

Frequently Asked Questions: Ophthalmology

Question	Answer
Institutions	
<p>Can you clarify the following requirement: “The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.”?</p> <p><i>[Program Requirement I.A.]</i></p>	<p>The Review Committee has not set a minimum time or amount of resources needed for the position of program director, and recognizes that this will vary with the program and the individual. While typical time requirements nationally range from 10-30%, the Committee seeks to know that both the program director and the residents feel the program allows the program director sufficient time and resources to complete the job adequately.</p>
<p>What is meant by “opportunity for continuity of care?”</p> <p><i>[Program Requirement I.B.4.]</i></p>	<p>Continuity of care comprises a variety of different concepts, each of which is enabled by the ability of the residents to examine patients at multiple points along their disease or treatment course. For example, residents should have the opportunity to follow patients through their pre-operative assessment, their surgical intervention, and their post-operative course. Residents should have the opportunity to follow patients at various points through the course of a disease process, both for acute conditions (e.g., conjunctivitis, cornea abrasions, hyphema) and chronic conditions (e.g., glaucoma, amblyopia), so that they may assess effects of medical or surgical interventions, as well as become familiar with the natural history of a disease. While a continuity of care clinic would provide these opportunities for residents, where this is not possible, rotations should be structured such that residents have the ability to participate in sustained patient follow-up.</p>
<p>What sort of arrangements should be made for residents on away rotations that preclude their attendance at conferences at the parent institution?</p> <p><i>[Program Requirement I.B.5.]</i></p>	<p>Possible alternatives including real-time teleconferencing or Web conferencing, or making the presentation and any materials distributed during the lecture available to residents either electronically or by hard copy. A DVD or CD of the lecture that the residents could view at their leisure would also suffice.</p>
<p>Can surgical cases performed on international rotations be counted toward the minima? Does it make a difference if program faculty members are also on an</p>	<p>While some educational goals may be met during international rotations, surgical cases performed during these rotations may not be counted toward the surgical minima required by the Review Committee, even if a program faculty member accompanies the resident, because the ancillary resources, local standard of care, and medical systems employed</p>

Question	Answer
<p>overseas trip and supervising the residents during a surgery?</p> <p><i>[Program Requirement I.B.7.]</i></p>	<p>on these rotations cannot be evaluated by the Committee.</p>
Program Personnel	
<p>When or under what circumstances can the Review Committee change a program's review cycle period?</p> <p><i>[Program Requirements II.A.4.m.]</i></p>	<p>Following any review, the Review Committee has the authority to determine the length of time before the next review. Additionally, if the Review Committee becomes aware of significant changes in a program that could affect resident education (e.g., closure of a facility, departure of significant faculty), the Committee may recommend an earlier review.</p>
<p>What is the process to follow when a particular resident needs additional time beyond the 36-month program period to successfully complete his/her residency education?</p> <p><i>[Program Requirement Int.B.3. & II.A.4.r.]</i></p>	<p>Whenever this is considered necessary, the program director should notify the Review Committee promptly, and should provide a detailed account of all reasons explaining why additional time has been recommended, the program designed for the resident, and what steps will be taken to ensure it does not negatively impact the education of other residents in the program. The Review Committee will review such cases on an individual basis, and work with the program director to address the concerns mentioned above. The program director should not make any agreement or contractual arrangement with a resident without Review Committee approval. Requests for temporary resident complement increases of one month or more must be entered in ADS on the ACGME website.</p>
<p>What is the responsibility of the program director when residents need to be on extended leave (up to six months)? What is the program director's responsibility if a resident is required to remain in a program beyond his/her expected graduation time, either to make up lost time, or for educational remediation?</p> <p><i>[Program Requirement Int.B.3. & II.A.4.r.]</i></p>	<p>In both cases, the program director must notify the Review Committee promptly, and provide an explanation of why any modifications to program length are necessary. Both extended residents absences and a temporary resident complement increase may affect the other residents in the program. The program director must evaluate the effects any such modifications may have on remaining residents in the program, and outline what steps have been made to protect and balance their educational and service needs, i.e., to make sure their educational program is not hindered by either excessive service or dilution of resources. Requests for temporary resident complement increases of one month or more must be entered in ADS on the ACGME website.</p>
<p>Do required online education modules count as lecture hours even though they are not face-to-face?</p> <p><i>[Program Requirement II.A.4.t.]</i></p>	<p>If online teaching modules are required and the program can document satisfactory completion of these modules, they may count as lecture hours and should be included in the Program Information Form.</p>

