs have a designated person responsible for confirming the dates of training for any graduate of the residency; those dates are often all that is required in granting privileges. If you are unsure whether to recommend that a request for privileges be approved, consult legal counsel through your office of GME.

The Problem Resident

Problematic residents are a sensitive issue that surfaces more frequently than most departments generally recall. While many reasons may explain a change or aberrancy in behavior, your recognition of a problem is the most important aspect of effectively dealing with the situation. Many program directors and chairs initially attempt to counsel and support the "problem resident" on their own. If the problem continues or gets worse, they may obtain the help of the university and office of GME. Most institutions and medical schools have employee wellness centers for handling potential psychiatric or substance abuse issues. Indicate your request to provide assistance in your due process documentation; your office of GME may have guidelines already in place.

Don't allow personal bias to interfere with the assistance of a problem resident. Recruit other faculty or committees to help deal with the overlying stress that is created by the situation. Face-to-face meetings between the problem resident and program director should be attended by another staff or faculty member to help avoid potential charges of bias or harassment. To protect the resident and support any decision made by the program director or department chair, unacceptable behavior must be documented with evidence and corroborated by other residents, staff, faculty, or patients. In general, it is far better to initiate action against a resident based on evaluations in the core competencies (e.g., professionalism) than on specific charges of substance abuse or other violations that may be difficult to prove. For more information on disciplinary action, probation, and dismissal, see section "Administrative Issues and Problems."

In some cases, residents may be required to take a leave of absence before resuming training. A formal policy regarding such situations should be available in writing to residents and may be available as an institution-wide policy established through the office of GME. Keep in mind that some residents may request special status under the Americans with Disabilities Act (ADA) for psychiatric disorders, including substance abuse problems, in which case legal counsel should be sought.

Evaluation of the Faculty

The ACGME requires residents to evaluate the faculty in an anonymous and confidential fashion, typically done at the completion of each rotation. To keep these evaluations anonymous, the residency coordinator should compile a report annually that includes both objective data as well as subjective comments to the chair. The chair then relays any pertinent information to the individual faculty members.

At the end of each rotation, the education committee should also review resident evaluations of the faculty. The committee meets periodically to discuss faculty performance and can offer constructive criticism to improve the caliber of teaching in the program.

Evaluation of the Program

By the Residents

To maintain ACGME accreditation, each program must be evaluated by its residents and faculty in an anonymous and confidential fashion. The evaluation by residents should distinguish each specific rotation the written goals for that rotation, and whether the goals were achieved.

In addition, a yearly informal review by the entire group of residents is helpful. Additionally, the results of the ACGME resident survey, which is performed every 2 years, are available to the Program Director and may provide valuable feedback and areas for improvement.

Additional methods for determining program effectiveness are the exit questionnaire and a survey of graduates who completed the program 1 and 5 years prior. These evaluations provide valuable feedback regarding training, faculty, and general issues in the department. Although the immediate postgraduate period guarantees fresh input, a delay of several months or more may provide better perspective. The information garnered from the exit questionnaire and post graduate surveys should be gathered and discussed formally with the department chair to help initiate program and curriculum changes.

By the Faculty

The ACGME now requires that faculty confidentially and anonymously evaluate the program annually. These surveys may be more general and focus on strengths, weaknesses, and suggestions for improvements in the program.

Role of Faculty

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Full-time Faculty

The ideal residency has adequate full-time faculty in all ophthalmic subspecialties. This faculty should see resident education as a high priority, on a par with patient care and research. Full-time faculty must be expected to:

- Involve residents in patient care in their clinics, taking adequate time to show interesting findings, point out things residents missed, and review differential diagnosis and management

- Allow residents to participate in their surgery at a level appropriate to the residents' skills

- Present didactic material in their subspecialty or area of interest

- Act as role models and mentors for residents, and participate in meaningful evaluation of resident performance

- Involve residents in their clinical research as appropriate

Unfortunately, some faculty members may neglect residents or see them only as workers. Current health care economics have negatively impacted academic medical centers: pressure for clinical productivity impairs academic faculty's ability to devote adequate time to teaching. And the pressure to see a large number of patients may relegate the resident to technician status, while time constraints in the OR may impact resident participation.

Lasting solutions will likely require funding from the federal government or other sources earmarked specifically for medical teaching. Meanwhile, program directors must work closely with department chairs and medical school leadership to find ways to assure compensation for teaching. Involvement in teaching should be a criterion for academic advancement.

Community-based Faculty

It is generally undesirable to rely on part-time staff for significant portions of resident education unless the ophthalmologists are intimately involved with the program and sit on committees. But in smaller programs, some subspecialty areas may have to be covered by part-time, community-based ophthalmologists or optometrists. Community physicians may provide residents:

- Perspectives on alternative approaches to clinical problems

- Advice on practice management

- Additional insights at grand rounds and journal clubs

In some institutions the volunteer faculty member must provide resident education, through either direct clinical supervision or lectures, to maintain a clinical appointment. Medical student teaching may also be required to maintain a medical school appointment.

Coordination Between the Chair and Program Director

In the past, many chairs acted also as program directors. As ophthalmology residencies have evolved and requirements become more complex, the division of duties has become more common. Program directors, however, rarely control their own budgets or determine other faculty's compensation. Difficulties arise when residents and staff expect the program director to make decisions that affect a program's resources; when it comes to such changes, especially as they relate to faculty, the chair must be involved. So, the chair and program director must establish a good working relationship. In addition to frequent informal contacts, regular meetings can be used to discuss program, faculty, and resident issues.

Chairs must also understand that when they make unilateral decisions, this undermines the program director's authority. When issues arise, chairs may have a tendency to deal with the problem then and there, without seeking input from the program director. After all, this is their Department, and chairs are used to making difficult decisions. Unfortunately, residents are like teenagers. They quickly identify areas where "father" (the chair) and "mother" (the program director) can be divided. Like parents of teenagers, chairs and program directors need to consult each other and present a united front. (Parenthetically, the tendency to appoint junior faculty as program director may contribute to this phenomenon. The experience of raising one's own teenagers is good training for many of the issues that confront program directors.)

Teaching, Supervising, and Evaluating Roles

Mentoring of junior faculty is critical to establishing faculty as teachers. To help the adjustment toward a teaching role, courses are available to new faculty in some universities, but faculty orientation and education is an area that remains neglected. Many medical schools affiliated with large universities are developing better opportunities for faculty to build their teaching skills. Check with the office of Graduate Medical Education (GME), dean's office, or other graduate school directors for more information. As there remains a need for formal study of teaching methods in medicine, some departments may reward such research with academic promotion.

Given that traditional pedagogy is largely unacceptable by today's standards, time, direct observation, and input from residents should help optimize the strengths of various faculty members and define their teaching roles in the department. The senior clinician whose lectures are boring and pedantic may function better as a surgical mentor. Junior faculty who have difficulty giving up parts of their developing surgical practice can still present excellent case conferences. Again, assistance from the chair in formulating strategies for faculty involvement, especially in terms of compensation and promotion, is essential.

Didactic Responsibilities

In an ideal world, subspecialty faculty wouldn't require supervision to communicate their area of expertise to the residents. But this ideal is seldom met: individual faculty may be poor teachers or unwilling to service the program's curriculum. Utilize visiting professors and community physicians, or consider teleconferencing to help with limited resources. Encourage faculty to update their didactic lectures yearly to keep them fresh. In larger departments, rotating lectures among faculty is another way to stimulate interest.

The preparation of lectures is time consuming, not every faculty member is a good lecturer, and there is evidence that the lecture is not a particularly effective teaching method. The RRC requires a minimum of six hours a month of case presentation conferences "attended by several faculty and a majority of residents." Such case conferences, where faculty can provide their own perspective on specific problems, are probably the most effective method of involving the majority of clinicians in didactics.

The program director should attend at least some lectures or conferences given by each of the faculty. This allows the program director to assess personally whether a particular faculty member has the ability to teach and in what format. Resident evaluations of individual faculty are invaluable in determining how teaching tasks should be distributed. Resident input into the scheduling of conferences, via an administrative chief resident or otherwise, should allow the didactic program to improve incrementally.

Facilitating Research

While the primary purpose of a residency is clinical training, programs should educate residents in the research arena. The key feature of an academic program is the spirit of inquiry fostered by the faculty and adopted by the residents. Even though many residency programs have rigorous clinical requirements, residents often find time to pursue their research interests. Departments may have individual faculty with excellent mentoring skills in clinical or bench research; steer residents toward these faculty members. If the department has a director of research, consider asking this individual to facilitate contact with university researchers and to improve interaction between laboratory and clinical researchers. Be wary, however, of faculty who demand residents complete multiple, labor-intensive projects, like reviewing large volumes of clinical material or writing book chapters.

Advisory Roles

Advisory roles are not defined in most departments. The program director's role as advisor is awkward because it incorporates both evaluation and support. Often residents find their own mentors in resident-friendly faculty or subspecialists in their area of emerging interest. Program directors may assign advisors to each resident, especially in larger programs. As in other areas, individuals differ in their ability as advisors and mentors, and consideration should be given to both the needs of the resident and the skills of the advisor. Some residents will work well with

younger faculty who are close to them in age and interests; others may prefer senior faculty who mentor them in fellowship choices and applications. In the event of remediation, provide an advisor/mentor to help encourage the resident and establish tutorial opportunities.

Evaluation of the Faculty

The chair is ultimately responsible for faculty evaluations. In evaluating the training program, the program director and residents must provide input about faculty to the chair, specifically assessing faculty teaching methods and availability. The program director should collate this information and meet with the chair to consider future program changes as well as assist in decisions for compensation and promotion. See sample "Staff Evaluation Form."[1]

Common Problems

Communication Barriers between Residents and Attendings

Opportunities for informal interaction between residents and faculty, such as sharing the same lunch tables, are helpful in breaking down communication barriers. When a resident and faculty member are having a problem, one party often comes to the program director even before talking with the other. The program director must listen to both points of view before acting. Decide whether the problem is simple enough for the parties to solve or whether you or the chair should mediate. Be sure to have all the facts before bringing the parties together.

Dealing with Problem Faculty

Problematic faculty present an extremely difficult situation for the program director. In many programs the program director is a junior person who may have trained under the "problem faculty" member. Even in this situation, however, it is probably best for the program director to meet directly with the faculty member first and address the issues. There is a chance that the program director and faculty member will work out a mutually acceptable plan for corrective action. At the very least, the program director won't be blamed for escalating the problem prematurely. If there is an inadequate response, the program director should then involve the chair.

References

1. Department of Ophthalmology, University of Missouri-Kansas City School of Medicine. Kansas City, MO; 2000.

Resident Issues

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Challenges of Entering Residency

Being an ophthalmology resident in a rapidly changing health care system is complicated and poses unique problems. Ophthalmology residents are directly scrutinized: after a preliminary year during which they are one of many, they often become part of a much smaller group, and their behavior, skills, and knowledge are closely observed by several faculty, staff, and fellow residents.

As the program director tries to see the big picture of resident education, with the ultimate goal of producing physicians able to practice independently and competently, the resident focuses on a smaller picture. Residents are concerned about their relationships with other residents and supervising faculty. Residents face increasing scrutiny over their reported work hours. Residents wade through mandatory educational programs in which they may see no benefit (eg, HIPPA training). They may have moved to a new city for training and may struggle with housing and family as they adapt to their new work and living environment. For all these reasons, the program director must be sensitive, aware, and poised to help.

Residents at each level of training will have unique problems and needs that the program director must address.

During PGY-2, resident issues include:

- Transitioning to a new work environment

- New fellow residents (smaller programs make this more critical)

- Developing a new skill set, eg, the eye exam

- Learning a new medical language

- On-call responsibilities

- Being at the bottom of the hierarchy

- Family obligations

- Desire to maintain a personal life

- Financial obligations or difficulties

During PGY-3, resident issues include:

- Introduction to surgery and surgical responsibility

- Teaching first-year residents and students

- Higher expectations from faculty and the program director

- Consideration of subspecialty training opportunities

- Continued financial and family/personal obligations

During PGY-4, resident issues include:

- Dealing with surgical complications

- Supervisory responsibilities

- Administrative responsibilities

- Fellowship applications and match

- Job interviews and career planning

- Extended financial and family/personal obligations

Growth and Development

Resident development is directly related to the program structure, the program director's use of educational tools, and the interaction among the residents and staff. The program director must create detailed goals and objectives by year, competency, and rotation to reflect the curriculum and help direct residents in their studies and skill development. Skill and knowledge levels differ greatly among residents upon their entrance into a residency training program, so the program director must provide supervision guidelines and periodically review how they are being followed. The resident portfolio is a useful tool for the program director and the resident to help keep track of accomplishments and training objectives.

