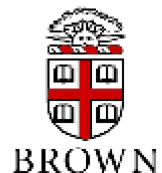
DEPARTMENT OF OPHTHALMOLOGY

Rhode Island Hospital

Written Curriculum

Rhode Island Hospital

A Lifespan Partner



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*The General Clinic Encounters at RIH and the VA expected during the 3-year residency sum to a total of 2,554 patient encounters. These encounters only account for approximately 54% of the resident time during the residency and do not account for patients seen during the subspecialty clinics (~35% of the resident's time) nor the encounters with patients during the operative (11% of the resident time) and/or consultative settings. 25

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I. Educational Purpose

A. Mission Statement

The primary purpose of the program is to produce superior clinical, surgical and academic ophthalmologists who are trained in all areas of modern clinical and surgical skills. The residents are afforded a rich clinical and surgical experience due to the volume and diversity of ophthalmic diseases at Rhode Island Hospital and the Veteran's Administration community.

The clinical and surgical experience of the program is complemented by a rigorous academic lecture schedule designed to promote resident advancement in medical and surgical knowledge and to develop fine presentation skills. The residents are urged to pursue research and scholarly activities and to participate in the development of new knowledge, learn to evaluate research findings and develop habits of inquiry as a continuing professional responsibility. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with our faculty.

The residents' growth should parallel their personal development. During their training, many will form lifelong relationships both professionally and socially. We encourage our residents to pursue their extracurricular interests to bring about compassionate and well-balanced physicians.

The ophthalmology training program will provide each resident the support and resources needed to help maintain and develop these relationships, to meet family obligations and handle personal issues they may encounter during their three years with us.

The quality of education offered by the Brown program ranks highly among its peers, yet a committed faculty continuously searches for new ways to improve upon its structure. Your participation and feedback regarding your experience is welcome.

William G. Tsiaras, M.D, Chairman

B. Program Description

Lifespan, Rhode Island's first health system, was founded in 1994 and it's partners include the region's best names in health care: The Rhode Island Hospital (RIH), Miriam Hospital, Bradley Hospital, and Newport Hospital. In 2001, Lifespan reported 1,174 beds, 9,852 employees, 2,407 affiliated physicians, 173,403 emergency department visits, and 48,050 patient discharges.

RIH is a private, not-for-profit acute care hospital. Founded in 1863, RIH has grown to become the oldest and largest hospital in Rhode Island, the fourth largest in New England, and a nationally recognized research and academic medical center. It serves as the level one trauma center for southeastern New England with both pediatric and adult capabilities. The emergency department sees more than 100,000 patients a year; more than 22,000 of these are trauma patients. This makes the emergency department at RIH one of the five busiest in the United States. The RIH medical center

encompasses Women & Infants Hospital, which is the state's largest obstetric and women's health facility and Hasbro Children's Hospital, which is RIH's pediatric division and the state's only pediatric referral center. RIH provides a full range of diagnostic and therapeutic services to patients, with particular expertise in cardiology, oncology, neurosciences, orthopedics, pediatrics, and ophthalmology. RIH is affiliated with and serves as the major teaching hospital for Brown Medical School.

Rhode Island Hospital

593 Eddy Street
Providence, RI 02903
(401) 444- 4000
www.lifespan.org/partners/rih

The core of the Department of Ophthalmology at RIH is the resident eye clinic. The department began in 1967 and continues to grow as an academic department. Under the current direction of William G. Tsiaras, MD the department provides a broad educational experience for its residents and recognizes that the programs success depends as much on the quality of its residents as much as it does on the quality of the faculty.

The residency program is constructed based on a three-year training program model with two positions annually. Six ophthalmology residents staff the clinic: two in each postgraduate year (PGY) at the PGY-2, PGY-3, and PGY-4 levels.

Although most of the residency training is at RIH, for the majority of the second year and part of the third year the resident is assigned to the Providence Veterans Administration Medical Center (VAMC) ophthalmology clinic. The VAMC is dedicated to providing high quality comprehensive outpatient and inpatient healthcare to veterans residing in Rhode Island and southeastern Massachusetts. Each veteran who comes to the VAMC for care is assured personalized care by a team of health care providers. A Primary Care Provider coordinates each patient's medical care, patient education needs, and referrals to any of the medical centers 32 subspecialty clinics that include ophthalmology. The VAMC's Ambulatory Care Program is supported by a general medical and surgical inpatient facility that delivers a broad range of services in medicine, surgery, and behavioral sciences. The medical center has approximately 199 beds, 150 board certified physicians, and a total of 740 full-time employees who complete the healthcare delivery team of professional, technical, administrative and support personnel. Nationally and internationally recognized clinical research activities enhance patient care in oncology, heart and lung diseases, hypertension and psychological disorders. The VAMC is also affiliated with Brown Medical School.

Providence VA Medical Center

830 Chalkstone Ave.
Providence, RI 02908-4799
(401) 273-7100
www.visn1.med.va.gov/providence/

II. Goals and Objectives

A. Resident Goals and Objectives

1) Knowledge. Development of a broad fund of basic science and clinical knowledge through lecture, reading, and interactive conference and review sessions.

2) Develop a personal program of self-study and professional growth with guidance from the teaching staff.

3) Participation fully in the educational activities such as the regularly scheduled conferences, which cover the following subspecialty areas: retina, glaucoma, cornea, oculoplastics, neuro-ophthalmology, pediatric ophthalmology, uveitis, low vision, and ophthalmic pathology.

4) Participate in safe, effective, and compassionate patient care under supervision, commensurate with his/her level of advancement and responsibility.

5) Participate in institutional programs and activities involving the medical staff, and adhere to established practices, procedures, and policies of the other institutions participating in activities and rotations assigned as part of the specific training program.

6) Conform to Hospital bylaws, policies, procedures, and regulations and applicable federal and state laws.

7) Complete all patients' medical records within the time period specified by the Hospital.

8) Supervised direct patient care experience which allows the resident to:

   a) Master ophthalmologic examination skills,
   b) Formulate and workup differential diagnoses,
   c) Manage clinical problems of increasing complexity,
   d) Develop and exercise clinical and ethical decision making abilities,
   e) Develop patient communication techniques, and
   f) Work effectively as a member of the medical care team.

9. Skills- Graduated supervised procedural and surgical experience including:

   a.) Modern cataract and anterior segment techniques including strabismus and oculoplastic techniques,
   b.) Anterior and posterior segment laser surgery,
   c.) Exposure to all areas of subspecialty surgery, and
   d.) Completion of the minimum numbers for operative experience as mandated by the Residency Review Committee (RRC) for Ophthalmology (see Appendix A).

10. Development of teaching skills by assuming responsibility for teaching and supervising other junior house officers and medical students.

11. To provide residents with exposure to research, to teach them to knowledgeably assess research results, and to motivate residents to pursue academic research projects.

12. Participation in the annual Ophthalmology Knowledge Assessment Program (OKAP). The OKAP is administered annually in mid-April.

13. Preparation for ABO written and oral board certification exams.

14. Preparation for ophthalmic practice.

    a.) Apply cost containment measures in the provision of patient care.
    b.) Ethics:
        i. Patient care responsibilities and
        ii. Ethics of inter-collegial relations.
    c.) Risk management.
    d.) Policies of sexual harassment, discrimination, and substance abuse.
    e.) Practice management:
        i) Contractual negotiations,
        ii) Hiring/supervising employees,
        iii) Financial management,
        iv) Working with associates,
        v. Third party payers,
        vi. Managed care,
        vii. Medicare/Medicaid, and
        viii. Private insurance.

B. Goals and Objectives Based on Site

1. Rhode Island Hospital (RIH)

Each resident will spend the majority of their time at RIH. The resident is expected to perform the goals and objectives based on their level of training.

a.) Outpatient Eye Clinic. Under faculty supervision the resident is expected to:

i. See patients with appointments in the eye clinic,
ii. See consultations from the emergency department and inpatient settings,
iii. Teach and supervise medical students and other residents rotating through the Department,
iv. Manage patients through medical and/or procedural intervention as indicated,
v. To interact professionally with patients, staff, faculty, and other residents, and
vi. Obtain experience with the Electronic Medical Records Information System at the RIH.

b.) Operating Room. Under direct faculty supervision the resident is expected to:

i. Perform and assist in the surgical intervention of patients seen through the General Eye Clinic,
ii. Directly coordinate the pre- and postoperative management of the surgical patient, and
iii. Communicate with operative anesthesia and staff to arrange for the surgical management of patients.

2. *Providence VA Medical Center (VAMC)*

Each resident will spend the part of his or her time at the VA during his or her PGY-2 and PGY-3 years. The resident is expected to perform the goals and objectives based on their level of training.

a.) Outpatient Eye Clinic. Under faculty supervision the resident is expected to:

i. See patients with appointments in the eye clinic,
ii. See consultations from the emergency department and inpatient settings,
iii. Manage patients through medical, procedural, and surgical intervention as indicated,
iv. To interact professionally with patients, staff, faculty, and other residents, and
v. Obtain experience with the Electronic Medical Records Information System at the VAMC.

b.) Operating Room. Under direct faculty supervision the resident is expected to:

i. Perform and assist in the surgical intervention of patients seen through the General Eye Clinic,
ii. Directly coordinate the pre- and postoperative management of the surgical patient, and
iii. Communicate with operative anesthesia and staff to arrange for the surgical management of patients.

C. Goals and Objectives Based on Year

1. *Objectives for First Year (PGY-2)*

a.) Development of a core knowledge base through attendance of daily didactic lectures in the department's curriculum, use of the American Academy of Ophthalmology (AAO) Basic and Clinical Science Course (BCSC), and presentation and attendance at clinical conferences and grand rounds.

b.) Learning of elementary refraction and contact lens fitting techniques.

c.) Development of proper techniques involved in a thorough ophthalmologic examination of the anterior and posterior segment.

d.) Acquire a basic understanding of ocular diseases and their medical management.

e.) Assisting in the supervision, teaching, and evaluation of medical students and residents from other specialties rotating through ophthalmology (e.g., emergency medicine, etc.).

f.) To workup and manage general eye clinic patients on initial and subsequent follow-up evaluations in the department of ophthalmology at RIH where most of their time is spent.

g.) Performance of supervised minor surgical procedures (e.g., chalazion excision, etc.).

h.) Development of facility with management of most ophthalmic emergencies via emergency room coverage and inpatient consultations.

i.) Exposure to patients on the subspecialty service with an introduction to examination techniques and management of basic problems in the areas of retina, glaucoma, cornea, ophthalmic plastics, neuro-ophthalmology, pediatric ophthalmology, and uveitis.

j.) Exposure to ophthalmic pathology with emphasis on clinicopathological correlation.

k.) Identification of an area of research interest and pursuit of an original project with faculty guidance.

2. *Objectives for Second Year (PGY-3)*

a.) Reinforcement of their core knowledge base through attendance of daily didactic lectures in the department's curriculum, use of the AAO BCSC, and presentation and attendance at clinical conferences and grand rounds.

b.) Increasing clinical decision making in management of general clinic and emergency patients.

c.) Assisting in supervision and teaching of first year residents.

d.) To workup and manage general eye clinic patients on initial and subsequent follow-up evaluations in the department of ophthalmology at the VAMC where most of their time is spent. While at VAMC the second–year resident assumes responsibility for the medical and surgical care of these patients.

e.) Introduction to cataract surgery; the second-year residents will begin performing large excision extracapsular cataract surgery with intraocular lens implantation and then modify their technique to include scleral tunnel phacoemulsification later in the year as they develop more proficiency with intraocular surgery.

f.) Training in and performance of ophthalmic plastic and strabismus surgery.

g.) Training in techniques of anterior and posterior segment laser surgery (e.g., YAG laser capsulotomy and panretinal photocoagulation).

h.) Development of interpretative skills in assessing diagnostic tests such as fluorescein angiograms, radiologic images, etc.

i.) Performance of ophthalmic consultations in a general medical hospital and emergency room setting.