Question	Answer
<p>What sorts of formats qualify for the case presentation conferences that must be held at least six hours per month?</p> <p><i>[Program Requirement II.A.4.t.]</i></p>	<p>In addition to the grand rounds format, didactic case presentations, morbidity and mortality conferences, and continuous quality improvement conferences could also fulfill this requirement.</p>
<p>How much of a lag period is acceptable for getting surgical cases entered into the resident case log system?</p> <p><i>[Program Requirement II.A.4.u]</i></p>	<p>Residents are encouraged to log the information in a timely fashion following involvement in a surgery. Barring undue circumstances, most residents should be able to do so regularly on a (bi)weekly basis.</p>
<p>Why have a total surgeon plus assistant minimum number of procedures?</p> <p><i>[Program Requirement II.A.4.v.]</i></p>	<p>Instead of requiring a certain number of procedures as an assistant, the Review Committee decided to use this measure as a surrogate for overall surgical volume for a program.</p>
<p>What is the definition of a resident acting as primary surgeon? How do I count multiple procedures on a single patient?</p> <p><i>[Program Requirement II.A.4.v.]</i></p>	<p>See “Definition of a Surgeon” under the Program Resources tab of the Ophthalmology Review Committee page here.</p>
<p>If a program has faculty members who were not educated in the U.S., and hence are ineligible for American Board of Ophthalmology (ABO) certification, how will the Review Committee view this with respect to “acceptable qualifications”?</p> <p><i>[Program Requirement II.B.2.]</i></p>	<p>The Review Committee will examine factors such as the faculty member’s residency and fellowship education; Board certification or equivalent in their country of origin or education; membership in specialty societies; and academic achievement. In appropriate cases, some faculty members who are not eligible for ABO certification may be recognized as acceptable by the Committee, and will be exempt from further citations. However, ABO certification and participation in maintenance of certification for time-limited certificate holders is expected of all ophthalmology faculty members with U.S. residency education. U.S.-educated neurologists who serve as neuro-ophthalmology residency faculty members should have appropriate Board certification in neurology.</p>
<p>Can you clarify the following requirement: “The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.”?</p>	<p>Among the program faculty, representation of scholarly activity is required in the form of regular presentations at local, regional, or national meetings; participation in original research, or clinical trials; publication in peer-reviewed journals; or grant writing/submission. Not all faculty members need to participate in these activities, and not all activities mentioned need to occur within a single program. However, the Review Committee seeks to know that the residents have exposure to a faculty that is involved in</p>

