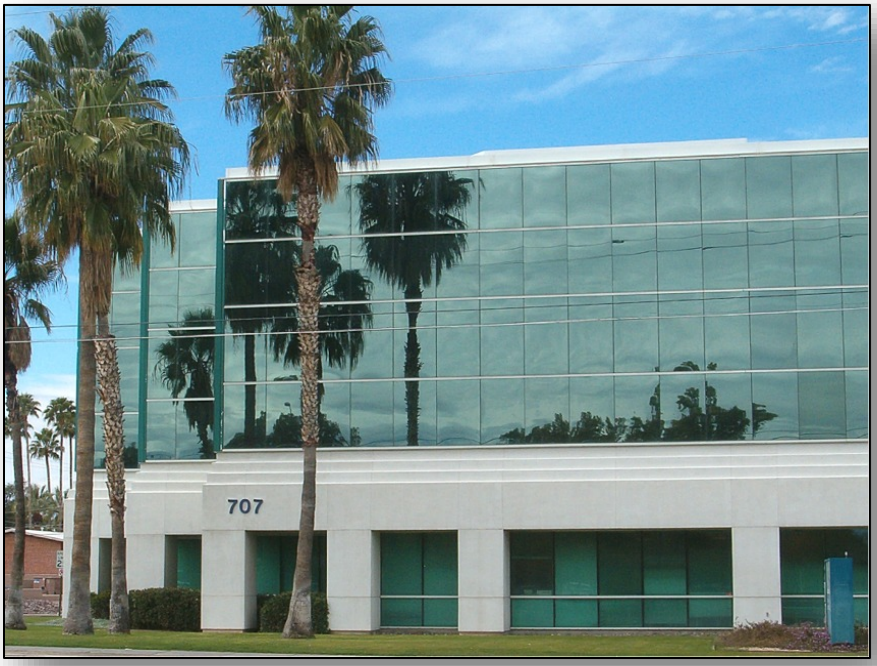
THE UNIVERSITY OF ARIZONA
College of Medicine

University of Arizona Program

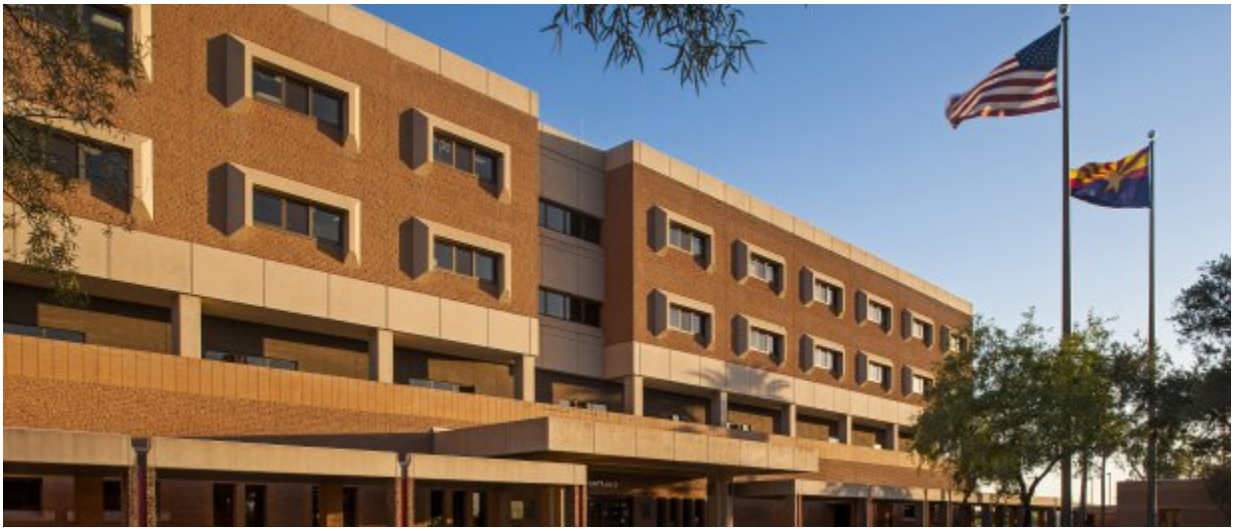


DEPARTMENT OF OPHTHALMOLOGY

RESIDENCY PROGRAM MANUAL
2018-2019 Academic Year

OPHTHALMOLOGY AND VISION SCIENCE

University of Arizona College of Medicine at South Campus Program



DEPARTMENT OF OPHTHALMOLOGY

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1. EDUCATIONAL GOALS AND OBJECTIVES

A. Goals

The goals of the Ophthalmology Residency Program are to:

(1) Train ethical, comprehensive, and compassionate ophthalmologists.

(2) Provide residents with enough didactic instruction and clinical experience to obtain American Board of Ophthalmology (ABO) certification.

(3) Provide residents with the fundamental scientific background in ophthalmology to prepare them to become life-long learners.

(4) Provide residents with skills to practice evidence-based medicine.

B. Objectives

The objectives of the Ophthalmology Residency Program are to:

(1) Provide residents with a strong scientific understanding of the fundamentals of ophthalmology.

(2) Provide residents with clinical skills in all subspecialties of ophthalmology.

(3) Provide residents with broad surgical experience in all subspecialties of ophthalmology

(4) Encourage residents to perform literature reviews and use critical thinking skills to make informed patient care decisions.

(5) Provide residents with an understanding of ethical, legal, and moral issues involved in eye care and medical care.

(6) Provide residents with the fundamental business and managerial skills for a systems-based practice.

2. STATEMENT OF PURPOSE

A. Introduction

The Ophthalmology Residency Program offers a three-year program that blends clinical training, academic activities, and research opportunities. There are two residents in each of the three years of the program. This handbook provides a general description of the program, the structure of the residency training at the affiliate institutions, and the standards and expectations of resident performance.

The Department of Ophthalmology staff consists of six full-time ophthalmologists at University of Arizona (UA). There is a large associate staff of affiliate/associate (“volunteer”) faculty, two full-time optometrists, two research faculty, and a supporting staff of technical personnel. There are three full-time and four part-time physicians at the Southern Arizona Veterans Administration Health Care System (SAVAHCS). Three affiliated hospitals – Banner-University Medical Center Tucson

(BUMCT), Banner-University Medical Center South (BUMCS), and SAVAHCS, each with active inpatient/outpatient services, as well as research and teaching facilities, are involved in the residency program.

Approximately 19,000 patients per year visit the Ophthalmology clinics at Alvernon. Rotations are also provided at SAVAHCS, where there are approximately 15,000 patient visits. Residents participate in state-of-the-art diagnostic and therapeutic interventions for these patients. The residents also rotate with community physicians:

- Ann McColgin, MD, and Mingwu Wang, MD, PhD; Cornea Associates
- Patrick Tsai, MD, MHA; Tucson Eye Care (general/glaucoma)
- Wayne Bixenman, MD (neuro-ophthalmology)
- Kathleen Duerksen, MD (oculoplastics)
- Mikel Lo, MD; About Faces Cosmetic Surgery (oculoplastics)
- Brock Bakewell, MD, William Fishkind, MD, Jeff Maltzman, MD, and Brian Hunter, MD; Fishkind, Bakewell, Maltzman and Hunter Eye Care and Surgery Center (refractive surgery)
- April Harris, MD, Cameron Javid, MD, Egbert Saavedra, MD, and Mark Walsh, MD; Retina Associates Southwest (retina)
- John Christoforidis; Retina Specialists of Southern Arizona (retina)

Each facility has its own unique qualities. The Department of Ophthalmology provides intensive faculty contact with private practice in an academic setting. SAVAHCS has a resident-oriented program with excellent faculty presence. Corneal diseases are the focus of the rotation with Cornea Associates (Ann McColgin, MD, and Mingwu Wang, MD, PhD). Dr. Tsai provides experience in general ophthalmology and glaucoma in a private practice setting. Drs. Bakewell, Fishkind, Maltzman, and Hunter provide experience in a refractive surgery private practice setting. Retina Associates Southwest and Dr. Christoforidis provide experience in vitreoretinal conditions in private practice settings. Dr. Duerksen and Lo provide experience in oculoplastics in private practice settings.

B. **Core Competencies**

In accordance with ACGME guidelines, residents are expected to develop competencies in six core areas:

- Patient Care and Procedural Skills
- Medical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice

C. **Academic Program**

The foundations of the didactic program of the residency are weekly conferences in the various subspecialties and weekly clinical teaching rounds. In addition, there are wet labs, unique conferences, and journal clubs. There are conferences provided by the Tucson Ophthalmological Society, an annual conference organized by the Arizona Ophthalmological Society, and occasional guest speakers at industry-sponsored events in the Tucson community. Resident participation in the Tucson Ophthalmological Society meetings is expected, unless a meeting conflicts with a scheduled resident conference, which takes priority for resident attendance.

D. **Clinical Training**

During the three years of residency, residents assume increasing responsibility for patient care and education. Beginning residents are closely supervised, and then given increasing autonomy as they demonstrate proficiency and understanding. Residents prepare case presentations, organize journal clubs, and assist in teaching medical students and other residents rotating through ophthalmology. In addition, senior residents, with faculty supervision, are expected to supervise and teach junior residents. Faculty are assigned and available for consultation with the residents on all rotations.

(1) ***First Year Resident***: The first year resident performs complete ocular examinations in the outpatient facilities, becoming proficient in gonioscopy, indirect ophthalmoscopy, tonometry, biomicroscopy, refraction, and physiologic testing. The resident rotates through the Alvernon clinics, SAVAHCS for a continuity care clinic and oculoplastics, the practice of Dr. Bixenman for neuro-ophthalmology, the private practice of Dr. Tsai for general ophthalmology and glaucoma, the private practices of Drs. Duerksen and Lo for oculoplastics, the private practice of Drs. Bakewell, Fishkind, Maltzman, and Hunter for refractive surgery, and the private practices of Retina Associates and Dr. Christoforidis for retina. The resident gains extensive experience in evaluating walk-in and emergency patients on a daily basis. The earliest encounters with ocular trauma are during the first year; and there is exposure to the subspecialty services, including contact lenses, cornea and external disease, glaucoma, neuro-ophthalmology, oculoplastics, pediatrics, and retina. The resident begins assisting at surgery during this year, and performs minor surgical procedures.

(2) ***Second Year Resident***: The second year resident rotates through cornea and external disease, general, glaucoma, pediatrics, and retina. The resident participates in rotations at the private practices of Dr. Wayne Bixenman, Dr. Patrick Tsai, Cornea Associates, Retina Associates Southwest, and Dr. John Christorofidis. The resident also rotates at the SAVAHCS for continuity clinic and oculoplastics.

(3) ***Third Year Resident***: During their third year, the resident serves as Chief Resident for three months of the year and manages clinics at SAVAHCS for nine months. The resident at this stage of training performs surgery under faculty supervision. Based on the problem, the resident's experience, and attending preference, there will be successive levels of autonomy. The resident will be involved with the pre-operative and post-operative care of each surgery performed. As Chief Resident, the resident will have responsibility for scheduling their clinical and surgical duties. They will be given a block of time each week for administrative responsibilities. They will also assist in supervising the junior residents. At the conclusion of the third year, the residents are expected to be able to enter practice without direct supervision.

All residents participate in wet and dry labs, receiving instruction on surgical techniques and suturing. The wet lab is equipped with a microscope and phacoemulsification unit.

E. **Responsibilities of the Chief Resident**

The Chief Resident responsibilities are divided between those internal to the Department operation and external (sponsoring institution). During the senior year, the Department responsibilities (call, location, rounds presentations assignments, etc.) may be shared between the senior residents on a rotation determined by the senior residents. However, external duties may be peer selected or determined by the Program Director at the beginning of the year.

(1) The Chief Resident is responsible for collecting vacation requests, screening vacation requests for appropriateness, and passing the information to the program coordinator. The requests will be approved by the Program Director.

(2) The Chief Resident is responsible for scheduling call for first call and back-up (second) call, and providing the schedule to the program coordinator. **The schedule must comply with duty hour standards**. The scheduled will be approved by the Program Director.

(3) The Chief Resident is responsible for the content of weekly teaching rounds–creating the schedule of presenting residents and ensuring the program content is appropriate. The Chair or Program Director will approve any outside speaker.

(4) The Chief Resident is responsible for preparing the monthly resident assignments based on the core rotations, and providing the schedule to the program coordinator. He/she also responsible for reassigning residents as necessary, i.e. when a resident is off due to illness, or when a clinic is cancelled due to faculty illness, and providing the updated information to the program coordinator. He/she points out deficiencies or problem areas to the Program Director. The Chief Resident is also responsible for preparing the monthly medical student assignments.

(5) The Chief Resident surveys the lecture schedule, and points out deficiencies or problem areas to the Program Director. When more than six residents are going to miss a lecture (conference, vacation, sick) on a lecture, he/she must contact the program coordinator, who will inform the lecturer, who has the option to reschedule or proceed with the scheduled lecture.

(6) The Chief Resident assures that attendance is taken at the regularly scheduled lectures. If he/she is unable to be present, he/she assigns this task to another resident. The Chief Resident is responsible for providing accurate attendance records to the program coordinator. If a resident does not attend the entire lecture, the amount of time the resident was present for the lecture must be noted on the attendance sheet.

(7) The Chief Resident is responsible for the agenda at semi-annual resident/faculty meetings, which are held in fall (September) and spring (March).

(8) The Chief Resident, or his designee, should attend the clinical faculty meetings to provide input about the residency program

(9) The Chief Resident facilitates collegial and professional interaction among the residents.

(10) The Chief Resident is responsible for attending the quarterly Chief Resident dinner held by the GME office. ACGME requires representation from all programs. If the Chief is on vacation/sick/emergency surgery, then another resident from the same program must attend (preferably the other senior resident).

(11) The Chief Resident is responsible for attending the annual program evaluation committee meeting.

F. **Research**

The research interests of the Department of Ophthalmology center on amblyopia, corneal diseases, glaucoma, retinal diseases, strabismus, and vision development. Optics, ocular physiology, and pharmacology are integral parts of the research program. There are always ongoing clinical studies evaluating new treatment modalities. There is also a basic science lab on the second floor of the Medical Research Building (near BUMCT).

While the Department has no formal research requirement, residents are encouraged to participate in a research project. The Department offers laboratory facilities and the guidance of faculty who are involved in full- or part-time research. The faculty will also provide education on how research is conducted, research design, hypothesis testing, statistics, and epidemiology, as well as statistical assistance. Residents are encouraged to present their research at national meetings, such as those held by the Association for Research in Vision and Ophthalmology (ARVO), the American Society of Cataract and Refractive Surgery (ASCRS), and the American Academy of Ophthalmology (AAO). The Department makes every effort to support these activities through faculty mentorship.

Research topics may include results of basic or clinical research. The objective of this requirement is to provide an understanding of the mechanics of preparation of a scientific paper as well as to strengthen the residents' ability to critically evaluate publications. If funds are available, the Department will cover the cost of all reasonable production expenses; anticipated expenditures must be pre-approved by the Department (submit request to program coordinator).

(1) ***Human Subjects Protection Program (HSPP)***: Human subjects training is required for all residents. The CITI Course in The Protection of Human Research Subjects is available online through the HSPP at orcr.arizona.edu/hspp/training. This program should be completed within the first two months of training (by August 31, 2018). After completion of the course, the resident is responsible for providing a copy of the certificate to the program coordinator, which will be placed in the resident's portfolio. The resident must also to complete conflict of interest (COI) training at https://uavpr.arizona.edu/COI, as well as submit a Disclosure of Significant Financial Interests, even if the resident has no significant interests to disclosure.

(2) ***IRB Approval***: IRB approval must be obtained for all research projects involving human subjects. The "Determining Human Research" form must be provided for all research projects not requiring IRB approval. All forms are available on the HSPP website at orcr.vpr.arizona.edu.

3. **EDUCATION**

A. **Basic Responsibilities**

Each resident is primarily responsible for his/her own education. Learning begins with study, both of patients and text. The patient is the single most important teaching tool for residents, who must be treated with respect and dignity.

B. **Core Competencies**

In accordance with ACGME guidelines, residents are expected to develop competencies in six core areas: patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

(1) **Patient Care and Procedural Skills**

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:

- must demonstrate competence in patient care, including:
  - evaluating and assessing pre-operative ophthalmic and general medical indications for surgery and surgical risks and benefits;
  - managing systemic and ocular complications that may be associated with surgery and anesthesia;
  - obtaining informed consent; and
  - providing acute and long-term post-operative care.

Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents:

- must demonstrate competence in patient care, including:
  - intra-operative skills;
  - performing ophthalmic procedures as primary surgeon, including:
    - cataract;
    - cornea;
    - glaucoma;
    - glaucoma laser;
    - globe trauma;
    - oculoplastics/orbit;
    - retinal/vitreous; and,
    - strabismus.
  - using appropriate local and general anesthetics.