3. *Objectives for Third Year (PGY-4)*

a.) Expanding their core knowledge base through attendance of daily didactic lectures in the department's curriculum, use of the AAO BCSC, and presentation and attendance at clinical conferences and grand rounds.

b.) Increasing clinical and surgical decision making in management of general clinic and emergency patients.

c.) Assisting in the teaching and supervision of first and second year residents.

d.) Training in the indications for, performance of, and complications of anterior segment surgery, including basic techniques and advanced procedures.

e.) Training on the indications for, performance of, and complications of surgery in the subspecialty disciplines of glaucoma, retina, cornea, ophthalmic plastics, and pediatric ophthalmology. By the completion of the third year, the number of surgical cases in each subspecialty area is expected to far exceed the minimum requirements suggested by the residency review committee of the Accreditation Council for Graduate Medical Education (ACGME) (See Appendix A.).

f.) Supervising coverage of the ocular trauma service and learning of the medical and surgical management of ocular trauma.

g.) Most of their time is at RIH with some time spent at the VA Medical Center.

h.) Act as Chief Resident when assigned:

i. Submit call schedule,
ii. Submit presentation schedule for Grand Rounds,
iii. Responsible for the continuity of care in the eye clinic,
iv. Manage the clinic and surgical service and ensure that both are adequately covered,
v. Set the standard for morale among the house staff and thereby promote the highest delivery of quality care to our patients and institute good team spirit, and
vi. Ensure that vacation requests are submitted per vacation policy.

D. Subspecialty Goals and Objectives

1. *Cataract*

Although no formal rotation or subspecialty clinic in cataract is arranged, the resident is exposed to the diagnosis and management of the cataract as part of the general ophthalmology clinic. The summary of the educational goals and objectives for the residents in managing cataract include the following:

a.) Establish a fundamental knowledge of cataract as outlined in the objectives for Section 11 of the AAO BCSC.

i. Describe the normal anatomy, embryologic development, physiology, and biochemistry of the crystalline lens.
ii. Identify congenital anomalies of the lens.
iii. Distinguish types of congenital and acquired cataract.
iv. Describe the association of cataracts with aging, trauma, medications, and systemic and ocular diseases.
v. Appropriately evaluate and manage patients with cataract and other lens abnormalities.
vi. Explain the principles of cataract surgery techniques and associated surgical technology.
vii. Develop an appropriate differential diagnosis and management plan for intra-operative and postoperative complications of cataract surgery.
viii. Identify special circumstances in which cataract surgery techniques should be modified and develop appropriate treatment plans.

b.) To attend didactic lecture sessions on cataract and cataract surgery.

c.) To receive basic examination techniques, diagnostic testing, and history and physical examination methods in the context of cataract; e.g., potential acuity and glare meter testing.

d.) Attend surgical laboratory introductive course to cataract surgery.

e.) Introduction to the operating room, prepping and draping techniques, forms of anesthesia, operating microscope, and immediate postoperative care in the context of the cataract patient.

f.) To understand phacodynamics and the variously commonly employed phacoemulsification techniques.

g.) To master A-scan ultrasonography and intraocular (IOL) calculations.

h.) Mastery of surgical techniques occurs by observation and assisting and when experience has been accumulated to perform actual surgical cases as primary surgeon under direct supervision by the faculty.

i.) To understand and perform YAG laser capsulotomy for management of posterior capsular opacification.

2. *Retina*

The summary of the educational goals and objectives for the resident in the retina subspecialty include the following:

a.) To establish a fundamental knowledge of retina as outlined in the objectives for Section 12 of the AAO BCSC.

   i. Describe the basic structure and function of the retina and its relationship to the vitreous and choroids.
   ii. Recognize specific pathologic processes that affect the retina or vitreous.
   iii. Choose appropriate methods of examination and ancillary studies for the diagnosis of vitreoretinal disorders.
   iv. Incorporate data from major prospective clinical trials in the management of selected vitreoretinal disorders.
   v. Explain the principles of medical and surgical treatment of vitreoretinal disorders.

b.) To attend didactic lecture sessions and clinics attended by board certified ophthalmologists who have completed fellowship training in retina.

c.) To receive basic examination techniques, diagnostic testing, and history and physical examination methods in the context of retina.

d.) To acquire the following examination skills:

   i. Macula examination through the use of 60 or 90 diopter lens and contact lenses (e.g., macular, three mirror, and goniolens);
   ii. Indirect ophthalmoscopy with the 20 diopter lens; and
   iii. Advanced examinations techniques; e.g., color fundus drawings.

e.) To be familiar with the indications and interpretations of ancillary testing:

   i. Color fundus photos;
   ii. Fluorescein angiography (FA) and indocyanine green (ICG) angiography;
   iii. A and B scan ultrasonography; and
   iv. Electroretinogram (ERG).

f.) To recognize and manage the emergent treatments of ancillary testing such as FA.

g.) To observe and perform laser treatments of the macula and peripheral retina.

h.) To know key points from landmark studies such as the following:

i. Early Treatment Diabetic Retinopathy Study (ETDRS);
ii. Diabetic Retinopathy Study (DRS); and
iii. Diabetic Retinopathy Vitrectomy Study (DRVS).

i.) To obverse and assist the diverse group of surgical vitreoretinal procedures and to be familiar with their indications. To perform as primary surgery procedures such as core pars plana vitrectomy (PPV), vitreous tap/injection, indirect laser photocoagulation, and scleral buckle procedures under direct faculty supervision as experience is gained.

3. Glaucoma

The summary of the educational goals and objectives for the residents in the glaucoma subspecialty include the following:

a.) To establish a fundamental knowledge of glaucoma as outlined in the objectives for Section 10 of the AAO BCSC.

i. Identify the epidemiologic features of glaucoma, including the social and economic impacts of the disease.
ii. Summarize recent advances in the understanding of hereditary and genetic factors in glaucoma.
iii. Outline the physiology of aqueous humor dynamics and the control of intraocular pressure (IOP).
iv. Review the clinical evaluation of the glaucoma patient, including history and general examination, gonioscopy, optic nerve examination, and visual field.
v. Describe the clinical feature of the patient considered a "glaucoma suspect".
vi. Summarize the clinical features, evaluation, and therapy of primary open-angle glaucoma and normal-tension glaucoma.
vii. List the various clinical features of and therapeutic approaches for the primary and secondary open-angle glaucomas.
viii. Explain the underlying causes of the increased IOP in various forms of secondary open-angle glaucoma and the impact these underlying causes have on management.
ix. Review the mechanisms and pathophysiology of primary-angle glaucoma.
x. Review the pathophysiology of secondary angle-closure glaucoma, both with and without pupillary block.
xi. Outline the pathophysiology and therapy of infantile and juvenile-onset glaucoma.
xii. Differentiate among the various classes of medical therapy for glaucoma, including efficacy, mechanism of action, and safety.
xiii. Compare the indications and techniques of various laser and incisional surgical procedures for glaucoma.
xiv. Describe cyclodestructive treatment for refractory glaucoma.
xv. Summarize the indications for and use of low-vision aids in glaucoma patients.

b.) To attend didactic lecture sessions and clinics attended by board certified ophthalmologists who have completed fellowship training in glaucoma.

c.) To be familiar with basic examination techniques and diagnostic testing in the context of glaucoma; e.g., measurement of IOP.

d.) To gain experience with interpreting optic discs and visual fields in the context of glaucoma.

e.) Mastery of surgery and laser techniques occurs by observation and assisting and when experience has been accumulated to perform actual surgical cases as primary surgeon under direct supervision by the faculty.

f.) To obtain experience in the medical applications of initial and continuing glaucoma therapy in children and adults.

g.) To be familiar with combined surgeries and their respective indications; e.g., cataract surgery and trabeculectomy.

4. *Cornea and External Disease*

a.) The summary of the educational goals and objectives for the residents in the cornea and external disease subspecialty include the following:

i. To establish a fundamental knowledge of cornea and external disease as outlined in the objectives for Section 8 of the AAO BCSC.
ii. Describe the anatomy and molecular biology of the cornea.
iii. Explain the pathogenesis of common disorders affecting the eyelid margin, conjunctiva, cornea, and sclera.
iv. Recognize the distinctive signs of specific disease of the ocular surface and cornea.
v. Describe how the environment can affect the structure and function of the ocular surface.
vi. Outline the steps in an ocular examination for corneal or external eye disease and choose the appropriate laboratory and other diagnostic tests.
vii. Summarize the developmental and metabolic alterations that lead to structural changes of the cornea.
viii. Identify topographical changes of the cornea and describe the risks and benefits of corrective measures.
ix. Assess the indications and techniques of surgical procedures for managing corneal disease, trauma, and refractive error.
x. Apply the results of recent clinical research to the management of selected disorders of the conjunctiva and cornea.
xi. Integrate the discipline of corneal and external eye disease into the practice of ophthalmology.

b.) To attend didactic lecture sessions and clinics attended by board certified ophthalmologists who have completed fellowship training in cornea and external disease.

c.) To receive basic examination techniques, diagnostic testing, and history and physical examination methods in the context of cornea and external disease.

d.) To learn advanced slit lamp biomicroscopy of the ocular surface, cornea, and anterior segment.

e.) To learn the use of the keratometer, topographer, and pachymeter and to be familiar with their applications.

f.) To be familiar with the use and applications of bandage contact lenses, cyanoacrylate glue, and amniotic membrane.

g.) To appropriately utilize the microbiology laboratory with corneal cultures and smears.

h.) To be familiar with the appropriate use of antimicrobials and the appropriate use of immunosuppression for anterior segment inflammatory diseases.

i.) To evaluate and manage penetrating injuries to the eye as well as foreign body removal, chemical injuries, and corneal abrasions.

j.) To recognize the basic mechanisms underlying a dry eye, utilize basic diagnostic techniques, and devise appropriate treatment strategies.

k.) To establish a basic fundamental knowledge of the following:

i. Photorefractive Keratectomy (PRK);
ii. Phototherapeutic Keratectomy (PTK); and
iii. Laser in situ Keratomileusis (LASIK).

l.) To be proficient with the surgical technique of tarsorrhaphy and to understand the basic principles of penetrating keratoplasty.

m.) To be familiar with the etiology and management of corneal perforations.

5. Pathology

The summary of the educational goals and objectives for the residents in the pathology subspecialty include the following:

a.) To establish a fundamental knowledge of pathology as outlined in the objectives for Section 4 of the AAO BCSC.

i. Explain the functioning, capabilities, and limitations of an ophthalmic laboratory.
ii. Summarize the histopathology of common ocular conditions in order to improve diagnostic acumen.
iii. Explain the basic histopathology of common ocular conditions as viewed by light microscopy.
iv. Correlate clinical and pathologic findings.
v. Identify characteristics that differentiate intraocular tumors.
vi. Describe the basic principles of immunohistochemistry, flow cytometry, and polymerase chain reaction (PCR).
vii. Communicate with the ocular pathologist.
viii. Select from the many textbooks available on ocular pathology.
ix. Identify ophthalmic lesions that indicate systemic disease.
x. Summarize new information about the most common primary tumors of the eye.
xi. Identify those lesions that are life threatening to patients.
xii. Assess modern treatment modalities for ocular tumors that offer the patient the best possible survival and that minimize disfigurement and loss of function.
xiii. Describe new and current treatment modalities for intraocular tumors.
xiv. Provide useful genetic data to those at risk for developing retinoblastoma.
xv. Describe useful ancillary tests that help the clinician to differentiate the various ocular tumors.

b.) To attend didactic lecture sessions and clinicopathological conferences attended by board certified ophthalmologists who have completed fellowship training in pathology.

c.) To obtain intramural laboratory experience in gross and microscopic examination of pathological specimens with a qualified pathologist.

d.) To appropriately utilize the pathology laboratory with surgical specimens.