For most residents, the ophthalmology residency training program is a new environment where group cooperation is essential, but the ability to independently examine and make clinical decisions is critical for development and success. Frequent interaction with the residents is key. Through regularly scheduled group meetings between the residents and program director, residents are free to express their opinions without fear of retribution. Individual meetings with the program director also prove useful. A mentor program that matches one faculty member to each resident may aid in role modeling and allow the residents to express concerns that they do not feel comfortable presenting to the program director.

At each level of training, residents cope with different growth and development issues.

During PGY-2, resident issues include:

- Learning new instruments and a new vocabulary
- Balancing a personal life with a professional life
- Interaction with different attendings, coworkers, and patients
- Learning the concise exam

During PGY-3, resident issues include:

- Increasing responsibility and autonomy
- Increasing surgical procedures
- Research projects and publications or presentations
- Triaging consults
- Interaction with coworkers
- Deciding future career goals
- Personal life

During PGY-4, resident issues include:

- Increased interaction with attendings
- Further increase in responsibility and autonomy
- Acting as mediator and delegator for all junior residents
- Balancing surgical volume with that of fellow residents
- Learning the majority of surgical techniques in all fields
- Teaching other residents and medical students
- Making a fellowship decision
- Preparing for possible relocation
- Personal life

Ethical Issues

Many programs provide residents with the Academy's *The Ethical Ophthalmologist: A Primer*, (I'm not sure that this is still in print which is unfortunate because it was a valuable resource for residents and program directors) and the programs review it each year. They also provide formal ethics lectures and journal clubs, as well as informal discussions on ethics throughout the year. Hospitals will occasionally offer special events and lectures on ethics that are pertinent to the ophthalmology resident. Encourage residents to follow ethical codes with their own patients and others. Although ethics is often a part of the curriculum in some form or another, the program director should observe how residents talk to their patients and note resident behavior. It is easy to see how physicians can become entrepreneurial over time. While role modeling is important, the program director should also attend to the residents' independent approach to their clinical and surgical responsibilities. You may find that finances do not drive decision making in resident physicians, but "numbers" or personal quotas may.

Support

Residents in training frequently feel as if they are on the front line for the department. Help residents understand that they are part of a much larger team involved in patient care and resident education. This team consists of residents in a hierarchical group, faculty, ancillary support staff, the program director, and the chair. Usually a core group of faculty has the closest involvement with the residents on a daily basis and serves as their immediate support. The program director should work with this group to understand resident interactions and how support can be improved while independent decision making is maintained. Regular meetings between the residents and the program director are critical to help the program director understand where the program works and where it fails to provide adequate resident support.

To help solve more complex problems that affect the educational process, patient care, and training requirements, these meetings should occasionally include key faculty, the chair, or relevant administrators. Residents must be involved in program changes, as their impression of those changes often differs from what the program director perceives.

The residency must have a formal written policy for supervision of residents that is distributed to residents and faculty. The on-call schedule should identify the appropriate contact physician and contact number. Residents should have a clear understanding of when and how to contact their backup and should never be chastised for unnecessary contact. A clear message of faculty support to the residents is essential. The program director should remind faculty of their responsibility to support resident development, and any deficiencies identified by the program director need to be addressed through cooperative departmental action.

The program director or a designee (when the program director is away) should always be available to the residents as problems frequently arise and need immediate attention. Scheduling tasks may be delegated to a chief resident, but issues related to faculty support, medicolegal concerns, hospital policies, or the like require the direct attention of the program director. The residents may have a limited perspective on these issues, and without guidance, they may make serious errors. The program director should be reachable by phone, pager, e-mail, etc, and the

residents should be comfortable making contact at any time. Residents must understand that the program director is ultimately responsible and will have to answer for their actions.

In addition, remember that residents at each level will have a slightly different support system. Initially, the first-year residents are supported primarily by their senior residents. On-call problems work through the resident hierarchy and eventually reach faculty. As the residents advance each year, their support continues to shift from resident to department faculty. When available, fellows provide an additional layer of support to the residents in this hierarchical training model.

Relationship with the Program Director

Establishing effective relationships with all the residents is not an easy task. Regardless of whether the program director is selected from junior or senior faculty, the role is immediately seen as supervisory. The resident–program director relationship can easily become impersonal, and the resident may be cautious about interacting. Program directors should promote themselves as advocates of resident education rather than taskmasters or sheriffs. At times, the program director will need to be strong and deal with serious issues, but it should always be clear to the resident that the program director is trying to support the resident and the training program. Again, be accessible and welcome resident contact. A resident dinner, picnic, or group activity with the program director outside the hospital environment helps build a better relationship. Meeting with the residents on an individual basis to review their activities, scores, evaluations, and career goals is important and required at least twice a year by the Accreditation Council for Graduate Medical Education (ACGME). By providing guidance, identifying a mentor, suggesting research, etc, program directors remind their residents that they are there for support and growth, not simply to keep them in line. At each level of training, residents should have equal access to the program director; developing a positive relationship early provides for a more successful 3-year experience.

Recruitment and Selection: Ophthalmology Matching Program

Resident Selection Process

The program director must develop a process for recruitment and selection of residents for the training program. Optimally, this process should involve the chair, key faculty, and the chief resident. If helpful, additional faculty can be involved to participate in this important and frequently overwhelming task. The program must have a written policy on resident selection and eligibility, maintained as an official department document. Applications should be reviewed by selected faculty and the program director. Interviews are normally held over a 2- to 5-day period with interviews conducted by select faculty, the program director, or the chair. Resident interviews should be an opportunity to show off the program. Some selling ideas include:

- Tours of the facilities by residents and faculty

- Lunch or dinner with residents and faculty

- Close resident clinics to make residents available for questions and discourse

- Introductory presentation by program director or chair to welcome candidates and introduce program structure and goals

- Up-to-date support materials: brochures, Web sites, etc

The entire process should be reviewed with current residents and applicants through an informal or formal exit poll. OMP and AUPO guidelines should be understood and followed. Remember that after the interview, AUPO guidelines forbid contact with candidates to negotiate placement on the rank list.

Applicant Interviews

Many institutions have their own specific guidelines regarding resident selection and interviews, and the program director must understand how the guidelines affect the resident training program. Institutional guidelines often follow nationally promoted policies for gender, religion, age, and handicap discrimination, and the policies should be explained to faculty involved in the interview and selection process. Generally, the program director and chair or a residency selection committee determines overall faculty involvement, number of interviews, length of interviews, etc. Because some interview methods may be threatening to candidates or provide less useful information for the program, the entire process should be evaluated annually from both a faculty perspective and a candidate's perspective. A formal applicant evaluation or discussion with current residents can provide a great deal of useful information to assess the interview experience.

International Medical Graduates

While all applications and candidates should be reviewed fairly, the training and education of International Medical Graduates (IMGs) are often difficult to evaluate, and the program director may need to contact references to verify qualifications. The program director must understand the ACGME eligibility requirements as well as the institutional requirements for IMG training. Visa status is a frequent problem and cannot be ignored (most institutions offer GME support that includes assistance with visa issues). State licensure requirements may also be different for IMGs, and the program director must be certain that these requirements can be met by the applicant.

Resources

www.ama-assn.org/ama/pub/category/10365.html

www.acgme.org

www.sfmatch.org

Administrative Issues and Problems

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The program director should pay careful attention to administrative issues of potential concern: absences from the program, physician impairment, sexual harassment and gender abuse, and all related disciplinary action. For most residency programs, these issues are addressed by specific guidelines outlined in the House Staff Manual or Guide from the sponsoring institution; the guidelines are developed by the Graduate Medical Education Committee (GMEC), reviewed by university counsel, and are binding on all house staff in the institution. Your program handbook should conform to these policies; if your department has recommended modifications to any policy, they should be presented to the GMEC for approval prior to implementation.

Absences

Absence from the training program may occur for various reasons, including authorized vacation, attendance at scientific meetings, illness, maternity or paternity leave, jury duty, family and medical leave, and military leave. Institutional policy regarding vacation is strict: residents must be allowed the minimum vacation time authorized, even in disciplinary situations. The program director must also be aware that eligibility for the American Board of Ophthalmology examination is contingent upon completion of 36 calendar months of training, absence for vacation or other reasons included. But if a resident's absence exceeds the usual time periods, consider providing remedial training to make up the lost time. Any alterations to the schedule and related resident duties must be requested in advance from the Residency Review Committee (RRC). Procedures for altering the schedule are documented on the Accreditation Council for Graduate Medical Education (ACGME) Web site, www.acgme.org. Unauthorized absences from the program are cause for disciplinary action.

Procedures for resident requests for absence should be formally developed by the department and monitored by the residency program administrator and the director. Typically, requested absences must be coordinated with the faculty chief of the affected rotation and fellow residents on the rotation to ensure adequate coverage of clinic and emergency call. The department should also develop policies to anticipate absences, eg, requiring advance notice from residents who wish to schedule a leave.

The UCLA policy on absences may be reviewed at www.medsch.ucla.edu/public/residencies/policies/leave.htm.

Impairment

If a resident appears impaired because of substance abuse, stress, fatigue, psychiatric illness, or other cause, the program director may investigate. Otherwise, the case is referred to the sponsoring institution, which typically has guidelines and policies in place to ensure a confidential assessment of the problem and any appropriate intervention. The severity of

impaired activity may dictate the level of counseling required; in cases in which academic probation is involved, remediation may involve completion of a formal rehabilitation program.

The UCLA policy on impaired physicians may be reviewed at www.medsch.ucla.edu/public/residencies/resident/Medical_Staff_Health_Policy.pdf.

Sexual Harassment

Most institutions have well-defined policies on management of all issues related to sexual harassment. It may be useful to assign a faculty member or small departmental committee to educate faculty, house staff, and ancillary personnel on harassment issues. This same committee can provide counseling and possible remediation for minor offenses that don't require formal legal action. At UCLA, several impartial outlets are available for employees to obtain anonymous counseling or report activities, and house staff is briefed on all aspects of these outlets during orientation at the beginning of their training program.

The UCLA policy on sexual harassment may be reviewed at www.medsch.ucla.edu/public/residencies/policies/sexual_harassment.pdf.

Disciplinary Action, Due Process, and Grievance Procedures

The office of GME should have a defined process for all formal disciplinary action, and the process may be modified slightly by your department. Written guidelines must describe the probation, suspension, grievance, and reappointment procedure, and thorough documentation of resident deficiencies must be maintained throughout a case.

The key to any problematic situation is the careful and continuous documentation of all activities that transpire. Once the problem is identified, the program director, chair, or faculty advisor may inform the resident. Precisely indicate the problem and the steps required to resolve the problem. If established deadlines are not met, the resident's probationary status might change to dismissal or nonrenewal of contract. The office of GME must be included in efforts beyond simple admonishment, especially when institutional counsel might become involved. Additionally, in some states, the board of licensure requires notification of any disciplinary action; in all cases, you should report the dismissal of a resident.

Do not assume all of the responsibility when dealing with disciplinary issues and problems. Residents should be nurtured in all ways possible. In cases of potential substance abuse or mental instability, seek your institution's assistance or wellness program for employees (this may be a necessary course of due process). Assign faculty mentors to help troubled residents when necessary. Remember that the program director is obligated to help residents complete their training satisfactorily. Probation and dismissal tasks are among the most difficult and discomforting of all your responsibilities; make certain that your department has a clear system for assisting you with such problems.

Probation and Dismissal

Probation and dismissal may be indicated for either academic or behavioral reasons. Academic probation or suspension must be based on inadequate performance, as determined by written goals for a given rotation or for progression from one year to the next. Probation or suspension for behavioral reasons, including substance abuse and inappropriate conduct toward staff, patients, or colleagues, should be tied to substandard evaluations in the corresponding core competencies (eg, professionalism). Most commonly, problems can be attributed to weaknesses in the core competency areas of patient care (clinical skills or surgical skills), medical knowledge, professionalism, or interpersonal and communications skills. At the beginning of the training program, residents should be advised of the program's expectations, including those of professionalism and interpersonal skills. Consequences for failure to meet standards should also be specifically outlined: advancement in the program is not guaranteed, and the annual renewal of training contracts depends upon satisfactory performance.

The program director must carefully monitor any deficiencies in performance, provide timely counseling to the resident, and develop a plan for correction (with a timeline for completion and consequences of incompletion); all aspects should be documented in writing and signed by both the resident and program director. Counseling may be informal and kept from the permanent record if the offense is minor and corrected. More serious and uncorrected deficiencies require written documentation in the permanent record. At UCLA, the GMEC has developed a graduated series of actions that may lead to suspension and dismissal in the most serious cases. Each action is well outlined and the process is available for review by the resident. For those serious offenses and disciplinary actions, a formal grievance policy is outlined. Program directors are most effective in mitigating these situations when they are familiar with the institutional policy and proactive in the process, knowing the implications of each step.

The UCLA policy on disciplinary actions may be reviewed at
www.medsch.ucla.edu/public/residencies/policies/due_process.pdf.