(2) **Medical Knowledge**

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

- must demonstrate competence in their knowledge of the basic and clinical sciences specific to ophthalmology.
- must demonstrate competence in their knowledge of: cataract surgery, contact lenses, cornea and external disease, eyelid abnormalities, glaucoma, neuro-ophthalmology, ocular trauma, optics and general refraction, orbital disease and ophthalmic plastic surgery, pathology, pediatric ophthalmology and strabismus, systemic disease consults, uveitis, visual rehabilitation and refractive surgery, and retinal/vitreous diseases.

(3) **Practice-Based Learning and Improvement**

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Residents are expected to develop skills and habits to be able to meet the following goals:

- identify strengths, deficiencies, and limits in one's knowledge and expertise;
- set learning and improvement goals;
- identify and perform appropriate learning activities;
- systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

- incorporate formative evaluation feedback into daily practice;
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- use information technology to optimize learning; and,
- participate in the education of patients, families, students, residents and other health professionals.

(4) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents are expected to:
- communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- communicate effectively with physicians, other health professionals, and health related agencies;
- work effectively as a member or leader of a health care team or other professional group;
- act in a consultative role to other physicians and health professionals; and,
- maintain comprehensive, timely, and legible medical records, if applicable.

(5) **Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Residents are expected to demonstrate:
- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society and the profession; and,
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

(6) **Systems-Based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents are expected to:
- work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- coordinate patient care within the health care system relevant to their clinical specialty;
- incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- advocate for quality patient care and optimal patient care systems;
- work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- participate in identifying system errors and implementing potential systems solutions.

C. **Required Reading**

Residents should read about specific diagnostic entities encountered in clinic each day. In addition, residents should read the Academy of Ophthalmology (AAO) *Basic Clinical and Sciences Course* (*BCSC*) completely.

The *BCSC* mirrors the core curriculum of basic and clinical science training in the residency program. The faculty (full-time, part-time, and volunteer) is sufficiently large and diversified to provide the clinical expertise for the didactic training. Residents are required to participate in the *BCSC* curriculum. An eBook version of *BCSC* is available to all residents (and faculty) at http://elibrary.aao.org/. Username and password will be provided by the program coordinator. The eBook is protected and cannot be printed.

Residents who want a printed copy of the *BCSC* can purchase from the American Academy of Ophthalmology (AAO) at a discount rate for members. Membership forms can be obtained by calling 415-561-8581 (www.aao.org). AAO membership is complimentary to first year residents.

To assist in the new resident's introduction to ophthalmology, the following specific textbooks/manuals are recommended. These are:

(1) *Practical Ophthalmology: A Manual for Beginning Residents*
(2) *Fundamentals and Principles of Ophthalmology* (Book 2, *BCSC*)
(3) *The Fine Art of Prescribing Glasses Without Making a Spectacle of Yourself*, B. Milder and M.L. Rubin
(4) *Wills Eye Manual*

Practical Ophthalmology: A Manual for Beginning Residents and *Fundamentals and Principles of Ophthalmology* are available from the American Academy of Ophthalmology (AAO) (www.aao.org). *The Fine Art of Prescribing Glasses Without Making a Spectacle of Yourself* can both be purchased from www.amazon.com. A voucher for the *Wills Eye Manual* is usually provided to 1st year residents by Allergan some time after July 1.

Arizona Health Sciences Library Online Textbook Access: Many ophthalmology textbooks are available online through the Arizona Health Sciences Library website. Your will need to use your UA netID login and password to access the ebooks.

1. Go to the Arizona Health Sciences Library website at www.ahsl.arizona.edu.
2. Click the "Top resources" heading on the top banner.
3. Click "ClinicalKey | First Consult" from the dropdown list.
4. Click "ClinicalKey."
5. Click "Books."
6. Click "Filter By"on the left sidebar.
7. Click "Specialties" on the left sidebar.
8. Click "+ More Subspecialties" on the left sidebar.
9. Select "Ophthalmology."

There are 50 online textbooks, which includes all subspecialties, as well as atlases, video atlases, general ophthalmology references, differential books, therapy references, etc. Some of these books, such as *Ryan's Retina*, *Cornea*, and *Glaucoma* are the go-to sources for general information on a topic. Of course, by the time a book goes to print some of the

information requires updating and the journal articles will help fill in the contemporary gaps for presentation.

ClinicalKey also has direct access to a few of the most cited ophthalmology journals, but access to a larger number may be achieved through the PubMed portion of the Arizona Health Sciences Library portal.

Albert and Jakobiec's Principles and Practice of Ophthalmology is an excellent all-round reference work in ophthalmology (available from www.amazon.com) or online through the Arizona Health Sciences Library. One should not consider the Jakobiec book to be all encompassing, and residents are expected to read other specialty textbooks and peer-reviewed literature. Residents should consult faculty members before investing in an expensive reference work.

D. **Journal Subscriptions**

Residents are encouraged to become a member of the AAO (membership is free). The journal, *Ophthalmology*, is included in the membership. Membership in the American Society for Cataract and Refractive Surgery (ASCRS) is complimentary to ophthalmology residents, and residents are encouraged to join. Members will receive the *Journal of Cataract and Refractive Surgery* as a benefit of membership (www.ascrs.org).

E. **Arizona Ophthalmological Society Membership**

Residents are encouraged to join the Arizona Ophthalmological Society (AOS) (membership is free). The AOS serves as a source of educational, social, and ethical exchange for the ophthalmologists in the state. Their annual meeting is held each spring at the High Country Conference Center in Flagstaff with excellent invited speakers. The membership application is available online at www.azeyemds.org.

The AOS sponsors one or more residents for AAO Advocacy Day, which is held annually in Washington, DC, during spring (April 6-13, 2019). Residents are contacted by Jeff Maltzman, MD, by email when the time to apply is approaching. Interested residents should contact Dr. Maltzman and submit a completed application, including a short essay. The selected residents are required to give a short presentation to the faculty and residents at rounds after attending.

4. EDUCATIONAL LEAVE/EXTRAMURAL COURSES

A. **Educational Leave**

Residents are eligible for up to five (5) days of educational leave per year. This includes presentations at national conferences (excluding AAO for seniors) and courses (excluding the review course for 2nd year residents). To be eligible for educational leave for conferences, see "presentations" below. To be eligible to use educational days for courses (such as CORE), residents must provide proof of attendance or vacation will apply.

(1) ***Presentations***

Residents who present work (paper, poster, etc.) at national meetings as the presenting (first) author are eligible for up to two days educational leave (the day of the presentation, plus the day immediately before or after the presentation for travel). The resident must have a faculty member as advisor of the project and the faculty member must be a co-author. To be eligible for

educational leave, poster printing, and travel funds (if needed/available), approval must be obtained from the Program Director or Department Head prior to submission of the abstract. To apply, complete the Resident Abstract Approval/Travel Grant Application (Forms, page 42), get the signature of the faculty advisor, and submit to the program coordinator. The application form is available online in the forms folder of "public resident files." Presentations may also be funded by grant funds of an individual faculty member, if the presentation is for a funded research project. If a presentation is not funded by the Department, Banner, or research funds, residents must provide their own funding, but may still be eligible for educational leave.

(2) ***Conferences/Courses***

- *2nd Year Review Course*: Second year residents will be granted up to four days of educational leave for the review course.

- *3rd Year AAO*: Third year residents who attend the AAO annual meeting will be granted up to three days of educational leave, and up to $850.00 for reimbursement of eligible travel expenses. Residents must use vacation for any additional days for this conference (not eligible for additional educational days). Residents must submit receipts for eligible travel expenses to the program coordinator within 30 days after their return. Receipts not returned within the deadline will <u>not</u> be reimbursed.

To be eligible for reimbursement for travel expenses for conferences, residents must submit the following information to the program coordinator: (1) name and dates of conference/course, (2) email confirmation for presentation, (3) planned airline itinerary, and (4) name and address for hotel. This information must be provided at least 30 days in advance to allow time for the travel to be authorized. Travel expenses may not be eligible for reimbursement if authorization was not obtained in advance.

Per University policy, there will be no reimbursement for alcoholic beverages. **Residents can <u>ONLY</u> be reimbursed for their <u>OWN</u> expenses**.

B. **Extramural Courses**

Residents are expected to attend all ophthalmology courses held in Tucson unless the meeting conflicts with a resident conference. These include Tucson Ophthalmological Society meetings, Arizona Ophthalmological Society meetings in Tucson, Residents' Day event (Science of Eye Disease Seminar/Jorge Rodríguez Memorial Lecture), and other Department-sponsored courses. A list of these courses is made available throughout the year.

C. **Community Service**

Residents are required to participate in a charitable undertaking once a year. Such activities include assisting with the glaucoma/diabetic retinopathy screenings at St. Elizabeth's Health Center, Lions Club-sponsored surgery, etc.

D. **BLS Certification**

All residents must be BLS certified. Banner and SAVAHCS provide free BLS recertification for residents, but it is each resident's responsibility to schedule and attend BLS recertification courses in a way that minimizes clinic disruption. Evidence of current BLS certification must be provided to the program coordinator for the resident's file. The program coordinator can schedule a BLS class through Banner.

5. BASIC EQUIPMENT

Incoming residents are required to purchase lenses for viewing the fundus or borrow a set from the program (20D, 90D, 4-mirror gonio lens). A 20-diopter lens is recommended for indirect ophthalmoscopy (panretinal 2.2 is an option). For biomicroscopy, purchase a 90-diopter lens (residents usually prefer Volk or Nikon). Resident will also need a 4- or 6-mirror gonioscopy lens (Zeiss, Posner, or Sussman), which can usually be purchased from Volk or Ocular Instruments. If borrowing a set of lenses from the program a $100 deposit is required. The deposit will be refunded when the lenses are turned. Lost or damaged lenses must be replaced.

To begin training in strabismus and oculoplastic surgery, it is important that residents purchase a pair of operating surgical loupes with powers of 2 to 3×. Lombart is the company preferred by most residents; a resident discount is available. Another item that might be helpful is an indirect ophthalmoscope. This is not required, but it will facilitate patient examinations when on call. Indirect ophthalmoscopes can be rather expensive, so this should not be a priority item.

Residents are also required to have a cell phone.

6. SUPERVISION POLICY AND LINES OF RESPONSIBILITY

A. Supervision Policy

The supervision of residents in the Ophthalmology Residency program is determined by both general and situation specific considerations. General considerations include an optimal resident education experience while maintaining patient safety and quality of patient care. The principle underlying both general and situation specific supervision is the absolute necessity that there must be a well defined attending physician in charge who determines the level of resident supervision and the amount of responsibility allowed for the resident.

Resident training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings with a goal to develop resident physicians into independent practitioners by allowing increasing responsibilities in the assessment of patients and the development of therapeutic strategies. Thus, in our program as the resident year (PGY-2, PGY-3, PGY-4) progresses they are given graduated responsibility. However, all aspects of patient care rendered by resident physicians must receive close supervision and are ultimately the responsibility of the attending physician.

Definition of Supervision

Supervision is an intervention provided by a supervising practitioner to a resident. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the resident, and role modeling. ***Note***: This definition is adapted from Bernard JM & Goodyear RK, *Fundamentals of Clinical Supervision* (2nd ed.), Needham Heights, MA: Allyn & Bacon, 1998.

Categories of Supervision

1. ***Direct***: Direct supervision exists when attending faculty are in contact with the patient and participate in providing care together with the resident (e.g., attending physician in OR with resident).

2. ***Indirect***
   a. Direct supervision immediately available: Attending physically present (e.g., outpatient clinic).
   b. Direct supervision available: Attending immediately available via phone/electronically AND ability to be physically present if necessary (e.g., in-house or page for questions).
3. ***Oversight***: Supervising attending reviews patient care after care has been delivered (e.g., overnight call).
4. ***General***: General supervision exists when attending faculty are involved in patient care through instruction and the establishment of a system of patient care within which the resident must function.

Supervision and Patient Settings

The Department of Ophthalmology has three major participating affiliated teaching sites (BUMCT, BUMCS, and SAVAHCS). In addition, there are several (five) affiliated teaching sites based in the offices of community ophthalmologists who have voluntary attending faculty appointments with the University of Arizona. Supervision policies will be defined for each teaching site, since there are some minor variations. However, all teaching sites have the same premise of close and careful supervision by the attending faculty who maintain the ultimate authority for patient care.

B. **Lines of Responsibility**

The lines of responsibility flow according to experience. The senior residents are held responsible for the actions of the residents junior to them. In turn, the faculty is responsible for the actions of residents under their direct supervision. The Program Director is responsible for the education and conduct of all residents in the teaching program. The chief of service at each institution is ultimately responsible for the staff and resident physicians who are participating in patient care at the respective institution.

Outpatient Clinics

BUMCT and BUMCS

Patients referred via BUMCT or BUMCS and seen as outpatients will be evaluated at the Alvernon Clinic. Attending faculty members will staff both general and subspecialty outpatient clinics. PGY-2 and PGY-3 residents will be assigned, on a monthly rotation, to most of these clinics. The PGY-4 Chief Resident is also assigned to the Alvernon Clinic. Supervision will be provided by the attending faculty member in charge of these clinics. Resident involvement will range from observation of attending examinations to partial or complete patient evaluations/examinations. All components of the resident examinations will be duplicated by the attending faculty. Any resident entry in the patient's electronic medical record will be checked for accuracy by the attending faculty who will enter an attestation statement into the electronic medical record. The category of supervision will, therefore, be: (1) direct or (2a) indirect with direct supervision immediate availability.

SAVAHCS

At SAVAHCS, the outpatient eye clinics are managed by the residents with faculty supervision present at all times (1, direct or 2a, indirect with direct supervision, immediately available). Documentation of all patient encounters **must identify the supervising practitioner and indicate the level of involvement**. Four types of documentation of resident supervision are allowed:

(1) **Attending progress note** or other entry into the medical record.

(2) **Attending addendum** to the resident's note.

(3) **Co-signature** by the faculty implies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of CPRS function "Additional Signer" is **not acceptable** for documenting supervision.

(4) **Resident documentation** of attending supervision. [Includes involvement of the attending (e.g., "*I have seen and discussed the patient with my supervising practitioner, Dr. 'X', and Dr. 'X' agrees with my assessment and plan*"), at a minimum, the responsible attending should be identified (e.g., "*The attending of record for this patient encounter is Dr. 'X'.)]*

The following table summarizes supervision policies at SAVAHCS regarding new and return patients in the outpatient clinical setting.

New Patient or New Consult Visit	Attending must be physically present in the clinic. Every patient who is new to the facility must be seen by or discussed with the attending.	An independent note, addendum to the resident note, or resident note description of attending involvement. Co-signature by attending alone is not sufficient documentation.
Return Visit	Attending must be physically present in the clinic. Patients should be seen by or discussed with an attending at a frequency to ensure effective and appropriate treatment.	Any of the four types of documentation. The attending's name must be documented.
Outpatient Discharge	Attending will ensure that discharge from a clinic is appropriate.	Any of the four types of documentation.

Inpatient Consultation

BUMCT and BUMCS

PGY-2 and PGY-3 residents will spend a total of three months during their first two years of training on a consultation rotation. Monthly rotations on the consultation service will assure maximum continuity of care. Consultations requested during working hours will receive a complete evaluation by the resident (2b, indirect supervision), who will arrange to see the patient with the on-call attending faculty that same day who will provide direct supervision (1). The electronic medical record will be completed by the resident and each category of the exam will be documented and recorded by the faculty member. In addition to new patient consultations, residents will round with the on-call attending (1, direct supervision) on inpatients requiring daily follow-up examinations and a note will be entered in the patients chart by both the resident and the faculty member ((1) attending progress note, (2) attending addendum, (3) attending co-signature with attestation).

Consultations that are requested after 5:00 p.m. and on weekends are seen, if necessary, by the on-call resident (PGY-2 and PGY-3) and supervision is provided by the on-call attending faculty (1, direct; or 2a or 2b, indirect).

For after-hours and weekend consultation requests, the on-call resident is expected to make the appropriate decision regarding the urgency of the consult, i.e., bedside or as scheduled clinic outpatient visit. If the consultation can safely wait until the following morning, the on-call resident can communicate this to the consult resident. Senior residents and/or faculty may assist the junior resident in this decision-making process. If a particular outpatient clinic is appropriate for scheduling, then the attending faculty member staffing that clinic should provide approval.

To facilitate smooth consultative services, it is Department policy that a member of the service requesting the consultation should communicate directly with the on-call resident; the Department discourages clerical or technical staff from handling consults being called to Ophthalmology as this reduces the ability to prioritize consultations. Also, the name of the faculty member, rather than the resident, requesting the consultation is required.

When a consultation with another service is requested by Ophthalmology, it is the responsibility of the Ophthalmology on-call resident to communicate directly with a member of the requested service to facilitate the transfer of information and make arrangements for the consultation. The resident must also update the electronic consult order in EPIC.