6. *Neuro-Ophthalmology*

The summary of the educational goals and objectives for the residents in the neuro-ophthalmology subspecialty include the following:

a.) To establish a fundamental knowledge of neuro-ophthalmology as outlined in the objectives for Section 5 of the AAO BCSC.

i. Explain the importance of an accurate and detailed history to the differential diagnosis of neuro-ophthalmic disease.
ii. Describe the critical importance of follow-up and its potential for modifying the diagnosis.
iii. Outline the necessity of tailoring the neuro-ophthalmic examination.
iv. Select the most appropriate test in order to manage the neuro-ophthalmic problems in a cost-effective manner.
v. Explain possible systemic implications of ophthalmic disorders.
vi. Appraise the anatomy of the visual pathway in order to localize lesions.
vii. Define the anatomy of the vascular system and the importance of it to neuro-ophthalmic pathology.
viii. Describe the association between pupil and eyelid position and ocular motor pathology.
ix. Review pathophysiology and management of diplopia and central ocular motor disorders.
x. Assess eye movement disorders and the ocular motor system.
xi. Review anatomy of other cranial nerves.
xii. Identify the effects of systemic disorders on visual and ocular motor pathways.

b.) To attend didactic lecture sessions and clinics attended by board certified ophthalmologists who have completed fellowship training in neuro-ophthalmology.

c.) To receive basic examination techniques, diagnostic testing, and history and physical examination methods in the context of neuro-ophthalmology.

d.) To gain experience with interpreting optic discs and visual fields in the context of neuro-ophthalmology (Kinetic Goldman, Automated Humphrey, Confrontation, and Amsler Grid).

e.) To learn the physiology and neuroanatomy of the pupil, cranial nerves, and the visual sensory and ocular motor pathways.

f.) To acquire the following examination skills:

i. Visual sensory: Visual acuity, pinhole vision, color vision testing, and visual fields;
ii. Pupillary examination: afferent pupillary defects and pharmacologic testing;
iii. Ocular motor examination: cover/uncover, cross-cover, Lancaster red green, red glass and light, deviations (Krimsky, Hirschberg, and prism cover), forced ductions, and tests for myasthenia gravis (ice test, Tensilon, and Prostigmin); and
iv. Cranial nerve examination.

g.) To appropriately utilize the laboratory and radiology department with neuro-ophthalmologic testing.

h.) To be familiar with the interpretations of the following radiological images:

i. Computed Tomography (CT) and
ii. Magnetic Resonance Imaging (MRI), etc.

7. *Oculoplastics*

The summary of the educational goals and objectives for the residents in the oculoplastics subspecialty include the following:

a.) To establish a fundamental knowledge of oculoplastics as outlined in the objectives for Section 7 of the AAO BCSC.

i. Describe the normal anatomy and function of orbital and periocular tissues.
ii. Identify general and specific pathophysiological processes (including congenital, infectious, inflammatory, traumatic, neoplastic, and involutional) that affect the structure and function of these tissues.
iii. Choose appropriate examination techniques and protocol for diagnosing disorders of the orbit, eyelids, and lacrimal system.
iv. Select from among the various imaging and ancillary studies available those that are most useful for the particular patient.
v. Develop appropriate differential diagnoses for disorders of the orbital and periocular tissues.
vi. Compare the indications for enucleation, evisceration, and exenteration.
vii. Distinguish between functional and cosmetic indications in the surgical management of eyelid and periorbital conditions.
viii. Outline the principles of medical and surgical management of conditions affecting the orbit, eyelids, and lacrimal system.
ix. Recognize the major postoperative complications of orbital, eyelid, and lacrimal system surgery.

b.) To attend didactic lecture sessions and clinics attended by board certified ophthalmologists who have completed fellowship training in oculoplastics.

c.) To receive basic examination techniques, diagnostic testing, and history and physical examination methods in the context of oculoplastics.

d.) To acquire the following examination skills of the eyelids and orbit:

i. Hertel exophthalmometry and ptosis measurements.

e.) To appropriately utilize the radiology, photography, and pathology departments with evaluation of orbital fractures and lesions.

f.) To be familiar with the interpretations of radiological images: e.g., CT, MRI, etc.

g.) To acquire skills to appropriately manage orbital trauma.

h.) To observe, assist, and subsequently perform supervised minor surgical procedures; e.g., lid lesion excision, lateral canthotomy, nasolacrimal duct probing, tarsorrhaphy, etc.

i.) To observe, assist, and subsequently perform faculty supervised major surgical procedures; e.g., lid laceration repair, nasolacrimal duct intubation, ptosis surgery, enucleation, etc.

j.) To be familiar with the indications and technique for blowout fracture repair, evisceration/exenteration, decompression, eyelid reconstruction, and cosmetic eyelid surgery.

k.) To appropriately manage the anophthalmic socket.

8. *Pediatric Ophthalmology*

The summary of the educational goals and objectives for the residents in the pediatric ophthalmology subspecialty include the following:

a.) To establish a fundamental knowledge of pediatric ophthalmology as outlined in the objectives for Section 6 of the AAO BCSC.

i. Describe evaluation techniques for young children that provide the maximum of information with the least trauma and frustration.
ii. Outline the anatomy and physiology of the extraocular muscles and their fascia.
iii. Explain the classification, diagnosis, and treatment options for ambylopia.
iv. Describe the commonly used diagnostic and measurement tests for strabismus.
v. Classify the various esodeviations and exodeviations and describe the management of each type.
vi. Identify vertical strabismus and special forms of strabismus and formulate a treatment plan for each type.
vii. List the possible complications of strabismus surgery and describe guidelines to minimize them.
viii. Differentiate among various causes of congenital and acquired ocular infections in children and formulate a logical plan for the diagnosis and management of each type.
ix. List the most common disease and malformations of the cornea, lacrimal drainage system, anterior segment, and iris seen in children.
x. Describe the diagnostic findings and treatment options for childhood glaucoma.
xi. Identify common types of childhood cataracts and other lens disorders.
xii. Outline a diagnostic and management plan for childhood cataract.
xiii. Identify appropriate diagnostic tests for pediatric uveitis.
xiv. Differentiate among various vitreoretinal diseases and disorders found in children.
xv. List the characteristics of ocular tumors and phakomatoses seen in children.
xvi. Describe the characteristic findings of accidental and non-accidental childhood trauma.
xvii. Outline the current joint policy statement regarding the role of vision in learning disabilities and dyslexia.

b.) To attend didactic lecture sessions and clinics attended by board certified ophthalmologists who have completed fellowship training in pediatric ophthalmology.

c.) To receive basic examination techniques, diagnostic testing, and history and physical examination methods in the context of pediatric ophthalmology.

d.) To acquire the following examination skills:

i. Assess vision in the neonate, infant, and child;
ii. Basic measurements of strabismus: Hirschberg, Krimsky, cover/uncover, and alternate cover; and

iii. Advanced examinations techniques: stereo acuity testing, cycloplegic refraction, retinoscopy, binocularity testing, and special motor testing.

e.) To be familiar with the indications, techniques, and complications of extraocular muscle surgery.

f.) To appropriately manage ambylopia and retinopathy of prematurity.

g.) To observe, assist, and perform faculty supervised extraocular muscle surgery and to be familiar with other advanced pediatric surgical techniques; e.g., cataract and glaucoma surgery.

9. Uveitis

Although no formal rotation or subspecialty clinic in uveitis is arranged, the resident is exposed to the diagnosis and management of the uveitic patient as part of the general and subspecialty clinics. The summary of the educational goals and objectives for the residents in the uveitis subspecialty include the following:

a.) To establish a fundamental knowledge of uveitis as outlined in the objectives for Section 9 of the AAO BCSC.

i. Outline the immunologic and infectious mechanisms involved in the occurrence and complications of uveitis and related inflammatory conditions, including acquired immunodeficiency syndrome.
ii. Identify general and specific pathophysiological processes that affect the structure and function of the uvea, lens, intraocular cavities, retina, and other tissues in acute and chronic intraocular inflammation.
iii. Choose appropriate examination techniques and relevant ancillary studies.
iv. Develop appropriate differential diagnosis for ocular inflammatory disorders.
v. Describe the principles of medical and surgical management of uveitis and related intraocular inflammation, including indications for and complications of immunosuppressive agents.

b.) To attend didactic lecture sessions on uveitis.

c.) To receive basic examination techniques, diagnostic testing, and history and physical examination methods in the context of uveitis.

d.) To be familiar with the classification of the uveitic syndromes.

e.) To understand the basic immunology of the eye.

f.) To appropriate utilize the laboratory in the diagnostic uveitic algorithm.

g.) To recognize the specific signs and complications of uveitis.

h.) To be familiar with the medical and surgical management of uveitis and the side effects of therapy.

i.) To be aware of the surgical considerations in the diagnoses of uveitis (e.g., conjunctival biopsy and anterior chamber paracentesis) and in operating on the uveitic patient (e.g., cataract surgery, vitrectomy, etc.).

10. *Optics, Refraction, CL, and Low Vision*

The summary of the educational goals and objectives optics, refraction, contact lenses, and low vision include the following:

a.) To establish a fundamental knowledge of optics, refraction, contact lenses, and low vision as outlined in the objectives for Section 3 of the AAO BCSC.

i. Outline the theory and terminology of physical optics.
ii. Discuss the clinical and technical relevance of such optical phenomena as interference, coherence, polarization, diffraction, and scattering.
iii. Review the basic properties of laser light and how they affect laser-tissue interaction.
iv. Outline the principles of light propagation and image formation and work through some of the fundamental equations that describe or measure such properties as refraction, reflection, magnification, and vergence.
v. Explain how these principles can be applied diagnostically and therapeutically.
vi. Identify optical models of the human eye and how to apply them.
vii. Define the various types of visual perception and function, including visual acuity, brightness sensitivity, color perception, and contrast sensitivity.
viii. Summarize the steps for performing streak retinoscopy.
ix. Summarize the steps for performing a manifest refraction using a phoropter or trial lenses.
x. Describe the use of the Jackson cross cylinder.
xi. Describe the indications for prescribing bifocals and common difficulties encountered in their use.
xii. Review the materials and fitting parameters of both soft and rigid contact lenses.
xiii. Explain the optical principles underlying various modalities in refractive correction: spectacles, contact lenses, intraocular lenses, and refractive surgery.
xiv. Discern the differenced among these types of refractive correction and how to apply them most appropriately to the individual patient.
xv. Discuss the basic methods of calculating intraocular powers and the advantages and disadvantages of the different methods.
xvi. Describe the conceptual basis of multifocal IOLs and how the correction of presbyopia differs between these IOLs and spectacles.
xvii. Recognize the visual needs of low vision patients and how to address these needs through optical and nonoptical devices and/or appropriate referral.
xviii. Describe the operating principles of various optical instruments in order to use them more effectively.

b.) To attend didactic lecture sessions and contact lens clinics attended by ophthalmologists and/or optometrists experienced in contact lens fitting.

c.) To demonstrate the knowledge, understanding, and skills required to perform the fitting of both soft contact lenses and rigid gas permeable (RGP) lenses.

d.) To understand the indications for and uses of low vision aids.