Subspecialty Fellowships

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Fellowship Statistics

Many residents choose to pursue fellowship training in a subspecialty area of ophthalmology following completion of their residency training. Subspecialty fellowships are available in the areas of anterior segment, cornea/external disease, glaucoma, neuro-ophthalmology, oculoplastics, ocular pathology, pediatric ophthalmology, uveitis, and retina. Table 1 reviews fellowship match data from 1996-2005; between 34% and 46% of graduating ophthalmology residents during this period obtained fellowship training. The percentage of residents seeking fellowship training is slowly and steadily increasing. Because some applicants apply to more than one subspecialty, the match statistics, particularly in the subspecialties of anterior segment, neuro-ophthalmology, and pediatrics, are skewed.

Timetable for Fellowship Application

Fellowship positions in ophthalmology are filled through a computerized match process similar to that used by residency programs. With the exception of oculoplastics, all subspecialty fellowships participate in the Ophthalmology Fellowship Match Program (OFMP) that occurs in mid-December. Table 2 outlines the timetable for fellowship application (except oculoplastics). Residents usually decide whether to pursue fellowship training at the end of the second year of residency, and the OFMP begins accepting requests for registration in May. Although there is no specific registration deadline, residents interested in fellowship training should be encouraged to register early so that they receive match materials as soon as they become available. The updated directory of participating fellowship programs is made available online in June.

While applications to ophthalmology residency programs are generally made with a standard application using the Central Application Service (CAS), most fellowship programs require completion of an institution-specific application. Fellowship applicants should contact individual training programs for information and application materials. Usually 3 or 4 letters of recommendation are also required, and it is standard that a letter be provided by the chair and residency program director. Application materials should be completed and sent to programs during the summer; fellowship interviews are conducted in the fall. Applicants and programs submit their rank-order preference list to the OFMP prior to the match deadline in early December, and applicants and programs are notified of the match results in mid-December. Additional information about the ophthalmology fellowship match is available at www.sfmatch.org.

In contrast to other ophthalmology fellowships, oculoplastics fellowship programs (with the exception of about 5 programs) participate in a separate match processed by the National Residency Matching Program (NRMP). The oculoplastics fellowship match occurs 8 months

earlier than others, during the second year of residency. For this reason, it is important that program directors organize their curriculum to allow some exposure to oculoplastics during the first and second years of residency training. Table 3 outlines the timetable for oculoplastics fellowship applications. Additional information about the oculoplastics fellowship match is available at www.nrmp.org.

Accreditation of Fellowship Programs

Unlike ophthalmology residency programs, fellowship programs are not required to undergo any accreditation process. As a result, fellowships are not subject to the same stringent educational guidelines and periodic review process that residency programs bear. There has been considerable debate over whether fellowship programs should be accredited by the Accreditation Council for Graduate Medical Education (ACGME), but presently there are no accredited/board certified fellowships in ophthalmology.

Given that ophthalmic subspecialty fellowships are unregulated and offer a variable range of quality and experience, the Association of University Professors of Ophthalmology (AUPO) established the Fellowship Compliance Committee (FCC). The FCC manages a voluntary process through which fellowship programs are reviewed for compliance with standardized minimum requirements; each subspecialty society is responsible for setting its own evaluation criteria. Admitted programs are monitored periodically to ensure that they remain in compliance. By filling out an online application and survey, a program may initiate the review process. More information is available at the AUPO FCC Web site at www.aupofcc.org.

Role of Fellows

In many programs, fellows assume positions as faculty members at the instructor level. They may assist in supervising resident surgery, provide didactic lectures, and participate in journal clubs. Though fellows can be a valuable resource for the clinical and surgical training of residents, their instruction should not replace that by the full-time faculty.

Avoiding Conflicts

The program director must ensure that fellows complement residency training and do not compete with the clinical and surgical activities provided by residents. To balance the load, the program director should clearly define lines of responsibility in patient care. Conflicts among residents and fellows generally arise when there is ambiguity in patient care responsibilities (e.g., when it is unclear whether a surgical case should be performed by a resident or fellow, or when it is unclear whether emergency care should be provided by a resident or fellow). Specifically describing patient care responsibilities during the orientation of residents and fellows serves to avoid conflicts. If conflicts arise, the program director should act quickly to resolve the problem, and then clarify the policy to avoid similar conflicts in the future.

Table 1. Fellowship Statistics

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Percentage of third-year residents in fellowships[†]	34%	36%	40%	41%	40%	42%	43%	46%	45%	46%
Percentage successfully matched[‡]										
Anterior segment	9%	27%	22%	21%	21%	18%	8%	21%	13%	----
Cornea/external	66%	55%	54%	56%	71%	72%	66%	72%	75%	79%
Glaucoma	65%	68%	56%	78%	84%	78%	75%	70%	88%	83%
Neuro-ophthalmology	50%	30%	67%	100%	50%	60%	50%	33%	33%	100%
Oculoplastics	47%	55%	40%	44%	37%	NA	58%	41%	37%	41%
Pediatrics	51%	65%	69%	66%	61%	54%	50%	56%	59%	63%
Retina	55%	55%	63%	83%	70%	74%	62%	74%	79%	77%
Other	45%	36%	24%	39%	64%	18%	42%	23%	43%	95%

[†]Percentage of 3rd-year residents in fellowships =

$$\frac{\text{number of 3rd-year residents matching into fellowships}}{\text{total number of 3rd-year residents}} \times 100$$

[‡]Percentage successfully matched =

$$\frac{\text{number of matched positions}}{\text{total number of match lists submitted}} \times 100$$

NA = Data not available from National Residency Matching Program

Please note that some applicants apply to more than one subspecialty. Data presented are integrated from the Ophthalmology Fellowship Match Program (OFMP) and the National Residency Matching Program (NRMP).

Table 2. Timetable for Fellowship Application[*]

May	• The Ophthalmology Fellowship Match Program (OFMP) begins accepting requests for registration.
June	• An updated directory of participating programs is available online to registered applicants. • Applicants should be contacting individual training programs for information and application materials.
Summer	• Application materials should be completed and sent to programs.
Fall	• Programs conduct interviews.
November	• Applicants and programs submit their rank-order preference lists to the OFMP.
Mid-December	• Applicants and programs are notified of the match results.

[*]All ophthalmology subspecialties except oculoplastics

Table 3. Timetable for Oculoplastics Fellowship Application

December	• Registration begins for the Oculoplastics Fellowship Match.
Winter	• Application material should be completed and sent to individual programs. • Programs conduct interviews.
Late March–Early April	• Applicants and programs submit their rank-order lists before deadline in mid-April.
Late April	• Applicants and programs are notified of match results.

Preparing for an ACGME Site Visit

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Timeline

According to its Web site, the Accreditation Council for Graduate Medical Education (ACGME) reviews approximately 2,200 programs a year (www.acgme.org). The ACGME can accredit programs for any duration from 1 to 5 years, and the period from 1 site visit to the next is generally called the accreditation cycle. About midway through the accreditation cycle, your program will undergo an Internal Review (IR) sponsored by your hospital's internal Graduate Medical Education Committee (GMEC). For an example of one program's IR policy, visit the Emory Eye Center Institutional Policies Web site at www.med.emory.edu/GME/GMEPolicies05-05.htm. The IR is mandatory and you must have documentation of the review available for your Residency Review Committee (RRC) site visit. It is the IR committee's responsibility to review the program and ascertain whether it is meeting the ACGME Institutional and Program Requirements for your specialty. The IR committee's report may recommend areas that need improvement before the site visit. Use these suggestions to improve upon any of the program's weak areas and as leverage with your chair. The program director and residency coordinator should monitor the program requirements for their specialty as many are modified regularly and are the basis of the site visit. The most current program requirements may be found at www.acgme.org/acWebsite/RRC_240/240_prIndex.asp

The program director and residency coordinator can anticipate the next site visit by using the length of accreditation stated in the program's latest ACGME accreditation letter. Detailed documentation and complete records should be maintained and updated to complete the Program Information Form (PIF); among the most common mistakes is having no documentation for activities, evaluations, and affiliation agreements that are, in fact, in place. Preparation for the actual site visit should begin about 1 year before the visit.

Ongoing Preparation

At the start of each academic year, provide the new residents with a copy of the program requirements, institutional requirements, and the goals and objectives for the program itemized by each year and rotation. One idea is to maintain a "Resident Handbook" containing all important program information, including an overview of the program policies, educational objectives by year and rotation, rotation schedules, faculty and resident contact information, hospital policies pertaining to house staff, and information on house staff benefits. The residents should understand that it is a working document and that they are expected to add any pertinent information that is distributed to them throughout the year. The general competencies should be incorporated into the program's goals and objectives. Take time during orientation to define the competencies, explain the specific components of each, and describe how they will be taught and evaluated during the coming year.

- The residents must evaluate teaching faculty on an annual basis. These evaluations should be reviewed by the program director. If any deficiencies are present, they should be addressed with individual faculty by the chair or program director. Evaluations must be done in an anonymous fashion. An easy way to conduct this is through a Web page or Word document that can be filled out, printed (no handwriting), and left in the residency coordinator's mailbox.

- The residents must evaluate rotations throughout the year. These evaluations should be reviewed by the program director who then addresses any issues that were identified. A file should be maintained.

- Written evaluations of resident performance should be collected at the end of each rotation, reviewed by the program director, and filed in each resident's file. The program director should meet with the residents at least semiannually to discuss performance. This meeting must be documented.

- Residents must input all surgical cases into the ACGME online surgical log throughout the year. The program director and staff should monitor the surgical log on a bimonthly basis to ensure that the residents are inputting their cases correctly.

- Ensure and document resident compliance with moonlighting and duty hour policies.

Twelve Months Prior to the Site Visit

- Familiarize yourself with the Program and Institutional Requirements. These documents contain the "correct answers" to the PIF and will help you explain how your program operates in fulfilling the requirements.

- Visit the ACGME Web site and download the PIF for your specialty. The PIF for ophthalmology programs is located at www.acgme.org/acWebsite/RRC_240/240_pifIndex.asp.

- Review all affiliation agreements and rotation agreements to make sure that they meet the common and specific program requirements. If the agreements fail to meet any of the requirements, be sure to make any necessary changes and have them reviewed and approved by the GMEC. Agreements must not be more than 5 years old.

- Request electronic versions of the teaching faculty's CVs to keep on file.

- Rigorously document in an electronic format all resident conferences and lectures. Begin calculating the number of hours spent in basic and clinical science instruction, case presentation conferences, and pathology instruction, which includes experience in grossing and examining pathological specimens.

- Assemble a site visit team. Identify the key players in your department and notify them, especially the residents and directors at affiliated hospitals, of the upcoming site visit.

These are the individuals you will be calling on to help write the PIF, and they need to be informed well in advance.

- Develop an action plan that includes a list of tasks and deadlines. Break down the tasks into smaller parts and assign some of the key players to write or rewrite various sections of the PIF. Be sure to establish a deadline for all drafts to be delivered.

Four to Six Months Prior to the Site Visit

- Collect the statistical information—patient visits, OR procedures, refractions, etc, and especially information from affiliated hospitals—required to complete the PIF. This information may take some time to collect because it involves other offices, including hospital administration offices, the accounting office, and the medical records department. Information may be estimated in several ways. Using the number and type of patients seen in given period, you can extrapolate, multiply, and arrive at a statistical estimate for specific procedures performed over time. As long as you document how you arrive at the estimate, many methods can be used.

- Conduct a survey of your residents addressing the same issues in the Resident Survey by the ACGME. A sample version may be downloaded from the ACGME Web site at www.acgme.org/Resident_Survey/sampleResSurvey.pdf.

- Review previous accreditation letters and check for any citations. Prepare responses to previous citations.

- Prepare explanations of major changes in your residency program since the last site visit.

- Check all rotation and affiliation agreements to make sure they are current and meet institutional and program requirements. Be sure to have all of them on file and ready to show the site visitor.

- Audit resident files to make sure they contain copies of rotational or monthly evaluations, written semiannual evaluations of performance, surgical logs, the house staff agreement (contract), and training licenses.

- The program director and residency coordinator should complete the competencies addendum to the PIF using the form at https://www.acgme.org/ads/default.asp, which is located on the ACGME Web site under the Accreditation Data System link.

- Collect those sections of the PIF that were assigned to other team members. Edit the sections so that they read as though one person wrote the entire document.

- Review important policies (duty hours, access to file, grievance, and remediation) with residents. Documentation of these policies should be in the resident handbook.

Three to Four Months Prior to the Site Visit

- The program will receive formal notification of the site visit date and the name of the site visitor and contact information. Reserve a private space, preferably within the department, where the site visitor may conduct all of the interviews.

- The program will receive information about the Resident Survey with instructions to pass along to the residents. Residents will have up until 3 weeks prior to the site visit to complete the survey.