SAVAHCS

At SAVAHCS, during regular hours, if an in-patient consultation is required, an effort will be made to transport the patient to the eye clinic for an examination by the senior resident in the clinic. Direct supervision (1) will be provided by the attending faculty member staffing the clinic. If transportation is not possible, the resident on the consult service will be requested to evaluate the patient at the bedside; the MOD attending faculty (medical officer of the day) in the clinic (2a, indirect supervision immediately available) will follow with his/her evaluation of the patient within 24 hours, and will provide an independent note or addendum to the resident's note.

If the ED has a need for a patient consultation during regular hours between 7:30 a.m. and 4:00 p.m., the patient will be referred to the Optometric Section clinic. After the evaluation, if indicated, the patient will be referred to the Ophthalmology Section and the senior resident in the clinic will evaluate the patient with direct (1) or indirect (2a) supervision by the attending faculty member staffing the clinic. Patients referred by the ED to the eye clinic after 4:00 p.m. will be seen by the senior resident in the eye clinic, again with either direct (1) or indirect (2a) supervision.

Patients seen in the ED after-hours, with a need for ophthalmic consultation, will be seen by the first-call resident in the ED; supervision will be provided by the ED attending faculty on duty (1 or 2a); and/or the back-up senior resident on-call, and/or the Ophthalmology faculty member on-call (2b), if necessary.

Inpatient Admissions

BUMCT and BUMCS

New patients may be admitted to the hospital from the clinic or ED setting. At times, the resident and the supervising attending will participate together (1, direct supervision) in evaluating the patient and writing admission orders. At other times, the resident will admit the patient and write orders (2a or

2b, indirect supervision, and the supervising attending must examine and evaluate the patient within 24 hours.

Please see table below summarizing supervision policies regarding new patients, continuing inpatient care, consultations (see section above "inpatient consultation" for more detailed information), and discharge.

New Admissions	Attending must see and evaluate the patient within 24 hours.	The attending will review the resident note, attest to the note, and addend as necessary.
Continuing Care	Attending available on as-needed basis.	
Consultations	Attending must see and evaluate the patient within 24 hours.	
Discharge	Resident will complete.	

SAVAHCS

New patients may be admitted to the hospital from the clinic or ED setting. At times, the resident and the supervising attending will participate together (1, direct supervision) in evaluating the patient and writing admission orders. At other times, the resident will admit the patient and write the orders (2a or 2b, indirect supervision, and the supervising attending must examine and evaluate the patient within 24 hours.

Please see table below summarizing supervision policies regarding new patients, continuing inpatient care, consultations (see section above "inpatient consultations" for more detailed information), and discharge.

New Admissions	Attending must see and evaluate the patient within 24 hours.	An attending note or addendum documenting findings and recommendations regarding the treatment plan within one calendar day of admission (No exceptions for weekends or holidays).
Continuing Care	Attending must be personally involved in ongoing care.	Any of the four types of documentation, at a frequency consistent with the patient's condition and principles of graduated responsibility.
Consultations	Attending physician must supervise all consults performed by residents.	An independent note, addendum to the resident's note, or resident note description of attending involvement. Co-signature by attending alone in not sufficient documentation.
Discharge	Attending must be personally involved in decisions to discharge patient.	Co-signature of the discharge summary is required.

Operating Room (OR)

Direct supervision by the attending supervising physician for ALL surgical procedures performed by the resident in the BUMCT OR, the BUMCT Surgery Center, and the SAVAHCS OR is required. There is no exception to this rule.

BUMCT and Surgery Center OR

- *History and Physical*: H&P (pre-op) may be performed by resident or attending faculty. If done by resident, supervision is either direct (1) or indirect (2a or 2b). If done by resident, attending must confirm findings within 24 hours of surgery (Day of Surgery Attending H&P co-signature). H&P is valid for 30 days.

- *Surgical Consent Form*: May be performed by resident or attending faculty while in clinic (1, direct supervision). In some cases, attending fills out form; resident reviews surgery with patient and obtains patient signature during evaluation by resident in pre-op clinic (2a or 2b, indirect supervision). Surgical consent is valid for 30 days.
- *Pre-operative Note*: Pre-op note obtained by resident and signed electronically by attending the day of surgery (1, direct supervision or 2a, indirect supervision).
- *Brief-operative Note*: Completed by resident and signed electronically by attending faculty (1, direct supervision, or 2a, indirect supervision) within 2 hours of surgery (not necessary if operative note is typed into EPIC within 2 hours)..
- *Operative Note*: Must be completed by resident within 24 hours of surgery (1, direct supervision, or 2a, indirect supervision; signed off electronically by attending faculty.

SAVAHCS

- Patient notes and patient procedure resident notes must be completed the same day of the visit. There are no exceptions.
- *History and Physical (as part of pre-op) by Resident*: Is valid for 30 days; beyond that must be repeated or updated verbally on the phone with a physical exam at bedside.
- *Surgical Consent Form:* Must be completed by resident within 60 days before surgical procedure; beyond that must be redone. Notify in OR consult if the patient is long distance, and then the consent can be done at bedside the morning of surgery.
- *Pre-Operative Note*: Must be completed by resident prior to the surgical procedure the day of surgery.
- *Brief Operative Note:* Must be completed by the resident within 2 hours of the surgical procedure.
- *Operative Note*: Must be completed by the resident with 24 hours of the surgical procedure.

Emergency Department (ED)

<u>BUMCT ED and BUMCS ED</u>

PGY-2 and PGY-3 residents will be on first call (with rare exceptions, for example, when seniors are attending the annual AAO meeting, PGY-3 residents will act in capacity of back-up call for after hours emergencies.) Senior resident (PGY-4) will act as back-up call for the ED. Ophthalmology ED call is "home call" and the Department requirement is that the resident will not be further than 30-minutes distance from the ED. The first call residents will receive extensive supervision by PGY-4 residents and attending faculty on-call (especially PGY-2 residents in the initial six months of their training). PGY-2 residents will be required to travel to the ED for the first 6-months of their residency to examine all patients when a consultation is requested by the ED. They will present all patients to the senior resident on-call to determine the necessity of the senior resident going to the ED to examine the patient +/- the need to present the patient to the attending faculty on-call (depending on the findings some patients will fall within the "must call attending list"; see below). After this 6-month period, the PGY-2 resident (and all PGY-3 residents at beginning of academic year), if deemed competent, will be able to provide consultation by phone, with referral to an outpatient clinic the following day, if appropriate.

A completely equipped eye room is available in both the BUMCT and BUMCS EDs. A comprehensive list of conditions/findings has been compiled and is intended to trigger a "must call" by the first-call resident to either the senior resident or the supervising on-call attending ophthalmologist, or both (see "Must Call List" below). This rule will be strictly enforced and adhered to by junior PGY-2 and PGY-3 residents.

Supervision will be available by the supervising attending in the ED for all residents (PGY-2, PGY-3, PGY-4) at all times (1, direct and 2a, indirect with direct supervision immediately available). Even though the attending ED is immediately available, if procedures are necessary, certain procedures may require (1) direct supervision by the attending ophthalmologist on-call, or residents may proceed with performance of procedures with indirect supervision by the attending ophthalmologist on-call (2b, indirect with direct supervision immediately available by phone/electronically) if proper training and "sign-off" have been attained (see lists under "Supervision of Procedures other than OR"). Oversight supervision (3) (e.g., supervising attending reviews care the following morning) by the attending faculty member on-call for the first-call and/or senior resident is always a possibility depending upon the condition and experience of the residents on-call. Supervision policies followed will depend upon situation specific considerations and the experience of the resident on-call.

The first call and back-up residents will also cover inpatient consultations at BUMCT and BUMCS after-hours for the resident on the consult service (see section defining responsibilities of consult resident). A portable slit lamp is available in a storage room adjacent to the ICU at BUMCT. There are two indirect ophthalmoscopes: (1) in the cabinet in the ER, and (2) underneath the desk in the resident work area of the ED. At BUMCS, a portable slit lamp is available in the fast track area of the ED, and an indirect ophthalmoscope is available from the nursing station.

A call list of supervising ophthalmology attending faculty will be maintained and easily accessible on-line. Duty hours will be strictly adhered to by the resident on-call.

If after-hours examinations are scheduled at the Alvernon Clinic (follow-up urgent care BUMCT and BUMCS), patients must be seen at by at least two residents or a resident and faculty member. **Residents are not allowed to see patients alone in the Alvernon Clinic after-hours.**

SAVAHCS ED

An eye call room is available in the ED, and is fully equipped for ocular examinations. ED patients will **not** be taken for examination to the eye clinic in building 80 after-hours. The only exception will be for the use of equipment that is not available in the ED, e.g., ultrasonography unit. If this is necessary, security will be notified by the resident and security will need to escort resident and patient to the eye clinic and standby during the entire exam.

ED supervision policies defined above apply to SAVAHCS ED. An attending ED physician will be on the premises at all times to offer direct (1) or indirect (2a) supervision. The ophthalmologist attending on-call will offer either direct (1), indirect (2a or 2b), or oversight (3) supervision depending upon the situation specific conditions and the experience of the residents on-call.

If an inpatient consultation is requested of the resident on-call, equipment, including a hand-held slit lamp must be transported to the bedside.

The call list of supervising attending faculty will be comprised of SAVAHCS attending staff, not BUMC attending staff; the call list of supervising attending faculty will be maintained and easily accessible on-line, if necessary. Duty hours will be strictly adhered to by the resident on-call.

Affiliated Preceptor Teaching Sites (Community Rotations)

All residents have periodic rotations to several affiliated teaching sites (five) during their PGY-2 and PGY-3 years. A primary preceptor at each teaching site has a faculty appointment with the Department of Ophthalmology at the University of Arizona. The primary preceptor at each site will act as the supervising attending with two of the five sites having physician colleagues of the primary

preceptor occasionally acting as the supervising physician. Categories of supervision at these teaching sites will be (1) direct or (2a) indirect (supervision immediately available). These categories will apply to all aspects of the teaching experience, e.g., clinical examinations, clinic procedures, and procedures in ASCs or hospital operating rooms. The residents on these community rotations will primarily act as an observer or assistant during performance of the clinic or surgical procedures (they will, rarely, act as the primary surgeon).

Supervision of Procedures other than OR
(In general, performed in ED or clinic)

Requires DIRECT Supervision (attending in the room)

- Lid or facial lacerations involving the lacrimal system
- Any operating room procedure
- Laser to the macula
- Laser to peripheral retina (eg retina tear)

Requires at least ONE DIRECTLY observed procedure + attending sign off before indirect supervision (attending available by phone). May also be observed by a resident that has been signed off for the procedure but sign off must be by an attending.

- Repair of eyelid or facial lacerations SIMPLE (not involving the eyelid margin and no significant disruption of the normal tissue architecture) (may also be supervised/staffed by an ED attending, but sign off must be by attending)
- Insertion and removal of punctal plugs
- Punctal cautery
- Tarsorrhaphy
- Removal of ocular sutures
- Lateral canthotomy and cantholysis (at the attending's discretion and on a case by case basis, this may be performed emergently without the attending's presence)
- Removal conjunctival/corneal foreign body
- Corneal or conjunctival cultures
- Excision of simple eyelid mass
- Incision and drainage of lid abscess
- Anterior segment OCT
- Intralesional injection of Kenalog
- Anterior chamber paracentesis (at the attending's discretion and on a case by case basis, this may be performed emergently without the attending's presence)

Requires at least TWO DIRECTLY observed procedures + attending sign off before indirect supervision (attending available by phone). May be observed by another resident who is signed off for the procedure but signing off is by attending only.

- Repair of eyelid or facial lacerations COMPLEX (significant disruption of normal architecture or involvement of the margin).
- Chalazion removal
- Adhesive repair of corneal perforations
- Retrobulbar or peribulbar anesthesia
- Laser suture lysis
- Subconjunctival or subtenons injections
- YAG laser capsulotomy
- Laser peripheral iridotomy
- Laser peripheral iridoplasty

- Anterior chamber and vitreous tap/inject
- Corneal scraping

Requires at least TWO DIRECTLY observed procedures + Sign off before Indirect Supervision (attending available onsite)

- Intraocular injections
- Laser trabeculoplasty
- Vitreous tap and inject

The following procedures may be performed with Indirect Supervision (attending available by phone) without prior observation

- Administer topical and oral medications, and diagnostic eye drops
- Removal of skin sutures
- Insertion of bandage or other contact lenses
- Removal or insertion of ocular prostheses
- IV injection of fluorescein for fluorescein angiography
- Administer local injection anesthesia other than as listed above

Transition of Care (Hand-offs)

The goals for transition of care are to:

- Minimize the number of transitions in patient care.
- Ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- Ensure that residents are competent in communicating with team members in the hand-over process.
- Ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Protocol

Prior to or during the transition of patient responsibilities from one physician to another physician, there will be a person-to-person communication regarding the following:

- Any updates the transferring team made in the electronic transfer tool records/consult list.
- Any lab, radiology, or other tests that require follow-up, and the conditional plans for the results.
- Any pertinent recent or upcoming communication between ophthalmology and other services or patients and patient's family.
- Any foreseeable problems and conditional plans for each.
- Any patients currently on the ophthalmology inpatient service.

The transferring team will review the records in the electronic transfer tool/consult list before transferring care to the next team and make a note of the issues to be addressed in the upcoming personal communications with the receiving team.

The receiving team will also review the records in the electronic transfer tool/consult list before accepting care and make notes of the issues to be addressed in the upcoming personal communications with the transferring team.

Alternatively, the transferring and receiving physicians may review the records in the electronic transfer tool/consult list together interacting to clarify the duties and foreseeable problems which will be transferred.

Informed means of communicating specific types of information:

- Consultations that have not been staffed: verbal + [electronic tool].
- Patients to be seen in red eye clinic: verbal + [electronic medical record note clearly stating at minimum the information that is required or handwritten notes with the same minimum information requirement].

Baseline Information: If a condition exists in which acute change from a baseline status is of importance, then the receiving team MUST:

- Best: One of the receiving team members will see the condition prior to the transfer + verbally discuss any uncertainties with a transferring team member.
- Acceptable (when best is not possible): The transferring team will provide a detailed drawing/ description which is labeled + discussion with a receiving team member.

or

- The transferring team will provide digital photographs which can be accessed by the receiving team in a HIPAA compliant manner + discussion with a receiving team member.

Requirements for transferring a consult/ED/red eye clinic patient from the hospital to an outpatient setting for follow-up is as follows:

- Address and phone number of follow-up clinic and directions, if required
- An appointment time, date, and the attending physician's name

or

- If the hours of clinic operation make the above impossible, then the patient name, MRN, contact number, service or physician to be seen, and the timeframe for follow-up should be given to Yvonne Borror (694-1478) or Ruben Bustamante (694-1497) at the Alvernon clinic on the next business day for scheduling.
- There will be a regular Monday clinic for the purpose of follow-up of weekend patients. The call team may establish a list of patients and follow-up times to be given to the clinic before 8:00 a.m. Monday.