III. Program Content

A. Cataract and Lens

B. Vitreoretinal Disease

C. Glaucoma

D. Cornea, External Disease, and Refractive Surgery

E. Ophthalmic Pathology

F. Neuro-Ophthalmology

G. Oculoplastic Surgery and Orbit

H. Pediatric Ophthalmology and Strabismus

I. Uveitis

J. Optics, Retinoscopy and Refraction, Contact Lenses, and Low Vision Rehabilitation

K. Ophthalmic Practice

IV. Teaching Methods

A. Program Overview

The residency program is a three-year program with two positions annually. Six ophthalmology residents staff the clinic: two in each postgraduate year (PGY) at the PGY-2, PGY-3, and PGY-4 levels. The residency program is constructed based on a three-year training program model. These guidelines are inclusive of both didactic knowledge acquisition and acquired clinical skills transfer, and are set forth in broad terms on a year-by-year and a subspecialty-by-subspecialty basis. Resident learning and development is provided through a combination of lectures, supervised patient care activities, graduated hands-on procedural and surgical experience, research, and independent study. The implementation methods vary based upon the clinical setting and the year of training. Each year blends the procedural and operative experiences with the clinical experiences of ambulatory outpatient care, and consultative and inpatient care. The goal of the curriculum is to train ophthalmologists who are capable of providing "state of the art" comprehensive ophthalmologic care and to help interested residents prepare for additional fellowship training. Through the eye clinics at RIH and the VAMC, the residents are exposed to a variety of clinical ophthalmologic problems in a diverse patient population comprised of both children and adults. Resident education is supplemented by a wide variety of patients examined each day as part of the ophthalmology consultation service and emergency room coverage. Due to the number of residents in the program, in lieu of assigning a resident to a subspecialty rotation, the residents staff subspecialty clinics attended by an ophthalmologist that has completed fellowship training in that discipline. Subspecialty clinics are dedicated to retina, glaucoma, cornea, oculoplastics, neuro-ophthalmology, pediatric ophthalmology, contact lens, and low vision. Although no formal subspecialty clinics are arranged for cataract and uveitis the residents achieves didactic experiences specifically focused on these subjects as part of the general departmental curriculum and the clinical experiences are included in the general clinic and in the cornea, retina, glaucoma, and pediatric ophthalmology clinic depending upon exactly which lens or uveitic disorder is being investigated. Upon completion of the residency, graduates should possess the knowledge and experience necessary for membership in the American Board of Ophthalmology (ABO). More importantly they should have the clinical skills, interpersonal skills, professional attitudes and behaviors, and experiences to become an outstanding ophthalmologist.

B. Clinical and Operative Experience Based on Year of Training

1. *First Year Ophthalmology Resident (PGY-2)*

The resident spends the majority of time at the general ophthalmology clinic at Rhode Island Hospital. The two residents are designated as either RIH A or RIH B (see attached monthly and yearly schedule for the Department of Ophthalmology). In depth exposure is to a diverse group of

patients is provided. The emphasis is on the fundamentals of differential diagnosis and clinical problem solving. Residents in the first year master the techniques of history-taking and eye examination, gain expertise in the care of patients in a variety of inpatient and ambulatory settings and develop competence in procedural skills. The resident is always supervised directly by a senior resident and attending coverage is available 24 hours a day. The resident participates in the education and supervision of medical students rotating on the ophthalmology service. The resident participates in the general departmental curriculum described below. In addition the resident shares call coverage with the second year resident to cover both the Rhode Island Hospital and the Providence VA Medical Center. The resident participate in Class I and/or Class III surgeries as directed by the chief resident at Rhode Island Hospital. The resident coordinates the consultation service at Rhode Island Hospital covering all consultations requested by the adult and pediatric emergency departments and the inpatient units. The resident participates in subspecialty clinics at Rhode Island Hospital staffed by attending physicians fellowship trained in that subspecialty. The resident also participates in subspecialty rotations arranged at private attending offices. The resident is expected to obtain the clinical experiences as shown in the following table. Note these are expected annual maximal figures based on the current clinical curriculum. These figures are based on a 4 week monthly schedule and do not include all variables; e.g., vacation, academic conferences, Holidays, clinic conflicts, patient cancellations, etc. Actual numbers will need to be reassessed on an annual basis. Subspecialty experience includes both clinical and procedural experiences.

PGY-2	Annual Maximal Figures
Clinic Patient Encounters (RIH)	918
Clinic Patient Encounters (VA)	0
Consultations (ER/Ward) (RIH)	200-250
General eye clinic experience	1102 hours
Subspecialty experience	818 hours total
Vitreoretinal Disease	224 hours
Glaucoma	112 hours
Cornea and External Disease	96 hours
Neuro-ophthalmology	48 hours
Oculoplastic Surgery and Orbit	96 hours
Pediatric Ophthalmology	96 hours
Contact Lenses	64 hours
Low Vision	32 hours
Other unspecified	50 hours total
Surgical experience (Class I & III)	50 hours
Operative experience (Class I & III)	50 hours total
Other subspecialties (RIH; Class I & III)	50 hours
Combined experiences	1920 hours total

2. *Second Year Ophthalmology Resident (PGY-3)*

The resident spends the majority of time at the general ophthalmology clinic at the VA Medical Center with some time at the general ophthalmology clinic at Rhode Island Hospital. The 2 residents are designated as either VA A or VA B (see attached monthly and yearly schedule for the Department of Ophthalmology). In depth exposure is to a diverse group of patients is provided. The resident is always supervised directly by a senior resident and/or attending coverage that is available 24 hours a day. The resident expands his or her knowledge bases and increases in the supervisory role of the first year residents. The resident participates in the general departmental curriculum described below. In addition the resident shares call coverage with the first year resident to cover both the Rhode Island Hospital and the Providence VA Medical Center. The resident participate in Class I and Class III surgeries at both affiliated institution as directed by the chief resident at each respective institution. The resident coordinates the consultation service at the Providence VA Medical Center covering all consultations requested by the emergency departments and inpatient units. The resident participates in subspecialty clinics at both institutions staffed by attending physicians fellowship trained in that subspecialty. The resident also participates in subspecialty rotations arranged at private attending offices. The resident is expected to obtain the clinical experiences as shown in the following table. Note these are expected annual maximal figures based on the current clinical curriculum. These figures are based on a 4 week monthly schedule and do not include all variables; e.g., vacation, academic conferences, Holidays, clinic conflicts, patient cancellations, etc. Actual numbers will need to be reassessed on an annual basis.

PGY-3	Annual Maximal Figures
Clinic Patient Encounters (RIH)	246
Clinic Patient Encounters (VA)	516
Consultations (ER/Ward) (VA)	100-200
General eye clinic experience	1200 hours
Subspecialty experience	720 hours total
Vitreoretinal Disease	304 hours
Glaucoma	48 hours
Cornea and External Disease	48 hours
Neuro-ophthalmology	32 hours
Oculoplastic Surgery and Orbit	160 hours total
Clinic & Procedural experience	32 hours
Surgical experience (Class I & III)	128 hours
Pediatric Ophthalmology	32 hours
Cataract and Lens	96 hours total
Surgical experience (Class I)	96 hours
Operative experience (Class I & III)	224 hours total
Oculoplastic Surgery (VA, RIH)	128 hours
Cataract and Lens (VA)	96 hours
Combined experiences	1920 hours total

3. Third Year Ophthalmology Resident (PGY-4)

The resident spends the majority of time at the general ophthalmology clinic at Rhode Island Hospital with some time at the general ophthalmology clinic at the Providence VA Medical Center. The 2 residents are designated as either RIH C or RIH D (see attached monthly and yearly schedule for the Department of Ophthalmology). In depth exposure is to a diverse group of patients is provided. The resident is always supervised directly by attending coverage that is available 24 hours a day. The resident consolidates his or her knowledge bases and assumes the role of a unit as a supervisor (chief resident) for the first and second year residents. The resident thus functions as a chief resident at the institution to which they are assigned (RIH C, chief at Rhode Island Hospital; RIH D, chief at the Providence VA Medical Center. The resident participates in the general departmental curriculum described below. In addition the two third year residents share back-up call coverage of the junior residents covering both the Rhode Island Hospital and the Providence VA Medical Center. The resident participate in Class I and Class III surgeries at both affiliated institution. The resident participates in subspecialty clinics at both institutions staffed by attending physicians fellowship trained in that subspecialty. The resident is expected to obtain the clinical experiences as shown in the following table.

PGY-4	Annual Maximal Figures
Clinic Patient Encounters (RIH)	630
Clinic Patient Encounters (VA)	144
General eye clinic experience	792 hours
Subspecialty experience	1128 hours total
Vitreoretinal Disease	288 hours
Glaucoma	48 hours
Cornea and External Disease	48 hours
Neuro-ophthalmology	48 hours
Oculoplastic Surgery and Orbit	96 hours
Pediatric Ophthalmology	192 hours
Cataract and Lens	288 hours total
Surgical experience (Class I)	288 hours
Contact Lenses	24 hours
Other unspecified	96 hours total
Surgical experience (Class I & III)	96 hours
Operative experience (Class I & III)	384 hours total
Cataract and Lens (RIH; Class 1)	96 hours
Cataract and Lens (VA; Class I)	192 hours
Other subspecialties (RIH; Class I & III)	96 hours
Combined experiences	1920 hours total

4. *Summary of Clinical and Operative Experiences*

During the three year residency based on the above tables the summarized clinical experiences (maximal figures) based on the three-year residency model is as follows: Note these are expected annual maximal figures based on the current clinical curriculum. These figures are based on a 4 week monthly schedule and do not include all variables; e.g., vacation, academic conferences, Holidays, clinic conflicts, patient cancellations, etc. Actual numbers will need to be reassessed on an annual basis.

	PGY-2	PGY-3	PGY-4	Maximal Figures*
General Clinic Encounters (RIH)	918	246	630	1794
General Clinic Encounters (VA)	0	516	144	660
Consultations (ER/Ward) (RIH)	200-250	0	0	200-250
Consultations (ER/Ward) (VA)	0	100-200	0	100-200
General eye clinic experience	1102 hours	1200 hours	792 hours	3094 hours
Subspecialty experience	818 hours	720 hours	1128 hours	2666 hours
Vitreoretinal Disease	224	304	288	816
Glaucoma	112	48	48	208
Cornea & External Disease	96	48	48	192
Neuro-Ophthalmology	48	32	48	128
Oculoplastic Surgery	96	160	96	352
Clinic & Procedural	96	32	96	224
Surgical (Class I & III)	0	128	0	128
Pediatric Ophthalmology	96	32	192	320
Cataract and Lens	0	96	288	384
Surgical (Class I)	0	96	288	384
Contact Lenses	64	0	24	88
Low Vision	32	0	0	32
Other unspecified	50	0	96	146
Surgical (Class I & III)	50	0	96	146
Operative experience (I & III)	50 hours	224 hours	384 hours	658 hours
Cataract (RIH; Class 1)	0	0	96	96
Cataract (VA; Class I)	0	96	192	288
Oculoplastic (VA, RIH)	0	128	0	128
Other (RIH; Class I & III)	50	0	96	146
Combined experiences	1920 hours	1920 hours	1920 hours	5760 hours

*The General Clinic Encounters at RIH and the VA expected during the 3-year residency sum to a total of 2,554 patient encounters. These encounters only account for approximately 54% of the resident time during the residency and do not account for patients seen during the subspecialty clinics (~35% of the resident's time) nor the encounters with patients during the operative (11% of the resident time) and/or consultative settings.

Schedule

Follow the Resident 2003/2004 Academic Year Schedule.

Each first year resident will be assigned to either RIH A or RIH B. Each second year resident will be assigned to either VA A or VA B. These schedules reflect the level of their involvement at the VAMC. The VA A resident is at the VAMC fulltime except for one half day a week at RIH to allow for patient continuity. The resident has OR time reserved on Monday and Wednesday mornings and has precedence over those times. The VA B resident is as the VAMC part time, at RIH part time, and three half-day sessions devote to subspecialty assignment. The VA Retina is time for retina procedures with Dr. Tsiaras and Greenberg on Wednesday afternoon and Thursday mornings, respectively. The subspecialty assignment guarantees the resident time devoted to the assigned subspecialty; i.e., they have no other responsibilities or commitments to RIH or the VAMC unless they are on-call.

Each third year resident will be assigned to either RIH C or RIH D. These schedules reflect the level of their involvement at the RIH. The RIH C resident is the RIH chief resident and is the operating resident. He/she has precedence over all surgical cases posted. He will run the clinic and assign residents operative assignments when necessary. He is responsible for ensuring the clinic runs smoothly. He has OR time on Tuesday afternoons for 2 cases and may post cases at other times as warranted. He is a "Floating" resident on Monday mornings to allow him to assist in the clinic when necessary, assist and post cases with Dr. Ducharme during his operative time on Monday mornings, increase his operative experience with other attendings, or he/she may use the time for administrative reasons. He will also be at the VAMC one half day a week to allow for patient continuity. The RIH D resident is the senior resident at the VAMC. The resident has OR time reserved on Monday and Thursday afternoons and has precedence over those times.