- Remind key individuals of the date of the site visit. Make sure that there are no scheduling conflicts with the faculty who will meet with the site visitor.

- Continue to edit the PIF as needed. Seek assistance from the office of GME if any help is needed or if you would like them to review the document before it is final.

One to Three Months Prior to the Site Visit

- The site visitor will contact the program to establish an agenda. The visitor will tell you the best means for communication and will request times for meeting with specific individuals in the department. Those individuals should be notified and meeting times reserved.

- The residents must select a group of their peers to meet with the site visitor, and the list of names must be given to the program director and/or residency coordinator.

- Meet with the designated institutional official to review institutional citations. The site visitor may inquire about both program and institutional citations during the site visit, but the visitor may not request a copy of the actual internal review or institutional review reports.

- Meet with the residents. Remind them of program and institutional policies and of the program's educational goals and objectives. Review the general competencies and their definitions, and discuss what tools are being used to measure the competencies. Explain the reasons for accreditation, what to expect during the site visit, and appropriate behavior for that day. The site visitor may ask the residents whether they were coached, so don't coach, just educate and remind.

- Hold a similar meeting with faculty who are scheduled for meetings with the site visitor. The faculty are expected to be completely conversant with program requirements, educational goals and objectives, policies, etc.

- Finalize the PIF and obtain the appropriate signatures. Make enough copies for the RRC, the site visitor, and the program's files.

- Check the Resident Survey Web site to see how many residents completed the survey. If fewer than 80% of the residents have commented, start sending reminders.

- To avoid conflict and delays, make sure that the schedules for faculty and residents who will be interviewed are cleared for the day of the site visit.

One Month Prior to the Site Visit

- Mail the PIF to the site visitor.

- Send the site visitor a travel packet containing maps, directions, and information on transportation and parking.

- Make arrangements for coffee, water, breakfast, and other accommodations to be available in the room on the day of the site visit.

- If the site visitor has requested to meet with individuals over lunch, make arrangements for appropriate meals. Lunch should be in the same room so the business of the visit is uninterrupted.

- Speak with or e-mail faculty and residents again. Be certain that everyone involved is familiar with all requirements, the PIF, etc.

- Assemble in a rolling file cart the files that are most likely to be needed for the day of the site visit. You can bring the cart with you in the morning and have that information at your fingertips should the site visitor ask to see it. Documents to include in this cart are: recent faculty evaluations, resident lecture sign-in sheets, rotation evaluations, on-call schedules, rotation schedules, patient care statistics, surgical logs, educational goals and objectives, monthly calendars, sample resident files, and any other files you may think are important to have on hand.

- Check current and former resident files for completeness. Every site visitor is unique and will request to see different documents, but pay particular attention to written resident evaluations, surgical logs, and House Staff Officer Agreements (contracts that delineate the terms of the residents' employment and educational rights and responsibilities).

One to Five Days Prior to the Site Visit

- Prepare the meeting room. Make sure that it is clean and free from all inappropriate paraphernalia.

- Anticipate last-minute changes and make contingency plans. Have an extra resident and faculty member on stand-by in case someone gets sick, stuck in traffic, or otherwise delayed.

- Reconfirm meeting times with faculty and residents; plan for everyone to arrive early to avoid any delays.

- Reconfirm any breakfast and lunch plans.

- Make copies of the itinerary and distribute it to everyone involved in the site visit.

The Day of the Site Visit

- Meet the site visitor and proceed to the interview room.

- Ask the site visitor for any preference on how to conduct the visit so that the itinerary is met. It is the responsibility of the program director and residency coordinator to keep the day on schedule and flowing smoothly.

- The program director and residency coordinator should expect to remain in the room with the site visitor for a majority of the visit, but not for the session with the residents. Some site visitors, however, encourage the participation of the program director and residency coordinator throughout.

- The residency coordinator should be prepared to access the program's electronic version of the PIF to make any changes requested by the site visitor. The pages of the PIF that are changed must be copied and added to all of the copies of the PIF.

- The visit may end with a wrap-up session. The site visitor may inform the program director and residency coordinator of the next steps, when the report will be submitted, and when the program will be reviewed by the RRC.

Special Events

Stephanie Goei, MD
Department of Ophthalmology, Medical College of Georgia

Mina Chung, MD
University of Rochester Eye Institute

Orientation

Consider providing a 2-week orientation period for PGY-2 residents. During this time, the residents are given introductory lectures in the subspecialty areas as well as didactic and practica on refraction, tonometry, visual field testing, and the use of ophthalmic instrumentation, such as slit-lamp and indirect biomicroscopy; plan for a morning of lectures and an afternoon of hands-on activity. PGY-2 residents can be eased into the clinical arena by shadowing upper-level residents in an assigned clinic.

The faculty, chief resident, fellow senior residents, eye photographer, perioperative P.A., lead technician, residency program coordinator, and program director all help to orient the new residents. See sample "Ophthalmology Resident Orientation Schedule."[1]

The PGY-2 resident begins taking call July 1 and is assisted by a backup PGY-4 resident during each patient exam. This practice continues until Labor Day, when the program director meets with senior residents to determine whether junior residents are ready to work independently and use their discretion to call PGY-4 residents for assistance.

Program Social Events

Social activities outside of the work environment promote collegiality and improve morale among residents, ancillary staff, and faculty. Several events are usually scheduled during an academic year, some for faculty and residents only, and others for ancillary staff and families as well. These sample activities offer multiple opportunities for interaction outside of the workplace:

- *New resident welcome party and barbecue hosted by the chair or program director.* Held in July. Residents, faculty, and families (including children) invited

- *Departmental softball game and barbecue at local park.* Held in autumn. All staff (technicians, secretaries, O.R. personnel), residents, faculty, and families invited

- *Holiday party.* The venue can vary from year to year; consider a faculty home or reception hall

- *Billiards or bowling competition.* Held during cold winter months. Faculty vs. residents (the stakes can be interesting)

- *Post OKAP barbecue hosted at program director's home.*

- *Hockey or baseball game.* Department purchases tickets for staff, residents, and faculty

- *Alumni and resident research day.* Held on Friday and Saturday morning with a banquet on Friday night. Spouses invited.

- *Resident graduation with evening festivities catered at a faculty home or conference center.* Families of residents and faculty welcome

- *Journal clubs.* Held monthly either in a restaurant or catered in a faculty home. Community ophthalmologists encouraged to attend.

References

1. Emory Eye Center, Emory University School of Medicine, Atlanta, Georgia

Appendix

Emory Eye Center
Emory University School of Medicine

Residents Day
Research Presentations

Saturday, June 4, 2005

Guest Lecturer:
Kirk H. Packo, M.D.
Chairman, Department of Ophthalmology
Director of Retina Service
Rush University Medical Center
Chicago, Illinois

Learning Resource Center, Calhoun Auditorium
Emory Eye Center
1365B Clifton Road, T-Level
Atlanta, GA   30322

10:30 am   Wayne R. Lo, M.D.
            "Implementation and Initial Patient Selection For Pegaptanib (Macugen) Treatment In an
            Academic Retina Service"
            Sponsor: G. Baker Hubbard, M.D.

10:40 am   Marc J. Spirn, M.D.
            "Spontaneous and Traumatic Vitreous Hemorrhages in Children"
            Sponsor: G. Baker Hubbard, M.D.

10:50 am   Leiv M. Takle, Jr., M.D.
            "Periocular Cutaneous Lesions and Their Management Through Mohs Reconstructive Surgery"
            Sponsor: C. Robert Bernardino , M.D.

11:00 am   Break

11:10 am   Thomas M. Aaberg, Sr., M.D., MSPH, will introduce the Guest Lecturer, Kirk H. Packo, M.D.
            "Managing the Ocular Diseases in Patients with Severe Mental Disabilities:Ethical and
            Technical Challenges"

˜LUNCH˜

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SENIOR RESIDENTS
Christopher S. Banning, M.D.
Kevin M. Barber, M.D.
Chris S. Bergstrom, M.D.
D. Hunter Cherwek, M.D.
R. Keith Shuler, M.D.

SECOND YEAR RESIDENTS
Stephen T. Bailey, M.D.
Blaine E. Cribbs, M.D.
Wayne R. Lo, M.D.
Marc J. Spirn, M.D.
Leiv M. Takle, M.D.

FIRST YEAR RESIDENTS
John B. Davies, M.D.
Evan S. Loft, M.D.
Kristina M. Price, M.D.
Adrienne L. Ruth M.D.
Bryan J. Schwent, M.D.

2005 RESIDENTS SCIENTIFIC SESSION
PRESENTATION PROGRAM

8:00 am   Continental Breakfast

8:30 am   Introduction and Welcome
               Thomas M. Aaberg, Sr., M.D., Maria M. Aaron, M.D., Geoffrey Broocker, M.D.

8:45 am   Christopher S. Banning, M.D.
               "Visual Outcomes After Wavefront-Optimized Photorefractive Keratectomy"
               Sponsors: J. Bradley Randleman, M.D., C. Diane Song, M.D., and
               R. Doyle Stulting, M.D., Ph.D.

9:00 am   Kevin M. Barber, M.D.
               "Outcomes of Extracapuslar Cataract Extraction Performed by Resident Surgeons"
               Sponsor: Geoffrey Broocker, M.D.

9:15 am   Chris S. Bergstrom, M.D.
               "Transpupillary Thermal Therapy for Choroidal Melanoma"
               Sponsor: Thomas M. Aaberg, Sr., M.D., MSPH

9:30 am   D. Hunter Cherwek, M.D.
               "The Resident Ophthalmologist Learning Curve for Phacoemulsification"
               Sponsor: J. Bradley Randleman, M.D.

9:45 am   R. Keith Shuler, M.D.
               "Anti-Apoptotic Effects of Tauroursodeoxycholic Acid in the Murine Retina"
               Sponsor: Jeffrey H. Boatright, Ph.D.

10:00 am Break

10:10 am Steven T. Bailey, M.D.
               "Evaluation of Chemoreduction with Focal Consolidation for Retinoblastoma Treatment and Analysis of Predictive Clinical Features"
               Sponsors: G. Baker Hubbard, M.D.

10:20 am Blaine E. Cribbs, M.D.
               "Treatment of Cystoid Macular Edema in Retinitis Pigmentosa with Intravitreal **Triamcinolone**"
               Sponsor: Jiong Yan, M.D.

The Emory Eye Center wishes to thank the following for their generous support of Residents Day 2004.

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1st Year Rotation Schedule

Resident	1st Rotation July 18–Aug. 14	2nd Rotation Aug. 15–Sept. 11	3rd Rotation Sept. 12–Oct. 9	4th Rotation Oct. 10 - Nov. 6	5th Rotation Nov. 7 - Dec. 4
Emily Graubart, MD	Retina	Grady/Refraction*	Glaucoma	Grady	VAMC
Parul Khator, MD	Glaucoma	Grady	VAMC	Grady/Refraction*	Retina
Phoebe Lenhart, MD	Grady/Refraction*	VAMC	Grady	Retina	Grady
Paul Pruett, MD	VAMC	Grady	Retina	Grady	Glaucoma
Jeremy Wolfe, MD	Grady	Glaucoma	Grady	VAMC	Grady/Refraction*
Mia Woodward, MD	Grady	Retina	Grady/Refraction*	Glaucoma	Grady

Resident	6th Rotation Dec. 5 – Jan. 8	7th Rotation Jan. 9 – Feb. 5	8th Rotation Feb. 6 – Mar. 5	9th Rotation Mar. 6 – Apr. 2	10th Rotation Apr. 3 – Apr. 30
Emily Graubart, MD	Grady	Pathology	Grady	Neuro	Grady/Plactics
Parul Khator, MD	Grady	VAMC	Grady	Pathology	Grady
Phoebe Lenhart, MD	Glaucoma	Neuro	Grady/Plastics	VAMC	Grady
Paul Pruett, MD	Grady/Refraction	Grady/Plastics	VAMC	Grady	Pathology
Jeremy Wolfe, MD	Retina	Grady	Pathology	Grady	Neuro
Mia Woodward, MD	VAMC	Grady	Neuro	Grady/Plastics	VAMC

Resident	11th Rotation May 1- June 4	12th Rotation June 5 – June 30
Emily Graubart, MD	VAMC	Grady
Parul Khator, MD	Neuro	Grady/Plastics
Phoebe Lenhart, MD	Pathology	Grady
Paul Pruett, MD	Grady	Neuro
Jeremy Wolfe, MD	Grady/Plastics	VAMC
Mia Woodward, MD	Grady	Pathology

1st Year Rotation Schedule (cont'd)

1st Year Grady/Plastics Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Bernardino Clinic - Emory	Wojno Clinic Emory	Wojno Clinic Emory	Wojno OR Emory	Grand Rounds
P.M.	Grady	Grady	Grady	Grady	Grady

1st Year Grady/Refraction Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Grady Peds • No Laser	Grady	Grady	Grady	Grand Rounds
P.M.	Grady Peds No Laser	Grady-Refraction Sue Primo	Grady	Grady	Grady-Refraction Ken Rosengrem

1st Year Retina Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Martin Clinic	Aaberg Clinic	Hubbard Clinic	Martin Clinic	Grand Rounds
P.M.	Martin Clinic	Yan Clinic	Hubbard Clinic	Grady CC	Grady CC

1st Year Neuro-Ophthalmology Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Newman	Biousse Clinic	Newman Clinic	Biousse Clinic	Grand Rounds
P.M.	Newman	Biousse Clinic	Newman Clinic	Biousse Clinic	Grady CC

1st Year Pathology Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Pathology	Grady CC	Pathology	Pathology	Grand Rounds
P.M.	Pathology	Pathology	Pathology	Pathology	Pathology

1st Year Rotation Schedule (cont'd)

1st Year Glaucoma Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Hylton clinic	Beck Clinic	Costarides Clinic	Beck Clinic	Grand Rounds
P.M.	Costarides Clinic	Beck Clinic	Grady CC	Hylton Clinic	Beck/Costarides Clinic

Every other Wednesday PM 5:30 Neuroradiology Conference
When Dr. Stulting has finished in the OR, the resident is expected to go the Clinic with Dr. Song. If Dr. Stulting is out of town or not in the OR, the resident is expected to be in the Clinic with Dr. Song.
There is a 12:30 pm Neuro-Ophthalmology Lecture in 11th Floor Neurology Grady Conference Room every other Tuesday.
Check the Grand Rounds Lecture Schedule for exact dates. You are expected to attend and be on time!
C.C. = Continuity Clinic at Grady.