Must Call Attending List

1 = Must call attending now
2 = Must call senior now
3 = Can wait < 8 hours to call attending who is seeing the patient in clinic or to be staffed next day if inpatient
4 = Can wait > 8-16 hours until being seen by an attending in clinic if outpatient or staffed as an inpatient
5 = Have patient call for appointment as instructed or staffed within 24 hours if inpatient

Trauma/General

4	Admission	2,1	Ruptured globe/suspected rupture
2	Leaking surgical incision	2	Sudden loss of vision, unknown cause
4	Hyphema IOP<29, no corneal blood staining	2,1	Acute blind painful eye
2	Hyphema treated IOP >29 or corneal blood staining		
4	Traumatic optic neuropathy		
2	Orbital hemorrhage with APD or decreased vision or treated IOP > 25		
4	Orbital blow out Fx with intact globe, symmetric eye pressures (3 mmHg) and no posterior segment pathology except edema		

Cornea

4	Probable infectious keratitis	4	Corneal graft rejection
2	Partial thickness cornea laceration		
4	Corneal foreign body outside central 5 mm	4	Cornea FB central 5 mm

***Cornea** (continued)*

3 Chemical exposure high pH with IOP asymmetrically elevated (>5 mmHg) or loss of limbal vasculature >180 degrees or pH > 8 for 30 minutes

4 Chemical exposure, red eye, symmetric lOPs, pH < 8 on arrival

2,3 LASIX flap dislocation

4 LASIX subflap infiltrates

4 Neurotrophic corneal Ulcer

4 HSV keratitis

4 HSV uveitis, corneal edema

4 HZ uveitis, lid involvement

Lid/Lacrimal System

2 Full thickness lid laceration through margin

4 Dacryocystitis

4 Lid lac with no margin or lacrimal system involvement simple

2 Lac to lacrimal system

4 Preseptal cellulitis

Orbit

3 Postseptal cellulitis

4 Orbital tumor/mass

4 Thyroid eye disease with optic nerve involvement

4 Lacrimal gland mass

Pediatric Emergencies

4 Leukocoria child

4 New onset tropia child

3 Hyperacute conjunctivitis

Glaucoma

2 Uncontrollable IOP with pain, treated IOP >35

1,2 Uncontrollable NVG (pain & IOP >35)

3 Acute angle closure, treated IOP <30 and pain much better

2,1 Acute angle closure unable to lower IOP <35 or continued pain

3 Uncontrollable Uveitis (IOP >35)

2,1 Blebitis

3 Lens induced glaucoma uncontrolled

3 Postop IOP spike uncont

Neuro

4 Amaurosis fugax

2 Optic nerve edema (R/O GCA)

4 Isolated 4-6th nerve palsy

4 Unknown new onset tropia or movement disorder

3 Pupil sparing 3rd nerve palsy

2,1 Pupil involving 3rd

3 Recent onset optic neuritis

4 Ischemic optic neuropathy lab normal, no GCA sx

3 cavernous sinus or orbital apex syndrome

3 Infiltrative optic neuropathy

2,1 Ischemic optic neuropathy lab? or + or sx + for GCA

Retina

2,1 Peripheral retina break

2,1 Retinal detachment – call retina attending on-call

5 CSR > 45 years

2,4,5 CSR young patient

3 New loss of vision

2,1 Vitreous heme (if B-scan shows pathology other than vit heme)

2,1 Choroidal mass

3 Recent CRAO

4 Recent LOV with presumed CNV

2,1 Exogenous endoph

3 Recent CVO BVO, BRAO

4 Acute PVD with heme

2,1 Presumed Endogenous endophthalmitis (call retina on-call)

2,1 Acute posterior segment inflammation

2,1 Acute retinal necrosis

4 Acute flare of pars planitis

4 VKH, sympathetic oph

4 Acute sarcoidosis

7. DUTY HOURS AND FATIGUE

A. **Duty Hours**

Duty hours are defined as all clinical and academic activities related to the program, i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as lectures, rounds, and conferences (AAO, ARVO, review course). It also includes "Sight Savers," hospital committee meetings, and on-site resident interview time. Duty hours do not include reading studying, and preparation time spent away from the duty site.

Residents are expected to be familiar with the duty hours policy (outlined below) and avoid violating the policy. Residents **MUST** notify the Chief Resident or Program Director for reassignment if necessary to avoid a duty hours violation.

(1) Duty hours are limited to 80 hours per week averaged over a four-week period, inclusive of all in-house call activity and moonlighting.

(2) Residents are provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. Vacation or leave days are not counted in the average. Averaging must occur by rotation.

(3) Resident should have 10 hours free of duty, and must have 8 hours between scheduled duty periods.

On-Call Activities

Continuous on-site duty must not exceed 24 consecutive hours. Residents may remain on duty for up to FOUR additional hours to continue to provide care to a single patient. Justifications require continuity for severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under these circumstances, the resident must hand over the care of all other patients to the team assuming care and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the Program Director. The resident must complete the form online. The Program Director will track these episodes and report them to the Graduate Medical Education Committee (GMEC) on a quarterly basis.

At-Home Call (or Pager Call)

Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty when averaged over four weeks. At-home call must not be so frequent or taxing to preclude rest or reasonable personal time for each resident.

WHAT COUNTS TOWARD DUTY HOURS

- All clinical activities
- All scheduled activities, such as lectures and rounds
- Hours spent in the hospital while on home call
- Conference hours, such as AAO, ARVO, and review course
- Hospital committee meetings, such as GMEC meetings and resident interviews
- Internal moonlighting, such as Sight Savers
- External moonlighting

WHAT DOES NOT COUNT

- Reading, studying and academic preparation time spent away from the hospital ambulatory site
- Voluntarily staying at the library or hospital when no additional duties are planned over the next ≥2 hours
- Travel time to/from conferences

HOME CALL

- Hours spent in the hospital when on at-home call count toward the 80-hour weekly limit but do not apply to the 8-10 hour "off duty" period which is reserved for in-house call.
- Frequency of at-home call is not subject to every third night or the 24+4 limit.

Exception to Maximum Duty Period Length

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. If this occurs, the Exception to Maximum Duty Period Length form (see Forms, page 40) must be completed and submitted to the program coordinator within 48 hours.

B. **Fatigue**

All faculty and residents will be educated to recognize the signs of fatigue and sleep deprivation in themselves and others, and must apply these policies to prevent and counteract its potential negative effect on patient care and learning. The GMEC requires that all residents and faculty complete the "Sleep, Alertness, and Fatigue Education in Residency" (SAFER) program yearly. This educational module, prepared by the SAFER Task Force from the American Academy of Sleep Medicine, is designed to educate on the effects of sleep deprivation. This module is presented during orientation, as well as yearly to all faculty and established residents. It is also available in the public resident files. The program will maintain a record of all who have successfully completed the training module.

If a resident has signs of fatigue or sleep deprivation after extended duty, the resident is to take a strategic nap of 30 minutes, as suggested by the SAFER program, or delay participation in the next morning's activities up to two hours. If the resident's duty on the subsequent morning is at SAVAHCS, then the resident must contact the site director or chief resident either that morning or by 8:00 a.m. the morning of the clinic. The patients in that resident's clinic will be distributed amongst the other residents and faculty clinics for the first two hours. The duration of rest may be extended as needed by mutual consent of the resident and the site director or chief resident. The decision for needed rest can be made by either the resident or the faculty member and must be respected.

If a resident is scheduled to be at any of the other sites, including SAVAHCS, then the corresponding faculty of that site must be contacted directly or through the chief resident, program coordinator, or program director by the start of that clinic.

If a resident is on call and determines that fatigue and sleep deprivation from continued responsibility will compromise care, then the back-up resident and then the faculty member will assume call until which time the primary resident has recovered adequately. A two-hour period is the usual time, but this may be modified accordingly.

8. **ON CALL DUTIES AND SCHEDULE OF ASSIGNMENTS**

The resident on-call policy provides for appropriate coverage for providing the care of ophthalmologic emergencies at the BUMCT, BUMCS, and SAVAHCS. The usual policy is for two residents to be assigned at all times: a junior resident on first call and a senior resident on back-up, or second call. A faculty member is designated for on-call at BUMCT and BUMCS, and a different faculty member is designated on-call for SAVAHCS.

The first call resident may take call from home, or any other location accessible by the pager, provided the resident is never more than a half an hour away from any one of the above hospitals under ordinary travel conditions. Typically, first call coverage is provided by a given resident, one week night in eight and one weekend in eight. The call schedule must be agreed upon by the first and second year residents and MUST comply with duty hours standards. The Chief Resident is responsible for scheduling call and giving the schedule to the program coordinator in a timely manner (by July 15 for August through December, and December 15 for January through June). The program coordinator MUST be notified of any changes in the call schedule.

Second call coverage is usually provided by a third year resident, although, at times, a second year resident may provide back-up to a first year resident on an as-needed basis. The second call coverage is routinely performed from home approximately every fourth weekend. No more than two consecutive weekend calls are allowed; and no more than two weekend calls in a four-week period are allowed. The schedule MUST comply with duty hours standards. Again, call may be taken from home, or any other location accessible by the pager, provided the resident is never more than a half an hour away from any one of the above hospitals.

Faculty take call from home on a rotation as well, with the faculty call schedule being coordinated by the program coordinator. **A schedule of faculty "on-call" will be maintained at all times**. The schedule includes the on-call faculty member for BUMCT and BUMCS, as well as the on-call faculty member for SAVAHCS.

Whenever a resident receives an emergency call, he/she must respond appropriately. "Appropriately" usually requires the resident to see the patient; upon occasion, the inquiring service may merely be requesting guidance. If there is any chance that an injury/illness is sight or life-threatening, even if not recognized as such by the calling service, or if the ophthalmology resident is in doubt, the ophthalmology resident **MUST** see the patient. The PGY-2 residents, for the first six months of residency, **MUST** travel to the ED and see all patients if requested by the ED physician.

Major vision or life-threatening situations must **ALWAYS** include the participation of faculty. **No resident may admit or take a patient to surgery without faculty participation**. A copy of the patient's medical record must be provided to faculty as soon as is practical. Patients seen by residents without faculty involvement **MAY** be scheduled for follow-up at the appropriate interval with a faculty member.

After regular hours (5:00 p.m. to 7:00 a.m.), if any potential surgical case is identified by the first-call resident (PGY-2 or PGY-3), the senior back-up call resident **MUST** personally examine the patient to verify that surgery is necessary (exceptions are allowed for obvious trauma with photodocumentation reviewed electronically by senior and/or faculty). The faculty on-call is then notified by the senior on-call resident. If the faculty agrees with the management plan, the OR is booked for the surgery (in rare cases, e.g., when there is a slight delay in contacting the on-call faculty, the senior may proceed to book the OR to expedite the process). The faculty **MUST** communicate his/her desire to see the patient in the clinic, ED, pre-op holding area, etc. **BEFORE** wheeling the patient into the OR suite. The senior back-up call resident, in the process of examining the patient, will review the H&P with the first-call resident, review imaging available (MRI, CT), B-scan (should be printed), lab data, and other available data prior to surgery, and be prepared to review and discuss this material with the attending upon their arrival.

The first-call resident is responsible for staying "in-house" until the case starts. The purpose for this is for the first-call resident to observe and participate in the admitting process, complete the H&P, learn how to manage pre-operative issues, write orders, etc. (If issues, such as duty violations, etc. prevent this responsibility, the senior resident will resume these duties.) If there is considerable delay in the start time, the faculty may allow the first-call resident to return home until the case starts.

After hours, the senior back-up call resident will be expected to be the primary surgeon or assistant as deemed appropriate by the attending. The first-call resident will stay in the OR to observe the surgery. The attending surgeon will have the prerogative to alter this policy depending on the circumstances, e.g., duty hour issues, case more appropriate for first-call resident as primary surgeon or assistant, etc.

The "on call" resident will receive all requests for consultations from BUMCT and BUMCS from 5:00 p.m. until 7:00 a.m. the following day and on weekends and holidays; all consultations will be phoned in by another housestaff officer or faculty member.

A resident going "off call" remains responsible for the patient's follow-up care unless the resident makes another arrangement. Residents rotating off clinical services must notify the resident going "on call" of all patients for whom he/she is responsible. This is vital for the maintenance of continuity of care.

While on call, residents will provide emergency and consultative services in a timely fashion and within the limits of individual competence.

First year residents must consult with the second or third year resident "on-call" for all patient encounters prior to initiating care until adequate experience is obtained.

There is an on-call examination room available in the Emergency Department of BUMCT, BUMCS, and SAVAHCS. Residents must not transport patients to SAVAHCS Eye Clinic unless escorted by the security guard. All BUMCT and BUMCS patients seen for follow-up urgent care on the weekends must be seen by a resident and faculty in the Alvernon clinic. **Residents NEVER see patients alone in the clinic after hours**.

There is an on-call fully equipped examination room available in the ED of BUMCT and BUMCS. A portable slit lamp is available in a storage room adjacent to the ICU at BUMCT. There are two indirect ophthalmoscopes: (1) in the cabinet in the ER, and (2) underneath the desk in the resident work area of the ED. At BUMCS, a portable slit lamp is available in the fast track area of the ED, and an indirect ophthalmoscope is available from the nursing station. In addition, a portable slit lamp with attached indirect ophthalmoscope is housed in a storage room in the surgical ICU at BUMCS for use in examining inpatients who cannot be transferred to the ED. Patients seen for follow-up urgent care in the Alvernon Clinic after hours and on weekends must be seen by at least two residents or a resident/faculty attending.

A SAVAHCS patient must not be seen at Alvernon and vice versa unless prior authorization is obtained.

Patients Seen Through the BUMCT Emergency Room

Many patients present with ocular trauma to the emergency room. Some do not need to be seen by the Ophthalmology resident on call, but the resident is notified about the need for follow-up. Under these circumstances, when the resident receives the call from the Emergency Room, he/she should obtain the following information:

(1) Patient's name
(2) Patient's medical record number
(3) Patient's date of birth

The resident should inform the patient to obtain proper authorization for a follow-up visit. After the resident gets off the phone with the Emergency Room, he/she should call Yvonne Borror (694-1478) or Ruben Bustamante (694-1497) and leave a message on the answering machine containing the above information. The Front Desk staff should be provided with the patient's name, medical record number, and date of birth. When the Front Desk opens, the staff will know that patients should be coming in during the day, and will assign them times as available in attending clinics. The staff will then attempt to call the patient with the appointment time, or when the patient calls, he/she will be notified regarding the time. The resident should also record all off-hours visits with patients.

Call Rooms

- BUMCT: The call room at BUMCT is room 5606. The outside entry code and the inside entry code for room 2 is 0876.

- BUMCS: There are two call rooms available at BUMCS (shared with Psychiatry residents).

Ophthalmology	Room 210	Door Code 9139
Psychiatry	Room 557	Code 5312

  Psychiatry residents will stay in the psychiatry ward (room 557) unless the room is full or a gender issue arises, in which case they will spill over into call room 510. Ophthalmology resident will use call room 210 if the same sex is present, or proceed to call room 557. Note that the top bunk in the call rooms is not made, but linens should be available.

- SAVAHCS: There is a shared call room available at SAVAHCS. This room is adjacent to the Emergency Department. The Administrative Officer of the Day (AOD) in the Emergency Department can provide access into the room. The Surgical Services Office can also provide instructions on access.

9. CONSULTATION POLICY

See Inpatient Consultation under Supervision.

10. **RESIDENT SURGICAL EXPERIENCE**

Residents may be the primary surgeons in cases that are within the scope of their training and experience. At SAVAHCS, all of the surgery performed by residents is subject to approval by faculty. All resident surgery must be staffed by faculty. Surgical patients at BUMCT may arise from on-call consults or from faculty clinics. Surgical patients from outpatient clinics must be approved and staffed by faculty; all cases will be evaluated for appropriateness of surgery and ability of the resident to serve as the primary surgeon. Residents will be assigned to assist faculty during surgery on specific days.

Monocular patients are not typically considered candidates for intraocular surgery by residents, and these surgical cases will usually be performed by faculty. In addition, other complicated surgical cases, as determined by the faculty, will be assigned to faculty for their surgery.

Phacoemulsification is considered to be an advanced surgical procedure that requires prior demonstrated proficiency by the surgeon. Prior to beginning phacoemulsification surgery as primary surgeon, the resident must carefully adhere to the guidelines regarding wet/dry lab experience and surgical logs stated under total quality improvement (Section 11.B, page 30), as well as complete required reading and video viewing.

Resident Surgical Patients (SAVAHCS)

- All patients should be given pre-op and post-op instructions on cataract surgery at the time of approval of their surgery.

- All pre-operative laboratory data should be checked one week prior to the surgical date to check for any possible contraindications to surgery. The routine labs expected are an EKG within six months, and CBC and electrolytes including glucose within one month. If the patient has other medical conditions that may affect their ability to lie flat, remain still, or has severe cardiac or pulmonary disease, anesthesia should be contacted to check for recommendations on additional work-up or specific instructions.

- All patients are contacted on the day prior to surgery by PAT for instructions and to answer any patient questions.

- 96 hours prior to the day of surgery, confirmation of an updated H&P, consent and any additional pre-op clearance, as well as clearance from attending surgeon, should be noted in the surgical OR consult, e.g.: Case reviewed and discussed with Dr. X. H&P, consent is current. Patient cleared for surgery.

Below are the operative minimum numbers per ACGME.

Ophthalmology Resident Operative Minimum Numbers

Procedure	Minimum Requirement (Surgeon)
Cataract - Total (S)	86
Laser Surgery - YAG Capsulotomy (S)	5
Laser Surgery - Laser Trabeculoplasty (S)	5
Laser Surgery - Laser Iridotomy (S)	4
Laser Surgery - Panretinal Laser Photocoagulation (S)	10
Corneal Surgery	
Keratoplasty (S+A)	5
Pterygium/Conjunctival and Other Cornea (S)	3
Keratorefractive Surgery - Total (S+A)	6
Strabismus - Total (S)	10
Glaucoma - Filtering/Shunting Procedures (S)	5
Retinal Vitreous - Total (S+A)	10
Intravitreal Injection (S)	10
Oculoplastic and Orbit - Total (S)	28
Oculoplastic and Orbit - Eyelid Laceration (S)	3
Oculoplastic and Orbit - Chalalzia Excision (S)	3
Oculoplastic and Orbital - Ptosis/Blepharoplasty (S)	3
Globe Trauma - Total (S)	4

S = Surgeon Procedures Only
S+A = Surgeon and Assistant Procedures

Residents are expected to input surgeries on which they are the first assistant as well as cases on which they are the primary surgeon. This is necessary for the program to show a progressive graduated and broad surgical experience.