Surgical logs

The ACGME mandates that residents report their operative experience. The resident is required to keep track of each and every procedure or surgery that they are involved in. These are to be entered into the online Resident Case Log System through the ACGME (http://www.acgme.org/. Experiences to report include:

All classes (Class 1 and Class 3) of procedures.

All types of procedures (Cataract, Cornea, Strabismus, Glaucoma, Retina, Oculoplastics, and Trauma). All surgeries and minor procedures (laser PRP, focal, YAG, and lid lesion excision, chalazion) should be entered.

These logs are vital in allowing the program to monitor the progress of the resident. Gaps in logs are unacceptable and may lead to disciplinary action if not completed. These logs are also one gauge as to how our program is compared to other programs nationally. These logs may also be required as the resident applies to fellowship programs and hospital privileges.

Clinic

Patient care is the primary responsibility of the resident and it takes precedence over all other functions of the resident. Residents are expected to give efficient, thorough, and comprehensive examinations to patients while displaying appropriate concern and empathy towards them and their problems.

a.) General Clinic Patients

The resident is expected to see scheduled patients on their template and emergency/walk-in patients when necessary. Patients should be seen by the order based on the time of their appointment. Every effort should be made to see "priority patients" as soon as possible:

i. ACI inmates or patients escorted by a policeman,
ii. Patients dependant on agency transportation,
iii. Inpatient consultations, and
iv. Patient in acute distress.

During the residency the resident is expected to perform:

- >1,500 refractions,
- >3,000 outpatient visits where the resident is performs a substantial portion of the exam and has responsibility for the care of the patient, and
- >1,000 outpatient visits where the resident is directly supervised by the teaching staff and the attending also examines the patient and discuses the management before the patient leaves the clinic.

All resident are expected to help the clinic run smoothly. No resident should leave the clinic unless all patients have been seen unless otherwise instructed by the chief resident.

Every patient must have the basic elements of the eye examination. The VA and IOP needs to be recorded on every visit unless contraindicated; i.e., EKC. If the last visit by a different resident recorded a VA of NLP recheck it yourself. All acute patients require a dilated examination unless contraindicated. All routine examinations should have a dilated exam annually unless instructed otherwise. Always check as to when the last DFE was performed.

b.) Subspecialty Clinics

Patients are assigned to the subspecialty clinic rather than to see a specific doctor. Residents are expected to share in the workload and to present the patients to the assigned subspecialty attending.

Consultations

Consultations need to be seen promptly and on the day the consult is requested unless the requesting service states otherwise and that this is documented in the chart. Consultations are to be performed by the first year resident and/or the on-call resident when indicated. All questions regarding diagnosis and management should be directed to an appropriate faculty member.

Home call is a privilege. Every call should be treated as if you are in the hospital; i.e., see every patient you are requested to see promptly unless other arrangements are made and this is agreed to by both you and the requesting service. If you are consulted always ask:

a.) Patient identifying information and location,
b.) Reason for consultation (e.g., Fungemia, rule out fungal ball),
c.) Urgency of consultation (When would you like me to see the patient?),
d.) Dilation status (Can we dilate the patient?), and
e.) Thank the service for the consultation and state that you will be happy to see the patient.

A full History and a complete ocular examination including a dilated examination is required on every patient. For those where the dilated fundus examination (DFE) is deferred. The patient should be examined with the direct ophthalmoscope and then seen daily until the full DFE is performed.

Have an attending see the patient within 24 hours from when the consult is requested where possible. Make sure the consult is complete before involving the attending. Priority of coverage should go to:

a.) The attending assigned to the clinic,
b.) The general attending on call for the week,
c.) The subspecialty attending on call where indicated,
d.) The program director, and
e.) The chairman.

C. Didactic Experiences (Departmental Curriculum)

1. *BSCS*

The BSCS is a highly recommended curriculum of basic knowledge and new developments in ophthalmology but is not meant to be an exhaustive survey of the entire field. Therefore, preparation for the OKAP should also include other authoritative sources, like texts and scientific journals that cover the entire range of topics. The resident is encouraged to establish his or her own study pace to get through the BSCS material.

2. *Lectures*

These are a required part of residency education and must be attended by all residents. They are required by the ACGME and will help with preparing for both the AAO OKAP and the ABO WQE. Students are expected to prepare for topics presented and to have completed reading assignments when applicable. Lectures are devised to supplement the AAO BCSC and are by no means intended to serve as a substitute. A sign in book kept in Sally Martone's office verifies mandatory attendance.

A monthly lecture schedule is provided 1-2 weeks before the first of the month. This schedule is part of the written curriculum for program. These lectures are designed to cover all sections as outlined in the program content.

The faculty put much time and energy into these lectures. It is their courtesy to us and we should respond to them in kind. Please be prompt and ensure that the equipment is set up as necessary for the faculty. For those residents obliged to the VA they are excused at 7:40 AM.

3. *Grand Rounds*

a.) Grand Rounds take place on the first Saturday of each month September through June. No Grand Rounds takes place during the summer months of July and August. These conferences start at 7:30 AM with coffee and pastries, informal interactions with faculty and examination of patients. The conference follows from 8:00 to 9:30 AM.

b.) It is the responsibility of the 3rd year operating RIH resident (RIH C) to submit the presenters for each Grand Rounds conference. At least 2 residents need to present at each conference. Presentations should last 15-20 minutes with a review of pertinent literature and time for questions and interaction with faculty. It is highly advisable to have patients to attend the conference where possible as it makes it more enjoyable for all attendees.

c.) A Morbidity and Mortality (M & M) conference should be held at least annually depending on the availability of patients. VA patients are not permitted to be presented at this conference.

d.) Please share interesting cases.

4. *Surgical Conferences*

These are held the first Monday evening of the month from 5:30 – 7:30 PM. Refreshments will be provided. The topics will focus on surgical decision-making and practical approaches to the spectrum of ophthalmic surgeries performed. Topics to be included for the 2004/2005 academic year are as follows:

a.) Introduction to the OR: Consent, patient work-up, anesthesia, prep, operating room procedures, and the operating microscope.
b.) ECCE surgery: Decision making in the wide incisional extracapsular approach
c.) Phacoemulsification: Phacodynamics
d.) Phacoemulsification: Tips and Pearls
e.) Filtering procedures: Decision making
f.) Oculoplastic procedures: Decision making
g.) Pediatric ophthalmology procedures: Decision making
h.) Vitreoretinal laser procedures: Decision making
i.) Vitreoretinal operative procedures: Decision making
j.) Corneal and other anterior segment procedures: Decision making
k.) Refractive Surgery: Decision making
l.) Trauma Surgery: Decision making

5. *Journal Club*

These sessions are held monthly and are to be announced as to the time and location by the proctor. Journals to be reviewed include the following titles at a minimum. The coordinator of these sessions is King W. To, M.D. It is the responsibility of the RIH chief resident to assign the articles for discussion.

a.) Ophthalmology

b.) Archives of Ophthalmology
c.) Survey of Ophthalmology
d.) American Journal of Ophthalmology

6. *Pathology Conferences*

These sessions are held monthly and are to be announced as to the time and location by the proctor. The coordinator of these sessions is King W. To M.D. who is fellowship trained in ophthalmic pathology.

7. *Ethics Conference*

These sessions are held annually and are to be announced as to the time and location by the proctor. The coordinator of these sessions is William G. Tsiaras, M.D. These have been held at his residence in past years during the summer and/or fall months.

8. *Examinations*

OKAP

The Ophthalmology Knowledge Assessment Program (OKAP) is a standardized test taken annually by our residents and is mandatory. The OKAP takes place on a Saturday morning during the first or second week of April. The location varies but will be assigned when possible. Vacations are not permitted for this date.

The OKAP assesses the cognitive knowledge by a written examination. It is designed to aid in the resident's education by pointing out their academic strengths and weaknesses, areas for further study, and assessing the standings with other residents throughout the country. It should be pointed out that these results are confidential as the AAO releases OKAP results only to the resident and their program director, but scores also may be disseminated to other program faculty in support of their intended educational purpose. (Upon request the resident will be given the names of faculty member who have knowledge of their performance on the exam.).

The OKAP examination is one of the AAO's clinical-education programs. It is a 250-item multiple-choice test that is administered to ophthalmology residents in each year of training. It is designed to measure the ophthalmologic knowledge of residents, relative to their peers, in order to facilitate the ongoing assessment of resident progress and program effectiveness.

Each annual OKAP examination is carefully constructed to be a valid and reliable measure of ophthalmic knowledge. An OKAP score carries information about how well a resident had done relative to the other residents who have taken the examination.

The primary purpose of the OKAP is to support the clinical and basic-science education of residents by providing them a way to assess their ophthalmic knowledge relative to their peers and to identify individual objectives. The OKAP is also designed to provide program directors with information that is useful in the formative evaluation of residents' progress and program effectiveness. OKAP test results are never to be used in a punitive manner or as the sole gauge of a residents' overall ophthalmic proficiency. Consideration for other relevant factors such as clinic

acumen, surgical skill, patient rapport, and case-management ability always must enter in to the process of resident evaluation. There is no passing or failing associated with the OKAP.

The OKAP is developed from a Content Outline that is divided by subspecialty into the same 12-section format as the AAO BSCS. The BSCS is a highly recommended curriculum of basic knowledge and new developments in ophthalmology but is not meant to be an exhaustive survey of the entire field. Therefore, preparation for the OKAP should also include other authoritative sources, in addition the BSCS, like texts and scientific journals that cover the entire range of topics in the Content Outline. The Content Outline has been distributed to residency programs and to department of ophthalmology, for use by faculty and residents.

From 1980-1992 the Academy and the Board administered the same exam as both the OKAP and the written qualifying examination (WQE) administered by the American Board of Ophthalmology (ABO), but because the Academy and the Board are two separate organizations and their respective exams actually perform two different functions, the OKAP and WQE became two separate exams in 1993. The OKAP and WQE and comprised of entirely different test questions with different psychometric proprieties, and emphasize different aspects of ophthalmic knowledge. (For example, the OKAP gives greater emphasis to basic science questions.) Although the two exams are now separate, they both assess the knowledge, experience, and skills necessary to deliver high standards of quality patient care in ophthalmology. Accordingly, all items for both exams are still written and reviewed by the Academy and the Board. This joint process of item development ensures continuity of assessment, from the first year of training to Board certification, and also ensures that the OKAP will continue to be an excellent way to prepare for the WQE. Both exams are administered by the American College Testing (ACT) Inc. ACT also provides assistance in the development of test items and with the psychometric analysis of items performance.

Residents are expected to perform above the mean when compared to the residents at one's own level of training. OKAP scores will be reviews to assess the need for remedial studies.

Residents that obtain a score less than 30 on the percentile rank below for the whole test will be placed on academic probation. This is a formal disciplinary action explained in the later section on Due Process. This level of performance if maintained will lead to failing the written portion of the board certification process. A remedial study program will be initiated between the resident and the program director.

Residents that obtain a score less than 30 on the percentile rank for three or more sections will be placed on academic warning and will be expected to perform remedial work in those subjects. Academic warning is not a formal disciplinary action. Rather it is an informal process where remedial work is planned to further the education of the resident.

