



Ophthalmic Teaching Problems: The Ayes Have It!*

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The problems associated with the teaching of ophthalmology to medical students in today's university setting are by no means unique to ophthalmology. However, these problems are more severe in small departments such as ophthalmology and are more disruptive to the teaching process than similar problems in larger departments. The purpose of this paper is to identify some of the more important teaching problems and propose solutions to them.

Problem: De-emphasis of Ophthalmic Curriculum. As curriculum changes have taken place in medical schools in recent years, ophthalmology along with other small specialties has had its teaching time reduced or entirely eliminated. This problem is universal and is important enough to have been the subject of the opening address of the Third Congress of the European Society of Ophthalmology. The speaker at this opening address was concerned with the deterioration of the status of ophthalmology as measured in the number of hours assigned to it in the curriculum of medical schools (2). The subject content and time spent in ophthalmic teaching cannot be left to the discretion of other departments who are concerned with their own specialty-oriented curriculum or a core-curriculum because comprehensive and complete instruction in the eye, its diseases, and their treatment will not be their primary objective. The problem can only be rectified by having representatives from all departments, large and small, on curriculum committees and by having medical school administrations committed to the concept of excellent medical education within all

specialties and not at the expense of smaller specialties.

Problem: Efficient Presentation of Ophthalmic Curriculum. Assuming there are no severe organizational or administrative situations to restrain and disrupt ophthalmic teaching, ophthalmology is well suited to the efficient use of modern teaching concepts and techniques. Studies have been performed using the questionnaire format to gather information on what the curriculum content for medical school ophthalmology should be, and these can be used as a starting point to develop a useful curriculum or to change the present curriculum (4, 5).

Audio-visual resources are very useful since many ophthalmic diseases can be precisely recorded by photography. Programmed texts are available commercially on basic ophthalmology, and mannequins are becoming available for realistic teaching of ophthalmology (1). Ophthalmology departments should be the first to use and develop video taped lectures, surgery, and basic examining techniques. This emphasis on audio-visual materials allows understaffed and small departments to use their faculty more effectively (3). The solution to this problem is to develop an adequately funded curriculum that could utilize these developments.

Problem: Inadequate "Quality Control" of Medical Curriculum. The major fault of all medical education, in my opinion, appears to be the lack of "quality control" of the educational product. If techniques could be developed to monitor the medical curriculum in a direct fashion, a major benefit from such a program would be the elimination of redundant or irrelevant material from the curriculum. This would lead to more efficient use of teaching time. Figure 1 outlines the concept to be presented as one method of solving this problem.

* The views expressed by the author of this paper do not of necessity reflect those of the Department of Ophthalmology or the Institution. Reprint requests to Robert G. King, Jr., M.D.

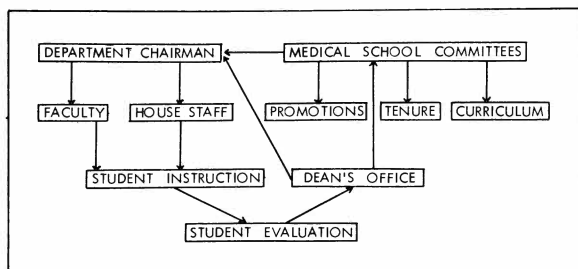


Fig. 1—Schematic for medical curriculum evaluation. The department chairman initiates the teaching process which results in student evaluation. The dean's office processes the information and channels it back to each department and the appropriate committees.

All the parties directly involved in medical student teaching have a definite bias in evaluating their own specific medical curriculum. It appears a third party with the necessary information and authority to criticize each department's curriculum would have less bias and would add valuable perspective to curriculum evaluation. The logical unit to control this evaluation would be a division of the dean's office in the medical school administration.

The most important part of this type of curriculum "quality control" should be the student himself. This logically follows since the student knows what he thinks he needs to be taught, what he has been taught, and whether the subject rotation was effective in teaching that particular subject. I believe this type of "quality control" would work best by requiring each student to fill out a standard form after completion of each departmental rotation. This form should supply a list of faculty and house staff involved in his teaching and request an evaluation of the time each faculty and house staff member spent in didactic teaching and in the clinical setting. The student should be asked to list the most and least relevant parts of the material covered. Student ideas should be obtained as to how the course could be improved by changes in lecture time, patient care time, audio-visual techniques and so forth. In this fashion, each faculty member and the curriculum content would be evaluated by each student. Over a period of a few months, a student consensus and curriculum profile of that specific subject could be obtained.

These student evaluation forms would be the property of the dean's office. Periodically the digested material of the student evaluation would be sent to the respective department chairman for de-

partmental analysis. Upon analysis of these forms within the dean's office, and with the input from each department and the curriculum committee, the following should result. Those departments which did not and could not use their block of student teaching time effectively would be identified, and the time would be made available for use by other specialties. The parts of the curriculum not felt relevant could be eliminated. Subjects considered less important by some departments but requested by the students as necessary, would have a greater chance for time allotment in the curriculum.

The digested information concerning the amount of time spent in teaching by each faculty member could also be recorded on each faculty member's activity and effort report as the student's evaluation of that teaching. This would give the administration an additional source of information concerning that specific faculty member's activity and could be used in the consideration of promotions, tenure, and so forth.

It appears the main disadvantage of the above concept for a "quality control" of the medical curriculum could be the additional paper work required to process the student evaluations. A properly designed computer program would undoubtedly decrease the paper shuffling and significantly increase the usefulness of information that has been gathered.

In general, the more constructive the discussion concerning the quality of a medical school curriculum, the better the curriculum should be. Students who are intimately involved in each department rotation should have a channel through which they can routinely express their collective view and know that it would be seriously considered. Almost without exception, in each ophthalmology rotation a student will ask why more classroom exposure or clinical time is not available for certain ophthalmic subjects. Departments such as ophthalmology frequently lack the size and influence needed to modify the general medical school curriculum to allow more teaching time for their specialty. By using the evaluation process outlined in this paper, all medical school departments would have to be more objective in evaluating their own specific curriculum. If an unfair distribution of teaching time was present, according to the students' evaluation, the problems could be identified and decisions made as to whether this problem should be corrected.

It is imperative that a continuing evaluation of the medical school curriculum be carried out to

insure a quality educational product. As the body of medical knowledge grows, the curriculum has to have less relevant parts eliminated and teaching efficiency increased. In addition to the more routine methods of curriculum evaluation used in the past, the student's opinion should be formally and routinely used to add additional information for curriculum evaluation and to add another important point of view. By providing a mechanism for this type of student "vote," the student can influence the educational process of which he is a part. Hopefully, medical students would then feel that their constructive evaluation would be important, and their "ayes" would produce a better medical educational system to give them the knowledge they will need to become better physicians.

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