ACGME Definition of a Surgeon

Basic Principle: To be recorded as the surgeon, a resident must be present for **all** of the critical portions, and must perform the **majority** of the critical portions of the procedure under appropriate faculty supervision. Involvement in the preoperative assessment and the postoperative management of that patient is an important element of that participation. Only the first assistant (not the second, third, etc.) may record a procedure as assistant. A resident may only record a case as assistant if the resident is first assistant to: (1) a faculty member performing the procedure, or, (2) another resident performing the procedure under faculty supervision.

Clarifications

(1) If a resident completes **one** side of a bilateral procedure, the resident can count that as one case, surgeon. If a resident completes **both** sides of a bilateral procedure, this still counts as one case, surgeon. If two residents **each do one** side of a bilateral procedure, each resident can record the procedure as the surgeon, provided that each fulfills the stated criteria for performance as surgeon on one side.

Example: If a resident performs a bilateral blepharoplasty, then the resident counts it as one case as surgeon. If, however, one resident does one side of the blepharoplasty and the other resident performs the procedure on the other side, each resident may record the procedure as a surgeon case.

(2) If a resident completes an operation which involves multiple procedures, the resident may record all the procedures as separate cases, provided that the resident performs the majority of the critical portions of the procedures. However, if the multiple procedures all fall within the same subspecialty category (e.g., cataract, cornea, strabismus, glaucoma, retina/vitreous, oculoplastics/orbit, globe trauma), then only one case may be recorded.

Example: A resident performs a combined procedure involving trabeculectomy and cataract extraction. The resident may record both procedures as surgeon cases.

Example: A resident performs bilateral medial rectus muscle recessions and anterior transposition of the right superior oblique muscle on a patient. The resident may record only one procedure as surgeon.

Example: A resident performs a scleral buckle procedure combined with pars plana vitrectomy. The resident may record only one procedure as surgeon.

Example: A resident performs bilateral blepharoplasty combined with bilateral ptosis repair. The resident may record only one procedure as surgeon.

(3) In an operation which involves multiple procedures, more than one resident may be recorded as the surgeon, provided that the resident perform the majority of the critical portions of one or more of the procedures.

Example: During planned pars plana vitrectomy combined with phacoemulsification of cataract, one resident performs the pars plana vitrectomy while another resident performs the cataract extraction. Each resident may record the procedure they performed as a surgeon case.

Disclaimer Statement

The stated minimum numbers of listed surgical procedures for ophthalmology residency education reflect the minimum clinical volume of these procedures which is acceptable per resident for program accreditation. Achievement of the minimum number of listed procedures is not tantamount to achievement of competence of an individual resident in a particular listed procedure. A resident may need to perform an additional number of listed procedures before that resident can be deemed competent in each procedure by the program director. Moreover, the listed procedures represent only a fraction of the total operative experience of a resident within the designated program length. The intent is to establish a minimum number of listed procedures for accreditation purposes, without detracting from the latitude that the program director must have to blend the entire educational operative experience for each resident, taking into account each resident's particular abilities.

This requirement does not supplant the requirement that, upon the resident's completion of the program, the program director should verify that the resident has demonstrated sufficient professional ability to practice competently and independently.

11. QUALITY ASSURANCE POLICY

A. QIPS Conference

QIPS conferences are held on a monthly basis, in a closed session limited to members of the Department of Ophthalmology. The goals of the QIPS conference are three-fold: (1) to discuss complications which have arisen during the care of patients in a free and open manner so that all may benefit from this experience without having to directly experience it themselves; (2) to provide a mechanism for monitoring the occurrence of complications, the rate of complications, and the need for remediation or modification of surgical privileges; and (3) to monitor and assess total quality improvement on an individual resident basis.

B. Total Quality Improvement

It is critical and imperative for residents to participate in a total quality management program for advancement of their surgical skills. This program has several requirements as enumerated below.

Wet/Dry Lab Experience

(1) Pig eyes will be utilized for wet labs (Alvernon wet lab facility only); artificial eyes utilized in Alvernon lab, BUMCT Surgery Center, and SAVAHCS OR. To acquire artificial or pig eyes for the Alvernon wet lab, contact the program coordinator; allow 7 to 10 days notice. To acquire artificial eyes at SAVAHCS, contact Krista Rosynski (x6106). (These eyes are to be used only at SAVAHCS; do not transport to Alvernon wet lab or BUMCT Surgery Center.)

(2) Supervision for the wet/dry labs will be provided by (a) resident only, +/- video when possible; (b) senior resident; (c) company representative; or (d) attending (see "table" on the next page).

(3) All wet/dry lab resident sessions **MUST** be electronically logged with information including date, total time of session, location, type of practice, supervision (see administration section for details). The Program Director will review resident progress at the 6-month evaluation session. Incomplete resident wet/dry requirements could delay resident progression to human phaco surgery.

(4) There will be orientation sessions for PGY-2 residents for the AMO Signature Unit and for PGY-3 residents for the Alcon Infiniti Unit (see table for details)

(5) Residents are encouraged to attend extramural phaco courses sponsored by Alcon and Bausch & Lomb (B&L): CORE Alcon Course for PGY-3 residents, CPE Alcon Course for PGY-4 residents, and B&L PGY-3 course (see Program Director for details). Expenses are paid by the sponsor.

(6) A comprehensive intramural phaco course will be sponsored annually by AMO with Dr. William Fishkind as the primary instructor. This will be held in the Alvernon conference room in May or June of each academic year.

Wet/Dry Lab Requirements

	PGY-2	PGY-3	PGY-4
1st Quarter	Lid Lac Wet Lab Canthotomy Paracentesis (Polonski, Alvernon)	Artificial/Pig Eyes x2 each (Attending) Corneal Suturing (Belin, OR9)	Alcon CPE Course/Ft. Worth (or 2nd Qtr) Corneal Suturing (Belin, OR9) (Remedial PRN)
2nd Quarter	Artificial/Pig Eyes x1 each (PGY-4, Alvernon)	CORE Alcon Course (or 3rd Qtr) Artificial/Pig Eyes x2 each (Self, video PRN)	Artificial Eyes x4 (Self, video PRN) (Remedial PRN)
3rd Quarter	Artificial/Pig Eyes x2 each (PGY-4, Alvernon) AMO Signature Demo (Pritchard ± Attending, ASC)	Artificial/Pig Eyes x2 each (Self, video PRN) Pig Eyes x2 Extracap (Attending, Alvernon)	 (Remedial PRN)
4th Quarter	Artificial Eyes x2 (Attending, ASC) SLT Model Eye x1 (Altenbernd, Alvernon) Wet Lab (AMO/Fishkind, Alvernon)	Artificial Eyes x4 each (Attending, ASC or OR 9) Alcon Infiniti Demo (Adam ± Attending, OR 9) Wet Lab (AMO/Fishkind, Alvernon)	Wet Lab (AMO/Fishkind, Alvernon) (Remedial PRN)

(1) # eyes listed are minimum
(2) ( ) = supervision and location
(3) Program Director monitors at 6-month evaluation
(4) No human phacos until requirements completed

Education – Videos and Reading for Cataract Surgery

Residents are required to view surgical videos and read selected book chapters to prepare themselves for cataract surgery. The Program Director will review resident progress at the 6-month evaluations. Incomplete requirements could delay resident progression to human phaco surgery.

REQUIRED EDUCATION VIDEOS FOR CATARACT SURGERY
(https://www.eyetube.net – Cataract)

First and Second Year Residents*

Wound Construction
1. Scleral Incisions (D.M. Colvard)
2. Testing Clear Corneal Incision Integrity (J.A.H.)
3. Corneal Incisions (D.M. Colvard)
4. Making a Square Incision

Capsulorhexis
1. Capsulorhexis (H. Gimbel)

Hydrodissection and Hydrodelineation *(H. Fine)*

Phacoemulsification
1. Basic Divide and Conquer (D.M. Colvard)
2. Using Hydrodissection (David Chang)
3. Managing Flow and Vacuum Levels with Today's Phaco Systems (R. Olson)

*Completion required before advancement to human cataract surgery.

Third Year Residents: Cataract

All of the above, PLUS

Phacoemulsification
1. Toric IOL's
2. Malyugin Ring and Trypan Blue with Small Pupil
3. Complete IFIS Case with Iris Prolapse (Bob Oshner)
4. Horizontal Chop (David Chang)
5. Vertical Chop (David Chang)
6. A Punctured Posterior Capsule (Howard Fine)
7. Malyugin Ring System for Small Pupils (Boris Malyugin)
8. Stop and Chop Technique (Bonnie Henderson)

Capsulorrhexis
1. Completing Surgery with Compromised Rhexis (B. Little)

Irrigation and Aspiration
1. Management of Intraocular Iris Prolapse (G. Hirshfield)
2. Insertion of 3-Piece IOL After Capsular Tear (R. Hoffman)

Video Journal of Cataract and Refractive Surgery
Another excellent source for cataract surgery videos is the "Video Journal of Cataract and Refractive Surgery." Dr. Robert H. Osher is the editor of this video journal and he is a leader in cataract surgery innovations; he enlists some of the best cataract surgeons in the world in making

these videos, which cover surgical complications and difficult cases. If you want to review instructions on how to place a tension ring, deal with a dropped nucleus or sculpt a very dense nucleus, this is an excellent source. The website is as follows: www.vjcrs.com and the passkey is 2389.

REQUIRED AND RECOMMENDED READING

Required Reading

1. Steinert RG, ed. *Cataract Surgery*, 3rd ed. Saunders, 2010. (Available online through Arizona Health Sciences Library, www.ahsl.arizona.edu.)
2. Chang DF. *Phaco Chop and Advanced Phaco Techniques: Strategies for Complicated Cataracts*, 2nd ed. Slack Inc., 2013.

All Residents

Cataract Surgery: For a one-month rotation, the following reading schedule is recommended:

Week 1	Chapters 1-7, 12, 13, 16-18
Week 2	Chapters 8-11, 14
Week 3	Chapters 17-19, 21, 24-26, 29, 30, 34
Week 4	Chapters 38-40, 44-49, 54-55

Senior Residents Only

Operating senior residents should have read the following by deadline dates below (*Phaco Chop* can be checked out by the program coordinator.)

Reading Deadline: July 30

Chapter 16	Capsulorrhexis: Sizing Objectives and Pearls
Chapter 17	Conquering Capsulorrhexis Complications
Chapter 18	Pearls for Hydrodissection and Hydrodelineation
Chapter 27	Strategies for Managing Posterior Capsular Rupture
Chapter 30	Posterior Capsule Rupture and Vitreous Loss: Advanced Approaches

Reading Deadline: December 31

Chapter 1	Why Learning Chopping
Chapter 2	Horizontal Chopping: Principles and Pearls
Chapter 3	Vertical Chopping: Principles and Pearls
Chapter 4	Comparing and Integrating Horizontal and Vertical Chopping
Chapter 5	Transitioning to Phaco Chop: Pearls and Pitfalls
Chapter 8	Understanding the Phacodynamics of Chopping
Chapter 9	Optimizing Machine Settings for Chopping Techniques
Chapter 10	Optimizing the Alcon Infiniti for Chopping
Chapters 25-30	Complicated Cataract Surgeries (*Cataract Surgery*; online)

Can be completed over a one-month period. A short, multiple-choice exam will be given. A passing score on the test is required prior to starting cataract surgery at the VA. Other residents will be tested at the end of their anterior segment and/or cornea rotations based on attending preference.

Patient Surgery

(1) All residents will serve as a surgical assistant on a subspecialty defined, specified number of surgical procedures before primary surgery of a specific procedure can be done.

(2) Pre-operative evaluation of cases scheduled as primary surgical cases must be approved by faculty for all primary surgical cases. In addition, the pre-operative evaluation for the first three primary surgical cases must be done with faculty who will staff the first three primary surgical cases.

Surgical Logs and Evaluation Tool

(1) All residents must maintain their surgical logs and track their rate of surgical complications on the web-based ACGME case log program (mandated by ACGME). **Surgery should be logged within 24 hours of the procedure**. **Failure to have surgical logs up-to-date by the third working day of the month, may result in loss of surgical privileges**. Surgical privileges will be restored as soon as all cases have been entered.

(2) Resident cataract surgery skills will be evaluated by a competency-based surgical tool referred to as the Phacoemulsification Assessment Tool: Resident Improvement Competency Keys. Each PGY-4 resident is required to have at least one of these forms completed, including discussion with the attending surgeon, for each surgical session (i.e., cataract surgical block). Forms should be completed by at least two surgical attendings. The forms will be monitored by the Program Director. If less than average rating scores (<3) are observed by the Program Director, he/she at their discretion, and with input from the attending surgeons, may place the resident in a remedial plan which would involve the resident returning to the wet/dry lab for further practice.

(3) At SAVAHCS, residents are expected to videotape all cataract surgery in which they act as the primary surgeon (using the recording equipment provided with the Leica Operating Microscope). In addition, at least one of the surgical videos must be reviewed and discussed with the attending surgeon for each surgical session (i.e., cataract surgical block). One video every two months (six total) must be submitted to the program coordinator for placement in the resident's portfolio. When possible, surgical videos submitted should be reviewed by at least two attending surgeons to ensure a diversity of surgical experience and to benefit from varied expertise of attending surgeons.

(4) At SAVAHCS, residents will strive to maintain a cataract surgery complication rate of less than 5%. As a general policy, two complications in any 10 consecutive cataract surgeries will result in a remedial plan for that resident. This will be decided upon by the Program Director with input from the attending surgeons. The remedial plan will involve practice in the wet/dry labs with some direct observation by one or more attending cataract surgeons.

C. **Continuous Quality Improvement (CQI)**

Residents are encouraged to participate in the continuous improvement process in the Department of Ophthalmology. One quality improvement project that involves all residents is an individualized surgical plan for tracking surgical complications and continued improvement (Dr. Smith). The Chief Resident, or his designee, should attend the clinical faculty meetings to provide input about the residency program. Semi-annual resident/faculty meetings are held to provide direct input about the program to the Program Director and Department Head. Furthermore, residents review the teaching program electronically on a semi-annual basis. The Program Director will meet with the residents on a monthly basis. In addition, several additional, informal meetings will take place throughout the course of the year at the conclusion of rounds to address specific program issues in a timely fashion. There is also an annual review of the program by a committee consisting of the residents, Program Director, faculty members, and program coordinator.

Residents may bring up issues anonymously. The Chief Resident may bring up issues at faculty meetings, preserving the anonymity of the source.

12. ATTENDANCE POLICY

A. Clinic/Surgery

Clinics begin at 8:00 a.m. and 1:00 p.m. at the Alvernon Clinic and SAVAHCS. Residents are expected to remain at the clinic unless excused by the supervising faculty. Residents are to be present five minutes before the start of each clinic.

The resident is expected to be in the operating room and dressed appropriately before the scheduled start–15 minutes at BUMCT and 30 minutes at SAVAHCS. In addition, residents should perform a check of laboratory and diagnostic tests, review and update the history and physical if necessary, review the informed consent, and review any unusual lens calculations with the attending at least 48 hours in advance of the surgical case. Also, some of the surgical attendings wish to review cases prior to the surgery; others are content to review the surgical cases in the pre-op area the day of surgery. Please consult each surgical attending for their desired policy. The day of surgery, laboratory tests, consent form, surgical site, and lens calculations should be rechecked upon arrival to the operating room. At SAVAHCS, if everything is in order, the resident will proceed to enter a pre-operative note in CPRS, which the attending must review and then enter an addendum that indicates he/she agrees with the resident's findings.

It is BUMCT and SAVAHCS policy that the pre-operative history and physical be completed by a member of the operative team. If the physical was performed by an outside physician, it should be reviewed and cosigned by a member of the surgical team.

B. Conferences

All residents must attend **ALL** scheduled Department conferences unless on vacation, sick leave, or involved in emergency patient care (emergency call or emergency consults).

Residents are required to attend 100% of all lectures except for vacation, SAFER, sick leave, emergency call, or the senior resident who is in surgery at the VA on Friday morning. This attendance must be attested to by the Program Director at the conclusion of the training program. Attendance is documented by the Chief Resident at all conferences and submitted to the program coordinator for permanent recordkeeping. Attendance at all conferences, etc., must be **PROMPT**; tardiness (more than 15 minutes late) must be documented on the attendance sheet, and credit will be given for the amount of time in attendance. Attendance is monitored, and if the resident's attendance rate is ≥95% during the 6-month review period, the resident will receive $100 for their AAO travel fund (or an interview day) (attendance between 90-94% will earn half).

Scheduled educational activities take precedence over all clinical activities; a resident may not be called away from any teaching activity for the delivery of patient care except in the case of an emergency which cannot await the conclusion of that activity.