Board Certification

The American Board of Ophthalmology (ABO) is a separate organization whose mission it is to serve the public by improving the quality of ophthalmic practice through a certification process that fosters excellence and encouraged continuous learning. Like the OKAP, the Board's Written Qualifying Examination (WQE) is also a 250-item multiple choice test in the field of ophthalmology, but the WQE is given to physicians who have completed a residency training program in ophthalmology and who are candidates for Board certification. The intent of the certification process is to provide assurance to the public and to the medical profession that

certifies a physician has successfully completed an accredited course of education in ophthalmology. The WQE is part 1 of the Board's certification process. Upon successful completion of the WQE, a candidate takes part 2, which is the Board's oral examination.

a.) Written Qualifying Examination (WQE)

The WQE is a multiple choice examination given simultaneously in designated cities in the United States in the spring of each year. It is necessary to pass this examination before being admitted to the Oral Examination. The topics covered in the Written Examination include the following:

i. Optics, Visual Physiology and Correction of Refractive Errors;
ii. Retina, Vitreous, and Uvea;
iii. Neuro-ophthalmology;
iv. Pediatric Ophthalmology;
v. External Disease and Cornea;
vi. Glaucoma, Cataract and Anterior Segment;
vii. Plastic Surgery and Orbital Diseases; and
viii. Ophthalmic Pathology

a.) Oral Examination

It is customary for the Board to hold two Oral Examinations per year. Candidates who pass the Spring WQE are assigned to the Oral Examinations in either the fall of that same year or the spring of the following year. The Oral Examination is administered in a half-day session. These examinations include developmental, dystrophic, degenerative, inflammatory, infectious, toxic, traumatic, neoplastic, and vascular diseases affecting the eye and its surrounding structures. In each of the oral examinations emphasis will be placed upon the following:

i. Data Acquisition
ii. Diagnosis
iii. Management

9. *Resident Attendance at Meetings*

Residents are allowed to attend AAO, ARVO, and other academic meetings only if they are presenting and have submitted a vacation request for cancellation of clinic form. This absence does not count against the vacation allotment if three days are used. If the resident is not presenting or takes more than three days to attend a meeting the resident will be allowed to attend; however, these days will be counted toward the vacation allotment.

The exceptions to his policy are that attendance at NEOS is not counted towards the vacation allotment and the third year resident may attend the AAO meeting regardless if they are presenting or not for three days that will not count against the vacation allotment.

NEOS

The New England Ophthalmological Society (NEOS) is a nonprofit group of more than 700 ophthalmologists (medical and surgical eye physicians) throughout New England. The mission is to provide for the study and advancement of ophthalmology, including the education of our

members. NEOS is the oldest specialty society in the United States in continuous existence since it's founding in 1884. The mission of NEOS is to promote excellence in eye care in the New England states through education of ophthalmologists, residents, fellows, allied ophthalmic personnel and the public.

The goals of NEOS are:

a.) To advance patient centered ethical standards for the delivery of eye care
b.) To provide effective membership communication and education through meetings and the NEOS web site: www.neos-eyes.org
c.) To make the public more aware that the NEOS is a public foundation for education in ophthalmology and to establish the NEOS as the leading New England source of information abut eye care with the public and the media.
d.) To insure adequate endowment to insure ophthalmic education in the new millennium.
e.) To insure for the education of ophthalmologists as the preferred providers of comprehensive eye care.

Meetings. NEOS offers five ophthalmologic educational meetings per year. Each meeting typically runs from 8 AM to 4 PM on a Friday and is divided into morning and afternoon sessions. The morning and afternoon sessions cover different topics. Each session has 8-10 talks and a panel discussion. Most of the talks are clinically oriented and are often given by experienced ophthalmologists from the New England area. Each session also has talks given by a Guest of Honor--a nationally or internationally recognized expert not from the New England area.

For NEOS meetings the clinics are canceled at both sites; i.e., RIH and the VAMC so that residents are able to attend this meeting. Residents are expected to attend unless they are on vacation. Only the first on-call resident is expected to remain behind to cover emergencies and consultations. The call coverage should be shared among all residents taking first call so that each resident may attend as many of the meetings as possible. Residents that operate the day before (on Thursday) will be required to stay to see their postoperative patients as arranged before leaving to attend the meeting.

Residents are encouraged to participate and submit an abstract for presentation at NEOS. Abstract are accepted from resident for the 5th meeting near the end of each academic year.

The meeting is at no cost to the resident.

The Dates for the 2004/2005 academic year are as follows:

October 15, 2004	March 4, 2005	May 20, 2005
November 19, 2004	April 8, 2005	

AAO

The American Academy of Ophthalmology (AAO) is a voluntary organization whose membership comprises 90% of US ophthalmologists, and is open to all ophthalmology residents. The Academy provides advocacy, assistance with practice management, and clinical education programs for the benefit of its members. The Academy has more than 27,000 members worldwide. Academy members are Eye M.D.s or D.O.s, doctors of medicine or osteopathy who specialize in the eyes and vision. The majority of Academy members are practicing physicians, who are comprehensive Eye M.D.s. These Eye M.D.s provide the full spectrum of eye care, from prescribing glasses and

contact lenses to the medical and surgical treatment of a wide variety of eye conditions. In addition, many Eye M.D.s are subspecialists, physicians who have special training and focus their practices in specific areas of ophthalmology, such as glaucoma, cataract or pediatric ophthalmology. The Academy is your best resource for ophthalmic education, meetings, advocacy and global eye care. Membership in the Academy is open to any ophthalmologist worldwide as well as medical doctors currently enrolled in an ophthalmology-training program.

- Education is a primary focus of Academy activities and the Academy offers a number of programs to meet the educational needs of Eye M.D.s and other members of the eye care team.
- The Academy's **Annual Meeting** is one of the largest and most important ophthalmic meetings in the world. This outstanding four-day event offers symposia, scientific papers, instruction courses, films, posters and exhibits designed to educate Eye M.D.s and others about the practical applications of new advances in eye care.
- The Annual meeting is held in late October each year and the deadline for abstract submission is early April. Residents are strongly encouraged to submit abstracts for presentation at this meeting.
- The Academy also develops and produces a wide range of print and electronic educational materials, including reference books, audio and videotapes, CD-ROMs, self-assessment programs and an online education center. These materials provide ongoing education for practicing Eye M.D.s, residents and other health professionals, and many programs and materials carry CME credit.
- Member in Training. A physician who holds a degree of Doctor of Medicine, Doctor of Osteopathy, or equivalent medical degree as determined by the board of trustees, and who is engaged on a full-time basis in an ophthalmology residency training program conducted either in the United States or in Canada that is acceptable to the board of trustees, or who has satisfactorily completed such a training program and is engaged on a full-time basis either in an ophthalmology fellowship training program conducted in the United States or in Canada or in a postgraduate educational course of training leading to an advanced degree at an accredited college or university in the United States or in Canada, or a foreign medical graduate who is otherwise eligible for International Membership and is engaged on a full-time basis in a postgraduate ophthalmology training program in the United States or in Canada, shall be eligible to apply for membership as a Member in Training.

ARVO

a.) **Mission.** The purposes of the Association for Research in Vision and Ophthalmology, Inc. (ARVO) shall be to encourage and assist research, training, publication, and dissemination of knowledge in vision and ophthalmology

b.) The Association's membership, comprised of more than 10,500 individuals, continues to grow. Some 44% of members reside in over 68 countries outside of the US. The membership is multidisciplinary and consists of both clinical and basic researchers (approximately 44% MD/Ophthalmologists, 26% PhD's, and 30% Other, including optometrists, osteopaths, and veterinarians).

c.) **Resident Membership (Category F) Dues:** $85.00

Student Individual enrolled at an institution of higher learning in a scientific field related to vision or ophthalmology. Limited to a total of 5 years. (Print subscriptions to *IOVS* are available for an additional $100/year.)

d.) All Annual Meeting Scientific Program are held in Fort Lauderdale, Florida and take place in late April or early May or each year. Abstract submission deadlines are in December. Residents are encouraged to submit abstracts and attend this meeting.

e.) Future Annual Meetings.

i.	2005	May 1 - May 6	v.	2009	May 3 – 8
ii.	2006	April 30 - May 5	v.	2010	May 2 – 7
iii.	2007	May 6 - May 11	vii.	2011	May 1 – 6
iv.	2008	May 4 – 9	viii.	2012	April 22 – 27

10. Summary of Didactic Curriculum

	PGY-2	PGY-3	PGY-4	Total
BSCS	Self-guided	Self-guided	Self-guided	Self-guided
Lectures*	176 hours	176 hours	176 hours	528 hours
Grand Rounds	24 hours	24 hours	24 hours	72 hours
Surgical Conferences	24 hours	24 hours	24 hours	72 hours
Journal Club	12 hours	12 hours	12 hours	36 hours
Pathology Conferences	24 hours	24 hours	24 hours	72 hours
Ethics	3 hours	3 hours	3 hours	9 hours
OKAP	4 hours	4 hours	4 hours	12 hours
NEOS	40 hours	40 hours	40 hours	120 hours
AAO	-	-	4 days	4 days

*Based on the first 3 months of the 2004/2005 academic year

V. Systems of Evaluation

1. *Evaluation of House Officers*

There is a clearly stated process for the evaluation of residents at RIH (Last revised October 16, 2003). The program director meets biannually with the residents to evaluate and monitor their progress in the program and to obtain their feedback and recommendations. The program director is also available to meet with residents when indicated as issues arise.

a.) The evaluation used is the long form established by the ACGME for evaluation of the ophthalmology resident (See pages following page 49).

b.) Each resident is evaluated by the program director and/or designee with the assistance of the teaching staff, for evidence of satisfactory progressive scholarship and professional growth, including demonstrated ability to assume graded and increasing responsibility for patient care. The evaluations must be accurately documented, dated and signed by both the evaluator and the resident.

c.) The evaluations will be based in part on written reviews provided by faculty members at the end of each rotation. Other appropriate sources include patients, peers, self, and other professional staff. Methods of evaluation shall come consist of direct and indirect observation, videotapes, faculty evaluations, and the OKAP.

d.) The evaluations are performed at least semi-annually. These are held in December and June for each resident with the Program Director and/or the Chairman.

e.) Separate surgical evaluations are completed at the end of each surgical procedure to allow for prompt feedback of the procedure. It is the responsibility of the resident to take the form to the attending and to return it to Sally Martone for the resident's file and for the program to monitor the resident's surgical progress (See page 49).

f.) The residents are evaluated against the same criteria when assigned to facilities outside the Hospital as part of the residency training (i.e., the Providence VA Medical Center).

g.) The residents are evaluated against the same criteria when assigned to private subspecialty attending as the resident participates in the clinical and surgical management of that attendings patients outside the Hospital as part of the residency training.

h.) The evaluation of performance is discussed with the resident. When weaknesses or deficiencies are identified, steps are taken promptly to improve performance and counsel the resident where appropriate.

i.) The evaluations are based on the following elements (Six General Competencies). Identification of general competencies is the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process.

I. PATIENT CARE

- Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:
  - Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families;
  - Gather essential and accurate information about their patients;
  - Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment;
  - Develop and carry out patient management plans;
  - Counsel and educate patients and their families;
  - Use information technology to support patient care decisions and patient education;
  - Perform competently all medical and invasive procedures considered essential for the area of practice;
  - Provide health care services aimed at preventing health problems or maintaining health; and
  - Work with health care professionals, including those from other disciplines, to provide patient-focused care.

II. MEDICAL KNOWLEDGE

- Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:
  - Demonstrate an investigatory and analytic thinking approach to clinical situations and
  - Know and apply the basic and clinically supportive sciences, which are appropriate to their discipline.

III. PROFESSIONALISM

- Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:
  - Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development;
  - Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices; and
  - Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

IV. PRACTICE-BASED LEARNING AND IMPROVEMENT

- Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:
    - Analyze practice experience and perform practice-based improvement activities using a systematic methodology;
    - Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
    - Obtain and use information about their own population of patients and the larger population from which their patients are drawn;
    - Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness;
    - Use information technology to manage information, access on-line medical information; and support their own education;
    - Facilitate the learning of students and other health care professionals.

V. INTERPERSONAL AND COMMUNICATION SKILLS

- Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:
    - Create and sustain a therapeutic and ethically sound relationship with patients;
    - Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills; and
    - Work effectively with others as a member or leader of a health care team or other professional group.

VI. SYSTEMS-BASED PRACTICE

- Residents must 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. Residents are expected to:
    - Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice;
    - Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources;
    - Practice cost-effective health care and resource allocation that does not compromise quality of care;
    - Advocate for quality patient care and assist patients in dealing with system complexities; and
    - Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

2. Promotion/Advancement of House Officers

Six ophthalmology residents staff the clinic: two in each year at the PGY-2, PGY-3, and PGY-4 levels.

