

Ophthalmology residency training in India: *Quo vadis?*

Residency training is an essential phase of metamorphosis in the life cycle of a medical student that marks the transformation of a theoretical generalist into a practically oriented specialist gearing up to assume personal responsibility for patient care. Over the years, the process of surgical training has evolved from an unstructured apprenticeship of unlimited duration in the distant past, and a more organized Halstedian pyramidal model in the 20th century, to the current standardized rectangular model with defined timelines.^[1,2] However, the essential Halstedian concept “See one, do one, teach one” continues to be ingrained in our residency training.

The process of residency training is physically, emotionally, and intellectually demanding. The essential requirements of an ideal residency program are a learning and working environment that fosters excellence in safety and quality of care and professionalism; faculty trained to teach, train, evaluate, and mentor; optimal exposure to patients, clinical investigations and procedures; and the necessary facilities and equipment to provide standardized care.

Even in situations where the facilities, faculty, training standards, evaluation, and exit criteria are all harmonized, and residency selection is based on meritocracy, the overall quality of the final output is known to vary substantially. The situation becomes much more complex when the entry points into the program are disparate, training standards and exit criteria vary, and the faculty and facilities range from exceptional to very basic, as in India.

About 60% of ophthalmic residency training in India is in the domain of government-run organizations, and the rest in private facilities. Training is imparted in varied settings – national institutes, regional institutes, medical universities, medical colleges, private institutes, and private hospitals, in rural and urban locations. Goals, culture, commitment, willingness to change, and the agility to implement change vary widely, and that often reflects in the quality of the output. Can we change this? Can we ensure that we produce safe and conscientious specialists uniformly with an ideal set of skills, knowledge, and attitude with optimal proficiency in all the domains of patient care? Can we do this despite all the ills that the system suffers?

Change for the better is driven more by the motivation and interest of the training imparters to excel and less by the threat of regulatory authorities. We also realize that quality teaching and learning can be accomplished even in the absence of state-of-the-art equipment by incorporating some of the Accreditation Council for Graduate Medical Education (ACGME) concepts of supervised training and graded and progressive responsibility.^[3] In every residency program, it is possible to provide an environment of teaching and learning by facilitating the residents to have “direct patient interaction under the guidance and supervision of faculty who give value, context, and meaning to those interactions” as envisaged by the ACGME.^[3] “As residents gain experience and demonstrate growth in their ability to care for patients, they may assume roles that permit them to exercise those skills with greater independence”^[3] and start imparting training to their juniors, thus relieving some pressure off the faculty. The ACGME states that “supervision has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.”^[3] While the numbers are important in surgical training, the foundation can be laid at wet laboratory training and by supervised step-by-step surgical exposure. Incorporation of these elements may reduce the dependency on “numbers” to gain confidence in surgical skills. Incorporation of the International Council of Ophthalmology OSCAR modules could make the surgical skills’ evaluation process more objective.^[4]

Residents have a major role to play in having their training transformed into a holistic experience by incorporating the six ACGME elements - medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.^[5] Their current conditioned and hypertrophic cataract-centric focus should give way to an open-minded intensive learning of comprehensive ophthalmology, and cherry-picking of “commercially viable” skills should change to a more broad-based approach. With the availability of vast and well-curated online resources, there is no excuse not to self-learn and fill in for any deficiencies in the training. They should aim to become good comprehensive ophthalmologists with essential surgical skills to be able to take care of about 80%–90% of patients that they may see as primary care ophthalmologists. An excellent foundation of comprehensive ophthalmology is essential to further build subspecialty skills.

Individual department heads and the residency training coordinators need to muster the will to change and lead the change. The increasing commercialization has resulted in a constraint in the time available for the teachers to teach. However, if their primary responsibility is to teach, time has to be found to accomplish it. Subtle reorganization within the department, time management, motivating the young faculty with an aptitude and interest to teach, and making them coordinate the teaching program, one-to-one mentoring of residents, having a fixed-time daily teaching schedule, all help in any given situation.