Rounds are held on Wednesday mornings from 7:00 to 8:30 a.m. Lectures are held on Friday mornings from 7:00 to 11:00 a.m., and other times as scheduled. **Residents are required to submit the title of their rounds presentation to the program coordinator on the Friday prior to the date of their presentation. On the date of the presentation, the residents must save a copy in their electronic portfolio.**

13. LEAVES OF ABSENCE

A. Vacation

(1) Banners grants annual paid allowance of four weeks per year to residents. This time off must be used during each 12-month appointment (July 1 through June 30). If all 20 days are not used, the time **cannot** be carried over to the next year.

(2) Vacation must be taken in non-consecutive blocks of 5 days from Monday through Friday. Exceptions may be made for fellowship or job interviews taken as individual vacation days. Although not encouraged, an exception may be made for a 5-day block outside Monday through Friday (such as Thursday through Wednesday of the following week). Residents will not be assigned to weekend call either immediately before/after their vacation week.

(3) Three residents (one per year) may be on vacation at a given time. Exceptions may be made for third year residents for fellowship/job interviews.

(4) Each resident must take one week during each quarter of the year (July through September, October through December, January through March, April through June). The week that includes Christmas is counted as a week in December. The week that includes New Year's counts as a week in January. Exceptions must be approved by the Program Director.

(5) Vacations scheduled while at SAVAHCS must be discussed and approved by the Section Chief of Ophthalmology and Program Director. Cancellation of VA clinics must be submitted at least 45 days in advance.

(6) Residents must submit all vacation requests to the Chief Resident by July 15 for August through December and November 19 for January through June. Vacation changes may be made with the approval of the Program Director.

(7) ***Priority System***: Chief>Third>Second>First year when selecting weeks of vacation. Conflicts are resolved by the current Chief. The Program Director has final say over all vacation requests.

(8) ***Blackout Periods***

a. No vacation during July.
b. No vacation during the consults rotation.
c. If a resident plans to take vacation during the week prior to or after the OKAP exam (March 23, 2019), he/she still must take the exam at the assigned time.
d. No first or second year vacations during the AAO meeting (October 27-30, 2018) since the third year residents will attend the meeting.
e. No first or third year vacations during the review course (to be determined; usually first week of March).
f. No first or second year vacations during the month of June.
g. No vacation on Residents' Day (June 14, 2019).
h. Third year residents are encouraged to use vacation during the interval between Residents' Day and June 30. Residency ends at the completion of the work day on June 30. **If the resident wishes to leave before June 30, he/she MUST reserve vacation time for that purpose**.
i. A resident may take vacation around resident interviews, but must be present for the interviews (December 14-15, 2018).

j. A senior resident may take vacation the week of mock exams (April 5, 2019) are given, but must participate in the orals.
k. A resident may take vacation the week of the LASIK (August 17, 2018) and Phaco (to be determined; usually in May) wet labs held by Dr. Hunter, but must participate in the wet labs.

(9) Residents who have already taken vacation during a holiday may not take vacation during that time again in the future, until all residents have had the opportunity to choose vacation during that time.

(10) Residents must use vacation to take the USMLE Step 3 examination.

B. **Sick Leave**

Residents are allowed a maximum of ten (10) days per calendar year. Sick leave should be reported to the Chief Resident who will notify the program coordinator. The Chief Resident will be responsible for notifying the attending(s) and appropriate staff connected with the rotation assigned to the sick resident. He/she will make arrangements to cover the sick resident's duties as completely as possible.

If a resident is sick for three consecutive days, the resident must provide a physician's note to return to work. If a note is not provided, the days the resident was out will count as vacation.

C. **Bereavement Leave**

Residents may take up to three paid working days as bereavement leave upon the death of a parent, parent-in-law, brother, sister, spouse, child, grandparent, grandchild, or any other person who is a member of the employee's established household. Up to five paid working days as bereavement leave may be granted to attend or arrange funeral services out-of-state.

For this purpose, a parent is defined as a natural parent, stepparent, adoptive parent or surrogate parent. A child is defined as a natural child, adoptive child, foster child, or stepchild.

D. **Holidays**

Residents have six (6) holidays per year: Independence Day, Labor Day, Thanksgiving, Christmas, New Year's Day, and Memorial Day. Residents who cannot be excused from their duties on a designated holiday will be granted another day off. The resident must notify the program coordinator of the date they will be off in place of the holiday within 10 days of the holiday worked. This "alternate" day must be one entire day.

There are SAVAHCS holidays that are not observed at Banner. On these holidays, such as Columbus Day and President's Day, all residents will be assigned to the Alvernon clinic or academic time (which must be taken by in the Alvernon resident area, or vacation time applies). If a resident is taking the day off and/or is out of town, vacation must be taken.

E. **Academic Time**

Occasionally, residents will have unscheduled time due to the unforeseen need for a faculty member to cancel clinic or surgery. Residents at Alvernon clinic must attempt to contact the faculty member to whom they are assigned to determine if that faculty member has any "duties" they wish the resident to complete (and the Chief Resident should be notified.). If the faculty member cannot be contacted,

the Chief Resident will make the resident assignment. (At least one resident must remain at the Alvernon clinic at all times. At SAVAHCS, a similar protocol will be followed except that the Section Chief should be involved in the decision to assign the resident a duty. Only if cleared by the faculty member and Chief Resident (and Section Chief at SAVAHCS) can the resident be excused from duties and be allowed to spend time in the Alvernon resident area (but must be available by pager). Any unused academic time can be carried over to the next academic year.

F. **Education Time**

Residents are granted five (5) educational days. This time can be used to attend courses, conferences, or studying. Study time must be taken in the Alvernon resident area.

14. RECORDKEEPING

A. Surgical and Clinical Logs

Every resident must maintain a log of all surgery he/she participates in. This log shall be kept in accordance with the definitions of surgeon or assistant as established by ACGME and must include:

(1) Diagnosis
(2) Procedure
(3) Surgeon or Assistant

All surgical information is entered by the resident into an online database (Resident Case Log System) maintained by the ACGME (www.acgme.org).

Under no circumstances are patient names or chart numbers to be included in this log; this protects the patient's confidentiality. Residents should, however, keep operative notes for their own records and information (complications, special management considerations, etc.).

Surgical summaries are made available monthly and at the end of the academic year (June 30) to the Program Director and respective resident. Residents are responsible for checking the accuracy and completeness of the statistics. Surgical summaries are available and discussed with the Program Director at the semi-annual reviews. The resident receives a copy of the final summary upon completion of the program.

Clinical logs are maintained to record the **number of patients** the resident sees each week. The resident should note how many patients are seen by subspecialty clinic, as well as the number of emergency patients. The resident enters the information into an Excel file located in their resident file. The program coordinator prints out quarterly clinical log sheets for each resident.

Maintenance of the surgical and clinical logs is the ultimate responsibility of each resident; it is impossible to assemble the log retrospectively. Timely maintenance of the surgical and clinical logs is monitored by the program; and residents who maintain their logs as required may be eligible to receive funds for their AAO travel fund (or interview time). The surgical log is a requirement for Board eligibility. Surgery should be logged within 24 hours of the procedure. Clinical logs at minimum should be entered on a weekly basis.

A signed copy of the final completed log is provided to the resident upon their completion of the program.

B. **Conference Attendance Log**

The Department maintains current and permanent records of all conferences, lectures, rounds, and journal clubs. This record shall contain all of the following:

(1) Date and time
(2) Number of hours
(3) Topic(s) hour-by-hour
(4) Title of lecture
(5) Lecturer/conference leader
(6) Topic for all rounds presentations and path signouts
(7) Resident attendance
(8) Faculty attendance

Sign-in sheets are provided for all lectures, and each resident in attendance must sign. It is the responsibility of the Chief Resident to obtain the signature of the lecturer and provide the completed and signed sheet to the program coordinator immediately after the lecture. The chief resident is also responsible for ensuring accuracy in attendance, including noting any lateness and reasons for absences.

Patients presented and discussed for a QIPS Conference will be recorded by the faculty member in charge of the QIPS Conference in accordance with the policy of the BUMC Quality Assurance office. QIPS documents are legal documents and any cases to be discussed must be recorded on a special form and submitted to the faculty coordinator.

15. **INCENTIVES**

Residents will earn incentives for completion of documentation and lecture attendance as indicated in the table below. The 1st year residents will earn funds for travel to the AAO meeting during their senior year. The 2nd year residents will earn interview days.

Documentation must be submitted in a timely fashion–on or before the deadline. Residents who are off on the due date are required to submit by the deadline; extensions will not be granted for time off. Documentation for the 6-month review includes all supporting documentation listed on the 6-month semi-annual review checklist (see Forms, page 38). The quarterly reports include completion of the surgical log, clinical log, and duty hours.

Lecture attendance must meet the requirements (≥95% of all lectures). Excused absences will be provided only for vacation, SAFER, sick leave, emergency call, or the senior resident who is in surgery at the VA on Friday morning (as documented by the Chief Resident). The Chief and program coordinator must be informed of these exceptions on the day of the lecture or the absence will not be excused. It is each resident's responsibility to sign the attendance sheet provided for each lecture (blank sheets are available if a sheet is not provided). At the end of each lecture or lecture session, the Chief Resident should provide the sign-in sheet(s) to the program coordinator. Those who attend 90-94% of the lectures will earn $50 (or 0.5 interview day).

Some lectures are recorded so that residents have an opportunity to review missed lectures. However, reviewing the material does not count toward attendance requirements. Any improprieties in the truthful representation of attendance, tardiness, etc. will be viewed as unprofessional conduct and appropriate consequences will ensue.

AAO Travel Funds	1st Year Residents			
	Oct	**Jul-Dec**	**Mar**	**Jan-Jun**
6-Month Review Packet Submitted by Due Date		$100		$100
Lecture Attendance Meets Requirements		$100		$100
Quarterly Reports Submitted by Due Date	$25		$25	

(Maximum is $450. This is in additional to the funds provided by Banner.)

Interview Days	2nd Year Residents			
	Oct	**Jul-Dec**	**Mar**	**Jan-Jun**
6-Month Review Packet Submitted by Due Date		1		1
Lecture Attendance Meets Requirements		1		1
Quarterly Reports Submitted by Due Date	0.5		0.5	

(5 interview days maximum accrual)

6-Month Review Packet = all documentation required to be submitted to complete the packet
Quarterly Reports = surgical and clinical logs

16. FACULTY ADVISOR

Each resident will choose a faculty member (either full-time, part-time, or affiliate/associate "volunteer") to serve as a faculty advisor. The Program Director and Department Head are not eligible to serve as a faculty advisor. The resident should meet **at least twice a year** to keep the advisor apprised of career goals, progress in the residency, and difficulties as they arise. This advisor will serve as the resident's advocate. The faculty advisor can be changed by the resident, if necessary. First year residents should choose an advisor within their first three months of residency. Residents must inform the program coordinator of their faculty advisor.

In November and May, each resident must complete a mentoring plan (self-assessment and self-reflection) (Forms, pages 21-24) to identify their strengths, deficiencies and limits in knowledge and expertise, as well as set learning and improvement goals. Then, the resident must meet with their faculty advisor to discuss their self-assessment, at which time the assessment will be signed. The signed assessment must be submitted to the program coordinator by November 15 and May 15. The assessment will be reviewed with the Program Director during the 6-month evaluation (January and June). **The resident must submit the mentoring plan by the deadline to be eligible to receive $100 for their AAO travel fund (or interview time) for the 6-month review period**.

17. RESIDENT EVALUATION OF FACULTY, PROGRAM, AND ASSIGNMENTS

A. Faculty

Residents evaluate the full-time clinical faculty twice a year using an online evaluation system (www.new-innov.com). Research and affiliate/associate ("volunteer") faculty are evaluated once a year (May/June). To preserve anonymity, resident evaluations of the faculty are tabulated anonymously.

In December and June, each resident will participate in an evaluation of individual full-time clinical faculty in the areas of:

(1) Clarity of lectures
(2) Completeness of curriculum
(3) Effectiveness of lectures
(4) Organization of material
(5) Suggested improvements

The evaluations will not be submitted to individuals other than the Department Head and Program Director. A sample of the evaluation form for clinical faculty is found in the Forms section (pages 30-31). A sample of the form for research and affiliate/associate ("volunteer") faculty is also in the Forms section (page 29).

B. **Program**

Residents evaluate the overall residency program twice per year. A six-month evaluation of the program is completed in November (Forms, pages 32-33) on the online evaluation system (www.new-innov.com). All comments remain anonymous and are summarized into a single report that is provided to the Program Director and clinical faculty for review. In April or May, residents complete an annual review of the program (Forms, page 28) on the online evaluation system. Both evaluations are mandatory.

C. **Rotation**

Pre-Rotation Review: At the beginning (within the first week) of each rotation, the resident is required to review the goals and objectives for that rotation together with the attending, and confirm that they have done so online through New Innovations (see "Confirming Curriculum" in the Appendices for instructions, pages 10-13). The confirmation must be done within the first week of the rotation. **Residents who complete/confirm in a timely fashion may be eligible to receive $100 for their AAO travel fund (or interview time) for the 6-month review period. Travel funds will be reduced $25 if not submitted within the required timeframe.**

Evaluation: At the end of each rotation, the faculty will review the resident's performance using an online evaluation system (www.new-innov.com). Once the faculty has completed the evaluation, the resident will be notified that the evaluation is available for signature. **Residents who sign all evaluations in a timely fashion may be eligible to receive $100 for their AAO travel fund (or interview time) for the 6-month review period**.

18. FACULTY EVALUATION OF RESIDENTS

Each resident will meet at least twice a year with the Program Director for a formal evaluation of the resident's performance. A sample six-month resident evaluation by the faculty is found in the Forms section on pages 1-18. After the faculty complete an online individual evaluation of the residents, the information for each resident is summarized into a single report and provided to the Program Director. The evaluation will be signed by both the resident and Program Director during the six-month evaluation.

All evaluations will be shared with the resident in a confidential conference; strengths, deficiencies, and plans for the correction of deficiencies, if they exist, will be discussed. An **appeals** mechanism is provided for a resident should he/she feel that the evaluation is inaccurate or unfair. To this end, the resident may request a formal meeting with the Program Director, any or all Department faculty

members, and his/her faculty advisor. If the Department Head and/or Program Director then reviews and changes the evaluation, the prior evaluation will be destroyed.

In addition, at the end of each monthly rotation and quarterly (July-September, October-December, January-March, April-June) for other rotations (such as continuity clinic and senior rotations), the faculty will evaluate the resident's performance during the rotation. In the last few days of the rotation, the resident is responsible for meeting with the faculty and having an evaluation completed for that rotation. After the online evaluation is completed by the faculty and signed by the resident, the evaluation will be printed by the program coordinator and provided to the Program Director for review at the resident's six-month evaluation. Sample rotation evaluation forms are found on in the Forms section (pages 1-18).

The Ophthalmic Clinical Evaluation Exercise (OCEX) is a tool developed by the ABO taskforce to assess core residency competency in the areas of patient care skills, medical knowledge and interpersonal skills (*Ophthalmology* 2004;111:1271-1274). A one-page checklist (Forms, page 25) will be used during observed resident/patient encounters. It is expected that the evaluation will be performed with each resident at least annually.

To fulfill the ACGME mandate that ophthalmic residency programs teach and access all six competencies, residency programs need valid assessment tools to show that surgical competence has been achieved. The Phacoemulsification Assessment Tool: Resident Improvement Competency Keys (Forms, page 27) is designed to facilitate assessment and teaching of surgical phaco skills. Surgical procedures are broken down to individual steps and each step is graded on a scale of beginner, intermediate, and advanced. The Phacoemulsification Assessment Tool should be completed at the end of the case and immediately discussed with the resident to provide timely, structured, specific performance feedback.

PGY-2 and PGY-3 residents will have a Phacoemulsification Assessment Tool completed by the attending surgeon for **ALL** surgical phaco cases in which they assist, perform some steps of the procedure, or are primary surgeon for the case. PGY-4 residents will have **one** form completed **per operative session** for a surgical phaco case in which they are the primary surgeon. The form must be signed by both the resident and attending surgeon, and submitted to the program coordinator for placement in the resident's portfolio. It is the responsibility of the resident to obtain and submit the forms. **Residents who submit the forms as required may be eligible to receive $100 for their AAO travel fund (or interview time) during the 6-month review period.**

It will be the responsibility of the senior resident at SAVAHCS to videotape each one of his/her surgical cataract cases; at least one of these per operative session will be selected to be reviewed by the attending surgeon that same day, either between cases or at the end of the surgical session. The resident must submit three recorded cases per six months–one at the beginning, during the middle and at the end of the six-month period.

19. **OTHER EVALUATIONS OF RESIDENTS**

In addition to the faculty evaluations, the residents are evaluated by technicians and patients. The technicians complete a written evaluation (Forms, page 37) on a semi-annual basis and submit them to the program coordinator, who summarizes the information. The summary is reviewed at the resident's six-month evaluation with the Program Director.

On a monthly basis, the technician or faculty gives a questionnaire (Forms, page 26) to a patient(s) seen by the resident and requests the patient to complete and return to the program. A copy of all questionnaires are available for review at the resident's six-month evaluation with the Program Director.