Promotion or advancement of house officers to the next level of the program depends upon the house officer's performance and qualifications. The criteria and goals, which are expected to be met by a house officer before he or she is advanced to the next level of training in the program, are indicated below. These criteria and goals are reviewed annually by the program and the program director and are made known to the house officers and faculty (Last revised October 16, 2003).

a.) Satisfy general goals and objectives of the program with acceptable progress in all areas.

b.) Satisfy specific goals and objectives based on year:

- i. Objectives for First Year (PGY-2),
- ii. Objectives for Second Year (PGY-3), and
- iii. Objectives for Third Year (PGY-4). At the completion of the program the resident should be competent to act independently in all areas.

c.) Satisfy specific objectives based on subspecialty:

- i. Cataract,
- ii. Retina,
- iii. Glaucoma,
- iv. Cornea/external disease,
- v. Pathology,
- vi. Neuro-ophthalmology,
- vii. Oculoplastics,
- vii. Pediatric ophthalmology,
- viii. Uveitis, and
- viii. Optics, refraction, CL, low vision.

d.) Satisfy lines of supervision and responsibility. The resident should be able to supervise and teach others with increasingly independence.

e.) Participate in resident, faculty, and program evaluation.

f.) Participate in the annual Ophthalmology Knowledge Assessment Program (OKAP) prepared by the AAO and administered by the ACT.

g.) Follow guidelines for resident duty hours and personal responsibility.

h.) Documentation of procedures and surgeries.

i.) Follow the moonlighting policy.

j.) Upon completion of the residency, graduates should possess the knowledge and experience necessary for membership in the ABO.

k.) Decisions about advancement or reappointment are concluded by the program director with advice of the clinical faculty and are to be communicated to the house officer no later than four months prior to the end of the house officer's current contract.

l.) Before the certificate of completion is awarded the resident is expected to complete the GME Final Steps Paperwork form and return it to Sally Martone who will return the form to Graduate Medical Education, Aldrich Building, Room 120.

- All outstanding obligations must be satisfied and equipment or keys returned.

- On-Call Room Keys, Gerry House, Department of Environment Services, APC Basement, Rom 25, Jimmy Medeiros
- Employee ID Badges, Security Office, Jane Brown Ground Floor, Scott LaRue
- Pagers (RIH); Telephone Office, Keystone Building, Arlene Moniz
- Library Books and Services (RIH), Peter Health Sciences Library, Aldrich Building
- Health Information Services (RIH), Medical Records, APC Basement, Jane Warner
- Debitek Cards (RIH), Graduate Medical Education, Aldrich Building, Room 120
- Department Keys, Sally Martone
- Department Books, Videos, Sally Martone
- Clean Rooms, Jane Cote and Samol Sock

3. *Inspection of House Staff Files:*

a.) **Policy**: RIH will allow residents to inspect their own files (Last revised April 15, 1999).

b.) **Procedure**

i. **Availability of files**
   - Residents may inspect their own files during the regular business hours of the department of medical education.

ii. **Entitled to access**
   - Only residents currently in service or on authorized leave of absence may have access to their file.
   - Applicants to the house staff, designated agents or any other persons are not permitted to see files.

iii. **Available for inspection**: A resident may inspect the following material from the file:
   - Application for residency,
   - Stipend information,
   - Notices of commendation, warning or discipline, and/or
   - Performance evaluations.

iv. **Excluded from inspection**: The following materials are excluded from resident inspection:
   - Records relating to the investigation of possible criminal offenses,
   - Letters of reference,
   - Material being developed for use in criminal, civil or grievance procedures, and/or
   - Information available under the Fair Credit Reporting Act.

v. **Stipulations**:
   - Files may not be removed from the office of medical education.
   - The contents of a file cannot be copied.
   - The director of medical education must be present when a resident inspects a file.
   - Only under special circumstances may residents inspect their file more than once a year.

vi. **Counterstatement**: A counterstatement may be placed in the file if a resident disagrees with the material in the file.

4. *Due Process of House Officers*

a.) Application of Policy (Last revised October 16, 2003).

i. The procedures described below are applicable to all post-doctoral trainees enrolled in the Hospital's GME program. The term "post-doctoral trainees" shall include physicians, or other graduates of a doctoral program who are enrolled in a Hospital-sponsored training program as residents or clinical fellows (hereinafter, "trainees"). Although trainees may also be appointed to the Medical Staff and/or may be employed by the Hospital, the procedures described below, and not the review and appeal procedures described in the Medical Staff bylaws for other Medical Staff members or the grievance or similar procedures afforded to Hospital employees through the Hospital's Human Resource Department, constitute the exclusive process by which any adverse action affecting a trainee's program appointment, employment, medical staff appointment or clinical privileges will be reviewed.

b.) Grievances

i. Residents who feel they have been treated unfairly under the interpretation or application of a policy, rule or procedure may file a grievance. Residents who believe that they may have a complaint involving sexual harassment are advised to follow the procedure set forth in the hospital's policy on "Sexual Harassment". Reasonable efforts should be made within each department and residency program to resolve grievances on an informal basis. Residents may also seek out the Director of GME/DIO for assistance with informal resolution of a grievance. The grievance process shall be conducted without the presence of legal counsel. This grievance procedure is not applicable to any decision regarding probation, suspension, non-renewal or termination. Resident appeals of these actions must be filed under the appeals process set forth in the "Right to Review" sections of this policy.

ii. A request for formal resolution of a grievance shall be submitted in writing by the resident to the Program Director within thirty days following the date when the resident first had knowledge of the incident that gave rise to the grievance. The Program Director shall notify the Director of GME/DIO. The Program Director may elect to respond and resolve the grievance, or may in his/her judgment, request that the Director of GME/DIO review and adjudicate the grievance. The Director of GME/DIO may elect to respond to the grievance or may elect to convene a committee of three members of the GMEC; the resident may select one member. The Program Director, Director of GME/DIO or the committee may review any records, or interview any persons whom they consider helpful for resolution of the grievance. The committee will provide a decision of the grievance to the Director of GME/DIO. The Program Director or Director of GME/DIO shall issue a decision of the grievance within thirty days.

iii. Residents who believe that they may have a complaint involving their training program, Program Director or faculty may submit the grievance in writing to the Director of GME/DIO. The Director of GME/DIO may elect to respond to the grievance or may elect to convene a committee of three members of the GMEC; the resident may select one member. The Director of GME/DIO or the committee may review any records or interview any persons whom they consider helpful for resolution of the grievance. The committee will provide a decision of the grievance to the Director of GME/DIO. The

Director of GME/DIO shall advise the resident in writing of the proposed resolution of the grievance within thirty business days after receiving the notification of the grievance.

c.) Procedures Prior to Initiating Formal Disciplinary Action

i. Program directors are encouraged to address and resolve minor instances of unsatisfactory performance or misconduct prior to invoking the formal disciplinary actions set forth below. Any trainee whose performance is assessed to be less than satisfactory by the program director may be placed on a remedial training status for a specified period of time, not to exceed six months. In such cases, the program director shall inform the trainee in writing of the deficiencies noted in academic, clinical and/or professional performance, and shall outline a program of remediation, as well as criteria for successful completion of the program. The trainee shall be requested to acknowledge being advised of his/her remediation status by signing the notification; refusal to do so shall be noted by the program director, setting forth the reasons for refusal if stated by the trainee. The director of GME/DIO shall also be notified of the trainee's remedial status, the reasons for the decision, and the plan for remediation.

ii. If the trainee is successful in completing the remedial program, the trainee will be removed from remedial training. Remedial status is not a formal disciplinary action and not subject to disclosure to any external inquiries. Documentation of the remedial training process will be incorporated into the trainee's evaluation and will be disclosed only upon written authorization of the trainee or legal process. In the case where deficiencies in the trainee's clinical performance are identified, the trainee may receive reduced or limited credit for the relevant portion of the training program pursuant to the applicable section below. The program director shall inform the trainee of such reduction in credit as part of the remedial training process.

iii. If the remedial training efforts are unsuccessful or where performance or misconduct is of a serious nature, the chief or program director may initiate formal disciplinary action as described below.

d.) Formal Disciplinary Action

Disciplinary action may be taken for due cause, including but not limited to any of the following:

i. Failure to satisfy the academic or clinical requirements of the training program;
ii. Professional incompetence, misconduct or conduct that might be inconsistent with or harmful to patient care or safety;
iii. Consistently substandard performance;
iv. Conduct which calls into question the professional qualifications, ethics, or judgment of the trainee;
v. Failure to function in a cooperative and reasonable manner with other trainees, employees, medical staff, patients, volunteers and/or visitors of the Hospital;
vi. Violation of the bylaws, rules, regulations, policies, or procedures of the medical staff, Hospital, or applicable department, division or training program, including, without limitation, any violation of the Hospital’s sexual harassment policy;
vii. Scientific misconduct.

e.) Specific Procedures

Formal disciplinary action may include, but is not limited to probation, suspension, or termination of the trainee from the training program during an academic year. Except under circumstances requiring an immediate emergency disciplinary action to preserve acceptable standards of care, safety, integrity or ethics at the Hospital, the following procedures will be followed.

i. Training Program Probation

- General
  - Training program academic probation (or "probation") means a temporary modification of the trainee's training program participation or responsibilities, designed to facilitate the trainee's accomplishment of program requirements. Generally, a trainee will continue to fulfill training program requirements while on probation, subject to the specific terms of the probation.
  - The program director, after consultation with the Chief, shall have authority to place the trainee on probation (with pay) and to determine the terms of the probation.
  - Probation may include, but is not limited to, special requirements or alterations in scheduling a trainee's responsibilities, increased supervision, and/or a reduction or limitation in clinical responsibilities.
  - The program director shall notify the trainee and the director of GME/DIO in writing of the probation, the reasons for the decision, the required method and timetable for correction, and the date upon which the decision will be re-evaluated. The trainee shall be requested to acknowledge being advised of his/her probation status by signing the notification; refusal to do so shall be noted by the program director, setting forth the reasons for refusal if stated by the trainee.
  - Within 30 days of receiving this notice, the director of GME/DIO will meet with the trainee for counseling and appropriate guidance after consultation with the program director.
  - The program director shall evaluate (in writing) the trainee at not less than 30-day intervals from the date of sending notification to the trainee. These evaluations must be signed by the program director and reviewed and discussed with the trainee. The trainee shall also sign the evaluation; refusal to do so shall be noted by the program director, setting forth the reasons for refusal if stated by the trainee.
  - Each such evaluation will be sent to the director of GME/DIO, who shall meet with the program director and/or trainee as deemed appropriate.
  - No trainee shall remain on probation for more than six months in total over the course of his/her training. If the trainee's performance remains unsatisfactory or other reasons for the probation have not been resolved, he/she may not continue as a trainee in a training program. The trainee will be informed in writing of his/her termination from the program pursuant to this provision.
- Right to Review
  - The trainee shall have the right to a review of the probation decision and shall be informed of this right when placed on probation. To initiate such a review, a

trainee must submit a written request for a review of the probation to the director of GME/DIO within five business days of the trainee's receipt of the notification of the probation decision. Failure to make a timely request for a review will constitute a waiver of the trainee's right to a review.