Question	Answer																						
[Program Requirement II.B.5.]	ongoing scholarly activity.																						
Resources																							
<p>What is considered “current diagnostic equipment?”</p> <p>[Program Requirement II.D.1.]</p>	<p>In all locations where patients are seen, standard “current diagnostic” equipment would include devices to measure visual acuity and obtain refractive data, slit lamps, direct and indirect ophthalmoscopes, and appropriate diagnostic lenses. In pediatric or adult motility clinics, prisms and tests to measure binocular function (e.g. Titmus, Worth 4 dot) should be present. Ready access to fluorescein angiography, ophthalmic photography and echography, visual fields, and retinal/optic nerve fiber analysis should be easily available for treating patients. Less commonly used tests such as visual evoked potential systems (VEP), electroretinography (ERG), electrooculography (EOG), should be available at least on-site for program use.</p>																						
Educational Program																							
<p>Does a temporary tarsorrhaphy count on the surgical logs, or does it have to be permanent?</p> <p>[Program Requirement IV.A.5.a.]</p>	<p>A temporary tarsorrhaphy can count and should be entered in the surgical logs.</p>																						
<p>What are the minimum operative numbers?</p> <p>[Program Requirement IV.A.5.a.(5)]</p>	<table border="1" data-bbox="747 870 1566 1333"> <thead> <tr> <th data-bbox="747 870 1031 943">Procedure</th> <th data-bbox="1039 870 1566 943">Current Minimum Requirement (*Surgeon; **Surgeon and Assistant)</th> </tr> </thead> <tbody> <tr> <td data-bbox="747 950 1031 984">Cataract*</td> <td data-bbox="1039 950 1566 984">86</td> </tr> <tr> <td data-bbox="747 990 1031 1024">Strabismus*</td> <td data-bbox="1039 990 1566 1024">10</td> </tr> <tr> <td data-bbox="747 1031 1031 1065">Corneal Surgery*</td> <td data-bbox="1039 1031 1566 1065">3</td> </tr> <tr> <td data-bbox="747 1071 1031 1105">Refractive Surgery**</td> <td data-bbox="1039 1071 1566 1105">6</td> </tr> <tr> <td data-bbox="747 1112 1031 1146">Glaucoma *</td> <td data-bbox="1039 1112 1566 1146">5</td> </tr> <tr> <td data-bbox="747 1153 1031 1187">Glaucoma Laser*</td> <td data-bbox="1039 1153 1566 1187">9</td> </tr> <tr> <td data-bbox="747 1193 1031 1227">Retina/Vitreous**</td> <td data-bbox="1039 1193 1566 1227">10</td> </tr> <tr> <td data-bbox="747 1234 1031 1268">Other Retinal*</td> <td data-bbox="1039 1234 1566 1268">25</td> </tr> <tr> <td data-bbox="747 1274 1031 1308">Oculoplastics/Orbit*</td> <td data-bbox="1039 1274 1566 1308">28</td> </tr> <tr> <td data-bbox="747 1315 1031 1349">Globe Trauma*</td> <td data-bbox="1039 1315 1566 1349">4</td> </tr> </tbody> </table> <p data-bbox="747 1339 1902 1396">* Operative minimums per class of procedures are now established only for cases where the resident is the <i>primary surgeon</i></p>	Procedure	Current Minimum Requirement (*Surgeon; **Surgeon and Assistant)	Cataract*	86	Strabismus*	10	Corneal Surgery*	3	Refractive Surgery**	6	Glaucoma *	5	Glaucoma Laser*	9	Retina/Vitreous**	10	Other Retinal*	25	Oculoplastics/Orbit*	28	Globe Trauma*	4
Procedure	Current Minimum Requirement (*Surgeon; **Surgeon and Assistant)																						
Cataract*	86																						
Strabismus*	10																						
Corneal Surgery*	3																						
Refractive Surgery**	6																						
Glaucoma *	5																						
Glaucoma Laser*	9																						
Retina/Vitreous**	10																						
Other Retinal*	25																						
Oculoplastics/Orbit*	28																						
Globe Trauma*	4																						

Question	Answer
	<p>** Operative minimums per class of procedures are established for cases where the resident is either the <i>primary surgeon and/or the assistant</i></p> <p>Residents are expected to input surgeries on which they are the first assistant as well as cases on which they are the primary surgeon. This is necessary for the program to show a progressive graduated and broad surgical experience. At least 364 total procedures (surgeon + assistant) should be completed at the end of the residency.</p>
<p>How were the minimum operative numbers determined?</p> <p><i>[Program Requirement IV.A.5.a.(5)]</i></p>	<p>In 2006 the Review Committee revisited the minimum operative numbers. As a surgical subspecialty, ophthalmology requires the development of competence in key surgical procedures and at least familiarity in others. While the Review Committee recognizes that achievement of minimum operative numbers does not assure individual competency, the minimums serve as a surrogate for measurement of adequacy of surgical volume offered by a program to its residents. The new minimums were set at the 20th percentile of procedures performed nationwide by residents. On review the past three years the Review Committee has decided not to change the minimums even though the numbers of surgeries nationwide has increased according to the Resident Case Log System.</p>
<p>Why have surgical categories with a very low minimum (e.g. 3 or 4)?</p> <p><i>[Program Requirement IV.A.5.a.(5)]</i></p>	<p>We recognize that residents will not achieve <i>competency</i> after only performing a handful of procedures in a particular discipline, but we require that residents do have <i>familiarity</i> with the procedures in each subspecialty. Familiarity can be defined as the ability to perform a procedure with assistance. The program director and faculty are the final arbiters for the assessment of a resident's competency for a procedure.</p>
<p>Does each resident have to meet the minimum operative numbers to graduate?</p> <p><i>[Program Requirement IV.A.5.a.(5)]</i></p>	<p>No. The program's per resident average should meet each minimum operative number. However, each resident must demonstrate sufficient competence to enter practice without direct supervision. In addition, the program director should ensure that residents have equivalent educational experiences (in general, there should not be wide variations in residents' surgical numbers). The program should also have a broad range of surgical experience, a progressive, graduated surgical experience (residents should assist on most procedures before acting as primary surgeon), and have appropriate supervision in surgery. A program may be cited for non-equivalent experience, lack of breadth of surgical experience, lack of a progressive, graduated experience, and inappropriate supervision despite meeting the minimum operative numbers. <u>and</u> there must be an assessment of surgical competency.</p>