20. **ORAL AND OKAP EXAMINATIONS**

A. **Oral/Written Examinations**

Senior residents will participate in one oral examinations ("mock orals") each year (April/May). The topics tested include anterior segment/optics, cornea/uveitis, glaucoma, neuro-ophthalmology, oculoplastics, pediatric ophthalmology, and posterior segment. The PGY-2 and PGY-3 residents will participate in a written examination each year (January/February). The Program Director will receive a written summary of each resident's performance, and will discuss the results of the exam with each resident individually.

B. **OKAP Examination**

All residents participate annually in the Ophthalmic Knowledge Assessment Program (OKAP) given by the ABO. The examination is taken at an authorized examination site. The results of each resident's examination will be used as one of the criteria for performance measurement.

Resident performance on the OKAPs will be the basis for the milestone defined by the ACGME (Medical Knowledge, MK-1; see table below).

Medical Knowledge Residents must demonstrate knowledge of established and evolving clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents must demonstrate level-appropriate knowledge in the following core domains: General Medicine, Fundamentals and Principles of Ophthalmology; Optics and Refraction; Ophthalmic Pathology and Intraocular Tumors; Neuro-Ophthalmology; Pediatric Ophthalmology and Strabismus; Orbit, Eyelids, and Lacrimal System; Cornea, External Disease, and Anterior Segment Trauma; Lens and Cataract; Refractive Management and Intervention; Intraocular Inflammation and Uveitis; Glaucoma; Retina/Vitreous.					
MK-1. Demonstrate level-appropriate knowledge					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Articulates knowledge of pathophysiology, clinical findings, and therapy for ophthalmic conditions routinely managed by non-ophthalmologists	Demonstrates basic knowledge of pathophysiology, clinical findings, and therapy for common ophthalmic conditions routinely managed by ophthalmologists	Demonstrates advanced knowledge of pathophysiology, clinical findings, and therapy for commonly encountered ophthalmic conditions and demonstrates basic knowledge of pathophysiology, clinical findings, and therapy for less commonly encountered conditions	Demonstrates advanced knowledge of pathophysiology, clinical findings, and therapy for less commonly encountered ophthalmic conditions	Educates junior resident and medical students and contributes to the body of knowledge of pathophysiology, clinical findings, and therapy for ophthalmic conditions

Individual scores will remain confidential, known only by the Department Head, Program Director, and respective resident. The results will be used by the Program Director as one of many criteria in evaluating resident performance. In addition, the results will be used by the Department in identifying programmatic strengths and weaknesses. Each resident will meet with the Program Director to discuss the results of their exam.

The OKAP examination reports individual subject scores, overall scores, and "core knowledge" scores as a percentile for all residents at the same level of training. If the resident scores below the 30th percentile on the overall OKAP exam, the resident will be required to read all subsections in which the score was below the 30th percentile. If the resident performs in the 30th percentile or

greater on the overall exam but below the 30th percentile on an individual subsection, the resident will be required to read the subsection in which the score was below the 30th percentile. The resident should meet with the faculty member who is responsible for the subsection. During the meeting, the resident will develop a written plan for study, along with a schedule of readings. The resident will keep a log of their reading schedule, including the date and time the reading started, the date and time the reading finished, and pages covered. Completion of the study program is reviewed with the Program Director at the 6-month review. Additional subsection testing may be required. **The resident who has an overall score below the 30th percentile on the OKAPs are forbidden from moonlighting and will not be eligible to apply for travel grants for presentations at conferences (such as ARVO and ASCRS)**.

Residents scoring above the 75th percentile in an individual subsection will be recognized for their achievement by notification of the faculty member responsible for that area and the Department Head. **Scoring below the 30th percentile will be reflected in the Department Head's letters of recommendation and the resident's summative evaluation.**

21. CLINICAL COMPETENCY COMMITTEE

The Clinical Competency Committee (CCC) will review all resident evaluations semi-annually (December and June). The CCC is also responsible for advising the Program Directors regarding resident progress, including promotion, remediation, and dismissal, and for preparing and assuring that the milestones for each resident are reported to the ACGME semi-annually. The CCC consists of at least three program faculty who are appointed by the program director.

22. INTERNATIONAL ROTATION

South Campus residents may participate in international rotations—one week in the 1st year and one week in the 2nd year.

1st Year (PGY-2) Resident

- Nogales with Dr. Maria Ramirez
- Spanish immersion
- One week (Monday-Thursday)
- Reimbursement for mileage/parking fee
- Program coordinator will arrange; notify if interested

Additional Opportunity (1 week)

- Must complete one week in Nogales in fall
- Nogales with Dr. Maria Ramirez
- One week (Monday-Thursday) in spring
- Reimbursement for mileage/parking fees
- Program coordinator will arrange; notify if interested

2nd Year (PGY-3) Resident

- Department-sponsored activity
- Transportation/lodging expenses usually covered by the program
- Not required to participate in Mexico

Additional Opportunity (1 week)

- Must participate in Department-sponsored activity
- Approval by Program Director and Department Head
- Meet University policies for international rotation – notify program coordinator at least 6 months in advance so required paperwork can be submitted for approval)
- Activity must occur after OKAPs
- Expenses not covered

23. PROMOTION (ADVANCEMENT)

Residents are advanced to positions of higher responsibility on the basis of evidence of their progressive scholarship and professional growth. This evidence includes satisfactory completion of rotations, documented attendance at educational activities, and an assessment of the resident's progress in achieving competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. This advancement is communicated to the GME Office by the annual submission of a promotion letter or summative evaluation (for graduating residents).

24. PROBATION AND DISMISSAL

In the event that a resident's overall progress is considered to be "unsatisfactory," he/she shall be placed on **probation**, but only after full consultation with the Department Head, Program Director, and faculty.

Probationary status shall be acknowledged in writing and accompanied by goals and objectives to be achieved in a reasonable amount of time (but in no case, greater than 6 months). If the identified deficiencies are not remedied during the probationary period, the resident may be subject to dismissal; the **appeals** mechanism noted in Section 18 and all the College of Medicine appeals mechanisms shall pertain should they be desired by the resident.

The UA College of Medicine Resident Physician Probation Procedures, Nonrenewal Procedures, and Suspension and Dismissal Procedures are kept on file (see program coordinator).

Time spent on probation will be made up at the discretion of the Program Director. A resident may be immediately pulled from surgery and put on probation if he/she is felt to pose a risk to patients.

25. PRACTICE PRIVILEGES AND OTHER ACTIVITIES OUTSIDE THE EDUCATIONAL PROGRAM

Moonlighting is discouraged because it detracts from the educational activities within the Department of Ophthalmology. Exemptions may be granted by the Program Director, in special circumstances. **Moonlighting may be done by a resident ONLY after consultation with the Program Director and Department Head.** Malpractice insurance coverage is provided by the University only for activities within the scope of a resident's educational curriculum; moonlighting activities are not covered. After approval, if it is found that moonlighting activities are interfering with learning, moonlighting must be discontinued. Moonlighting without permission is prohibited and is grounds for suspension and/or dismissal.

Residents who have received an overall score below the 30th percentile on their OKAPs, have received a "notice of deficiency," or are on academic probation are forbidden from moonlighting. Residents who do choose to moonlight must keep a log of their hours and report them to the program coordinator weekly, as well as enter the hours into duty hours in New Innovations.

Hours spent moonlighting are counted toward total duty hours and may be limited if total allowable hours worked in a given period is exceeded. All moonlighting hours MUST be recorded in your duty hours.

26. **BOARD ELIGIBILITY**

For a resident to be considered Board eligible, the Department Head must certify that the resident has satisfactorily completed the prescribed length of residency training, which is 36 months. The resident must also hold a valid and unrestricted license(s) to practice medicine in the United States. For details, see the ABO website (www.abop.org).

In the event that a resident has been placed on formal probationary status, the Department Head will consult with the Program Director and Department faculty to determine whether the time on probationary status shall be counted toward the Board of Ophthalmology's time requirement. Typically, time accrued while a resident is on official probation is **NOT** considered time "in good standing" in the program and is **NOT** usually applicable to the requisite 36 months of training. Additional training may be deemed necessary prior to granting certification of satisfactory completion of the residency program. The resident shall have the right to appeal as noted in Section 18.

27. **COMPLAINTS REGARDING WORK ENVIRONMENT**

The Graduate Medical Education Office and the Graduate Medical Education Committee strive to create an environment where residents can raise issues confidentially and without fear of retaliation. To this end, residents are provided several avenues in which they may communicate and exchange information on their working environment and their educational programs. First of all, residents are encouraged to discuss all issues with their Program Director, faculty mentor/advisor, Chief Resident and/or Department Head. Residents are encouraged to contact the GME Office at 626-7878 with any concerns about their ability to confidentially raise issues.

28. **COMMITTEES**

Residents are encouraged to participate in hospital committees. Each year, the residents select a representative and alternate to serve on the Graduate Medical Education Committee, an institutional committee charged with the responsibility of monitoring and advising on all aspects of residency education. Residents interested in participating in a committee should contact the program coordinator for information.

29. **COUNSELING SERVICE**

A counselor is available to discuss any issues of a personal or professional nature for residents and their families at no charge. To make an appointment, contact Dr. Gary Hellman at 626-7200 (press 1). Leave your name, program name, and a call back number when prompted. The appropriate housestaff counselor will response within 24 hours. For any emergencies or crises, please go immediately to the Emergency Department or call the Community Crisis Line at 622-6000.

30. **DRESS CODE**

At times when patient contact is anticipated, residents must dress and present themselves in a manner which is appropriate to the profession of medicine. Residents are expected to wear recently laundered white lab coats at their faculty's instruction, and name tags at all times while in the clinic. Residents should follow the general guidelines addressed in the Banner policy (see appendices; also available in the public resident files folder). Lab coats and laundry service for these coats are provided.

31. ADMINISTRATIVE SUPPORT

A secretary is not appointed for the residents, but administrative assistance is available as follows:

A. **Computer Issues**: Computers with software for word processing, graphics, presentations, and Internet access is available for use by residents in the resident office. Photo, slide, negative and document scanners are also available. Residents are expected to prepare their own documents. If problems occur with the computers or printer, please contact UA College of Medicine ITS at 626-8721.

VPN Access: For remote access to your files, it will be necessary to locate the specific location of your files. The first time accessing your files remotely, call the COM IT service desk for assistance. You can reach them at 626-8721 from 7:30 AM to 5:30 PM. The link for remote access is http://vpn.arizona.edu; requires your NetID username and password.

B. **Poster Printer**: A printer is available for printing research posters. The template for poster presentations is available on the Department's website at www.eyes.arizona.edu/deptforms.html ("Template for Posters"). When the document is ready for printing, submit the file to the program coordinator via email, USB drive, or CD-ROM.

C. **Travel**

To be eligible for reimbursement for travel expenses for national conferences, residents must submit the following information to the program coordinator: (1) name and dates of conference/course, (2) email confirmation for presentation, (3) planned airline itinerary, and (4) name and address for hotel. This information must be provided at least 30 days in advance to allow time for the travel to be authorized. Travel expenses may not be eligible for reimbursement if authorization was not obtained in advance.

Per University policy, there will be no reimbursement for alcoholic beverages. **Residents can ONLY be reimbursed for their OWN expenses**.

- ***AAO***: Third year residents who attend the AAO annual meeting will be granted up to three days of educational leave, and up to $850.00 for reimbursement of eligible travel expenses. Residents must use vacation for any additional days for this conference (not eligible for additional educational days). Residents must submit receipts for eligible travel expenses to the program coordinator within 30 days after their return. Receipts not returned within the deadline will not be reimbursed.

- ***Conference Presentations***: Residents who are granted travel funds for a presentation (paper, poster, etc.) at national meetings are eligible for up to two days educational leave (the day of the presentation, plus the day immediately before or after the presentation for travel). Residents must submit receipts for eligible travel expenses to the program coordinator within 30 days after their returns. Receipts not returned within the deadline will not be reimbursed.

- ***International***: South Campus PGY-2 residents who rotate in Nogales will be reimbursed for mileage and parking fees. Residents must submit departure/return time, mileage, and parking receipts within 30 days of the travel date. The resident is responsible for their own food and hotel accommodations.

  Hotel accommodations and most food will be provided for the residents who rotate in Kino Bay (or other designated location). Specific details will be provided when available.

D. **Departmental Purchases**: Any purchases (such as wet lab materials) that will be paid for by the Department must be approved by the Program Director. After approval is received, the purchase request must be submitted to the program coordinator who will inform you of purchase requirements (purchase order, credit card, etc.). Be sure to plan ahead, since it could take a couple of weeks (or longer) to get the paperwork processed before the purchase can be authorized.

32. PRE-DIPLOMA CHECKLIST

At the end of thirty-six (36) months, residents are to obtain initials documenting completion of the following pre-diploma checklist (see Forms, page 41) prior to receiving their diploma. Diplomas will not be handed out prior to the final day of the residency program.

33. POLICIES SPECIFIC TO INSTITUTION

A. BUMCT AND BUMCS

(1) Medical Records

Medical records, for both inpatients and outpatients, must be maintained in a timely fashion and according to BUMCT and BUMCS policies. All entries must be legible and complete.

The resident's 4-digit identification code **MUST ALWAYS** be affixed to his/her signature.

All new patients or initial examinations must include the following:

- Pertinent history and notation of allergies
- Best corrected vision
- Motility
- Visual field to confrontation
- External examination
- Slit lamp
- Intraocular pressure
- Fundus examination
- Impression
- Plan

A pre-operative exam and note by the staff or resident must be recorded within 30 days of surgery. The format is as follows, and all items must be present in a single note:

- Visual acuity with manifest refraction
- Manifest refraction
- Slit lamp examination OU
- Intraocular pressure OU
- Fundus examination
- Surgical indications (with specific functional complaints)
- Risk and alternatives discussed

(a) Operative notes on all resident surgeries and discharge summaries on all patients admitted by the resident must be dictated/entered by the residents; this is part of the educational experience.

(b) Operative notes must be dictated/entered on the day of surgery and reviewed by the resident and faculty before being signed and placed in the patient's medical record.

(c) Discharge summaries must be dictated/entered at the time of discharge and reviewed by the resident and faculty before being signed and placed in the patient's chart. At the time of surgery and discharge, all abnormal laboratory study and test results must be noted in a progress note and all these items must be addressed with an appropriate plan for follow-up.

All medical records must be completed as soon as possible after discharge and in no case more than seven (7) days after discharge.

(d) Delinquent medical records are a cause for disciplinary action within the Department. Records not cleared within one week will result in temporary cessation of surgical privileges.

(e) Within the Department, residents are required to document their clinical and surgical experience online. The scope of this responsibility is outlined in Section 14.

Orders on Patient Charts

(a) It is BUMCT and BUMCS policy that all orders on patients' charts be entered at the time they are given; however, some flexibility is provided by individual nursing stations as reasonable and appropriate.

(b) All signed orders, consult requests, progress notes, etc., must be accompanied by the physician's 4-digit identification code; this will facilitate the interpretation of illegible writing.

(c) When a verbal order is accepted by the floor staff, that order should be countersigned by the resident before leaving the hospital if the order is given during the daytime, or first thing in the morning if the order is given during the night.

(2) Department of Anesthesiology Guidelines for Patient Preoperative Preparation

NPO Guidelines*	
Ingested Material	**Minimum Fasting Period**
Clear liquids**	Stop **2** hours before surgery
Human milk	Stop **4** hours before surgery
Infant formula or non-human milk	Stop **6** hours before surgery
Light meal (e.g., toast and clear liquids)	Stop **6** hours before surgery
Heavy meal (e.g., fatty foods, meat, alcohol, large volume)	Stop **8** hours before surgery

*These guidelines apply to patients with normal gastric emptying who are scheduled for elective surgery. Patients with delayed gastric emptying (e.g., diabetic, obese, opioid use) may need longer period of fasting. Patients may be fasted longer than this for surgical indications, but

members of the Anesthesiology Department will not delay elective surgery for fasting if these guidelines are followed.

**Clear liquids= water, sugar water, apple juice, tea, Pedialyte, black coffee
Gastric tube feedings: stop clear liquids **2** hours before surgery; stop other liquids **6** hours before surgery
Jejunal tube feedings may be continued up until the times of surgery

Patients with normal gastric emptying who meet these criteria will be considered "fasted" for any elective procedure conducted under moderate sedation, deep sedation, general anesthesia, or major regional anesthesia at BUMC. These are the minimum acceptable fasting periods. Patients who have delayed gastric emptying may be instructed to fast for longer periods. Patients may also be instructed to be NPO longer for surgical indications, or to facilitate later changes in the time of surgery.

B. SAVAHCS

(1) Purpose

Residents rotate through SAVAHCS for one half-day continuity clinics per week during their first and second year of residency, and for nine months of the third year of their residency. Additionally, a first or second year resident manages the oculoplastic clinic. The third year residents who are rotating full-time through SAVAHCS return to the administrative offices of the Department of Ophthalmology for didactic lectures and conferences.