2nd Year Rotation Schedule

	1st Rotation July 1 – Aug. 14	2nd Rotation Aug. 15 - Sept. 18	3rd Rotation Sept. 19 - Oct. 23	4th Rotation Oct. 24 - Nov. 27	5th Rotation Nov. 28 - Jan. 8
John Davies, MD	VAMC	Neuro-Op	Path/Plastics	Grady	Cornea
Evan Loft, MD	Cornea	Grady	VAMC	Neuro-Op	Path/Plastics
Kristina Price, MD	Path/Plastics	VAMC	Grady	Cornea	Neuro-Op
Adrienne Ruth, M.D.	Neuro-Op	Path/Plastics	Cornea	VAMC	Grady
Bryan Schwent, M.D.	Grady	Cornea	Neuro-Op	Path/Plastics	VAMC

	6th Rotation Jan. 9 – Feb. 12	7th Rotation Feb. 13 – Mar. 19	8th Rotation Mar. 20 – Apr. 23	9th Rotation Apr. 24 – May 28	10th Rotation May 29 – June 30
John Davies, MD	Peds	Retina	Grady	VAMC	Glaucoma
Evan Loft, MD	Grady	VAMC	Retina	Glaucoma	Peds
Kristina Price, MD	Glaucoma	Peds	VAMC	Retina	Grady
Adrienne Ruth, M.D.	VAMC	Glaucoma	Peds	Grady	Retina
Bryan Schwent, M.D.	Retina	Grady	Glaucoma	Peds	VAMC

2nd Year – Path/Plastics					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Plastics Clinic	Plastics Clinic	Plastics OR	Plastics OR	Grand Rounds
P.M.	Grady CC	Pathology	Pathology	Pathology	Pathology

2nd Year Pediatric Ophthalmology Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Grady Peds	Hutchinson OR	Hutchinson Clinic	Lambert OR	Grand Rounds
P.M.	Grady Peds	Lambert Clinic	Hutchinson Clinic	Lambert OR /Hutchinson Clinic	Grady CC

2nd Year Rotation Schedule (cont'd)

2nd Year Neuro-Ophthalmology Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Newman	Biousse Clinic	Newman Clinic	Biousse Clinic	Grand Rounds
P.M.	Newman	Biousse Clinic	Newman Clinic	Biousse Clinic	Grady CC

2nd Year Cornea/Refractive Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Stulting Clinic	Song Clinic	Contact Lens	Stulting OR	Grand Rounds
P.M.	Stulting Clinic	Grady CC	Stulting Clinic	Stulting OR /Refractive	Phaco Wet Lab (2,4) Research (1,3,5)

2nd Year Glaucoma Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Beck OR	Costarides/ Hylton OR	Beck/Hylton CHOA OR 1,3,5 Costarides Clinic 2,4	Beck Clinic	Grand Rounds
P.M.	Costarides Clinic	Beck Clinic	Grady CC	Hylton Clinic	Beck/Costarides Clinic

2nd Year Retina Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Martin Clinic	Aaberg Clinic	Low Vision (1) Hubbard Clinic (2,3,4,5)	Martin Clinic	Grand Rounds
P.M.	Martin Clinic	Yan Clinic	Hubbard Clinic	Grady CC	Grady CC

3rd Year Rotation Schedule

	July 1 – Sept. 18	Sept. 19 – Nov. 27	Nov. 28 – Feb. 12	Feb.13 – Apr. 23	Apr. 24 – June 30
Steve Bailey, MD	Grady	VAMC1	Grady	Retina/Grady/ Laser	VAMC2
Blaine Cribbs, MD	VAMC2	Grady	VAMC1	Grady	Retina/Grady/ Laser
Wayne Lo, MD	Grady	Retina/Grady/ Laser	VAMC2	Grady	VAMC1
Marc Spirn, MD	VAMC1	Grady	Retina/Grady/ Laser	VAMC2	Grady
Leiv Takle, MD	Retina/Grady/ Laser	VAMC2	Grady	VAMC1	Grady

3rd Year VA Ophthalmology Rotations – VA 1					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	Clinic	Clinic	OR	Clinic	Grand Rounds
P.M.	Grady CC	Clinic	OR	Clinic	Clinic

3rd Year VA Ophthalmology Rotations – VA 2					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	OR	Clinic	Clinic	OR	Grand Rounds
P.M.	OR	Grady CC	Clinic	OR	Clinic

3rd Year Retina/Laser Rotation					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.	VAMC OR (1,3) PRP-Grady (2) IDC (4,5)	Contact Lens	IDC (1) ELV/Elective (2,3,4,5)	Grady CC	Grand Rounds
P.M.	VAMC C&P (1,3) Grady (2) IDC (4,5)	Contact Lens	ELV/Elective (1,2,3,4,5)	Grady Laser	Grady Laser

3rd Year Rotation Schedule (cont'd)

3rd Year Retina/Plastics/Elective					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
A.M.		Wojno Clinic	Bernardino OR		Grand Rounds
P.M.			Bernardino OR		Research

PRP Laser patients are to be scheduled <u>only</u> on the 2nd Monday of the month and must be approved by the Retina Resident. Other
times for <u>emergent</u> PRP Lasers may be selected by the Retina Resident on a case by case basis.

On the 2nd Monday and 4th Monday afternoon, **Diabetic Screeners (326)** will be dilated on arrival as usual but put into the general stack. If PRP Lasers or ROP exams are completed, the Retina Resident will pull the Diabetic Screener patients from the general stack (since they will still be coded as 326).

Ophthalmology Resident Orientation Schedule
July 1 – July 15, 2005

<u>All Orientation Lectures will be held in the Second Floor Conference outside the Residency Program Office unless otherwise noted.</u>

Emory Eye Center:	1365B Clifton Road, NE, Suite B2400
	Atlanta, GA 30322
	404-778-4530 – Terri Trotter
Grady Memorial Hospital Address:	Eye Clinic, 3rd Floor, 3K048 – Map Attached
	80 Jesse Hill Jr. Drive
	Atlanta, GA 30335
	404-616-5097 – Pat Rosier
Veterans Hospital (VAMC):	1670 Clairmont Road – Map Attached
	1st Floor
	Decatur, GA 30033
	404-321-6111 Ext. 7423 – Leona Lumpkin

<u>Thursday, June 30, 2005</u>

7:00 am: GME Orientation – Meet at the Emory Eye Center for GME Orientation. Terri will walk you over to WHSCAB Auditorium for Orientation – **Emily Graubart Only**

<u>Friday, July 1, 2005</u>

8:00 am – 9:00 am: Grand Rounds
9:00 am – 11:30 am: Introduction to the Grady System – Dr. Geoff Broocker
11:30 am – 1:00 pm: Lunch
1:00 pm: **All 1st years to Grady and VA clinics**
7:00 pm: **Pizza at the Mellow Mushroom. Residents will tell you which Mellow Mushroom**

<u>Sunday, July 3, 2005</u>

BBQ at Chris Bergstrom's (1:00pm). RSVP and let the Bergstroms know whether you're coming or not. Ms. Trotter's way big on RSVPing.

Tuesday, July 5, 2005

8:00 am – 10:30 am: Introduction to the Department of Ophthalmology – Ms. Terri Trotter and
                                     Dr. Maria Aaron
10:30 am– 11:30 am: Ocular Trauma – Dr. Maria Aaron
11:30 am – 1:00 pm: **Lunch with Dr. Aaron (it's on her)**
1:00 pm – 2:30 pm: Tour of Crawford Long Hospital – Dr. Maria Aaron
2:30 pm: To Grady Hospital for scrub cards, IDs, parking, etc. (questions ask
                                     Wayne/Steve/Brian)

Wednesday, July 6, 2005

8:00 am – 12:00 pm: **VA/Grady clinics**
12:00 pm – 1:00 pm: Lunch: Let's talk about it.
1:00 pm – 2:00 pm: IRB update – Alcides Fernandez
2:00 pm – 3:00 pm: Introduction to Retina – Dr. Jiong Yan
3:00 pm – 5:00 pm: **Take CITI online course** to get certified for research (can be done from
                                     any computer, even at home). http://www.citiprogram.org. Please ask
                                     Terri for employee ID number before completing program. For more
                                     info, go to Emory IRB site and look under CITI description for more
                                     information (i.e., must complete module 1)

Thursday, July 7, 2005 (Theresa System for Grady, **9 am – 11 am for Emily Graubart Only)**

8:00 am – 12:00 pm: VA/Grady Clinics
12:00 pm -1:00 pm: Lunch with Dr. Lynch. She's buying.
1:00 pm – 3:00 pm: Introduction to the VA "This is not Your Grandfather's VA" – Dr. Mary
                                     Lynch
3:00 pm – 5:00 pm: **VA Clinic**

Friday, July 8, 2005

7:00 am – 8:00 am: Cornea Conference
8:00 am – 9:00 am: Grand Rounds
9:00 am – 10:00 am: Introduction to Oculoplastics – Dr. Robert Bernardino
10:00 am – 11:30 am: Introduction to Pediatric Ophthalmology and Ocular Motility – Dr. Amy
                                     Hutchinson and Ms. Rachel Reeves
12:00pm – 1:00pm: Lunch – Angela Finch Pierson – **Merck**
1:00pm – 3:00pm: Chief Chats – Diabetic retinopathy/Glaucoma/Grady primer – Drs. Wayne
                                     Lo and Marc Spirn
3:00 pm – 5:00pm: **VA/Grady clinics**

Monday, July 11, 2005

8:00 am – 9:00 am: Chief Chats – "10 Most Common Consults at Grady" – Drs. Wayne Lo
                                 and Marc Spirn
9:00 am – 11:30 am: Principles of Ophthalmic Practice I and II – Dr. Broocker
11:30 am – 1:00 pm: Lunch – Angelo Clarici – Lombart
1:00 pm – 5:00 pm: **VA/Grady clinics**

Tuesday, July 12, 2005

8:00 am – 9:30 am: Slit-Lamp/Lensometry/Keratometry I – Paul Larson
9:30 am – 12:00 pm: Principles of Ophthalmic Practice III and IV – Dr. Broocker
12:00 pm – 1:00 pm: **Lunch – Lori Miles - Allergan**
1:00 pm – 2:00 pm: The Red Eye – Dr. Broocker
2:00 pm – 5:00 pm: **VA/Grady clinics**

Wednesday, July 13, 2005

8:00 am – 9:00 am: Visual Fields – Dr. Allen Beck
9:00 am – 10:00 am: Introduction to Strabismus – Dr. Scott Lambert
10:00 am – 12:00 pm: Slit-Lamp/Lensometry/Keratometry II – Paul Larson
12:00 pm – 1:00 pm: **Lunch – Hayne Thornton - Pfizer**
1:00 pm – 4:00 pm: Introduction to the Emory Laser Center – Dr. Brad Randleman
                                 EMORY LASER CENTER

Thursday, July 14, 2005

8:00 am – 9:00 am: Introduction to Cornea – Dr. Diane Song
9:00 am – 10:00 am: Introduction to Ocular Pathology – Dr. Hans Grossniklaus
                                 Auditorium - LRC
10:00 am – 11:30 am: Pictures taken in photography
11:30 am – 12:30 pm: **Lunch – Chuck Tippins - Alcon**
1:00 pm – 3:00 pm: Everything you Ever Wanted to Know About Neuro-Ophthalmology –
                                 Dr. Nancy Newman
3:30 pm– 4:30 pm: Mystery lecture (bring your own case, questions) – Dr. Broocker
4:30 pm: **Grady Clinic**

Friday, July 15, 2005

7:00 am – 8:00 am: Cornea Conference
8:00 am – 9:00 am: Grand Rounds
9:00 am – 12:00 am: The Art of Refraction – Drs. Sue Primo and Ken Rosengren
12:00 am – 1:00 pm: **Lunch – Bruce Ballard, Jeff Tadlu - Bausch and Lomb**
1:00 pm – 5:00 pm: **VA/Grady Clinics**

Resident Duty Hours Survey

Consider your experience averaged over a 4-week period, and answer the following:

- On average, excluding call from home, what was the number of hours on duty per week?