The All India Ophthalmological Society (AIOS) has invested time and energy into developing a common national curriculum for residency training. Instead of waiting for the wheels of the regulatory authorities to move to implement this curriculum, each program could voluntarily incorporate the essential aspects into their existing training modules. We will elaborate more on the

AIOS curriculum in one of the future issues of IJO. The seriousness of focus of AIOS and IJO on improving and standardizing residency training can be gauged by several publications in the past, and two important publications in the current issue.^[6-14]

Residency training programs in India have an immense and untapped potential. Patients are plenty, pathology is varied, teachers are vastly experienced, students are the cream of their fraternity, and AIOS is keen to partner – so all that we need now is the will to change and do our very best through what is possible under the circumstances, while continuing to energetically push for better facilities with all the gusto.

Santosh G Honavar

Editor, Indian Journal of Ophthalmology,
Editorial Office: Centre for Sight, Road No 2, Banjara Hills, Hyderabad - 500 034, Telangana, India.
E-mail: editorjournal@aio.org

References

1. Polavarapu HV, Kulaylat AN, Sun S, Hamed OH. 100 years of surgical education: The past, present, and future. *Bull Am Coll Surg* 2013;98:22-7.
2. Grillo HC. To impart this art: The development of graduate surgical education in the United States. *Surgery* 1999;125:1-14.
3. ACGME Common Program Requirements. Available from: http://www.acgme.org/Portals/0/PFAAssets/ProgramRequirements/CPRs_07012016.pdf. [Last accessed on 2017 June 15].
4. ICO OSCAR Tools. Available from: <http://www.icoph.org/resources/230/Surgical-Assessment-Tool-ICO-OSCAR-in-English-and-Spanish.html>. [Last accessed on 2017 June 15].
5. Swanson AG. The genesis of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education. *Bull N Y Acad Med* 1974;50:1216-21.
6. Gupta A. Ophthalmology postgraduate training in India: Stirring up a hornet's nest. *Indian J Ophthalmol* 2017;65:433-4.
7. Gogate P, Biswas P, Natarajan S, Ramamurthy D, Bhattacharya D, Golnik K, *et al.* Residency evaluation and adherence design study: Young ophthalmologists' perception of their residency programs – Clinical and surgical skills. *Indian J Ophthalmol* 2017;65:452-60.
8. Gogate PM, Biswas P, Natarajan S, Nayak BK, Gopal S, Shah Y, *et al.* Residency evaluation and adherence design study: Young ophthalmologists' perception of their residency programs II: Academics and Research dissertation. *Indian J Ophthalmol* 2017;65:12-18.
9. Ajay K, Krishnaprasad R, Divya DS. Ophthalmic surgical training in Karnataka and Southern India: Present status and future interests from a survey of final-year residents. *Indian J Ophthalmol* 2015;63:306-11.
10. Ajay K, Krishnaprasad R. Feedback of final year ophthalmology postgraduates about their residency ophthalmology training in South India. *Indian J Ophthalmol* 2014;62:814-7.
11. Thomas R, Dogra M. An evaluation of medical college departments of ophthalmology in India and change following provision of modern instrumentation and training. *Indian J Ophthalmol* 2008;56:9-16.
12. Grover AK. Postgraduate ophthalmic education in India: Are we on the right track? *Indian J Ophthalmol* 2008;56:3-4.
13. Gogate P, Deshpande M, Dharmadhikari S. Which is the best method to learn ophthalmology? Resident doctors' perspective of ophthalmology training. *Indian J Ophthalmol* 2008;56:409-12.
14. Murthy GV, Gupta SK, Bachani D, Sanga L, John N, Tewari HK. Status of speciality training in ophthalmology in India. *Indian J Ophthalmol* 2005;53:135-42.

Access this article online	
Quick Response Code:	Website: www.ijo.in
	DOI: 10.4103/ijo.IJO_502_17

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

Cite this article as: Honavar SG. Ophthalmology residency training in India: *Quo vadis?* *Indian J Ophthalmol* 2017;65:427-8.