The clinic at SAVAHCS is considered a "resident clinic," and residents are supervised by faculty who act as "consultants" and are present at all times. This allows the resident the opportunity to take significant responsibility for patient evaluation and management. This "team approach" provides a very good educational experience at all levels within the training program. In addition, the clinics offer a wide variety of general patients in addition to concentrated exposure to subspecialty patients in the subspecialty clinics.

During the third year VA rotations, residents are expected to become adept at:

(a) Anterior segment examination techniques, including reading prescriptions and refracting
(b) Posterior segment examination techniques, including indirect ophthalmoscopy
(c) Cataract surgery
(d) Corneal surgery
(e) Glaucoma surgery
(f) Retina surgery
(g) Laser of eye disease
(h) Surgical management issues, both pre- and post-operatively
(i) Medical management of all ocular problems.

(2) Local Program Director

The Ophthalmology Section at SAVAHCS is under the direction of the Section Chief, Robert Lindberg, DO, and he administers the daily operations of the clinic. Issues which affect the overall program are brought to the attention of the Program Director and Department Head. These are dealt with at the Department level and changes must be approved by the Section Chief and the Program Director.

SAVAHCS is considered a Dean's hospital with academic programs under control of the UA College of Medicine. Ophthalmology is considered a section and, as such, is under the direct auspices of the Surgical Service. The Surgical Service takes an active role in overseeing the financial aspects of the Ophthalmology Service and is responsible for distributions of salary funds and purchase of equipment. The UA Department of Ophthalmology with the approval of the SAVAHCS administration and Surgical Service appoints all SAVAHCS faculty and the Program Director. Control of the SAVAHCS academic curriculum and resident assignments, and decisions in academic matters, are directed by the Section Chief who must have full approval by the Program Director and Department Head at the UA College of Medicine.

The teaching faculty are members of SAVAHCS and UA Department of Ophthalmology faculty. These faculty are consultants with or without compensation, and include Drs. Agrawal, Belin, Carrozza, Dryden, Lindberg, Pugazhendhi, Thomas, and Villavicencio.

The program at SAVAHCS is evaluated by the Department of Ophthalmology via the standard formal resident evaluation of rotations conducted twice a year by the Program Director, the annual overall evaluation of the teaching program, and the formal evaluation of the individual faculty teaching efforts.

(3) **Facilities**

The facility at SAVAHCS is well suited for the residents and faculty members who participate in the clinic. There are six fully equipped ophthalmology examination lanes. There is a separate laser facility in the clinic with a solid-state multi-wavelength laser, diode, Nd:YAG laser, SLT laser, and an infrared diode laser. Other equipment available includes: automated perimetry, digital fundus and anterior segment photography, specular microscopy, and fluorescein angiography. The eye clinic is equipped with A/B Scan Ultrasound, IOL Master, Cirrus ocular coherence tomography, and Pentacam anterior segment tomography,

The operating room is equipped with two Zeiss operating microscopes, two Centurion (Alcon) phacoemulsification units, an anterior/posterior segment vitrectomy unit (Alcon Constellation) with endolaser, and a video monitor on the operating microscope. The operating room has capabilities for all intraocular and extraocular ophthalmologic procedures.

(4) **Educational Experience**

The didactic lectures and clinical conferences take priority over all other activities except emergency patient care. The schedule is arranged so that there are no conflicts during lecture time or clinical conference time for any of the residents. The Chief Resident or his/her designee is assigned to take attendance at all clinical conferences and to turn in this attendance to the program coordinator. This is recorded electronically and periodically monitored by the Program Director. Attendance by the faculty at morbidity and mortality conferences and weekly rounds is expected and noted by the Department Head.

(5) **National Mandates/OSHA and National Quality Forum**

SAVAHCS implements all national quality forum initiatives, OSHA requirements, and other national mandates related to patient access and timely follow-up. All residents are expected:

- to know the national patient safety goals and the yearly updates, which can be found on TUCNET.
- to know the proper procedure for the emergency “codes” which are located above the printer in the front office.

- to know location of the fire extinguisher (in eye clinic laser room and in the back hallway across from the OmniCell room) and the code cart (adjacent to the nurses station in the medical subspecialty clinic).
- to comply with OSHA standards in their patient examining rooms.
- to comply with SAVAHCS confidentiality policy including NO patient identifiable material in paper format and, if used, with permission, the material must be locked at all times unless being visualized by the treating provider.
- to use universal protocol for all procedures.
- to be prepared for surprise inspections.
- to have reusable medical equipment (RME) compliant documentation on file at the VA and be signed off for competence
- to comply with care of equipment in the examining rooms, which is on a list on the back of each door.
- to have the date of expiration (28 days from opening date) marked on the bottle of all drops and reusable medication vials in the examining rooms. Which need to be locked in the room's med box when not in use. (If it is not marked, it must be thrown away during unscheduled impromptu inspections that occur every 1-2 months.)

The above is explained in the national patient safety, universal protocol and ambulatory care/surgery guidelines at the following:

- Accreditation Program: Ambulatory Health Care National Patient Safety Goals
  https://www.jointcommission.org/assets/1/6/NPSG_Chapter_AHC_Jan2018.pdf

- Accreditation Program: Office-Based Surgery National Patient Safety Goals
  https://www.jointcommission.org/assets/1/6/NPSG_Chapter_OBS_Jan2018.pdf

(6) **Medical Records Documentation**

There are specific components that must be completed on all EMR records of a visitation. These include:

- Service Connection – first box that should be reviewed and marked as needed
- Diagnosis – it is vital that all relevant diagnoses found on the patient exam be included
- Visit Type – needs to match the number/complexity of the exam diagnoses
- Procedure
- Diabetic Screening Update – needs to be completed on all yearly diabetic exams
- Signature

If these are not complete, the record is suspended and held for edits and will appear on a list to be completed. Please comply and develop good habits when you start.

(7) **Medical Library**

Lynne Flance is very helpful in finding and retrieving articles for patient treatment.

(8) **Shared Calendars**

a. ***Attending Call Calendar***: There is an attending call calendar that is set up, and all residents should be able to access to check call coverage.
   http://vaww.visn22.portal.va.gov/intranet/Tucson/ (see the Clinical Corner box)

b. ***Surgical Calendar***: All residents are given VA email access. There is a surgical scheduling calendar that is accessible to all residents via Outlook (VA email). As you book surgeries, check the faculty call calendar for vacation and then put surgery in appropriate booked spot. Try to be accurate in maintaining this calendar, as well as completing all SAVAHCS-required paperwork for booking of routine and emergency surgery.

c. ***Resident Clinic Calendar***: Designates clinic and OR assignments and supervisory faculty.

(9) **Non-VA Care Consults**

Non-VA Care consults must be scheduled with review and approval by the Section Chief. SAVAHCS requires that these are distributed equally between all contracted providers. However, specific providers may be requested if they are the sole provider, other providers are not taking patients, or other "special circumstances." Do not enter specific provider names in consults unless there is documentation of a need for a specific provider. Direct all consults for eyes to the attention of Carol Penick, RN.

(10) **SAVAHCS Patients After Hours/Weekends**

SAVAHCS urgent care and post-op patients ***must*** be seen at SAVAHCS. When seen at the University Ophthalmology Clinic no true medical record is established and ***the visit is legally considered not to have taken place at all***. There are obvious legal implications to this, and in particular, SAVAHCS provides liability coverage only for those services provided at SAVAHCS, or those performed under a contractual arrangement and with prior authorization of SAVAHCS administration. In addition, in the absence of a BUMC medical record, the University does not provide liability coverage.

For practical purposes, the only SAVAHCS patients who can be seen at the University Ophthalmology Clinic are those being referred for services that cannot be provided at SAVAHCS (ERG's, urgent IVFA's, certain subspecialty consultations, etc.), and these patients become registered at the University at that time.

SEEING ED PATIENTS AT SAVAHCS

1. If the resident is contacted by the ED, the *default action should be for the resident to go to the ED and evaluate the patient*. When the resident then comes to the VA and actually evaluates the patient, they are in a position to have access to the clinic schedule and should be able to find the most appropriate, or least-busy clinic in which to have outpatient follow up in the coming day(s).
2. Whenever possible, the on-call resident should schedule VA eye clinic follow-up into their own Continuity clinic, or the clinic of the senior resident on backup call, if needed. Communication between the junior and accepting senior resident is expected.
3. If the ED physician said that he/she just needs direction, that's fine. But if this is the case, the resident should have the ability to check availability in the eye clinics in order to guide patient follow-up, directly contacting the patient, if necessary.
    a. Do not, do not, do not – just tell the patient to show up to the eye clinic for evaluation the next morning.
    b. Do not, do not, do not – schedule a patient into an attending clinic without prior communication with that attending.
    c. Do not, do not, do not – schedule into an other-than-your-own resident clinic without prior communication with that resident.

4. In this vein, every resident should have off-site access to the VA system.
5. After an appropriate time/date/clinic in which to place the patient, the resident places a Return To Clinic (RTC) order into CPRS and makes sure the patient knows this. You may also consider letting the front desk know you wrote the order: Grant, Latisha L. (Latisha.Grant@va.gov), Davis, Holly A. (Holly.Davis5@va.gov) ; Aguero, Daniella A.Daniella.Aguero@va.gov.
6. For a list of conditions you definitely should be seeing in the ED, please refer to the 'Must Call' list. Everything on that list represents a condition in which you should have seen the patient in the ED.
7. When an ED physician gives you a description that you don't understand or seems a situation where a non-ophthalmologist could miss an important finding (which are many), the patient should be seen. Don't assume that the patient's condition is straightforward and can safely be seen the following day. Take ownership of the patient's condition.

(11) **Patient/Clinic Cancellation Policy**

There are to be NO cancellations of SAVAHCS individual patients or clinics without approval of the Section Chief and Program Director. This policy is necessary to meet the wait time requirements of the cataract mandate program. SAVAHCS policy is no clinic cancellations less than 45 days. Exceptions can be made for career and fellowship interviews and emergent personal issues (such as sick leave). See the Section Chief for exceptions.

When you need to cancel a clinic(s) at the VA, Clinics will NOT be cancelled less than 45 days in advance except for emergency situations and unplanned surgical cases.

- All requests for clinic cancellation must be submitted through the automated electronic program available on TucNet.
- The official date of the request will be the TucNet submission date.
- Care/Service Line Chiefs are required to review leave requests and ensure that clinics are not cancelled less than 45 days in advance.
- Care/Service Line approvals/denials to requests will be processed within 72 hours.

Steps for Clinic Cancellations

- Check your proposed days out on the wall calendar in the attending office – *only one resident per PGY year allowed out at any one time. If those dates are crossed off on the calendar, you are **not** within the 45-day window and emergency provisions apply.*
- Cancel your clinics: Submit an electronic request on TucNet (available only on desktops at the VA).
  - Do this when you are thinking about taking time off.
  - Rule is **45 days**
  - Print a copy.
- Email Monica to inform her not to schedule surgery.
  - Make sure you get a response.
  - Print and save a copy.
- Call Monica to ensure that your OR schedule is blocked.
- Submit paperwork to admin for approval for time out, if needed for things like authorized absence.
  - Email Robyn Whipple for the paperwork.
    - Dr. Kettelle has a board in his office to keep track of who is here and who isn't (like my wall calendar, but better).
    - If you are gone with no approval, then you are AWOL.
- One week before you are scheduled to leave:
  - Double check clinics to make sure they are ALL clear.

        - Double check OR schedule with AMSA.
    - 1-2 days before you leave:
        - Triple check clinic schedule.
        - Triple check OR schedule.
        - Make sure ALL of your charts and alerts are clear and any unfinished patient issues (biopsy results, imaging, follow ups) are taken care of or assigned to another provider.
        -

It is advisable to print a copy of your request for your records. This must be done BEFORE you hit the "Submit" button. **All requests must be submitted at least 45 days in advance**.

Also:

- All residents are expected to return to clinic on time even if surgery runs over. The attending can complete the case.
- Residents CANNOT leave clinic to go to surgery if there are patients waiting to be seen.
- Residents CANNOT reschedule patients already checked into the clinic and waiting to be seen because of time pressure.

(12) **Surgery/24-Hour Post-Op Patients**

- One-day post-op appointments should be made with patient at the time of pre-op visit.
- ***Residents must notify front desk personnel of any changes to post-op appointments prior to the patient's arrival in clinic.***
- When scheduling patient appointments during "off" hours, especially post-op patients, it is the resident's responsibility to arrange with patient and patient's family. A new visit must be created in CPRS at the time of visit.
- **ALWAYS** use VA email when communicating with VA patients (Secure Messaging is best for this purpose).

(13) **Patient Notes**

The **vital** first step in assuring proper documentation is to make sure CPRS notes are attached to the correct appointment.

You must click on the provider/location tab next to the patient's name at the top of the toolbar of the patient's chart to do this properly. The CPRS system rejects any annual appointments that do not have notes attached. These appointments have to be tracked and replaced. A new clinic visit can and must be created for any "off" hour visits. Residents will be shown how to create a new visit during orientation.

*****VERY IMPORTANT:** Additionally, CPRS notes created for the Emergency Department or INPATIENT visits need to be written as an Eye Clinic note, **not** an emergency department or inpatient note. To do this, you would again click on the New Note tab, and then type in 'TUC EYE OPHTH-URGENT', or Tuc Eye and scroll down to the Urgent designation and click it. Then, begin your note.

(14) **Triage Protocol**

Triages are a fact of life in any eye clinic. We strive to follow a "chain of command" method of process these when they come up daily. This is our process for handling triages:

1. Phone call comes to the MSA/call center. These personnel determine if it should be directed to optometry or ophthalmology. The protocol is default to optometry resident, unless
   (a) patient has been seen within 30 days by ophthalmology
   (b) surgical patient in the 90-day post-op window
2. MSA then initiates the triage note and alerts the triage tech (designated on the weekly tech schedule) to its presence. The MSAs should either send a Skype message or communicate directly to let the tech know a triage is available.
3. Tech would then call the patient and determine as much information about the problem as possible (intended to be a brief conversation).
4. Tech would then alert the resident responsible for the triages (asterisk'ed on the clinic schedule**)
5. The resident will then review the information and put an RTC in or communicate back with the tech for more information or direction, and let the MSAs know to contact the patient.
6. If there are issues with any of this, the tech is to get hold of the MOD for the eye clinic at that time.

Residents:
1. Your job is to note that there is a triage message from the tech, and
2. When you evaluate the information, determine if the patient needs to be seen same day, or can be scheduled into a NOT-overbooked clinic in the future. This may involve
   (a) calling the patient for more information
   (b) consulting with the MOD
3. Make those arrangements and notify the front desk.

The exception to this orderly process is the patient who shows up at the window. In that case, the MSAs will refer these to the triage tech for the information gathering and presentation to the triage resident.

<u>Normal Resident Triage Schedule</u>

Monday
AM retina resident
PM glaucoma resident

Tuesday
AM post 1 resident
PM preop resident

Wednesday
AM retina laser resident
PM post 1 resident

Thursday
AM general resident
PM general resident

Friday
AM MOD (check schedule)
PM post 2 resident

(15) **Dirty Instrument Policy**

Dirty instruments CANNOT be placed in the clean utility room (OmniCell room). Transport boxes are kept in the OmniCell room. The doctor also needs to take a transport box when they get an instrument out of the OmniCell. Once the instrument is dirty, it must be placed in the transport box and walked over to the Dirty Utility Room 2317 (across from the conference room; code 4531).

The doctor is not allowed to wear gloves while walking the box over. Once inside the dirty room, the doctor must don gloves to remove the instrument from the transport box and place it in the dirty "Eye Bin." Then, the doctor must get a cavi-wipe and wipe the inside and outside of the box. Then, take off their gloves, wash hands and then walk the box back to the OmniCell room for safe keeping.

(16) **Axial Length Calculations**

See the appendix for information on axial length calculations.

34. MEDICAL MARIJUANA

In 2010, Arizona voters passed Proposition 203 to legalize medical marijuana (MMJ) for "qualifying patients" with "debilitating medical conditions," including glaucoma. The law requires patients seeking medical marijuana to receive a "recommendation" from a "doctor" to receive a MMJ card. Implementation of the state law has been delayed by a lawsuit filed in U.S. District Court challenging the law's federal legality.

It is against federal law to prescribe marijuana and this should never be done. However, patients may request that residents recommend them for MMJ based on a glaucoma diagnosis. Medically, the position of the American Glaucoma Society is that ophthalmologists NOT recommend MMJ. Legally, federal law prevails at the VA, where policy is NOT to recommend MMJ. At Alvernon, BUMCS, and BUMCT, residents work under their medical training license through the Department, and Department policy is that residents may NOT, under any circumstances, recommend MMJ.