- Excluding call from home, what was the maximum number of continuous hours worked?

- On average, how many hours did you spend in the hospital while taking home call?

- How often did you work more than 30 continuous hours (adding regular duty time and in-house duty on call)?

- How many days in the 4 weeks did you have completely free from all education and clinical responsibilities?

- Did you feel peer pressure to work beyond your scheduled shift?

PROGRESS SUMMARY

Resident _____   **Date** _____

	PGY 2	**PGY 3**	**PGY 4**

Patient Care

A.   Clinical

	PGY 2 Q1	Q2	Q3	Q4		PGY 3 Q1	Q2	Q3	Q4		PGY 4 Q1	Q2	Q3	Q4
Faculty Evaluation														
Record Review														
360° Evaluation														

B.   Surgical

	Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
Faculty Evaluation														
360° Evaluation														
Surgical Log														

Medical Knowledge

	Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
Faculty Evaluation														
Oral Exam														
Chart-Stim. Recall														
OKAP														

PBL & I

	Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
Faculty Evaluation														
Record Review														
M&M Summary														
Oral Exam														
360° Evaluation														
Course 330														
Course 332														

PROGRESS SUMMARY

Resident _____   **Date** _____

PGY 2   PGY 3   PGY 4

Interpersonal/
Communication Skills

	Q1	Q2	Q3	Q4
Faculty Evaluation				
360° Evaluation				
Patient Survey				

	Q1	Q2	Q3	Q4

	Q1	Q2	Q3	Q4

Professionalism

	Q1	Q2	Q3	Q4
Faculty Evaluation				
360° Evaluation				
Patient Survey				
Course 333				
Course 335				

	Q1	Q2	Q3	Q4

	Q1	Q2	Q3	Q4

Systems-Based Practice

	Q1	Q2	Q3	Q4
Faculty Evaluation				
360° Evaluation				
Patient Survey				
Chart-Stim. Recall				
Course 334				
Course 331				

	Q1	Q2	Q3	Q4

	Q1	Q2	Q3	Q4

PROGRAM EVALUATION

Date: _____

PGY-2, PGY-3, or PGY-4? _____

1. Which rotation had the greatest non-educational or service requirements?
_____
_____

2. How can the rotation stated in #1 be improved?
_____
_____

3. Which rotation is the most beneficial and why?
_____
_____

4. Which rotation was the least beneficial and why?
_____
_____

5. Do faculty discuss issues related to patient care, billing, and ethics?
_____
_____

6. What do you value most about the educational aspects of your training?
_____
_____

7. What do you value least?
_____
_____

8. How would you rate the overall quality of the curriculum?
   ☐ EXCELLENT   ☐ GOOD   ☐ FAIR   ☐ POOR

 9. Do you feel that the training program meets the educational goals and objectives?_____

10. How could we improve the training program?
_____
_____
_____
_____

Ophthalmic Clinical Evaluation Exercise (OCEX)

The OCEX is an observed encounter between a resident and a new patient. The evaluator should be present in the exam room for the entire interaction. The intent is to rate the resident in all the categories listed below and then provide immediate performance feedback. The rating system is:

1 - Does Not Meet Expectations   3 - Meets All Expectations

2 – Meets Some Expectations   4 – Exceeds Expectations

na - Not Applicable

Interview Skills

1. Introduced self	1	2	3	4	na	7. Review of systems	1	2	3	4	na
2. Obtained chief complaint	1	2	3	4	na	8. Med list	1	2	3	4	na
3. History of present illness	1	2	3	4	na	9. Past medical history	1	2	3	4	na
4. Pertinent negatives	1	2	3	4	na	10. Social history	1	2	3	4	na
5. Pain inquiry	1	2	3	4	na	11. Family history	1	2	3	4	Na
6. Allergies	1	2	3	4	na	12. Washed hands	1	2	3	4	Na

Examination

1. Best corrected Va	1	2	3	4	na	5. External	1	2	3	4	na
2. Pupils / RAPD	1	2	3	4	na	6. SLE	1	2	3	4	na
3. Visual Fields	1	2	3	4	na	7. IOP (+/- gonioscopy)	1	2	3	4	na
4. Motility	1	2	3	4	na	8. Funduscopy	1	2	3	4	na

Interpersonal Skills / Professionalism

1. Empathetic	1	2	3	4	na	5. Explained diagnosis	1	2	3	4	na
2. Respectful & courteous	1	2	3	4	na	6. Explained plan/options	1	2	3	4	na
3. Used language the pt Understands	1	2	3	4	na	7. Asked if patient had questions	1	2	3	4	na
4. Explained findings	1	2	3	4	na						

Case Presentation

1. Concise & clear	1	2	3	4	na	4. Appropriate differential Dx	1	2	3	4	na
2. Pertinent facts	1	2	3	4	na	5. Appropriate plan	1	2	3	4	na
3. Pertinent pos & negs	1	2	3	4	na	6. Response to attending's questions/suggestions	1	2	3	4	na

Comments: _____

We have reviewed this OCEX together.   Resident initials: _____   Evaluator initials: _____

Date: _____

OCEX Scoring Rubric				
	1 Does not meet	2 Meets some expectations	3 Meets all expectations	4 Exceeds Expectations
Interview Skills				
Introduction	Does not introduce him/her self	Introduces self as Dr. not as resident	Introduces self as resident physician	Introduces self to patient & family and shakes hands
Chief Complaint	Does not elicit a CC	Elicits CC but lacks relevant details.	Elicits CC & details	Elicits CC and subtle, relevant details
HPI	Does not elicit HPI	HPI lacks relevant details	HPI includes most important details	HPI includes all relevant details
Pertinent Negatives	Does not elicit pertinent negatives	Elicits some pertinent negatives	Elicits important pertinent negatives	Elicits even subtle pertinent negatives
Pain Inquiry	Does not elicit.	Pain is elicited, not characterized	Elicits scaled rating of pain (0-10)	Elicits scaled rating/ relieving/exacerbating factors
Allergies	Does not elicit.	Elicits medical allergies without symptom detail	Elicits medical allergies with symptom detail	Elicits medical & environmental allergies/symptoms
ROS	Does not elicit.	Elicits incomplete ROS	Elicits most important items in ROS	Leaves no stone unturned
Medication List	Does not elicit.	Obtains list, no dosages/frequency	Obtains list with dosages/frequency	Obtains list of meds/ & herbal remedies
Social History	Does not elicit.	Omits important details	Obtains important details	Elicits even subtle relevant details
Family History	Does not elicit.	Omits important details	Obtains important details	Obtains subtle relevant details of family tree
Hand Washing	Does not wash hands.	Washes his/her hands, no soap	Washes hands with soap	Washes hands before and after encounter
Exam				
Visual Acuity	Does not check	Checks, but not best corrected	Checks best corrected	Does additional, appropriate testing relevant to patient's history/exam
Pupils	Does not check	Checks light reaction, does not swing light	Checks light reaction and for RAPD	Does additional, appropriate testing relevant to patient's history/exam
Visual Field	Does not check	Confrontational VF done but incompletely	Confrontational visual fields done correctly	Does additional, appropriate testing relevant to patient's history/exam
Motility	Does not check	Checks ductions or versions	Checks ductions / versions and alignment in primary position	Does additional, appropriate testing relevant to patient's history/exam
External	Does not check	Observes without measurements	Checks lid fissures & for proptosis	Does additional, appropriate testing relevant to patient's history/exam
SLE	Does not check	Doesn't check all depths of AC and/or checks only 1 eye	Checks both eyes, entire anterior segment	Does additional, appropriate testing relevant to patient's history/exam
IOP	Does not check	Poor applanation technique	Checks IOP correctly OU	Does additional, appropriate testing relevant to patient's history/exam
Fundus	Does not check	Indirect or slit lamp biomicroscopy	Indirect and slit lamp biomicroscopy	Does additional appropriate testing relevant to patient's history/exam
Interpersonal Skills				

	1 Does not meet	2 Meets some expectations	3 Meets all expectations	4 Exceeds all expectations
Respectful	Disrespectful	Curt, does not listen to all of patient's questions/concerns	Listens to patient, responds to patient questions/concerns	Extremely attentive to patient's questions, concerns
Understandable	Constantly uses medical jargon the patient doesn't understand	Occasionally uses medical jargon the patient doesn't understand	Avoids or explains medical terms when used	Avoids or explains medical terms when used and frequently asks whether they are understood
Explained Findings	No explanation	Cursory explanation	Thoroughly explained all pertinent findings	Thoroughly explained all findings and used models/photos
Explained Diagnosis	No explanation	Cursory explanation	Thoroughly explained diagnosis	Thoroughly explained diagnosis and used models/photos
Explained Plan	No explanation	Cursory explanation	Thoroughly explained plan	Thoroughly explained plan and scheduled tests
Asked if Patient Had Questions.	Does not ask	Asked if patient had questions but didn't answer completely	Asked if patient had questions and answered questions thoroughly	Asked if patient & family had questions. And answered thoroughly. Gave phone # for patient to call with questions
Case Presentation				
Concise/Clarity	Unintelligible	Somewhat Disorganized	Clear, concise, organized	Meticulous, exact, succinct but complete
Pertinent Facts	Omits pertinent facts	Omits minor supporting facts	Covers all pertinent facts	Covers all pertinent facts and omits all irrelevant data
Pertinent Positives & Negatives	Does not mention	Mentions some pertinent positives & negatives	Covers all pertinent positives & negatives	Covers all pertinent positives & negatives, and omits irrelevant data
Differential Diagnosis	Does not mention	Provides basic but incomplete differential Dx	Provides appropriate differential Dx	Exhaustive differential Dx and cites literature
Appropriate Plan	Does not mention	Provides basic but incomplete plan	Provides appropriate plan	Provides detailed plan and cites literature
Response to Attending	Inappropriate	Listens but little response	Listens and responds appropriately	Responds appropriately and cites relevant literature

Resident On-Call Consultation Evaluation Tool (OCAT)

Medical Record # _____ Date of Service _____ Resident: _____

Evaluation Tasks	Score			Scoring Rubric	Comments
Appropriate History Documented	1	2	3	**History:** **1. Unsatisfactory:** History poorly documented, omitting key elements **2. Borderline:** Key points documented, minor points omitted **3. Satisfactory:** All pertinent points in the history clearly documented	
Appropriate Examination Documented	1	2	3	**Examination:** **1. Unsatisfactory:** Each key finding is not documented **2. Borderline:** Key examination findings are documented, minor findings are not **3. Satisfactory:** Complete ophthalmic examination clearly documented	
Assessment & Plan: Problem list	1	2	3	**Assessment & Plan: A. Problem List** **1. Unsatisfactory:** Omission of any exam finding in the problem list **2. Borderline:** Each identified exam finding listed, not in order of importance **3. Satisfactory**: Each identified exam finding, clearly listed, in order of importance	
Assessment & Plan: Differential Diagnosis	1	2	3	**Assessment & Plan B. Differential Diagnosis (ddx)** **1. Unsatisfactory:** Major omissions from ddx **2. Borderline:** Minor omissions from ddx **3. Satisfactory:** DDX listed for each item on problem list	
Assessment & Plan: Treatment Plan	1	2	3	**Assessment & Plan: C. Treatment Plan** **1. Unsatisfactory**: Plan lacks points that will compromise patient care **2. Borderline:** Plan lacks minor points **3. Satisfactory:** Plan is appropriate for ddx	
Consultation Promptness	1	2	3	**Consultation Promptness:** **1. Unsatisfactory:** The resident evaluates patient after 60 minutes **2. Borderline:** The resident evaluates patient between 30-60 minutes **3. Satisfactory:** The resident evaluates patient within 30 minutes	
Agreement with Resident's perceived urgency rating* 1.Minor (e.g. nonspecific symptoms, corneal abrasion, conjunctivitis, ecchymosis) 2. Significant (e.g. hyphema, orbital cellulitis, lid laceration, corneal ulcer, cranial nerve palsy) 3. Severe (e.g. open globe, papilledema, angle closure glaucoma, giant cell arteritis)	1	2	3	**Urgency Rating:** **1. Unsatisfactory**: Resident's rating is 2 levels different from evaluator's**.** **2. Borderline**: Resident's rating is 1 level different from evaluator's **3. Satisfactory**: Resident's rating is the same as the evaluator's.	