Question	Answer
<p>Residents should have documented experiences in practice management, ethics, advocacy, visual rehabilitation, and socio-economics. What exactly is meant by "advocacy"?</p> <p><i>[Program Requirement IV.A.5.b).(2)]</i></p>	<p>According to the American Academy of Ophthalmology (AAO) publication, <i>The Profession of Ophthalmology</i>, advocacy is a duty of the physician and requires that he/she support, defend, and protect his/her patients and the profession. Commitment to advocacy can empower one to directly affect legislation, regulation, policy, and public and professional opinion on patient care, patient's rights, access to health care, research funding, scope of practice, liability issues, and device and medication development. Residency programs should provide formats where residents can be exposed to and participate in these issues. Examples include the AAO's Advocacy Day and Mid-Year Forum, local legislative meetings and events, FDA conferences, or observation or service on an Institutional Review Board or other committee that protects patients' rights.</p>
<p>Documentation for self assessment and reflection</p> <p><i>[Program Requirement IV.A.5.c.]</i></p>	<ul style="list-style-type: none"> • Document a structured process for reflection in which a faculty advisor guides the resident in using feedback and evaluations to inform the self assessment process • Documentation of the semi-annual evaluation meetings in which these processes are demonstrated and provide evidence that this requirement is being addressed
<p>Documentation for EBM-related skills</p> <p><i>[Program Requirement IV.A.5.c.]</i></p>	<ul style="list-style-type: none"> • Document structured evidence-based medicine activities such as a journal club presentation, critical appraisal of a topic, or educational prescription with appropriate faculty oversight and formal assessment of skills • Additional documentation would be the written goals and objectives for this learning activity and how residents are assessed
<p>Documentation for quality improvement</p> <p><i>[Program Requirement IV.A.5.c.(4)]</i></p>	<ul style="list-style-type: none"> • Document the written project description of a full PDSA cycle in which an individual resident or group of residents actively participated with appropriate faculty oversight and formal assessment of skills, or proceedings from events in which quality improvement projects were presented orally
<p>Documentation for teaching skills</p> <p><i>[Program Requirement IV.A.5.c.(8)]</i></p>	<ul style="list-style-type: none"> • Document the written goals and objectives for this learning activity and how residents are assessed • Additional documentation should include evidence for structured teaching opportunities, feedback from learners such as medical students, or patient perceptions of the clarity of residents' explanations