- If the trainee requests review of the probation status, the director of GME/DIO shall meet with the trainee within ten business days and afford the trainee an opportunity to provide any information in his or her defense. After this meeting, the director of GME/DIO or his/her designee (s) following consultations with the Program Director, Department Chief and other appropriate individuals, if any, will render a final decision.
- The trainee shall receive written notification of the decision of the director of GME/DIO and the reasons for and consequences of the decision.
- Probation is a part of the trainee's permanent record.
- There is no further appeal from a decision to place a trainee on probation.

ii. Suspension

- General
  - The program director, after consultation with the Chief, may temporarily suspend the trainee from training program duties by placing him or her on an unpaid leave of absence for seriously deficient performance or seriously inappropriate conduct. Except when the interests of patient care may be adversely affected, the program director shall also consult with the Senior Vice President of Medical Affairs at the Hospital and the director of GME/DIO, before imposing suspension. A voluntary leave of absence that is approved by the program director in advance shall not be considered a suspension or other form of disciplinary action.
  - The Program Director shall provide the trainee with written notification of the reasons for the suspension, the required method and timetable for correction, and a date upon which the decision will be re-evaluated. The trainee shall be requested to acknowledge being advised of his/her suspension by signing the notification; refusal to do so shall be noted by the Program Director, setting forth the reasons for refusal if stated by the trainee. The written notification shall include a statement that suspension, if final, may be reported to the Rhode Island Board of Medical Licensure and Discipline. The written notification should also advise the trainee of his or her right to request a review of the suspension in accordance with the procedures outlined below. This notice shall precede the effective date of the suspension, unless a serious risk to patient care or the health or safety of an employee warrants immediate suspension, in which case the notice shall be provided at the time of the suspension.
- Right to Review
  - The trainee shall have the right to a review of the suspension decision. To initiate such a review, the trainee must submit a written request for a review of the suspension to the director of GME/DIO within five business days of the trainee's receipt of the notification. Failure to make a timely request for a review will constitute a waiver of the trainee's right to a review.

- If the trainee requests review of the suspension, the director of GME/DIO or his/her designee(s) shall meet with the trainee within ten business days and afford the trainee an opportunity to provide any information in his or her defense. After this meeting, the director of GME/DIO or his/her designee (s) following consultations with the Program Director, Department Chief and other appropriate individuals, if any, will render a final decision.
- The trainee shall receive written notification of the decision of the director of GME/DIO and the reasons for and consequences of the decision.
- There is no further appeal from a decision to suspend a trainee.
- No trainee shall remain on suspension for more than three months in total over the course of his/her training. If the reasons for the suspension have not been resolved at the end of the three-month period, he/she may not continue as a trainee in a training program. The trainee will be informed in writing of his/her termination from the program pursuant to this provision.
- Suspension is reportable to the Rhode Island Board of Medical Licensure and Discipline and part of the trainee's permanent record.

iii. Involuntary Termination From the Program During an Academic Year

- General
  - The program director, after consultation with the Chief, shall have authority to terminate a trainee from a training program, for reasonable cause, including but not limited to a failure satisfactorily to fulfill the requirements of the training program. Prior to the recommendation for termination of any trainee, the Chief and/or program director shall consult with the Senior Vice President of Medical Affairs for the Hospital and the director of GME/DIO. Dismissal of a trainee during an academic year shall constitute a termination. Failure to continue a trainee in a program beyond the academic year or failure to certify successful completion of a training program does not constitute a disciplinary action, as discussed more fully in applicable sections below.
  - Written notice of a recommendation of termination from a program, including the reasons for the decision and the effective date shall be provided by the program director to the trainee. The trainee shall be requested to acknowledge being advised of his/her involuntary termination by signing the notification; refusal to do so shall be noted by the program director, setting forth the reasons for refusal if stated by the trainee. The notice shall include a statement that termination, if final, may be reported to the Rhode Island Board of Medical Licensure and Discipline, and that an explanatory statement may also be submitted to the ACGME of the American Medical Association. The notice shall also state that the trainee may request a formal review of the termination in accordance with the procedures described below.
- Right to Review
  - The trainee shall have the right to a review of the termination decision. To initiate such a review, the trainee must submit a written request for a review of the termination to the director of GME/DIO within five (5) business days of

receiving notification. The written request must specify the reasons the trainee believes his/her case warrants review and special consideration. Failure to make a timely request for a review will constitute a waiver of the trainee's right to a review.

- If the request for a review is timely, the director of GME/DIO will arrange a hearing before a committee composed of the director of GME/DIO (who shall serve as chairperson), three faculty members on the Hospital staff association members and two Hospital house officers. The director of GME/DIO shall select the hearing committee members. The director of GME/DIO shall not serve on the committee if he or she made the recommendation to terminate or if he or she desires to be, or is to be, called as a witness at the hearing. In such event, or in the director of GME/DIO's absence or inability to serve, the director of GME/DIO shall appoint one other staff association member to the committee, which shall select a chairperson. The committee will conduct the hearing as soon as practicable, but in no instance more than 30 days from the date of receipt of the trainee's request for a review. By mutual agreement of the parties, this time may be further extended.
- The committee's sole function shall be to ascertain whether or not: (a) there was any reasonable basis to recommend termination, and (b) the provisions of this Policy were substantially adhered to. It shall not be the function of the committee to recommend alternative disciplinary action.
- Counsel at the hearing with whom he/she may confer, and counsel for other interested parties, as determined by the Committee, shall be entitled to attend may accompany the House Officer at his/her own expense. Such counsel shall be entitled to participate as may be determined in advance by the Committee. Furthermore, a record shall be kept of the hearing.
- Prior to the hearing, the trainee and the Hospital will exchange pertinent information concerning their respective presentations, including a list of witnesses. Prior to the hearing, the trainee and the Hospital will be given copies of, or be permitted to review, documents that will be submitted at the hearing. Both the trainee and the Hospital are responsible for contacting their respective witnesses, scheduling the order of their presentations at the hearing and coordinating the witnesses' appearance with the committee chairperson. The committee may prepare specific procedure guidelines for use at the hearing.
- The program director (or designee) will present the Hospital's response, and both the program director and the trainee may present witnesses and submit documentary material to the committee. Both parties will be permitted to question the other party and either party on evidence presented by the other party may make its witnesses and rebuttal statements.
- The committee will render a written decision, which shall be forwarded, to the trainee and the program director within days after completion of the hearing. Based on the committee's decision, the program director may reconsider the proposed disciplinary action. If the program director's recommendation is for termination, this recommendation and the committee's decision shall be forwarded to the GME Committee for review. If the GME Committee agrees with the recommendation to terminate, the recommendation shall be forwarded

to the Hospital's Board of Trustees for final action. If the GME Committee disagrees with the recommendation to terminate, then it shall, after discussion with the hearing committee and the program director, decide upon an alternative action, which action shall be communicated to the trainee and the program director for implementation.

- The trainee's stipend and benefits will continue during the period of the hearing process until action by the Board of Trustees, except that the stipend and benefits will cease at the end of the current appointment period should the hearing process continue beyond that period.

iv. Independent Evaluation

- If an evaluation of the trainee's performance by the program director and/or designee suggests a situation (such as, but not limited to: medical/mental health, behavioral and/or substance abuse problems) which places the trainee or his/her patients at risk, the director of GME/DIO may require an independent evaluation by the Physician's Health Committee of the Rhode Island Medical Society. The purpose of this independent evaluation is to determine the trainee's ability to perform his/her clinical duties and responsibilities. This independent evaluation may be required on its own or in addition to other formal disciplinary action described above.

v. Other Disciplinary Actions

- A trainee who is aggrieved by a formal disciplinary action other than probation, suspension or termination, may request a review of the action under the procedures described above.

vi. Nonrenewal of Contract

- Failure in performance to progress academically or professionally may be cause for a Program Director, after consultation with the Chief, to choose not to renew a trainee's contract. The resident must be provided with a written notice from the Program Director of intent not to renew the resident's contract no later than four months prior to the end of the resident's current contract. The trainee shall be requested to acknowledge being advised of the program's intent to not renew the trainee's contract by signing the notification; refusal to do so shall be noted by the Program Director, setting forth the reasons for refusal if stated by the trainee. The notice shall also state that the trainee may request a formal review of the intent not to renew in accordance with the procedures described below. If the primary reason(s) for the non-renewal occur(s) within the four months prior to the end of the contract, the program director must provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the contract.
- Evaluation by the teaching faculty must be considered when a Program Director decides to non-renew the contract for academic reasons. If the trainee is not already on probation or suspended when the decision to not renew is made, then the trainee should be informed and/or be placed in a remedial program prior to the decision to not renew his/her contract. When the decision to non-renew the contract is made, if the trainee is in remedial status, the remedial status may be extended to cover the remainder of the employment period. The director of GME/DIO should be notified

of any decision by a Program Director of any non-renewal of contract prior to the notification of the trainee.

- A failure to continue a trainee in a program beyond the current academic year does not constitute a disciplinary action.
- Right to Review
  - The trainee shall have the right to a review of the intent not to renew decision and shall be informed of this right. To initiate such a review, a trainee must submit a written request for a review of the intent not to renew to the director of GME/DIO within five business days of the trainee's receipt of the notification of the intent not to renew decision. Failure to make a timely request for a review will constitute a waiver of the trainee's right to a review.
  - If the trainee requests review of the intent not to renew, the director of GME/DIO shall meet with the trainee within ten business days and afford the trainee an opportunity to provide any information on his or her behalf. After this meeting, the director of GME/DIO, following consultation with the program director, Department Chief and other appropriate individuals, if any, will render a final decision.
  - The trainee shall receive written notification of the decision of the director of GME/DIO and the reasons for and consequences of the decision.
  - There is no further appeal from a decision to not renew a trainee's contract.

vii. Failure to Promote to Next Level of Training

- The decision to re-appoint and promote a trainee to the next level of post-graduate training shall be based on the amount of academic credit received for the year as determined by the program director upon review of the trainee's performance. The program director shall consider all evaluations of the trainee's performance and any other criteria that are deemed appropriate by the program director. Any trainee who is, in the opinion of the program director, subject to not being promoted due to academic performance should be placed in a remedial training program and should be notified at the earliest opportunity of any decision to reduce or restrict the credit given for one or more rotations during a given academic year. If the trainee continues in the program but his/her performance continues to be unsatisfactory, he/she may be placed on the next level of discipline. In the event a trainee is in a remedial training program at the time of the contract renewal, the program director may choose to:
  - Extend the existing contract for the length of time necessary to complete the remediation process, not the exceed six months;
  - Promote the trainee to the next level; or
  - Non-renew the contract pursuant to applicable sections above.
- A failure to provide full credit for a rotation or academic year or a failure to certify successful completion of a training program does not constitute a disciplinary action, and the trainee shall have no right to appeal such actions.

Surgical Evaluation

Rhode Island Hospital

Department of Ophthalmology

Resident Surgical Evaluation Form

Resident Name: ____________________ *Date of Surgery:* ____________________

Attending: ____________________

Procedure: ____________________ *Machine Used:* ____________________

Local:
- ☐ RIH
- ☐ VA
- ☐ Miriam

Anesthesia: ☐ Local ☐ GA☐ ☐ MAC ☐ Topical

Complications:____
____
____

Resident Strengths:____
____
____

Resident Weaknesses:____
____
____

Suggestions for Improvement:____
____
____

Attending Signature:____

VI. Methods of Improvement

1. *Weekly Departmental Meetings*

   The program director and the chairman will meet weekly to discuss matters pertaining to the functioning of the program. The department administrator Sally Martone will take minutes of these meetings. Available clinical faculty and the chief resident at Rhode Island Hospital are invited to attend.

2. *Monthly Residency Committee Meetings*

   The chairman, program director, and site directors at both Rhode Island Hospital and the Providence VA Medical Center will meet monthly to discuss matters pertaining to the functioning of the program. The directors of each subspecialty and the chief resident are invited to attend. A sign in sheet will be completed to document the attendance at the session.

3. *Monthly Departmental Staff Meetings*

   The staff at Rhode Island Hospital will meet monthly to discuss issues pertaining to the functioning of the general ophthalmology resident clinic at Rhode Island Hospital. Staff in attendance include all nurses, technicians, scheduling secretaries, administrative secretaries, the chief resident at Rhode Island Hospital, and the program director. Minutes of these meetings will be taken.

4. *Resident Semi-annual Evaluations*

   The semi-annually evaluations for each resident with the Program Director and/or the Chairman serve not only to evaluate the resident but for the resident to also evaluate the program. Notes pertaining to the resident's comments will be kept for discussion on improving the residency as warranted.

5. *Discussions with Issues as they Arise*

   As issues arise the applicable parties to ensure the smooth functioning of the residency program will discuss them.