Evaluator's Name: _____Signature: _____

MIDROTATION
RESIDENT EVALUATION

Rotation _____

Resident _____

Fund of Knowledge: (appropriate for year of training)
☐ Exceptional knowledge of work
☐ Thorough knowledge
☐ Well informed
☐ Limited knowledge
☐ Knowledge is inadequate

Recommendations for improvement:
_____
_____
_____

Quality of Work: (accuracy, thoroughness, reliability, and effectiveness)
☐ Outstanding, far above standards
☐ Above average
☐ Very few errors; consistent worker. Equals expected standards
☐ Meets minimum requirements
☐ Does poor work

Recommendations for improvement:
_____
_____
_____

Judgment: (analytical and decision-making capabilities)
☐ Exceptional analytical and decision-making ability
☐ Decisions are consistently logical and sound; good analytical ability
☐ Judgment is sound and reasonable
☐ Makes minor errors in judgment
☐ Neglects and misinterprets facts

Recommendations for improvement:
_____
_____
_____

Resident Signature_____   Faculty Signature_____

Retina

1. I   Diabetic Retinopathy I – (Clinical features DR, DCCT, UKPDS) -- DM
2. I   Diabetic Retinopathy II – Treatment -- (ETDRS, DRS) – DM
3. I   Trauma – Posterior segment -- PS
4. II   AMD I – Clinical and angiographic features --PS
5. II   AMD II – Treatment -- (MPS, PDT, etc) – PS
6. II   Other causes of SRNVM – (histo, choroidal rupture, myopia, angiod streaks) -- PS
7. II   Vascular Occlusions -- CRVO/CRAO/BRVO/BRAO -- AC
8. II   Macular Disease I -- Macular pucker/VMT/Macular hole – AC
9. II   Macular Diseasee II – CME, JXT, CSR, Macroaneurysm, others -- AC
10. II   ROP -- AC
11. II   Endophthalmitis -- TMAJr
12. III Uveitis I – Intermediate/posterior -- DM
13. III Uveitis II – Infectious – (toxo, ARN, Syphilis, TB) -- DM
14. III Uveitis III – CMV Retinitis -- DM
15. III Sickle Retinopathy and other peripheral NV -- TMAJr
16. III Peripheral Retinal Degenerations -- TMASr
17. III Rhegmatogenous RD and PVR -- TMASr
18. III Retinal Vascular Diseases / Exudative Retinal Detachment – (Coat's, FEVR, etc) -- TMASr
19. III Fleck Retina – AC
20. IV   Melanoma -- TMAJr
21. IV   Phakomatoses and Non-melanotic intraocular tumors -- TMAJr
22. IV   Retinoblastoma -- TMAJr
23. IV   Diabetic Retinopathy III – Surgical -- (indications, surgical techniques, DRVS) -- TMASr
24. IV   Inherited Retinal Diseases I – Electrophysiology, Macular Dystrophies -- New faculty
25. IV   Inherited Retinal Diseases II -- Retinal and Choroidal Dystrophies –New faculty

NOTE : Monthly one hour FA conferences

Optics and Low Vision

1. III Geometric Optics I – MA
2. III Geometric Optics II – ?NW/GR
3. III Geometric Optics III – ?NW/GR
4. III Physical Optics -- ?GR
5. III Ophthalmic Optics I -- SP
6. III Ophthalmic Optics II -- SP
7. IV   Low Vision -- NW

Contact lens

1. I   Soft CTL -- MW
2. I   RGP's -- MW
3. I   Advanced Cases -- Keratoconus, PK -- MW
4. I   CTL Care Systems and Complications -- MW

Glaucoma Lecture Series

1. I   Overview/Classification/POAG/Tonometry – Orientation -- ML
2. I   Visual Fields/Perimetry – Part II -- AB
3. I   Aqueous Humor Dynamics and Intraocular Pressure – ML
4. I   Pharmacology of Glaucoma -- ML
5. I   Angle Closure Glaucoma/Gonioscopy – TC
6. II   Glaucoma and The Optic Nerve -- TC
7. II   POAG and Normal-tension glaucoma -- AB
8. III Secondary Glaucoma I -- TC
9. III Secondary Glaucoma II -- TC
10. III Congenital and childhood glaucoma – ML
11. III Basic Principles of Lasers and Laser Techniques -- ML
12. IV Glaucoma Filtering Surgery and New Techniques -- ML
13. IV Cyclodestructive and Tube Shunt Procedures -- AB

Pathology Lecture Series

1. I   Inflammation and wound healing – Nariman Sharara
2. I   Pathology of Eyelids – Theresa Kramer
3. II   Pathology of the Conjunctiva I – Hans Grossniklaus
4. II   Pathology of the Conjunctiva II – Hans Grossniklaus
5. II   Pathology of the Cornea and Sclera I – Theresa Kramer
6. II   Pathology of the Cornea and Sclera II – Theresa Kramer
7. II   Pathology of the Retina I -- Hans Grossniklaus
8. II   Pathology of the Retina II -- Hans Grossniklaus
9. II   Pathology of the Uveal Tract I -- Hans Grossniklaus
10. II Pathology of the Uveal Tract II -- Hans Grossniklaus
11. III Pathology of the Peripheral Retina and Vitreous -- Hans Grossniklaus
12. III Pathology of the Orbit I -- Hans Grossniklaus
13. III Pathology of the Orbit II -- Hans Grossniklaus
14. III Pathology of Glaucoma – Theresa Kramer
15. IV Pathology of Intraocular tumors -- Hans Grossniklaus
16. IV Pathology of the Lens – Theresa Kramer

NOTE : CPC/Pathology Unknown Conference – Every month with a fifth Friday -- Hans Grossniklaus and Theresa Kramer

Neuro-ophthalmology Lecture

1. I   Visual Fields
2. I   Papilledema and pseudotumor cerebri
3. I   Optic neuritis and Multiple sclerosis
4. I   AION and temporal arteritis
5. II Pupils
6. III Third, Fourth and Sixth Nerve Lesions
7. III Supranuclear motility
8. III Nystagmus
9. III Transient visual loss
10. III Higher Cortical Function
11. IV Factitious visual loss

NOTE : 8 half hour Neuro-Radiology conferences

Pediatric Lecture Schedule

1. I   Pediatric Eye exam – Arlene Drack
2. I   Sensory testing – Arlene Drack
3. I   Anatomy of the Extraocular Muscles –Arlene Drack
4. I   Physiology of the Extraocular Muscles – Scott Lambert
5. II Infantile Esotropia – Arlene Drack
6. II Accomodative Esotropia – Scott Lambert
7. II Exotropia – Arlene Drack
8. II Pediatric Retinal Disorders – Scott Lambert
9. II Amblyopia – Arlene Drack
10. III Vertical Deviations -- ?
11. III A and V Patterns and Special Forms of Strabismus -- ?
12. III Cranial Nerve Palsies – Scott Lambert
13. III Phakomatoses – Scott Lambert
14. IV Strabismus Surgery and Complications – Scott Lambert
15. IV Ocular Electrophysiology – Scott Lambert
16. IV Ocular Manifestations of Child Abuse – Arlene Drack
17. IV Congenital Anomalies of the Optic Nerve – Scott Lambert
18. IV Congenital Cataracts – Scott Lambert
19. IV Pediatric Nasolacrimal Disorders – Scott Lambert
20. IV Inherited Eye Disease – Arlene Drack

NOTE : 4 half hour Pediatric Neuroimaging Conferences

Oculoplastics Lecture Series

1. I   Oculoplastics Anatomy/Trauma – TW – a Tuesday
2. I   Lacrimal System I – TW – Friday (9-10)
3. I   Lacrimal System II – TW – Friday (10-11)

4. I Graves Disease – TW – Friday (11-12)
5. II Entropion -- MM
6. II Ectropion -- MM
7. II Facial Palsy -- MM
8. II Benign Lid Lesions -- MM
9. II Malignant Lid Lesions -- MM
10. II Lid Reconstruction -- MM
11. III Infectious and Inflammatory Orbital Lesions – TW – a Friday
12. III Lymphoid Orbital Tumors – TW – a Friday
13. III Orbital Tumors – Vascular, Neurogenic, Childhood – TW – a Friday
14. III Lacrimal Gland Tumors and Other Orbital Tumors -- TW – a Friday
15. III Orbital Surgery -- TW – a Tuesday
16. IV Blepharoplasty -- MM
17. IV Brow Lift -- MM
18. IV Ptosis -- MM
19. IV Enucleation -- MM
20. IV Evisceration -- MM
21. IV Anophthalmic Socket and Prosthesis Fitting -- MM

Basic Science Lecture Series

1. I Anatomy of the Eye -- Grossniklaus
2. I Structural Basis of the Corneal Endothelium -- HE
1. I Physiology of Tears -- HE
2. II Embryology I – Grossniklaus
3. II Embryology II – Grossniklaus -- Video
4. III Biochemistry, retinal circuits, and Neurotransmitters – Iuvone
5. IV Preop and Postop Drugs and Solutions – Effect on the cornea -- HE

Miscellaneous

1. I Ethics I – (Informed consent, Patient rights, Delegation of Authority, Research) – Maria Aaron
2. I Ethics II – (New technology, Collegiality, Impaired Physician, Commercial relationships) – Maria Aaron
3. I Ethics III – (Compensation, Advertising, Resource allocation, Obligations to patient, society, family and self) – Maria Aaron
4. IV Medical Malpractice Risk Management I – Laura King
5. IV Medical Malpractice Risk Management I – Laura King
6. IV Managed Care Issues
7. IV Resident Legislative Advocacy Program
8. IV Contract Negotiations – Dr. Goodwin
9. II Billing and Coding – Dr. Goodwin
10. I A-scan Techniques – Rhonda Waldron (3 hours)
11. I B-scan Techniques I – Rhonda Waldron (3 hours)
12. I B-scan Techniques II – Rhonda Waldron (3 hours)

Comprehensive

1. I Anterior Uveitis – Maria Aaron
2. IV Lens and Cataract – Geoff Broocker
3. IV Phaco wet lab (3 hours) -- Geoff Broocker and Maria Aaron

EXIT INTERVIEW

Name: _____   Department: _____

Date: _____   Starting Date: _____ Termination Date: _____

Position Held: _____

1. Comment on the training and supervision you received in this position:

_____
_____
_____

2. Other comments about your position (coworkers, workload, equipment, etc.):

_____
_____
_____

3. Recommendations or changes you would suggest:

_____
_____
_____

4. General comments about employment at the University Medical Center:

_____
_____
_____

Employee Signature _____
Employee Number   _____

October 2005
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 **8:30 AM LEC-TURE: Vascular**
2	**3** 5:00 PM Fluorescein Work Session	**4** 8:00 AM Morning Rounds: Refractive Surgery	**5** **5:00 PM Resi-dents' Mtg**	**6** **8:00 AM INDI-VIDUAL SERVICE ROUNDS** **5:00 PM - 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)**	**7** 8:00 AM Morning Rounds: Pathology	**8** **8:30 AM LEC-TURE: Vascular**
9	**10** 5:00 PM Fluorescein Work Session Columbus Day (Observed)	**11** **8:00 AM - 9:00 AM Path Lectu-re - Dr. Syed**	**12** 8:00 AM Morning Rounds: Cell Biology (GSH) **5:00 PM . Faculty Meeting**	**13** 5:00 PM Vitreoreti-nal Conference	**14** **8:00 AM INDI-VIDUAL SERVICE ROUNDS**	**15** **A A O**
16	**17** 5:00 PM Fluorescein Work Session NO ROUNDS A A O	**18**	**19** 5:00 PM Orbit Conference	**20** 5:00 PM Neuro-Ophthalmology Conference	**21** 8:00 AM Morning Rounds: Contact Lens	**22** **8:30 AM LEC-TURE: Vascular**
23	**24** **8:00 AM INDI-VIDUAL SERVICE ROUNDS** 5:00 PM Fluorescein Work Session	**25** **8:00 AM - 9:00 AM Path Lectu-re - Dr. Syed**	**26** 8:00 AM Morning Rounds: Neuro-Ophthalmology 5:00 PM Cornea Conference	**27** 5:00 PM Vitreoreti-nal Conference	**28** 8:00 AM Morning Rounds: Perimetry	**29** M.A.R.C.; Colum-bia MO
30 Daylight Savings--set back 1 hour	**31** 8:00 AM Morning Rounds: Retina 5:00 PM Fluorescein Work Session Halloween					

September						
S	M	T	W	T	F	S
					1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