Question	Answer
Documentation for communicating with patients and families <i>[Program Requirement IV.A.5.d.]</i>	<ul style="list-style-type: none"> • The learning activity must include both a didactic component and an experiential component • Learning activities might address written communication (e.g., orders, history and physical examination, progress note, transfer note, discharge summary, operative reports, diagnostic reports), oral communication (e.g., presentations, transfer of care, interactions with patients, families, colleagues, members of the health care team) and/or non verbal skills (e.g., listening, team skills) • These should be structured learning activities (not just “on-the-job” training) with faculty oversight and feedback
Documentation for teamwork <i>[Program Requirement IV.A.5.d.(3)]</i>	<ul style="list-style-type: none"> • Documentation should include the written goals and objectives and curriculum (didactic and experiential) • Demonstrate that faculty actively engage the learners in developing these skills • Document that team member communication is bidirectional rather than unidirectional
Documentation for medical records <i>[Program Requirement IV.A.5.d.(5)]</i>	<ul style="list-style-type: none"> • Additional documentation (not required) might include a written policy for the completion of comprehensive, timely and legible medical records that includes monitoring, evaluation and feedback to residents
Documentation for professionalism <i>[Program Requirement IV.A.5.e.]</i>	<ul style="list-style-type: none"> • This activity should be structured, should demonstrate active faculty involvement (not just passive role modeling) and timely feedback to residents, and should include a mechanism for collecting evaluations (including routine multi-source assessment) • Additional documentation is provided by the written goals and objectives for this learning activity (must be available for site visitor review) and how residents are assessed
Documentation for promoting professionalism behavior <i>[Program Requirement IV.A.5.e.]</i>	<ul style="list-style-type: none"> • Approaches may include role modeling by program leadership, ongoing interactive conversations involving both faculty and residents about the elements of professionalism, particularly in the context of every day practice, policies regarding lapses in professionalism, and processes to address lapses when they occur
Documentation for remediation in professionalism <i>[Program Requirement IV.A.5.e.]</i>	<ul style="list-style-type: none"> • Approaches may include provision of immediate feedback, development of a plan specific to the behavior in question, monitoring for behavior change, decisions based on specified outcomes, and consequences that are aligned with the gravity of the lapse or breach if expectations are not achieved

Question	Answer
<p>Documentation for systems-based practice</p> <p><i>[Program Requirement IV.A.5.f]</i></p>	<ul style="list-style-type: none"> • Documentation should include the written goals and objectives for this learning activity, curriculum (didactic and experiential) that demonstrates the elements of systems-based practice, and assessment of resident outcomes
<p>Documentation for system errors</p> <p><i>[Program Requirement IV.A.5.f.(6)]</i></p>	<ul style="list-style-type: none"> • Important elements include identified faculty to guide the activity, mechanism to ensure active engagement by each resident, and evidence of experiential learning (not just passive presence at conferences or meetings) in which residents participate in identifying a system problem or error and contribute to a potential solution • Additional documentation includes the written goals and objectives for this learning activity and how residents are assessed • Aggregated resident outcomes may be in the form of percentage of residents that completed a patient safety or other systems-based practice project by the end of training, annual list of improvements that resulted from such projects, etc.
Evaluation	
<p>If our program evaluates residents electronically, and they sign off on the electronic evaluation, do we need to provide hard copies and have the residents sign in ink for a site visit?</p> <p><i>[Program Requirement V.A.]</i></p>	<p>Access to these evaluations must be available to the site visitor. Electronic accessibility could be acceptable provided it is not too time-consuming for the site visitor, and it is uncomplicated to verify that a full evaluation occurred and was reviewed with and acknowledged by the resident. However the program director should be prepared to quickly print a hard copy.</p>
<p>What methods of evaluation should Ophthalmology programs use?</p> <p><i>[Program Requirement V.A. 1.e.]</i></p>	<ul style="list-style-type: none"> • Direct Observation: Tools: Ophthalmic Clinical Exam (OCEX) or other structured assessment of a resident-patient interaction • 360 Degree Evaluation: Tools: Ophthalmology specific evaluation forms for peer, patient, supervisor, self, etc. • Portfolio: Tools: Ophthalmology specific portfolio with documentation of self improvement project, quality improvement and PDSA or other structured systems-based project, chart audit, learning plan, etc. • Written/Oral Examinations: Tools: Ophthalmic Knowledge Assessment Program (OKAP), ABO pass rate, AAO self assessment exams, etc.
Other	
<p>Please explain the categories in the surgical log for corneal surgery. Specifically, what is meant by refractive</p>	<p>Refractive surgery includes all incisional keratorefractive surgery, eg., LASIK, LASEK, PRK, relaxing incisions, etc. Refractive procedures such as clear lens extraction or intraocular contact lens implantation should be placed under cataract or other cataract.</p>

Question	Answer
surgery and other cornea?	There are separate categories for penetrating keratoplasty and pterygium excision, so other cornea would not include these but could include things like superficial or lamellar keratectomy, DSEK, DSAEK, corneal biopsy, removal of band keratopathy, etc. Other cornea should not include minor procedures that are often done in clinic such as suture removal, corneal cultures, removal of superficial foreign bodies, corneal burring, etc.

OPH_ED_072011