November						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
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November 2005
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
October S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	**1** 8:00 AM Morning Rounds: Low Vision	**2** 5:00 PM Residents' Mtg	**3** 8:00 AM - 8:45 AM TOWN MEETING 5:00 PM - 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)	**4** 8:45 AM - 2:30 PM CLINICAL CONFERENCE 3:30 PM - 5:30 PM LECTURE: Neuro-Ophth	**5**
6	**7** 5:00 PM Fluorescein Work Session	**8** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**9** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Faculty Meeting	**10** 8:00 AM Morning Rounds: Glaucoma 5:00 PM Vitreoretinal Conference	**11** Veterans Day	**12** 8:30 AM LECTURE: Neuro-Ophth
13	**14** 5:00 PM Fluorescein Work Session	**15** 8:00 AM Morning Rounds: Plastics	**16** 5:00 PM Orbit Conference	**17** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Neuro-Ophthalmology Conference	**18** 9:00 AM - 5:00 PM RESIDENT INTERVIEWS	**19** 8:30 AM LECTURE: Neuro-Ophth
20	**21** 8:00 AM Morning Rounds: Comprehensive/ Cataract 5:00 PM Fluorescein Work Session	**22** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**23** 5:00 PM Cornea Conference	**24** Thanksgiving UNIVERSITY HOLIDAY	**25** UNIVERSITY HOLIDAY	**26**
27	**28** 5:00 PM Fluorescein Work Session	**29** 8:00 AM Morning Rounds: Cornea	**30**		**December** S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	

December 2005
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	November 05 S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	January 06 S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		**1** 5:00 PM - 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)	**2** 8:45 AM - 2:30 PM CLINICAL CONFERENCE 3:30 PM - 5:30 PM LECTURE: Neuro-Ophth	**3**
4	**5** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Fluorescein Work Session	**6** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**7** 5:00 PM Residents' Mtg	**8** 8:00 AM Morning Rounds: Vascular 5:00 PM Vitreoretinal Conference	**9** 9:00 AM - 5:00 PM RESIDENT INTERVIEWS	**10** 8:30 AM LECTURE: Neuro-Ophth
11	**12** 5:00 PM Fluorescein Work Session	**13** 8:00 AM INDIVIDUAL SERVICE ROUNDS	**14** 8:00 AM Morning Rounds: Peds Ophth 5:00 PM . Faculty Meeting	**15** 5:00 PM Neuro-Ophthalmology Conference	**16** 9:00 AM - 5:00 PM RESIDENT INTERVIEWS 6:30 PM HOLIDAY PARTY	**17** 8:30 AM LECTURE: Neuro-Ophth
18	**19** 5:00 PM Fluorescein Work Session	**20** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**21** 5:00 PM Orbit Conference	**22**	**23**	**24**
25 Christmas	**26** UNIVERSITY HOLIDAY	**27** UNIVERSITY HOLIDAY	**28**	**29**	**30**	**31** New Year's Eve
			NO ROUNDS			

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January 2006
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 New Year's Day	**2** Hanukkah **UNIVERSITY HOLIDAY**	**3** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**4** 5:00 PM Residents' Mtg	**5** 8:00 AM Morning Rounds: Markus Kuehn / Research 5:00 PM - 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)	**6**	**7** 8:30 AM LECTURE: Neuro-Ophth
8	**9** 8:00 AM Morning Rounds: Retina 5:00 PM Fluorescein Work Session	**10**	**11** 8:00 AM INDIVIDUAL SERVICE ROUNDS **5:00 PM. Faculty Meeting**	**12** 5:00 PM Vitreoretinal Conference	**13** 8:00 AM Morning Rounds: Refractive Surgery	**14**
15	**16** Martin Luther King, Jr. **UNIVERSITY HOLIDAY**	**17** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**18** 5:00 PM Orbit Conference	**19** 8:00 AM Morning Rounds: Echography 5:00 PM Neuro-Ophthalmology Conference	**20** 8:00 AM INDIVIDUAL SERVICE ROUNDS	**21** 8:30 AM LECTURE: Neuro-Ophth
22	**23** 8:00 AM Morning Rounds: Neuro-Ophthalmology 5:00 PM Fluorescein Work Session	**24**	**25** 5:00 PM Cornea Conference	**26** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Vitreoretinal Conference	**27**	**28** 8:30 AM LECTURE: Neuro-Ophth
29	**30** 5:00 PM Fluorescein Work Session	**31** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed				

December 05						
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February 06						
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February 2006
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 5:00 PM Residents' Mtg	**2** 8:00 AM Morning Rounds: Perimetry 5:00 PM – 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP) Groundhog Day	**3** 8:45 AM - 2:30 PM CLINICAL CONFERENCE 3:30 PM - 5:30 PM LECTURE: Optics	**4**
5	**6** 5:00 PM Fluorescein Work Session	**7** 8:00 AM Morning Rounds: Heritable Diseases (EMS)	**8** **5:00 PM . Faculty Meeting**	**9** 5:00 PM Vitreoretinal Conference	**10** 8:00 AM Morning Rounds: Contact Lens	**11** 8:30 AM LECTURE: Optics
12 Lincoln's Birthday	**13** **8:00 AM INDIVIDUAL SERVICE ROUNDS** 5:00 PM Fluorescein Work Session	**14** **8:00 AM - 9:00 AM Path Lecture - Dr. Syed** Valentine's Day	**15** 5:00 PM Orbit Conference	**16** 8:00 AM Morning Rounds: Plastics 5:00 PM Neuro-Ophthalmology Conference	**17**	**18** 8:30 AM LECTURE: Retina
19	**20** 5:00 PM Fluorescein Work Session President's Day	**21** **8:00 AM INDIVIDUAL SERVICE ROUNDS**	**22** 5:00 PM Cornea Conference Washington's Birthday	**23** 5:00 PM Vitreoretinal Conference	**24**	**25** 8:30 AM LECTURE: Retina
26	**27** 8:00 AM Morning Rounds: Peds Ophth 5:00 PM Fluorescein Work Session	**28** **8:00 AM - 9:00 AM Path Lecture - Dr. Syed**				

	January								March					
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22	23	24	25	26	27	28		19	20	21	22	23	24	25
29	30	31						26	27	28	29	30	31	

March 2006
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
February S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 **April** S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30			**1** 5:00 PM Residents' Mtg Ash Wednesday	**2** 5:00 PM – 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)	**3** 8:45 AM - 2:30 PM CLINICAL CONFERENCE 3:30 PM - 5:30 PM LECTURE: Optics	**4**
5	**6** 8:00 AM Morning Rounds: Comprehensive/Cataract 5:00 PM Fluorescein Work Session	**7** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**8** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM . Faculty Meeting	**9** 8:00 AM Morning Rounds: Glaucoma 5:00 PM Vitreoretinal Conference	**10**	**11** 8:30 AM LECTURE: Retina
12	**13** 5:00 PM Fluorescein Work Session	**14**	**15** 5:00 PM Orbit Conference	**16** 5:00 PM Neuro-Ophthalmology Conference	**17** St. Patrick's	**18** 8:30 AM LECTURE: Retina
NO ROUNDS SPRING BREAK						
19	**20** 5:00 PM Fluorescein Work Session	**21** 8:00 AM Morning Rounds: Cornea	**22** 8:00 AM Morning Rounds: Cell Biology (Mullins) 5:00 PM Cornea Conference	**23** 5:00 PM Vitreoretinal Conference	**24** 8:00 AM INDIVIDUAL SERVICE ROUNDS	**25** 8:30 AM LECTURE: Retina
26	**27** 5:00 PM Fluorescein Work Session	**28** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**29**	**30** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Neuro-Ophthalmology Conference	**31**	

April 2006
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 **8:30 AM LEC-TURE: Retina** April Fools Day
2 Daylight Savings—set ahead 1 hour	**3** 5:00 PM Fluorescein Work Session	**4**	**5** 8:00 AM Morning Rounds: Neuro-Ophthalmology **5:00 PM Residents' Mtg**	**6** **5:00 PM - 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)**	**7** **8:45 AM - 2:30 PM CLINICAL CONFERENCE**	**8** **O K A P**
9 Palm Sunday	**10** 5:00 PM Fluorescein Work Session	**11** **8:00 AM - 9:00 AM Path Lecture - Dr. Syed**	**12** **5:00 PM . Faculty Meeting**	**13** 8:00 AM Morning Rounds: Retina 5:00 PM Vitreoretinal Conference Passover	**14** Good Friday	**15**
16 Easter	**17** **8:00 AM INDI-VIDUAL SERVICE ROUNDS** 5:00 PM Fluorescein Work Session	**18**	**19** 5:00 PM Orbit Conference	**20** 5:00 PM Neuro-Ophthalmology Conference	**21**	**22** **8:30 AM LEC-TURE: Retina**
23	**24** 8:00 AM Morning Rounds: Low Vision 5:00 PM Fluorescein Work Session	**25** **8:00 AM - 9:00 AM Path Lecture - Dr. Syed**	**26** **8:00 AM INDI-VIDUAL SERVICE ROUNDS** 5:00 PM Cornea Conference	**27** 5:00 PM Vitreoretinal Conference	**28**	**29** **8:30 AM LEC-TURE: Retina**
30 ARVO						

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May 2006
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 5:00 PM Fluorescein Work Session	**2**	**3** 5:00 PM Residents' Mtg	**4** 5:00 PM - 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)	**5** Cinco de Mayo	**6** 8:30 AM LECTURE: Retina
			NO ROUNDS			
			ARVO			
7	**8** 8:00 AM Morning Rounds: Perimetry 5:00 PM Fluorescein Work Session	**9** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**10** 5:00 PM . Faculty Meeting	**11** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Vitreoretinal Conference	**12** 8:00 AM - 4:00 PM ANNUAL OPTOMETRIC MTG 7:00 PM College of Medicine Commencement	**13** 8:30 AM LECTURE: Retina
14 Mother's Day	**15** 5:00 PM Fluorescein Work Session	**16** 8:00 AM INDIVIDUAL SERVICE ROUNDS	**17** 5:00 PM Orbit Conference	**18** 8:00 AM Morning Rounds: Echography 5:00 PM Neuro-Ophthalmology Conference	**19**	**20** 8:30 AM LECTURE: Retina Armed Forces Day
21	**22** 8:00 AM Morning Rounds: Bioinformatics (Scheetz) 5:00 PM Fluorescein Work Session	**23** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**24** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Cornea Conference	**25** 5:00 PM Vitreoretinal Conference	**26** 8:00 AM Morning Rounds: Contact Lens	**27**
28	**29** Memorial Day (Observed) UNIVERSITY HOLIDAY	**30** 8:00 AM Morning Rounds: Plastics	**31**			

April						
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June						
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June 2006
ROUNDS & CONFERENCE SCHEDULE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	May S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	July S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		**1** 5:00 PM - 6:00 PM Neuro-Radiology Conference; Franken Conf Rm (3567 JCP)	**2** 8:00 AM INDIVIDUAL SERVICE ROUNDS	**3** 8:30 AM LECTURE: Retina
4	**5** 5:00 PM Fluorescein Work Session	**6** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**7** 5:00 PM Residents' Mtg	**8** 5:00 PM Vitreoretinal Conference	**9** 8:00 AM Morning Rounds: Refractive Surgery	**10** 8:30 AM LECTURE: Retina
11	**12** 8:00 AM Morning Rounds: Comprehensive/Cataract 5:00 PM Fluorescein Work Session	**13**	**14** 5:00 PM . Faculty Meeting Flag Day	**15** IOWA EYE	**16** IOWA EYE	**17** IOWA EYE
18 Father's Day	**19** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Fluorescein Work Session	**20** 8:00 AM - 9:00 AM Path Lecture - Dr. Syed	**21** 8:00 AM Morning Rounds: Peds Ophth 5:00 PM Orbit Conference	**22** 5:00 PM Vitreoretinal Conference	**23**	**24**
25	**26** 5:00 PM Fluorescein Work Session	**27**	**28** 8:00 AM INDIVIDUAL SERVICE ROUNDS 5:00 PM Cornea Conference	**29** 5:00 PM Neuro-Ophthalmology Conference	**30**	

STAFF EVALUATION FORM

Date: _____

Staff: _____

Please circle the number that best describes the performance of the attending staff member named above. When you've completed the form, please seal it in an envelope directed to the program director and marked "Confidential." The envelope will be opened only by the department chair.

	Excellent	**Good**	**Fair**	**Poor**
Interest in teaching in the clinic:	4	3	2	1
Interest and attitude in the operating room:	4	3	2	1
Willingness to listen and discuss:	4	3	2	1
Willingness to be on time and remain for the scheduled time:	4	3	2	1
Willingness to work with residents on research projects:	4	3	2	1
Patience and helpfulness during surgery:	4	3	2	1
Overall performance as an educator:	4	3	2	1

Comments:

_____
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Office Use Only

Total Points Scored: _____

Overall Evaluation: _____